PARLIAMENT OF AUSTRALIA

No child left behind

Report into the Thriving Kids initiative

House of Representatives

Standing Committee on Health, Aged Care and Disability

December 2025

CANBERRA

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Acknowledgement

The Committee acknowledges the diverse communities who contributed to this inquiry, including individuals with lived experience of disability, advocacy organisations, and service providers. We recognise that language is powerful and evolving, and we have sought to make this report as accessible and inclusive as possible.

In preparing this report, the Committee has respected individual preferences for person-first and identity-first language, acknowledging that preferences vary between different disability communities and these choices reflect personal identity and pride.

Where possible, we have also reflected the language used in submissions received for this inquiry, to be true to how people described themselves. As a result, some language in this report may vary and is not always consistent.

We thank all contributors for sharing their perspectives and experiences. Our goal is to ensure that this report is not only informative but also accessible to all readers, regardless of ability, language, or background.

Foreword

Julia Gillard, as Prime Minister, introduced the legislation for the National Disability Insurance Scheme (NDIS) on 1 July 2013.

The scheme is publicly funded, not means tested, and it allocates funds to an individual, their guardian or a private plan manager to purchase goods and services from suppliers for disability support.

In 2024, legislation was passed to better manage the program costs. This latest legislation was introduced in response to the NDIS review which had raised concerns about fraud and poorly targeted support.

The NDIS is now a vital part of our social network and must be strengthened and preserved but how we do that takes time, thought, consultation and examination of the problems that are existing now and what may happen in the future.

As a paediatrician, seeing many families who had children with major disabilities, including physical or psychosocial disabilities and intellectual disabilities, I know how the advent of the NDIS gave certainty that their children would be cared for in the future after they are gone.

The NDIS was welcomed by many like myself working with children and adults with disabilities.

Paediatricians, nurses, disability support workers, psychologists, allied health workers and teachers all felt this was a huge time in history and were very supportive of the NDIS.

The NDIS was officially launched in July 2013. It moved through trial and transition phases to full scheme rollout across Australia by 2020. The NDIS now supports approximately 751,000 participants with an average national plan budget of $82,500 per participant.

The number of participants is increasing annually at around 9.5 per cent as is the budget. Most are children.

There is much conjecture as to why the numbers are increasing so quickly. Many children referred to the NDIS have developmental delays and/or autism. What is concerning is that the change is certainly multifactorial, however if current increases in spending are not altered NDIS spending will be over $100 billion per annum by 2032.

The ideals of the NDIS are important such as independence, choice, dignity, equity and inclusion however the scheme was rolled out with several structural flaws which continue to reduce the effectiveness of the scheme both in terms of its budget efficiency and providing support. This is particularly concerning for young children, as they are experiencing significant delays as well as poor coordination and non-evidence based supports.

The difficulties already mentioned in the NDIS for young children can be broadly summarised as:

1 Scheme organisation and management

   We have a public system that at its best works well at assessment and providing early intervention but such services have withered and in some cases disappeared with the advent of the NDIS and can be difficult to deliver in thin markets.

   We have, since the advent of the NDIS, developed a burgeoning private system that is very transactional, and therapy based and is very good at fostering its own business model. Registration of providers is important as is transparency and review owing to significant evidence of fraud and disfunction.

2 Clinical issues

   Who gets what supports and when? What does early intervention mean? How much therapy is enough? It is clear that navigating the system can be difficult and the most articulate can get the most support. Clearly supports differ for each individual child but they must be evidence based and delivered as much as possible locally and cost effectively.

3 Outcomes, data & evidence

   The collection of data about the children themselves, their families, what support they need and their outcomes are extremely important if we are to design a better system.

   However, obtaining this information is extremely difficult in the system at present and more needs to be done to make it more transparent, and evidence-based, in the future.

   Achieving the best possible outcomes for children and their families, and the taxpayer, is of course the paramount priority. This is best achieved through the appropriate collection of data and evidence, as it is imperative that decisions are made based on what works and what areas need to be rectified, strengthened, reduced or removed.

4 Education

   Aside from their parents and carers, children with major disabilities receive and rely on substantial support and care from their educators. Early education teachers and primary teachers play an enormous role in delivering life-long learning opportunities for children with a disability; however, the line is becoming increasingly blurred for these educators between being classroom teachers and being forced into therapist, counsellor, dietician etc roles for their students with a disability.

> Some indicators have found that approximately 200,000 students in public schools have been identified as having a disability, however they receive no additional funding to assist them, and their teachers, in the classroom.
>
> Therefore, it is now more important than ever that the education and health sectors work together, rather than parallel to each other, as a student’s health outcome, and their academic outcomes, are as important as each other.
>
> Parents and educators recognise significant roadblocks in accessing support as children transition through the different stages of education. It is very important that children with mild and moderate developmental difficulties receive support in the transitional stages as they progress into early childhood education, primary education and secondary education if they are to receive the optimal benefit from our education systems.

As has been seen, the advent of the NDIS has led to a number of changes to what were existing systems and to the rise of private providers and the diminution or disappearance of publicly funded supports, run by Federal, State or Territory jurisdictions or not for profit organisations.

The NDIS has subsequently been described as “the only game in town”, “the only lifeboat in the sea” or “the only port in the storm”. It has become very transactional and diagnosis focused leading to overdiagnosis, upgrading of diagnosis and a lack of evidence-based support. It has also led to significant delays in children accessing support, as they wait long times for assessment and diagnosis.

This is particularly true for the socially, economically and geographically isolated.

It is imperative that the NDIS be maintained and indeed strengthened to provide support for all people with severe disability.

Since its advent however, resources for people, including children with mild or moderate disabilities (and these are very subjective definitions) have become dependent on NDIS enrolment and has created significant delays in support being provided, particularly for high risk and high needs groups.

These include a range of children, particularly in some Aboriginal and Torres Strait Islander communities, children in out of home care, children whose parents lack financial resources or are from culturally and linguistically disadvantaged communities.

The announcement by the Federal Minister for Health, the Hon. Mark Butler MP, about the Thriving Kids initiative on the 20th August 2025 did create anxiety amongst a number of groups including parents and providers. However, the vast majority of stakeholders have been extremely supportive as they recognise the importance of early intervention, equity of access and evidence based policy.

I recognise this is a very important Inquiry and that we do already have publicly and not-for-profit funded systems that have provided services described as “foundational supports” for decades, as well as private paediatricians, allied health workers, educators disability support workers and nurses who also have long term involvement in producing care and support to children in whom developmental concerns have been raised.

They also will be important in providing ongoing supports but it is important that evidence-based interventions are followed and that interventions should be equitable and accessible across the country.

There are models of care that do provide services in rural, regional and remote areas, e.g. Royal Far West, Royal Flying Doctor Service, Angel Wings and many others.

These services can be strengthened and enhanced in virtually every State and Territory.

In some areas, ‘Flying Squad’ multidisciplinary teams lead by a developmental paediatrician (or other developmental experts) could use a hub and spoke model of care. This could provide assessment, training and help if there were concerns raised about children in regional, rural and remote areas.

Digital support, such as the Triple P parenting program, as well as programs provided by Karitane, Tresillian, Aspect and many others can also be provided on digital programs around the country.

The Thriving Kids initiative is hugely important to the future of our children and I thank the Health Minister for allowing our Committee to examine the needs and how to implement them.

I would like to thank all those who made submissions (almost 500 groups and individuals) and who appeared at public hearings. I would like to thank my many paediatric, health and education colleagues who have given me advice about how to proceed and how to improve outcomes for children and families who require support.

I would like to thank also everyone who has helped families deal with the needs of their children who have disabilities, most of who go above and beyond expectations to brighten the future for those children and their families.

I would like to thank the Committee members, all of whom were very engaged, positive and supportive of the Committee’s work. I would like to give special thanks to my esteemed Deputy Chair, Dr Monique Ryan MP, for her dedication and ongoing support of this Inquiry, for which I am deeply grateful.

I am also very grateful for the hard work, diligence and intelligence of the Committee Secretariat, especially Mr Paul Zinkel and Ms Kimberley Elliott, without whom we could not have completed our work.

I hope that our report is viewed in a positive light and that it helps improve access to supports for children who have physical, psychosocial or intellectual disabilities or delays, and contributes to making the NDIS sustainable in the long term.

We need to also make the NDIS and Thriving Kids transparent and allow scrutiny, with the ability to embed mechanisms to improve the systems over time.

As a paediatrician and as the Chair of this Committee, I firmly believe that the NDIS must be strengthened and protected to ensure it is sustainable in the future. This is imperative for the children and their families of today, and those of tomorrow.

Dr Mike Freelander MP
Federal Member for Macarthur
Chair

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Dr Mike Freelander MP	Macarthur, NSW

Deputy Chair

Dr Monique Ryan MP	Kooyong, VIC

Members

Ms Jodie Belyea MP	Dunkley, VIC
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Ms Anne Stanley MP	Werriwa, NSW

Terms of reference

The House of Representatives Standing Committee on Health, Aged Care and Disability will inquire into and report on the Thriving Kids initiative with the aim to:

- Examine evidence-based information and resources that could assist parents identify if their child has mild to moderate development delay and support parents to provide support to these children.
- Examine the effectiveness of current (and previous) programs and initiatives that identify children with development delay, autism or both, with mild to moderate support needs and support them and their families. This should focus on community and mainstream engagement, and include child and maternal health, primary care, allied health playgroups, early childhood education and care and schools.
- Identify equity and intersectional issues, in particular, children who identify as First Nations and culturally and linguistically diverse.
- Identify gaps in workforce support and training required to deliver Thriving Kids.
- Draw on domestic and international policy experience and best practice.
- Identify mechanisms that would allow a seamless transition through mainstream systems for all children with for children with mild to moderate support needs.

List of recommendations

Recommendation 1

4.278 The Committee recommends that the Thriving Kids Advisory Group undertake an inclusive co-design process and embed evidence-based policies and interventions, as well as the ability to formally review progress on these processes.

4.279 Included in this process should be recognised organisations and peak bodies with an established history in providing services and support for children with physical or psychosocial disabilities and intellectual disability, as well as individuals with lived experience of disability or care of persons with disability, First Nations, and culturally and linguistically diverse backgrounds.

Recommendation 2

4.280 The Committee recommends that the Australian Government establish a Thriving Kids Advisory Council, to advise Federal, State and Territory governments, and disability ministers, on the implementation of the Thriving Kids initiative.

Recommendation 3

4.286 The Committee recommends that the Thriving Kids initiative be implemented in phases and that the Thriving Kids Advisory Group consider appropriate safeguards to prevent loss of supports for children.

4.287 The Committee also recommends that the National Disability Insurance Scheme Act 2013 be amended to ensure that foundational supports are appropriately implemented.

Recommendation 4

4.292 The Committee recommends the Australian Government establish an Inspector-General of the National Disability Insurance Scheme.

Recommendation 5

4.296 The Committee recommends that Thriving Kids initiative include a provider registration process that is streamlined and proportionate. The process should

recognise and leverage existing registrations under other schemes for similar services, reducing duplication and administrative burden while maintaining appropriate safeguards and quality standards.

Recommendation 6

4.302 The Committee recommends that that the government adopt a commissioned service model for the Thriving Kids initiative to ensure appropriate and quality services are delivered across all jurisdictions. Wherever possible already existing services with appropriate regulation and safeguards should be used.

Recommendation 7

4.307 The Committee recommends that the Australian Government fund and implement improvements to technology for access to online and health advice services, with additional focus on improving these services in regional, rural and remote areas.

Recommendation 8

4.312 The Committee recommends that dedicated funding and staffing be allocated in the development of the Thriving Kids initiative to ensure the integrity and effectiveness of data management. Specifically:

- **Adequate resources should be provided to implement systems and processes that guarantee data accuracy, reliability, transparency and adherence to Indigenous Data Sovereignty principles.**
- **Data infrastructure must support interoperability, enabling seamless sharing and integration across relevant platforms and agencies to avoid duplication and enhance efficiency.**
- **Data collection and analysis should be structured to inform decision-making and drive best possible outcomes for families and children in need.**

Recommendation 9

4.316 The Committee recommends that there should be a single portal of entry with multiple referral pathways for all children with developmental concerns whether they are in the NDIS or not.

4.317 The Committee also recommends that the Thriving Kids Advisory Group ensures that participation in the Thriving Kids initiative will not preclude an individual from seeking to participate in the National Disability Insurance Scheme, once their time in the Thriving Kids initiative has concluded.

Recommendation 10

4.321 The Committee recommends that the Australian Government refer an inquiry to the Committee to undertake a rapid review of the Thriving Kids initiative after twenty-four months in operation. The Committee further recommends that the review be presented to the House in accordance with Standing Orders.

Recommendation 11

4.322 The Committee recommends that a consultative group of professional organisations (including allied health peak bodies, paediatricians, child psychiatrists, child & family nurses, early childhood educators, and school educators) and parents involved in the system themselves, be part of the review process.

Recommendation 12

4.326 The Committee recommends that the Australian Government works with the States and Territories to fund support improvements for children and families during times of transition. These would support families when children is transitioning into early education, from early education into primary education, or from primary education to higher education, as appropriate.

Recommendation 13

4.333 The Committee recommends that the Australian Government use both existing and new resources to work with the States and Territories to support children and their families in regional, rural and remote areas.

4.334 This is particularly important for children in regional, rural, and remote areas who have developmental issues and who can be supported through various means, such as using multidisciplinary teams using a hub and spoke system in regional, rural and remote areas.

4.335 By increasing funding and resources to already existing organisations who can deliver through a hub-and-spoke system, these supports can be made more readily available and therefore can improve equitable access for these children and their families, thereby ensuring that cost and distance is not a barrier.

Recommendation 14

4.341 The Committee recommends that workforce and resources be developed across all areas of support for families to navigate an extremely complex system and that, wherever possible, support should be provided by a range of workers to ensure equitable access for all, including:

- **regional, rural and remote areas, CALD and Indigenous communities, children in out-of-home care, parents and carers with disabilities themselves, and other high-risk communities.**

Recommendation 15

4.345 The Committee recommends that a separate item number, identical to the yearly review process available to geriatricians, be made available to paediatricians to conduct a yearly review for their patients, with case conferencing with other health professionals and educators involved.

4.346 The Committee also recommends that a child development check item number be available for GP's and allied health professionals, as well as similar childhood development checks be made available for early childhood educators, child and family nurses and community nurses in regional, rural and remote areas. This way, all children can have this as another portal of entry into the Thriving Kids initiative.

Recommendation 16

4.347 The Committee recommends that the Australian Government work with state and territory governments and the non-government school sector to increase transparency of the Nationally Consistent Collection of Data and the Schooling Resource Standard (SRS) – Students with Disability loading to better identify the need for this funding and ensure it is effectively targeted and used as intended.

1. Introduction

1.1 Australia's disability support ecosystem is a multi-layered and highly interconnected system involving federal, state, and local government agencies, non-government organisations, private providers and community-based initiatives. It encompasses a broad spectrum of programs and funding mechanisms designed to meet diverse needs—from early childhood intervention and education supports to health, housing, and employment services. This complexity stems from overlapping responsibilities across jurisdictions, fragmented service delivery models and the coexistence of mainstream and specialist systems.

1.2 In a response to the complexity of the system, 'people with disability, community organisations, advocates and governments worked hard to make disability reform a reality.'[1] In 2008, a cooperative approach by Australian governments to improve disability support, the National Disability Agreement, was signed. In 2011, the Council of Australian Governments (COAG) endorsed the National Disability Strategy.

1.3 In 2011 the Productivity Commission undertook an inquiry into a National Disability Long-term Care and Support Scheme. The Productivity Commission found:

> The current disability support system is underfunded, unfair, fragmented, and inefficient, and gives people with a disability little choice and no certainty of access to appropriate supports. The stresses on the system are growing, with rising costs for all governments.
>
> There should be a new national scheme — the National Disability Insurance Scheme (NDIS) — that provides insurance cover for all Australians in the event of significant disability. Funding of the scheme should be a core function of government (just like Medicare).[2]

1.4 On 1 July 2013, the *National Disability Insurance Scheme Act 2013* (Cth) came into effect, and the National Disability Insurance Agency (NDIA) was established to administer the scheme.

1.5 On 18 October 2022, then Minister for the National Disability Insurance Scheme (NDIS), the Hon Bill Shorten MP, established an Independent Review of the NDIS to examine the design, operations and sustainability of the scheme, including markets and workforce.

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[1] National Disability Insurance Scheme (NDIS), History of the NDIS, https://www.ndis.gov.au/about-us/history-ndis (accessed 26 November 2025).

[2] Productivity Commission Inquiry Report, *Disability Care and Support*, *Overview and Recommendations*, No. 54, 31 July 2011, p. 2.

1.6 This review followed multiple inquiries and reviews into the NDIS that have made a range of recommendations for change, including:

- Productivity Commission Review of NDIS Costs (2017)[3]
- Tune Review of the National Disability Insurance Scheme Act (2019)[4]
- 16 reports from the Joint Standing Committee on the NDIS.[5]

1.7 The final report of the National Disability Insurance Scheme Review, published in December 2023, called for:

> …a new system of supports for children outside the National Disability Insurance Scheme (NDIS). The Review called for improved accessible and inclusive mainstream supports, investment in more development- and disability-specific supports, and a new NDIS early intervention pathway for children.
>
> The Review found that developmental differences and delays are not always identified early in a child's life, when early intervention can make a big difference. Once identified, many children and families struggle to get the support they need, when they need it most.[6]

1.8 The Review made 26 recommendations and 139 supporting actions, including:

> - Invest in foundational supports to bring fairness, balance and sustainability to the ecosystem supporting people with disability.
>   - National Cabinet should agree to jointly invest in a capacity building program for families and caregivers of children with development concerns and disability.
>   - National Cabinet should agree to jointly invest in early supports for children with emerging development concerns and disability.[7]
> - Increase the scale and pace of change in mainstream and community inclusion and accessibility and improve the connection between mainstream services and the NDIS.
>   - All Australian governments should take steps to protect the right to inclusive education for children with disability and developmental concerns in early childhood education and care and schools.
>   - The National Disability Insurance Agency and the Department of Education, with state and territory education and disability agencies, should develop a plan to better connect the NDIS and school education systems and improve educational outcomes for children with disability.

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[3] NDIS Review, *Independent Review into the National Disability Insurance Scheme*, 2023, p. 238.

[4] NDIS Review, *Independent Review into the National Disability Insurance Scheme*, 2023, p. 21.

[5] NDIS Review, *Independent Review into the National Disability Insurance Scheme*, 2023, p. 179.

[6] Department of Health, Disability and Ageing, Thriving Kids Fact Sheet, 17 October 2025, p. 1.

[7] NDIS Review, *Independent Review into the National Disability Insurance Scheme*, 2023, p. 4.

    - All Australian governments should agree as a matter of priority to expand universally available child development checks, to ensure the early identification of children with developmental concerns and disability and enable early intervention.[8]
- Create a continuum of support for children under the age of 9 and their families.
    - National Cabinet should agree to jointly invest in a continuum of mainstream, foundational and specialist supports to address the needs of all children with disability and developmental concerns.
    - The National Disability Insurance Agency should reform the pathway for all children under the age of 9 to enter the NDIS under early intervention requirements.
    - The National Disability Insurance Agency should introduce a more consistent and robust approach to assessing developmental delay.
    - The National Disability Insurance Agency should change the basis for setting a budget to a whole-of-person level, and introduce a new needs assessment process to more consistently determine the level of need for each child and set budgets on this basis.
    - The National Disability Insurance Agency, in partnership with the Department of Social Services and the National Disability Supports Quality and Safeguards Commission, should require early intervention capacity building supports for children be based on best practice principles and evidence.
    - The National Disability Insurance Agency should develop and implement an approach for ongoing monitoring and evaluation of the effectiveness of early intervention for children.
    - The National Disability Insurance Agency should implement reforms to support the continuum and pathway for children using an iterative, inclusive approach to design and testing, and ensure participants experience a smooth transition to the new arrangements.[9]

1.9 At his National Press Club address on 20 August 2025, the Minister for Disability and the National Disability Insurance Scheme and Minister for Health and Ageing, the Hon Mark Butler MP, stated that the Government proposed to ‘return the scheme to its original purpose’ by ‘supporting people with significant and permanent care and support needs’ and ensuring the scheme becomes financially sustainable.[10]

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[8] NDIS Review, *Independent Review into the National Disability Insurance Scheme*, 2023, p. 5.

[9] NDIS Review, *Independent Review into the National Disability Insurance Scheme*, 2023, pp. 4-8.

[10] The Hon. Mark Butler MP, Minister for Health and Ageing, ‘Securing the Future of the NDIS’, Speech, National Press Club, 20 August 2025, pp. 3-4.

1.10 The Minister elaborated:

> Only around 1 in 50 people have significant and permanent disability – hence the need for a bespoke Scheme like the NDIS.
>
> But 10 in 50 young children experience developmental delay or autism – mostly at mild to moderate levels.
>
> That's a broad-based, mainstream issue that should be supported by broad-based, mainstream services.[11]

1.11 In his address, the Minister added that the 'NDIS model just doesn't suit their needs' and that 'many of those children are then being over-serviced.'[12]

1.12 The Minister announced that the Government would establish a Thriving Kids initiative, adding:

> Children with mild to moderate developmental delay or autism need a robust system of supports to help them thrive.
>
> A Program for Thriving Kids.[13]

1.13 Thriving Kids' aim is to focus on the early identification of 'developmental concerns' and the establishment of 'a national system of supports for children aged 8 and under with developmental delay and disability and low to moderate support needs and their families'.[14]

1.14 The initiative aims to ease pressure on the NDIS by offering earlier, more accessible interventions through mainstream services like GPs, early childhood education, playgroups and community health centres. The Minister stated:

> Diverting this group of kids over time from the NDIS is an important element of making the scheme sustainable and returning it to its original intent.[15]

1.15 According to the NDIS Quality and Safeguards Commission, 'more than 739,000 participants receive support from the National Disability Insurance Scheme (NDIS) with approximately 23% being children under the age of nine.'[16]

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[11] The Hon. Mark Butler MP, Minister for Health and Ageing, 'Securing the Future of the NDIS', Speech, National Press Club, 20 August 2025, pp. 11-12.

[12] The Hon. Mark Butler MP, Minister for Health and Ageing, 'Securing the Future of the NDIS', Speech, National Press Club, 20 August 2025, p. 10-11.

[13] The Hon. Mark Butler MP, Minister for Health and Ageing, 'Securing the Future of the NDIS', Speech, National Press Club, 20 August 2025, p. 12.

[14] Department of Health, Disability and Ageing, Thriving Kids, https://www.health.gov.au/our-work/thriving-kids (accessed 27 November 2025).

[15] The Hon. Mark Butler MP, Minister for Health and Ageing, 'Securing the Future of the NDIS', Speech, National Press Club, 20 August 2025, p. 12.

[16] NDIS Quality and Safeguards Commission, *Submission 377*, p. 1.

1.16 The Australian Government has committed to contributing $2 billion over 5 years towards the initiative, with the final program design to be settled between the Australian Government and state and territory governments.[17]

1.17 The Thriving Kids Fact Sheet provided by the Department of Health, Disability and Ageing states:

> Design is being informed by the findings of the Independent Review into the NDIS, national consultation on Foundational Supports held at the end of 2024 and continuing community consultation across multiple jurisdictions.
>
> Minister Butler will establish the Thriving Kids Advisory Group, co-chaired by Professor Frank Oberklaid. This will provide expert advice to the Minister around the program design and implementation arrangements over the coming months.[18]

1.18 The NDIS is only one component of a wider ecosystem that includes foundational supports, mainstream health and education services, and targeted programs such as the National Early Childhood Program (NECP) and the Early Childhood Targeted Action Plan (TAP) under Australia's Disability Strategy 2021–2031. These initiatives aim to ensure that children with disability or developmental concerns—and the families who care for them—receive timely, coordinated, and culturally responsive support.

About the Inquiry

Conduct of the inquiry

1.19 On 2 September, the House of Representatives Standing Committee on Health, Aged Care and Disability adopted an inquiry into the Thriving Kids initiative referred by Minister Butler.

1.20 On 4 September 2025, the Committee issued a media release announcing the inquiry and called for submissions.

1.21 The Committee invited submissions from a range of individuals and organisations with an interest in the current support systems available through the NDIS. This included federal and state government departments and agencies, industry groups and peak bodies, academics, health practitioners, medical organisations and the general public.

1.22 The Committee received 404 submissions, and an additional 19 supplementary submissions. The full list of submissions is at Appendix A.

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[17] Thriving Kids | Australian Government Department of Health, Disability and Ageing, https://www.health.gov.au/our-work/thriving-kids

[18] Thriving Kids Fact Sheet https://www.health.gov.au/sites/default/files/2025-08/thriving-kids-fact-sheet.pdf

1.23 Given that many submissions contained personal health-related information, the Committee asked individuals who lodged submissions to confirm that they would be comfortable with their submission being published on the Committee webpage.

1.24 The Committee also published a 14-question survey on its website for individuals and organisations to complete. The survey assessed experiences about support services available to help children with disability including developmental delay and autism.

1.25 The Committee received 1,194 survey responses by the deadline of 10 October 2025.

1.26 The Committee held seven days of public hearings:

- 3 October 2025 – Canberra, ACT
- 10 October 2025 – Canberra, ACT
- 20 October 2025 – Sydney, NSW
- 21 October 2025 – Melbourne, VIC
- 7 November 2025 – Canberra, ACT
- 17 November 2025 – Canberra, ACT
- 28 November 2025 – Canberra, ACT

1.27 A list of witnesses who provided evidence during these public hearings is at Appendix C. Transcripts of all public hearings are available on the Committee's website.

1.28 The Committee consulted widely throughout the inquiry and received submissions from individuals and organisations from every state and territory across Australia, including from many people living in regional, rural and remote areas.

1.29 In recognition of the high level of community interest in this inquiry, the Committee continued to consider contributions received after the submission deadline of 3 October 2025 on a case-by-case basis.

1.30 The Committee appreciated the strong public engagement in this inquiry, including from many individuals who have not previously participated in House of Representatives parliamentary committee inquiries.

1.31 The Committee greatly valued receiving informative submissions from individuals, family members, patient advocacy groups and peak bodies from small and large groups who spoke of changes needed to make the Thriving kids initiative more equitable and efficient.

Accessibility

1.32 The Committee was conscious of the importance of hearing first-hand from a diverse range of stakeholders, particularly people with lived experience of caring for children with developmental delay and disability with low to moderate support needs.

1.33 The Committee approached the inquiry with a focus on ensuring the accessible participation of stakeholders engaging in the inquiry and implemented a range of measures to support this. These measures included:

- posting media releases about the inquiry, public hearings and the invitation to submit to the inquiry on multiple sites including the inquiry webpage, X (Twitter), Facebook and Instagram
- handling inquiries and correspondence in a range of formats to assist some organisations/individuals who prefer receiving information in writing rather than via telephone
- developing a survey for individuals who are not familiar with the parliamentary inquiry process to provide input into the inquiry in a more accessible way
- accepting submissions to the inquiry in any format including Aboriginal and Torres Strait Islander and other languages, AUSLAN, and audio-visual evidence
- accommodating late submissions received to the inquiry
- contacting witnesses to ask about their accessibility needs for public hearings and offering for witnesses to appear virtually
- accommodating physical disability needs and individuals with sensitivities by being mindful of venue inclusions such as accessible bathrooms, disability parking, breakout rooms, a quiet space and natural light, clearly identified accessible signage, to name a few
- organising AUSLAN interpretation for public hearing witnesses when requested
- including a final, open invitation to people to appear to give evidence.

Report structure

1.34 This report is structured into 4 chapters, including this introduction.

1.35 Chapter 2 provides an overview of the NDIS, early childhood education and care, and supports available under the Australian education system including background, roles and challenges for each.

1.36 Chapter 3 examines evidence related to equity and inclusion received throughout the inquiry.

1.37 Chapter 4 considers the Thriving Kids initiative, and comparisons to existing programs and perspectives that should be taken into account when developing the initiative.

Acknowledgements

1.38 The Committee would like to thank everyone who completed the survey, provided written submissions, or gave evidence at public hearings.

1.39 This inquiry was sensitive, complex and technical. It required the Committee to have a comprehensive understanding both of the sector and of the experience of participants and service providers in it, as well as an understanding of what is proposed under the Thriving Kids initiative, before the Committee could consider making any recommendations aimed at addressing identified gaps.

1.40 This inquiry represents an opportunity to inform the Thriving Kids initiative, with a view to ensuring that it is fit for purpose and informed by a comprehensive understanding of the sector and the short- and long-term needs of stakeholders.

1.41 However, two issues have continually been raised in evidence that have impacted on the capacity of inquiry participants and the Committee to provide informed advice regarding potential benefits, opportunities, risks and gaps on the initiative:

- at the commencement of the inquiry and at the time of reporting, there is limited information available about what is being considered in the design of the program.
- the lack of adequately clear information and granular data about the sector as it currently operates, and about support for participants navigating it who are at varying levels of vulnerability.

1.42 Noting those challenges, the Committee is grateful to all who participated in the inquiry, particularly those who shared lived experience engaging with the challenges and complexities of the sector and who provided recommendations to ensure that future participants in much needed initiatives like Thriving Kids have a better experience.

2. The current ecosystem of supports for Australian children

2.1 The proposed Thriving Kids initiative has evolved against a backdrop of services provided at the Commonwealth and state/territory levels by the government through the health system, including the NDIS, the early childhood care system, and the education system. Support services for children with disability are also provided through the not-for-profit sector and other private providers.

2.2 This chapter sets out the current disability support landscape for children and their carers. It begins by providing a background of the sector prior to the NDIS, before setting out an overview of the establishment, framework, cost and profile of participants of the NDIS.

2.3 The chapter then discusses early childhood intervention and early childhood education and care, and how they are presently configured to support children with developmental delay, autism and developmental concerns including opportunities to enhance transition to education supports for children.

2.4 Supports for children available in Australia's education system is discussed, outlining existing school programs designed to support children with additional needs. This discussion includes programs agreed by Commonwealth and state and territory governments.

2.5 The chapter then moves to examples of additional support programs available for children and their families, some of which are provided by the Commonwealth directly, and others that have been developed by non-governmental organisations and are available in the community. These programs are only a sample of available programs. They include Inklings, Triple P, PlayConnect+ Project and the STaR Early Years Program.

2.6 The chapter concludes with an overview of the 2023 review of the NDIS focusing on the recommendation to enhance foundational supports, which foreshadowed the Thriving Kids initiative.

The National Disability Insurance Scheme

Supports prior to the establishment of the NDIS

2.7 In 2007, the Australian Government was one of the first signatories to the United Nations' Convention on the Rights of Persons with Disabilities (CRPD), which was ratified by Australia in 2008.[1]

2.8 In 2008, the Australian Government, along with all state and territory governments signed a National Disability Agreement (NDA). In the same year, the Early Intervention Services for Children with Disability (EISCD) introduced a combination of diagnostic, therapeutic and education intervention services.

2.9 The objective of the EISCD was to provide access to early intervention services for eligible children to assist them achieve their potential. There were two EISCD components with similar service delivery arrangements, the:

- Helping Children with Autism (HCWA) package which commenced in 2008 and targeted children with autism, and
- Better Start for Children with Disability (Better Start) initiative, which commenced in 2011 and targeted children with one or more of 16 disabilities.[2]

2.10 The program was demand-driven with eligibility based on administrative and diagnostic requirements. It operated to expand services delivered under the NDA and was one of several disability initiatives that would eventually transition to the National Disability Insurance Scheme (NDIS).[3]

2.11 The Australian Government committed $608 million to the EISCD between 2008 and 2016. This included $436 million allocated to HCWA from 2008 and $172 million for Better Start from 2011. The Department of Social Services (DSS) had overall responsibility for the program.[4]

2.12 In 2013 the National Disability Insurance Agency (NDIA) was established, and the *National Disability Insurance Scheme Act 2013* came into effect.[5] The objective of the

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[1] Australian Human Rights Commission, *United Nations Convention of the Rights of Persons with Disabilities (UNCRPD)*, December 2012, https://humanrights.gov.au/know-your-rights/rights-of-individuals/disability-rights/disability-rights/international-opportunities-and-the-crpd/united-nations-convention-rights-persons-disabilities-uncrpd (accessed 1 December 2025).

[2] Australian National Audit Office, *Early intervention Services for Children with Disability,* Auditor-General Report No. 24 2015—16, p. 7.

[3] Prior to the establishment of the NDIS, further legislative reforms were introduced in 2011. The National Disability Strategy 2010–2020 was also established in 2011. Australian National Audit Office, *Early intervention Services for Children with Disability*, Auditor-General Report No. 24 2015—16, p. 7.

[4] Australian National Audit Office, *Early intervention Services for Children with Disability,* Auditor-General Report No. 24 2015—16, p. 7.

[5] NDIS Website, *History of the NDIS*, 12 July 2023, https://www.ndis.gov.au/about-us/history-ndis (accessed 1 December 2025).

NDIS was to ‘work with people to plan, and to take account of their individual circumstances and needs’.[6]

About the scheme

2.13 The NDIS is run by the NDIA. An Australian is eligible to participate in the NDIS when they are born with or acquire a permanent and significant disability, which is defined as follows:

- a 'permanent’ disability means a person's disability is likely to be lifelong[7]
- a 'significant’ disability means a disability with a large impact on a person's ability to complete everyday activities.[8]

2.14 The NDIS also provides for an early intervention process where a person may not meet the criteria for substantial impairment but has a permanent disability. The early intervention process is available to adults and children that meet the eligibility requirements.[9] Early childhood intervention is discussed in detail below.

2.15 The NDIS funds reasonable and necessary supports and services that relate to a person's disability to help them achieve their goals. The general principles guiding the NDIS state these supports should:

- support people with disability to pursue their goals and maximise their independence; and
- support people with disability to live independently and to be included in the community as fully participating citizens; and
- develop and support the capacity of people with disability to undertake activities that enable them to participate in the community and in employment.[10]

2.16 The NDIS operates in all states and territories to connect participants with disability to support services in their community. This includes providing connections to doctors, community groups, sporting clubs, support groups, libraries and schools.[11]

2.17 Associate Commissioner Ms Natalie Wade, from the NDIS Quality and Safeguards Commission outlined why Australia has an NDIS:[12]

> We have an NDIS to realise the rights—the social and economic participation—of people with disability. It's why we have it. It's not designed to address every

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[6] Hon Julia Gilliard MP, Prime Minister, *House of Representatives Hansard*, 29 November 2012, p. 13877.

[7] The *National Disability Insurance Scheme Act 2013* provides that impairments that vary or are episodic in nature can be taken to be permanent for the purposes of participation in the NDIS, ss 24(2)–(3).

[8] *National Disability Insurance Scheme Act 2013*, s 24.

[9] *National Disability Insurance Scheme Act 2013,* s 25.

[10] *National Disability Insurance Scheme Act 2013*, s 4(11).

[11] NDIS Website, *Legislation*, 24 March 2025, www.ndis.gov.au/understanding/what-ndis (accessed 29 September 2025).

[12] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 8.

> protection and promotion of human rights of people with disability in Australia—quite the contrary. It only provides for 700,000 or so people … it certainly is a system that is best in its simplest form. Its form is very available for people when they need it, where they need it and how they need it.[13]

National Disability Insurance Scheme framework and agencies

National Disability Insurance Scheme Act

2.18 The *National Disability Insurance Scheme Act 2013* (Cth) (the Act) establishes the NDIA as well as the National Disability Supports Quality and Safeguards Commission (NDIS Commission).[14]

2.19 The Act sets out six main principles:

- the objects and principles under which the NDIS will operate
- how a person can become a participant in the NDIS
- how a participant's individual, goal-based plan is prepared and reviewed, including how the NDIA approves the funding of reasonable and necessary supports
- how a provider can become a registered NDIS provider
- the governance arrangements for the NDIA, including its CEO, Board, Independent Advisory Council, and Actuaries
- a process for internal and external review of certain decisions made under the NDIS Act.[15]

2.20 The Act also specifies that powers under the Act must be exercised having regard to the financial sustainability of the NDIS. The NDIS suggests that the scheme will achieve financial sustainability where:

- the scheme is successful on the balance of objective measures and projections of economic & social participation and independence, and on participants' views that they are getting enough money to buy enough high-quality goods and services to allow them reasonable access to life opportunities - that is, reasonable and necessary support; and

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[13] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 8.

[14] NDIS Website, *Legislation,* 24 March 2025, www.ndis.gov.au/governance/legislation (accessed 25 September 2025).

[15] NDIS Website, *Legislation*, 24 March 2025, www.ndis.gov.au/governance/legislation, (accessed 25 September 2025).

- contributors think that the cost is and will continue to be affordable, under control, represents value for money and, therefore, remain willing to contribute.[16]

National Disability Insurance Agency

2.21 The NDIA was established to deliver the NDIS and manage, advise and report on its financial sustainability.[17] The NDIA provides funding through the NDIS. The NDIA holds all the funding for the NDIS that is contributed by the Commonwealth and states and territories and approves the payments of individualised support packages.[18]

2.22 The NDIA is governed by a Board, and this Board is advised by an Independent Advisory Council. The Independent Advisory Council highlights issues affecting participants, families and carers.[19]

2.23 More specifically, the NDIA:

- provides information and referrals, links to services and activities, individualised plans and where necessary, funded supports to people over a lifetime
- helps empower and inform people with disability to be confident consumers
- provides service providers with clarity and transparency so they can grow their business and respond to need
- raises community awareness and encourages greater inclusion and access for people with disability to mainstream services, community activities and other government initiatives.[20]

National Disability Insurance Scheme Quality and Safeguards Commission

2.24 The National Disability Insurance Scheme Quality and Safeguards Commission (the NDIS Quality and Safeguards Commission) is an independent Australian Government regulator. It was established to regulate the NDIS using a nationally-

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[16] National Disability Insurance Scheme, *Insurance Principles and Financial Sustainability Manual*, November 2016, p. 18.

[17] Australian National Audit Office, *Decision-making Controls for NDIS Participants,* Auditor-General Report No. 14 2020–21, p. 14.

[18] NDIS Website, *Governance,* 16 May 2025, https://www.ndis.gov.au/governance (accessed 25 September 2025).

[19] Independent Advisory Council to the NDIS, *Advice*, https://www.ndis-iac.com.au/advice, (accessed 1 December 2025).

[20] NDIS Website, *National Disability Insurance Agency*, 22 January 2025, https://www.ndis.gov.au/understanding/what-ndis/whos-delivering-ndis/national-disability-insurance-agency (accessed 26 September 2025).

consistent approach to promote safe practices and improve the quality and diversity of providers' services.[21]

2.25 The NDIS Quality and Safeguards Commission was established by the NDIS Act and does the following:

- looks at the safety and quality of supports and services funded by the NDIS
- guides providers and works to follow the Code of Conduct and NDIS practice standards
- looks at fair pricing for NDIS-funded supports and services
- guides providers in using behaviour management plans to reduce restrictive practices
- receives and actions complaints from people with disability who have concerns about the safety and quality of NDIS funded supports and services.[22]

2.26 The NDIS Quality and Safeguards Commission does not regulate the NDIA. Commissioner Ms Louise Glanville outlined the challenge for the NDIS Quality and Safeguards Commission’s 950 staff overseeing thousands of providers of services to participants.[23]

> Essentially…we have about 280,000 providers now in this market, many of whom are not registered. About seven to eight per cent of that figure are registered, so that gives you some sense of the market that we can see and the market that we can't see. Many who are unregistered are also sole traders. These are all new dimensions and dynamics of the market in the way that we are seeing it generally.[24]

2.27 Ms Glanville continued:

> But, as a regulator, if I compare us to aged care, for example, I think I'm right in saying that there are about 2,000 aged-care providers. Compare that to the 270,000 NDIS providers. They have a mandatory registration system there [in aged care].[25]

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[21] NDIS Website, *The role of the NDIS Quality and Safeguards Commission*, 5 November 2025, https://www.ndis.gov.au/providers/becoming-ndis-provider/how-register/role-ndis-quality-and-safeguards-commission (accessed 25 September 2025).

[22] NDIS Website, *What we do*, 18 October 2024, https://www.ndiscommission.gov.au/about-us/what-we-do (accessed 29 September 2025).

[23] Ms Louise Glanville, Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 1.

[24] Ms Glanville, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, pp. 1-2.

[25] Ms Glanville, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 6.

Cost of the NDIS

2.28 The NDIS is projected to spend $46.2 billion this year. Data from 2025 indicates that the NDIS spending forecast is $700 million lower than originally predicted for the current financial year. This puts the year-on-year growth rate at around 10 per cent, down from 22 per cent in 2021–22 financial year. [26]

2.29 National Cabinet has set a target to reduce annual cost growth to 8 per cent by 1 July 2026.[27]

2.30 In the most recent financial year, the NDIS reported 'an increase in NDIS payments due to increased participation numbers and higher average costs per participant'. [28] It reported, 'Total payments in the year to 30 June 2024 were $41.8 billion, while the payments in the year to 30 June 2025 were $46.3 billion'.[29]

2.31 A recent NDIS report also stated that, 'In addition to average payments increasing over time, average plan budgets have also increased over time.'[30]

Budgeted spending for children with autism and developmental delay

2.32 The NDIS publishes datasets on the 'number of active participants and their average support budget by service district, age group, disability and support class.'[31] Based on participant numbers and plan budget data as of June 2025, the estimated annual committed total for participants aged 0–8 years was:

- $1.5 billion for children with autism
- $1.8 billion for children with developmental delay
- and $563.28 million for children with global developmental delay.[32]

2.33 The estimated actual spending for all diagnoses in the financial year 2024-25 was $2.2 billion for 173,465 participants between 0 to 8 years.[33]

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[26] Department of Health, Disability and Ageing, *Budget 2025-26: Strengthening the National Disability Insurance Scheme*, 30 July 2025, https://www.health.gov.au/resources/publications/budget-2025-26-strengthening-the-national-disability-insurance-scheme-html, (accessed 2 December 2025).

[27] National Disability Insurance Scheme, *Quarterly report to disability ministers Q4 2024 – 25 Summary Part A*, June 2025.

[28] National Disability Insurance Scheme, *Quarterly report to disability ministers*, Q4 2024-25, June 2025, Full Report, p. 75.

[29] National Disability Insurance Scheme, *Quarterly report to disability ministers*, Q4 2024-25, June 2025, Full Report, p. 75.

[30] National Disability Insurance Scheme, *Quarterly report to disability ministers*, Q4 2024-25, June 2025, Full Report, p. 77.

[31] National Disability Insurance Scheme, *Participant numbers and plan budgets data June 2025*, https://dataresearch.ndis.gov.au/datasets/participant-datasets (accessed 3 December 2025).

[32] National Disability Insurance Scheme, *Participant numbers and plan budgets data June 2025*, (accessed 3 December 2025).

[33] National Disability Insurance Scheme, *Participant numbers and plan budgets data June 2025*, (accessed 3 December 2025).

2.34 The NDIS's Quarterly report to disability ministers, Q1 2025-26 highlighted a recent increase in younger participants entering the NDIS with disabilities such as developmental delay, noting that on average, children have lower plan budgets than adults.[34]

Statistics relating to children participating in the NDIS

2.35 As part of their evidence to the inquiry the NDIA provided statistics on the participation rates of children on the NDIS. They highlighted that figures accurate to 30 September 2025:

- the number of active NDIS participants aged 0 to 14,
- participation in the NDIS calculated as the proportion of the general population (NDIS participation rate) and
- the number of NDIS participants with autism and their participation in the NDIS calculated as a proportion of the general population (NDIS participation rate for people with Autism).

2.36 According to the NDIS, South Australia (SA) had the highest participation rate of children aged between 0 to 14 active on the NDIS (8.25 per cent) when calculated as a proportion of the population in the state, while Western Australia (WA) had the lowest (4.83 per cent).

2.37 Of those individuals, the proportion of NDIS participants who have been diagnosed with autism is also highest in SA when calculated as a proportion of the population in the state and the lowest in the Northern Territory (NT). The table below provides more detailed information on every Australian State and Territory.

Table 2.2 Number of active NDIS participants aged 0 to 14 and number of active NDIS participants with autism aged 0 to 14 as at 30 September 2025

State	Active NDIS Participants 0 to 14	Population 0 to 14	NDIS Participation Rate 0 -14	Active NDIS Participants with autism 0 to 14	NDIS Participation rate for people with autism
NSW	94,521	1,530,205	6.2%	51,450	3.4%
VIC	89,724	1,224,054	7.3%	47,002	3.8%
QLD	69,885	1,013,034	6.9%	37,687	3.7%
WA	25,861	535,243	4.8%	14,792	2.8%
SA	26,038	315,588	8.3%	16,146	5.1%
TAS	5,852	94,513	6.2%	3,351	3.5%

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[34] National Disability Insurance Scheme, *Quarterly report to disability ministers*, Q1 2025-26, September 2025, p. 79.

ACT	4,806	86,235	5.6%	2,542	2.9%
NT	2,687	52,380	5.1%	1,163	2.2%
NAT	319,630	4,854,030	6.6%	174,226	3.6%

Source: National Disability Insurance Agency, *Submission 380*, pp. 6-14.

2.38 The four most prevalent disabilities for children aged 0 to 8 years are Developmental Delay (30,718); Autism (12,703); Global Developmental Delay (6,190), and Intellectual Disability (792), according to data provided by the NDIA. These numbers drop off significantly for Developmental Delay and Global Developmental Delay over the age of 9.

Table 2.3 Four most prevalent disabilities, broken down by age group at access decision in the 12 months, ending 30 September 2025

	0 to 8	9 to 14	15 to 18	19 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+	Total
Autism	**12,703**	**13,887**	**4,801**	**2,630**	**2,509**	**1,622**	**765**	**278**	**12**	**39,207**
Developmental Delay	**30,718**	**3**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**30,722**
Global Developmental Delay	**6,190**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6,191**
Intellectual Disability	**792**	**1,138**	**739**	**353**	**402**	**352**	**337**	**330**	**21**	**4,464**

Source: National Disability Insurance Agency, *Submission 380*, p. 16.

2.39 A recent NDIS Quarterly Report provides additional data on participants receiving support from the NDIS. The report states that 'as at 30 September 2025, 751,446 participants had approved NDIS plans' which 'represents a net increase of 12,032 participants since June 2025 (a 1.6 per cent increase).'[35]

- NDIS participation is highest among children aged 5 to 7, with around 10 per cent of Australian children in this age group being NDIS participants
- participation rates vary significantly by gender at younger ages. At the peak age of six, 16 per cent of males are participants—more than twice the rate for females (7 per cent). Much of the difference in children's participation rates by gender can be explained by differences in diagnosis by disability type

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[35] National Disability Insurance Scheme, *Quarterly report to disability ministers,* Q1 2025-26, September 2025, p. 18.

- 170,786 children under 9 years had an approved NDIS plan, and an additional 27,139 accessed early connections[36] during the quarter
- of the 170,786 children under 9 years with approved NDIS plans, 2,612 lived in remote or very remote areas
- 27,139 children accessed early connections—providing supports tailored to the child and family, regardless of NDIS participation.[37]

2.40 Of the 20,896 participants entering the NDIS, 10.3 per cent were First Nations Peoples; 7.6 per cent were CALD; and 1.9 per cent were from remote or very remote areas.[38]

2.41 Since 1 July 2023, the NDIA has extended Early Childhood arrangements (see below, paragraph 2.48) to children under 9 through its community partners. Previously, these arrangements were limited to children under seven. This change was aimed at ensuring families receive support during and after the transition to primary school.

Support provided by the NDIS

2.42 The NDIS care model invests in appropriate supports over the life of each participant. Eligible participants develop a plan with the NDIA, which identifies their individual goals and aspirations and the 'reasonable and necessary' supports required to help them achieve these.[39]

2.43 Plans generally cover a minimum 12-month period. Plans are reviewed with a participant prior to expiry, and a new plan is developed. Participants with an approved plan may purchase supports from service providers of their choice.[40]

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[36] See below, paragraph 2.52.

[37] National Disability Insurance Scheme, *Quarterly report to disability ministers,* Q1 2025-26, September 2025, pp. 18-20, 26.

[38] National Disability Insurance Scheme, *Quarterly report to disability ministers*, Q1 2025-26, September 2025, p. 20.

[39] Auditor-General Report No. 14 2020–21, *Decision-making Controls for NDIS Participant Plans*, p. 14.

[40] Auditor-General Report No. 14 2020–21, *Decision-making Controls for NDIS Participant Plans*, p. 14.

Figure 2.1 Participant pathway

Source: NDIS Annual Report 2015-16 p. 10.

2.44 Once a person becomes a participant in the NDIS, they develop a plan with the NDIA. The plan has two parts:

- the participant's statement of goals and aspirations, which is prepared by the participant and specifies their goals, objectives, aspirations and circumstances
- the statement of participant supports, which is prepared with the participant and approved by the CEO, and sets out, among other matters, the supports that will be provided or funded by the NDIS.[41]

Box 2.1 Examples of what an NDIS Plan may provide

Some examples of goals in a participants' plan may include things like improving speech or communication skills through therapy, getting help for everyday living activities or to purchase equipment, learning new skills or getting and keeping a job, becoming more independent, or making friends and connections.

NDIS participants will work with chosen service providers in their local area, to pursue specific support goals. Service providers are professionals who deliver supports and services such as physiotherapy, speech therapy or occupational therapy.

NDIS plans can also assist participants to work with a support worker, engage a carer, access assistive technology, or complete home modifications that help with everyday life.[42]

NDIS support pathways for children

2.45 There are two pathways to access the NDIS depending on the age of the participant. From July 2023, children aged 0 to 9 years can access the NDIS via the Early Childhood Approach and an Early Childhood partner. Children aged 9 and over can access the NDIS via the NDIS Pathway via a local area coordinator.

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[41] NDIS Website, *Legislation*, www.ndis.gov.au/governance/legislation (accessed 25 September 2025).

[42] National Disability Insurance Scheme, *Creating your plan*, Fact Sheet, October 2025.

Eligibility criteria

2.46 Children under 9 years might be eligible for the NDIS if they're:

- under 9 years and have a disability
- under 6 years and have developmental delay
- under 6 years and don't fully meet the definition of developmental delay but have developmental concerns.

2.47 Children 9 years and over might be eligible for the NDIS if:

- they have a disability that causes a significant impairment that affects their ability to take part in everyday activities
- their impairment is permanent or likely to be permanent.

Early Childhood Approach

2.48 The Early Childhood Approach is designed to support children under nine who may have a developmental delay or disability. The Early Childhood Approach also enables children who may not completely fit the definition of 'developmental delay', but have developmental concerns, to access necessary supports.

2.49 From 1 July 2023, the NDIA extended access to early childhood arrangements, through its early childhood partners in the community, to children younger than nine. These arrangements had previously been available to children younger than seven. This change was designed to ensure that children and their families were supported by an early childhood partner during and after their transition to primary school.

2.50 The Early Childhood Approach helps children younger than six with developmental delay or children younger than nine with disability, and their families to access support. Children younger than six do not need a definitive diagnosis to get support through the Early Childhood Approach where there are concerns about their development.[43]

2.51 The Early Childhood Approach aims to:

- provide timely support to ensure that families are able to access the supports they need
- provide information about best-practice early childhood intervention supports and how families can help their child
- increase confidence and capacity to manage and respond to each child's support needs

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[43] NDIS Website, *The early childhood approach for children younger than 9*, www.ndis.gov.au/understanding/families-and-carers/early-childhood-approach-children-younger-9 (accessed 29 September 2025).

- increase each child’s ability to do activities they need or want to do throughout their day
- increase each child’s inclusion and participation in mainstream and community settings like childcare or recreation
- provide information about, and referrals to, other support services if needed, like parent support groups.[44]

Early connections

2.52 Early connections’ are means of community-, health- or education-based supports aimed at supporting children aged less than nine who have developmental delay or disability, and their families. Examples of early connections include:

- community activities like playgroups and parent support groups
- mainstream health services like child and family health nurses or community health centres
- mainstream education services like early childhood education centres or preschools
- practical information to help parent’s or carers understand their child’s development and their needs
- peer support from other families
- NDIS early supports.[45]

2.53 Early connections is part of the national Early Childhood Approach, to support children younger than nine with delays in their development or with disability and their families.[46] Early connections is intended to provide quick access to supports that meet the needs of the child and their family, regardless of whether the child is an NDIS participant.[47] Some early connections are available to families living in Australia regardless of their citizenship or visa status. [48]

2.54 In its most recent quarterly report, the NDIS noted that throughout the September 2025 quarter, 27,139 children accessed early connections.[49]

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[44] NDIS Website, *The early childhood approach for children younger than 9*, www.ndis.gov.au/understanding/families-and-carers/early-childhood-approach-children-younger-9 (accessed 29 September 2025).

[45] Raising Children. The Australian parenting website, *NDIS early childhood approach: early connections & supports*, https://raisingchildren.net.au/disability/ndis/ndis-access-getting-support/the-ndis-early-childhood-approach-early-connections-and-supports (accessed 11 November 2025).

[46] NDIS Website, *Factsheet: Early connections*, https://www.ndis.gov.au/publications/booklets-and-factsheets#making-connections (accessed 11 November 2025).

[47] National Disability Insurance Scheme, *Quarterly report to disability ministers Q4 2024 – 25 Summary Part Ahttp://www.ndis.gov.au/publications/quarterly-reports*, p. 28.

[48] NDIS Website, *Early Connections*, 28 October 2024, accessed 12 November 2025 at https://www.ndis.gov.au/media/7762/download?attachment, p. 2.

[49] National Disability Insurance Scheme, *Quarterly report to disability ministers*, Q1 2025-26, 24 November 2025, p. 26.

2.55 Under early connections, NDIS early childhood partners link children and families to practical information, mainstream and community supports, and peer supports.[50]

2.56 Depending on individual circumstances, a child may move through the early connections program to become an NDIS participant on either the permanent disability criteria of the Act (s.24) or the early intervention criteria of the Act (s.25), or both the early intervention and permanent disability criteria (s.28).[51]

Early supports

2.57 Eligible children who are younger than six and have developmental concerns may also undertake a short-term program of early supports with the early childhood partner, designed to build capacity of the child and family and promote everyday learning. Children do not need to be an NDIS participant to receive early supports.

2.58 Early supports are short term – usually 3 to 6 months – but can continue up to 12 months and are documented in an early supports plan.[52]

National Best Practice Framework for Early Childhood Intervention

2.59 The Early Childhood Approach program discussed above is an example of early childhood intervention.

2.60 Early childhood intervention helps the child and family to build capacity while supporting greater inclusion in community and everyday settings, meaning each child will be provided with opportunities to grow and learn. Ideally, this approach is both family-centred and strengths-based.[53]

2.61 In November 2024, the DSS published ECIA National Guidelines: Best Practice in Early Childhood Intervention. The guidelines were developed in consultation with the early childhood intervention sector.[54]

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[50] NDIS Website, *Factsheet: Early connections*, https://www.ndis.gov.au/publications/booklets-and-factsheets#making-connections (accessed 11 November 2025).

[51] National Disability Insurance Scheme, *Quarterly report to disability ministers*, Q4 2024-25, June 2025, Full Report, p. 91.

[52] National Disability Insurance Scheme, *Early connections,* Fact Sheet, July 2024, pp. 3-4.

[53] NDIS Website, *The early childhood approach for children younger than 9*, www.ndis.gov.au/understanding/families-and-carers/early-childhood-approach-children-younger-9 (accessed 29 September 2025).

[54] Department of Social Services, *ECIA National Guidelines: Best Practice in Early Childhood Intervention*, https://www.dss.gov.au/early-childhood/resource/ecia-national-guidelines-best-practice-early-childhood-intervention (accessed 10 December 2025).

2.62 The Murdoch Children's Research Institute was involved in the development of the revised Framework, and noted the following in its submission to this inquiry:

> The National Best Practice Framework for Early Childhood Intervention and its resources provide detailed information about what best practice is, the universal principles and key practices that support implementation of best practice, and guidance on relevant outcomes and how to measure them. Families want to know that they are receiving best practice and practitioners want to deliver it.[55]

2.63 In its involvement in the development of the revised Framework, the University of Melbourne noted that:

> The Framework was developed through a rigorous and comprehensive research collaboration which included consultation with key stakeholders and end-users: that is, young people with disability, their parents, carers and families, Aboriginal and Torres Strait Islander families and community-controlled organisations, and ECI service providers and researchers.[56]

2.64 The types of programs provided through early childhood intervention were described by the Bathurst Early Childhood Intervention Centre (BECIS):

> We are a not-for-profit organisation and registered NDIS provider that employs specialist teachers and therapists to partner with parents/caregivers in providing support, resources and information tailored to meet the needs of children and the family as a whole. BECIS provides individualised therapies, programs, resources, information and connections to services that meet the needs of children with disabilities and/or developmental delays aged 0 to 8 years of age, and their families and carers.

The submission continued

> BECIS has established and collaborative relationships with a variety of stakeholders within the community. BECIS receives intake phone calls and face to face referrals from families, schools, early childhood services, community health, GPs, Paediatricians, Aboriginal Liaison persons, playgroups, local health services. We currently see at least one referral a day, where we may have to work with the family to identify a child's needs that may lead to developmental delay, neurodiversity and other concerns.[57]

2.65 Early childhood intervention and early childhood education and care can be interlinked. SDN Children's Services noted the following example of a program in its submission to the inquiry:

> The SDN Early Learning Program funded by the NSW Government prior to the introduction of the NDIS, was an early childhood education and intervention

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[55] Murdoch Children's Research Institute, *Submission 234*, p. 14.

[56] University of Melbourne, *Submission 261*, p. 5.

[57] Bathurst Early Childhood Intervention Service, *Submission 240*, p. 1.

> initiative designed to provide high-quality, inclusive, and play-based learning experiences for children from birth to school age who had mild to moderate developmental delays or disability. It included small, supported playgroups and early childhood intervention advice and support for early childhood education and care centres that the children attended.[58]

2.66 The Brotherhood of St Laurence noted the opportunities for integrated early childhood intervention and similar supports:

> Early years integrated approaches can provide a gateway to many types of supports that families may require. This might include information, advice and referrals, peer support through supported playgroups and parenting supports, and inclusive mainstream services such as early childhood education and care (ECEC). Integrated early years approaches are the perfect place to deliver programs within the Thriving Kids initiative or to be a welcoming front door to Thriving Kids programs delivered separately.[59]

Early Childhood Education and Care

2.67 The Early Childhood Education and Care (ECEC) system is designed to support the education, development, and care needs of children, and help prepare them for school. It supports families to re-engage in work or learning during their child's early years.

2.68 The ECEC is divided into two parts:

- Child Care Subsidy (CCS) approved services which focus on early learning and care for children aged 0 to 12 years, and
- dedicated preschool services designed to provide preschool programs to children a year or two before commencing schooling.[60]

2.69 Child Care Subsidy approved services are delivered in four ways:

- centre-based day care provides care to non-school aged children aged 0 to 5 years
- outside school hours care provides care primarily to school-aged children outside of school hours, such as before school, after school and during school holidays
- family day care is typically provided in the home of an educator, and
- in home care.[61]

2.70 In home care is a flexible form of ECEC that takes place in the family home and is targeted to assist parents or carers who are unable to access other approved care

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[58] SDN Children's Services, *Submission 186*, p. 4.
[59] Brotherhood of St Laurence, *Submission 254*, p. 6.
[60] Department of Education, *Submission 363*, p. 3.
[61] Department of Education, *Submission 363*, p. 3.

types due to working non-standard hours, being geographically isolated or challenging and complex needs within the family.

2.71 The Department of Education explained that:

> In the June quarter 2025, 6,231 providers were approved to operate 15,214 services and administer the CCS across the four CCS care types. In the June 2025 quarter, 901,046 children aged 0–5 years and 522,087 children aged 6–12 years used CCS-approved services.[62]

2.72 The National Quality Framework (NQF) provides the national approach to regulation assessment, and quality improvement for ECEC services. The NQF is designed to promote equity and inclusion of all children, including those with disability or developmental delay, by setting out requirements for high-quality, inclusive education and care.

2.73 The National Quality Standards (NQS) are part of the NQF and set out seven quality areas important to outcomes for children. The NQS supports inclusive practice through child-centred programming, responsive staffing, and collaboration with families and professionals.

2.74 In particular, the educational leader, coordinators and educators are required to work together with children and their families to make reasonable adjustments which ensure the meaningful participation of children with disability or additional needs in the ECEC service program.

2.75 The Early Learning and Care Council of Australia noted that children with disability can receive supports through early education centres:

> Currently, children receiving support under the NDIS may receive therapeutic services at their early learning service – in a group environment, in a private location, or a combination of both. Beyond receiving therapies, a child with additional needs will also learn in group settings alongside their peers, with teachers and educators adjusting their practices (and/or working with additional colleagues) to suit the child's requirements.[63]

Transition from early childhood education to schooling

2.76 Some contributions to the inquiry emphasised the importance of linking early childhood education and care, and the shift to schooling.

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[62] Department of Education, *Submission 363*, p. 4.

[63] Early Learning and Care Council of Australia, *Submission 166*, p. 3.

2.77 The Early Learning and Care Council of Australia noted that the transition from early childhood education to schooling is critical, especially for children with disability:

> Within the education system, the transition from early learning to school is a pivotal moment for all children – and is especially important for those with disability and additional needs.[64]

2.78 Playgroup Australia identified benefits that arise from wraparound support services:

> Transition to school is not just a milestone for children, it is a shift for the whole family. Playgroups can support parents and carers to feel confident advocating for their child, navigating school systems, and maintaining connections built in the early years. Families who receive this wrap-around support report less stress and greater confidence, making the transition a positive experience for everyone.[65]

2.79 The Australian Education Research Organisation (AERO) has undertaken research into effective transitions for children with disability from early childhood education to schooling and developed a practice guide that emphasises collaborative partnerships and child-centred approaches.[66] Further research in effective transitions is required, however.

Childhood supports in Australia’s education system

2.80 Children can access supports through the NDIS, the healthcare system, and the education system. Some evidence to the inquiry focused on the connections between these systems and how they could be enhanced. This is considered further in Chapter 4.

2.81 The following sections discuss a range of supports currently available in school systems for children with disability, developmental delay and autism.

Better and Fairer Schools Agreement

2.82 The Commonwealth government provides funding to all jurisdictions in Australia through the Better Fairer Schools Agreement 2025-2034 and the Better and Fairer Schools Agreement – Full and Fair Funding 2025-2034 (collectively known as the BFSA).

2.83 The BFSA provides significant additional Australian Government funding, which is tied to targeted reforms in each state and territory. These reforms include whole of system and/or whole of school approaches to identify and support student needs early, and initiatives that support connections between school and non-school

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[64] Early Learning and Care Council of Australia, *Submission 166*, p. 5.

[65] Playgroup Australia, *Submission 177*, p. 5.

[66] Australian Education Research Organisation, *Transitions to school for children with disability or developmental delay*, Practice Guide, August 2023, pp. 3-6.

supports. State and territory specific reforms for government, independent and Catholic schools and systems are outlined in each jurisdiction's bilateral agreement.

2.84 The Queenslanders with Disability Network noted that initiatives like the BFSA can help address the services cliff, and ensure children continue to receive support in their middle years:

> Schools must become central hubs of integrated services, aligned with national reforms such as the Better, Fairer Schools Agreement, ensuring children continue to receive support into the middle years.[67]

Nationally Consistent Collection of Data on school students with disability

2.85 The Nationally Consistent Collection of Data (NCCD) is an annual collection of information about Australian school students who are receiving educational adjustments due to disability. The NCCD was rolled out nationally in 2013 to reinforce inclusive education practices under the Disability Standards for Education 2005 and to inform policy development and implementation.

2.86 Dr Esmeralda Rocha from the Department of Education described the functional process of the NCCD in relation to the allocation of funding:

> Teachers will record the adjustments that they have been providing to students based on their needs in the classroom, so it is not diagnosis dependent. As soon as a child's functional need becomes apparent, they can document it. They need to have evidence of the child's disability, but it can be something like an individual learning plan, for example. They document the level of adjustment that has been required. There are four levels of adjustment. Three of them attract different levels of funding and one is unfunded—we call that the quality differentiated teaching practice level of adjustment. Then, based on the information that's been provided, it goes through to our system, and that's how we calculate how much student with disability loading is required each year.[68]

2.87 The Department of Education explained that

> Through the NCCD, we know that in 2024, 25.7% of school students received an educational adjustment due to disability (ACARA, 2024).[69]

Disability Standards for Education

2.88 Under the Disability Standards for Education (DDA), the Attorney-General may make Disability Standards to specify rights and responsibilities about equal access and opportunity for people with a disability, in more detail and with more certainty than the

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[67] Queenslanders with Disability Network, *Submission 279*, p. 24.

[68] Dr Esmeralda Rocha, Assistant Secretary, Inclusion and Disability Branch, Department of Education, *Committee Hansard,* 10 October 2025, p. 59

[69] Department of Education, *Submission 363*, p. 5.

DDA itself provides. This includes the Disability Standards for Education 2005 (the Standards).

2.89 The Standards clarify the obligations of education providers in Australia under DDA to ensure that students with disability can access and participate in education on the same basis as students without disability. This includes:

- providing reasonable adjustments for students with disability
- enrolment
- participation
- curriculum development, accreditation and delivery
- student support services.

2.90 Currently the Standards apply to all schools (government and non-government). The Standards also apply to additional educational institutions, and the Department of Education is amending the standards to apply to ECEC as well. Ms Esmeralda Rocha of the Department of Education provided:

> The Disability Standards for Education currently cover preschools, kindergarten and schools. However, we are amending the disability standards to cover educational early education providers as well. Currently, the National Quality Framework for early childhood education and care reinforces those obligations in the Disability Discrimination Act through guiding principles. ECEC services, early childhood services, are a key touchpoint for children and families in their early years, but we would note that not all children attend ECEC services.[70]

The Inclusion Support Program

2.91 The Australian Government's Inclusion Support Program (ISP) assists eligible CCS-approved services to include children with additional needs, including those with autism and/or developmental delay. Children must meet eligibility requirements for the CCS.

2.92 The program includes access to:

- professional support through contracted Inclusion Agencies
- specialist equipment libraries, managed by Inclusion Agencies
- funding to address barriers to inclusion, including to subsidise the employment of additional educators in a Centre Based Day Care (CBDC) or Outside School Hours Care settings.[71]

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[70] Ms Esmeralda Rocha, Assistant Secretary, Inclusion and Disability Branch, Department of Education, *Committee Hansard,* 10 October 2025, p. 55.

[71] Department of Education, *Inclusion Support Program Guidelines, Version 2.6*, October 2025.

2.93 The ISP was introduced in July 2016 and forms part of the Child Care Safety Net. It replaced the Inclusion and Professional Support Program, which ceased on 30 June 2016.

2.94 Early Childhood Australia noted:

> Inclusion Professionals within the Inclusion Support Program currently work within early childhood education and care services to provide guidance and advice to education teams to support inclusive practice. This includes support to include children with developmental or disability related needs as well as culturally diverse families, LGBTQI+ families and children that warrant unique or specialist support due to giftedness. The Inclusion Professionals assist with the development of strategic inclusion plans, access to additional educator funding, upskilling educator teams and facilitating access to assessment, early intervention or family support. The role of Inclusion Professionals could be expanded to include the use of screening tools (such as ASQ-TRAKS) and/or the delivery of programs (such as Inklings) working more directly with children and families, alongside the ECEC service team.[72]

2.95 The ISP focuses on building the capacity and capability of eligible ECEC services to include children with additional needs, alongside their typically developing peers.

2.96 The United Workers Union was critical of the ISP, suggesting that reforms were needed:

> …there are serious problems with the ISP, including the reliance on formal diagnosis for ongoing support, long wait times, and inadequate support and funding even where all criteria have been met. The reality is that educators are providing support to children with developmental delay, autism and other additional needs in services every day, but because of serious flaws in the ISP, many are doing it without the additional staffing resources, training or support they need.[73]

Connected Beginnings

2.97 Connected Beginnings draws upon the strength and knowledge of First Nations' communities to increase children and families' engagement with health and early childhood education and care.

2.98 The National Aboriginal Community Controlled Health Organisation provided the following summary of the program:

> Established in 2016, the Connected Beginnings program is delivered through partnerships between Backbone Organisations (funded by the Commonwealth Department of Education and supported by SNAICC) and the Health Partner

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[72] Early Education Australia, *Submission 335*, p. 4.

[73] United Workers Union, *Submission 263*, p. 15.

> (funded by the Department of Health and Aged Care and supported by NACCHO).
>
> The Connected Beginnings program provides a framework and funding to support the integration of early childhood, maternal and child health, and family support services with schools so that Aboriginal and Torres Strait Islander children are ready to thrive at school. It is a community-owned and led program that enables Aboriginal and Torres Strait Islander people to have a say in how activities funded are delivered to their people, in their own places and on their Country. It is place-based, and prioritises investments that meet the needs and aspirations of community whilst building Aboriginal and Torres Strait Islander community-controlled sectors.
>
> The program currently supports just under 25,000 Aboriginal and Torres Strait Islander children aged 0-5 years through its 50 sites across Australia.[74]

2.99 Ms Catherine Liddle of SNAICC discussed the application of the program:

> Something it might be able to hook into is Connected Beginnings, which is already on the ground in more than 50 sites. Connected Beginnings is a very cheap model, but it effectively provides the backbone that says, 'We've picked up that there is a child that needs a little bit of extra support.' This isn't a massive NDIS plan; this is something different. This is the one that says, 'Mum and dad might need a bit of help, to give them a couple of tools for when baby is laying on the ground in a supermarket.' How do you talk your child through that sort of moment in time? How do you help your babies go to sleep when their brains are so active and they're so tired that they can't come to school and engage the next morning?[75]

Initiatives supporting children and their carers

Key Federal Government frameworks

2.100 In December 2024, the Australian Government and all state and territory governments signed Australia’s Disability Strategy 2021—2031. This strategy is a commitment by all levels of government to build an Australia in which people with disability are valued, included and empowered to thrive.[76]

2.101 This strategy outlines a vision for a more inclusive and accessible society where all people with disability can fulfil their potential as equal members of the community.

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[74] National Aboriginal Community Controlled Health Organisation, *Submission 154*, p. 15.

[75] Ms Catherine Liddle, Chief Executive Officer, SNAICC - National Voice for our Children, *Committee Hansard*, 17 November 2025, p. 32.

[76] NDIS website, www.ndis.gov.au/understanding/australias-disability-strategy-2021-2031 (accessed 29 September 2025).

> The NDIS is a key part of the ecosystem of supports that Australians with disability rely on.[77]

2.102 The Department of Health, Disability and Ageing supports the National Early Childhood Program (NCEP) to support children with disability or developmental concerns.[78] This Department hosts the Australian Disability Strategy including key actions and resources.[79]

2.103 The DSS supports a national approach to early childhood intervention though the following:

- Early Childhood Targeted Action Plan (TAP) 2021—2031.This plan focuses on improving access to support for children with disabilities and developmental delays, and for their families. The TAP is a commitment under the Australian Disability Strategy. DSS works collaboratively with NDIA, Department of Health, Disability and Ageing, Department of Education and the National Indigenous Australian Agency (NIAA).
- Early Years Strategy 2024—2025 to enhance early childhood programs.
- National Framework for Protecting Australia's Children, which includes a focus on early intervention and support for vulnerable children and families.

Inklings program

2.104 In its supplementary submission to the inquiry, the Kids Research Institute provided some information on the Inklings program, stating:

> Inklings is a 10-session program that uses short videos of a caregiver interacting with their baby to help them to better understand the different ways that their baby communicates their thoughts, feelings and needs. With the guidance of a trained practitioner, caregivers learn strategies to build on their own strengths as a responsive communication partner for their baby.
>
> Inklings is baby-led, meaning the program guides caregivers to follow the natural interests and preferences of their baby, rather than encouraging a baby to engage in interests or behaviours that are not natural to them. By helping parents to adapt their own communication style to their babies' early developmental differences, babies are able to learn in a social environment that is adapted to meet their unique needs.[80]

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[77] NDIS website, www.ndis.gov.au/understanding/australias-disability-strategy-2021-2031 (accessed 29 September 2025).

[78] Department of Health, Disability and Ageing, *Early childhood intervention*, www.health.gov.au/topics/disability-and-carers/early-childhood-intervention (accessed 29 September 2025).

[79] Department of Health, Disability and Ageing, *Australia's disability Strategy,* www.health.gov.au/our-work/australias-disability-strategy (accessed 29 September 2025).

[80] Kids Research Institute, *Supplementary Submission 93.1*, p. 1.

2.105 The Kids Research Institute elaborated that the program:

> …supports caregivers to recognise, interpret, and attune to their baby's unique communication behaviours, and to respond to their baby in a way that shows understanding of their baby's desires, intentions, and needs.
>
> It is important to emphasise that caregiver-baby interactions are in no way a cause of neurodevelopmental delays or conditions. The aim of Inklings is to support a baby's social and communication development by enhancing caregivers' understanding of their baby's unique communication. The program facilitates babies and caregivers to engage in meaningful and developmentally supportive two-way interactions.
>
> Inklings supports caregivers to "pause, notice, and respond" to their baby's unique cues which increases the caregiver's responsive caregiving. There is strong evidence that increased sensitive and responsive caregiving styles early in life has positive downstream effects on child development and wellbeing. Inklings builds on strengths, not deficits; connection, not correction; and insight, not surveillance.[81]

2.106 They also noted that 'external evaluations of the SA and WA pilots of Inklings are underway; NDIA and La Trobe University are leading the WA evaluation and the SA Government and ARTD [a public policy advisory firm] are leading the SA evaluation.[82]

2.107 Several submissions to the inquiry raised concerns about elements of the Inklings Program.[83]

The Triple P - Positive Parenting Program

2.108 This program was developed by the Parenting and Family Support Centre at the University of Queensland and includes a suite of evidence-based programs to foster strong, healthy relationships, and support parents to confidently manage children's behaviour.

2.109 Free access to the training is funded by the Department of Health, Disability and Ageing through the Parenting Education Support Program (PESP).[84]

2.110 The program includes 'light touch' parenting support through to more intensive interventions, including targeted support for families of children with developmental

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[81] Kids Research Institute, *Supplementary Submission 93.1*, pp. 1-2.

[82] Kids Research Institute, *Supplementary Submission 93.1*, p. 3.

[83] See for example: Ms Shona Redmile, *Submission 11*, pp. 1-2; Be Space, *Submission 75*, p. 1; Ms Heather McKay, *Submission 116*; Autistic Self Advocacy Network of Australia and New Zealand, *Submission 181*, p. 9; Nobody Worse Off Coalition, *Submission 242*, pp. 6-7; Senator Jordon Steele-John *Submission 308*, pp. 2-3; Dietitians Australia, *Submission 329*, p. 18; Every Australian Counts, *Submission 273*, p. 11; Outcomes Therapy, *Submission 312*, p. 2; Yellow Ladybugs, *Submission 351*, p. 8; Australian Neurodivergent Parents Association, *Submission 360*; JFA Purple Orange, *Submission 376*, p. 23; Regional Autism Engagement Network Tasmania, *Submission 389*.

[84] Triple P International Pty Ltd, *Submission 310*, p. 3.

delay or disability. This more intensive intervention support is delivered through the Stepping Stones Triple P, which was developed by a team of clinical psychologists ‘specifically designed to support parents of children with developmental disabilities or delay’.[85]

2.111 Since the inclusion of the Stepping Stones Triple P program to the PESP at the end of 2024, more than 12,000 families have accessed the program.[86]

2.112 More than half a million families have participated in the program since it was rolled out in 2022, and 11,000 practitioners across 35 countries have been trained to deliver the program.[87] The program is available face-to-face or online.

2.113 The Parenting and Family Research Alliance noted that these types of parenting programs allow parents to ‘embed therapeutic strategies in everyday routines.’[88]

PlayConnect+ Project

2.114 The PlayConnect+ Project is a supported playgroup for children aged 0-8 years with disability or developmental concerns. The PlayConnect+ Project notes that ‘at least 50 per cent of this cohort presents with autism or autism-like behaviours.’[89]

2.115 The PlayConnect+ Project notes

> Families are encouraged to attend regardless of whether they have, or do not have, a formal diagnosis for their child. The emphasis is for parents/carers to act on their observations earlier and engage with broader disability supports rather than waiting for a medical diagnosis to trigger early intervention strategies.[90]

2.116 The program is delivered in person and online during school terms for those aged 5 and below, and in school holidays and weekends for children aged 5 to 8 years. PlayConnect+ Project notes

> In addition to the traditional playgroup format, PlayConnect+ delivery includes:
>
> - music therapy playgroups for families preferring a music-centric lesson format;
> - playgroups prioritising the enrolment of First Nations families with a focus on indigenous stories, art and music, and family support directed towards trusted culturally safe services;
> - playgroups in migrant communities where cultural and linguistic perspectives inform the learning approach and support for families; and

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[85] Triple P International Pty Ltd, *Submission 310*, p. 3.

[86] Triple P International Pty Ltd, *Submission 310*, p. 4.

[87] Triple P International Pty Ltd, *Submission 310,* p. 3.

[88] Parenting and Family Research Alliance, *Submission 201*, p. 2.

[89] NECP PlayConnect+ Project, *Submission 244*, p. 1.

[90] NECP PlayConnect+ Project, *Submission 244*, p. 1.

> - playgroups which partner with specialised programs that are resourced to support inclusion and engagement across a range of sectors and services.
>
> By offering free sessions, culturally responsive facilitators, and flexible attendance options, PlayConnect+ removes barriers that might otherwise prevent families from participating. The evaluation found this approach enabled access for families facing illness/disability, family breakdown, homelessness, financial, cultural, geographical and other constraints.[91]

STaR Early Years Program

2.117 This program was launched in 2002 as a pilot program and has grown over time. The program has four objectives:

1. Support families to enrol their children with a disability, developmental delay, or autism at a STaR-connected ECEC service.
2. Children have an Individual Learning Plan (ILP) that aligns with the family's priorities, the Early Years Learning Framework, NDIS, and allied health/therapy goals. This plan is updated at least three times each year.
3. Ongoing professional development and coaching for educators.
4. A transition to school program is provided in the year before school, including support for the school enrolment process, additional school orientation visits, and information sharing with the receiving school.[92]

2.118 The program is currently available in six ECEC centres in NSW.[93]

Other supports

2.119 Beyond the NDIS, the DSS outlined some of its direct service delivery support programs aimed at families provided by its Family and Wellbeing Group.

> …like a program called HIPPY, the Home Interaction Program for Parents and Youngsters, which is about enabling parents in the home to skill up and to teach their children in the home for preliteracy, motor skills and those sorts of things. It goes all the way to very intensive family services. We have a program called Children and Family Intensive Support that is delivered in the Northern Territory, in the APY Lands, which is a wraparound, whole-of-family, intensive service to build capacity and safety in the home of that family.[94]

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[91] NECP PlayConnect+ Project, *Submission 244*, p. 3.

[92] Special Teaching and Research (STaR) Ltd, *Submission 339*, p. 1.

[93] Special Teaching and Research (STaR) Ltd, *Early Years Program*, https://www.star.org.au/service/early-years-program/ (accessed 3 December 2025).

[94] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 1.

2.120 The Acting Group Manager of the Family Wellbeing Group at the DSS, Ms Jacqueline Hrast, outlined the Department funded about $420 million per annum to the community sector to deliver the children and family programs and a home interaction service for parents and children.[95]

> Through 2024-25 we had 245,000 clients through these programs. We collect demographic data on our clients through those programs, and our disability tick is for whether the parent or the child identifies as having a disability. We serviced 27,000 disabled clients in that financial year. In some of our programs they make up quite a considerable amount of the clientele.[96]

2.121 Ms Hrast also explained how these government support programs were 'eligible to everybody'[97] and are delivered through third-party providers, such as the not-for-profit sector and the community sector.[98]

> It's whether there's one available in your location, but, certainly, people enter our programs by finding them on resources that we fund, like Raising Children Network for example, or being referred by maternal and child health, their schools, their local health networks or their Aboriginal health medical service. They come into those programs and, usually through those, particularly the more middle to more intensive end programs, there are very qualified staff who can see if there's something else going on for that family. A child might be displaying early signs of developmental delay, for instance. That can be a place where that conversation can happen, and we can help connect that family to other services.[99]

2.122 Ms Hrast stressed the importance of its Family Mental Health Support Services program that the community sector is funded to deliver.[100]

> That's for children who are showing early signs of mental ill health or who are requiring additional strategies around anxiety and coping. Our clientele for that is around the 17 per cent of children identifying as having a disability. We don't need a diagnosis, an identity or criteria to respond to any of these needs.[101]

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[95] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 2.

[96] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 2.

[97] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 1.

[98] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 1.

[99] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, pp. 1-2.

[100] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 2.

[101] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 2.

Foundational supports

2.123 Many people and children with disability are not in the NDIS. Some people, who are not in the NDIS, may need more help than what is offered through mainstream or community services, like early childhood education, schools and community mental health programs.

2.124 Foundational supports are developed together by Commonwealth and state and territory governments to provide additional supports outside of the NDIS. There are two types of foundational supports; general and targeted supports.[102]

2.125 These supports are still under development. For example, the proposed Thriving Kids initiative is an example of a targeted foundational support.[103]

2022 NDIS review and response

The independent review

2.126 On 18 October 2022, the Minister for the NDIS started an independent review into the NDIS to ‘put people with disability back at the centre of the NDIS’. The purpose was to restore trust, confidence and pride in the Scheme.[104]

2.127 The Review looked at the NDIS’s design, operations and sustainability, and how to build a more responsive, supportive and sustainable market and workforce.[105]

2.128 The Review final report, *Working together to deliver the NDIS*, was released in December 2023. It made 26 recommendations with 139 actions to change the system that supports people with disability through:

- developing a unified system of support for people with disability
- an NDIS experience centred on the whole person and their support needs
- better support for children and adolescents through mainstream services and a significant expansion of services outside the NDIS
- more active government involvement and stewardship of NDIS markets to make them more efficient and effective

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[102] Department of Social Services, *Foundational Supports*, https://engage.dss.gov.au/foundational-supports/ (accessed 2 December 2025).

[103] Department of Health, Disability and Ageing, *Foundational supports for people with disability*, 1 December 2025, https://www.health.gov.au/our-work/foundational-supports-for-people-with-disability?language=en (accessed 3 December 2025).

[104] Department of Health, Disability and Ageing, *Release of the final report of the Independent Review into the NDIS*, https://www.health.gov.au/news/release-of-the-final-report-of-the-independent-review-into-the-ndis?language=en (accessed 12 November 2025).

[105] Department of Health, Disability and Ageing, *Release of the final report of the Independent Review into the NDIS*, https://www.health.gov.au/news/release-of-the-final-report-of-the-independent-review-into-the-ndis?language=en accessed 12 November 2025.

- improving service quality and ensuring appropriate safeguards and risk proportionate regulation.[106]

2.129 The Review concluded that there are not enough disability supports for people not eligible for the NDIS, compared to the level of need.[107] The Review found that the cohorts most likely to fall through this gap are children with disability, people with psychosocial disabilities and people with chronic health conditions.

2.130 Recommendation 1 of the Review was for the Australin Government to 'Invest in foundational supports to bring fairness, balance and sustainability to the ecosystem supporting people with disability.'[108] This recommendation included 12 actions. These included, staring with preparing and releasing a Foundational Supports Statement of Intent which defines foundational supports through two streams of activity, and that the Department of Social Services, with state and territory governments, develop and implement a Foundational Supports Strategy.[109]

2.131 Action 1.12 under the recommendation was:

> National Cabinet should agree to jointly invest in early supports for children with emerging development concerns and disability.
>
> This is a key element of a proposed continuum of mainstream, foundational and specialist supports for children with disabilities (see Recommendation 6). It should include support from a Lead Practitioner to help children who are not eligible for the NDIS to build their skills and participate in everyday activities. The Lead Practitioner should provide families with information about child development, building their confidence and knowledge to support their child in everyday routines. This should be in addition to the proposed capacity building program (see Action 1.8). It should also include implementing and evaluating a range of other early support models. The delivery of these early supports should be closely linked to and integrated with mainstream services, particularly education and early childhood services.

2.132 The panel for the review explained:

> Foundational supports would replace the ILC [Information Linkages and Capacity Building] grants program, so that it is reliable and available more widely. Foundational supports are essential supports for all people with disability. Governments should therefore measure and evaluate outcomes, and make

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[106] Department of Health, Disability and Ageing, *Release of the final report of the Independent Review into the NDIS*, https://www.health.gov.au/news/release-of-the-final-report-of-the-independent-review-into-the-ndis?language=en accessed 12 November 2025.

[107] NDIS Review, *Independent Review into the National Disability Insurance Scheme*, 2023, p. 53.

[108] NDIS Review, *Independent Review into the National Disability Insurance Scheme*, 2023, p. 60.

[109] NDIS Review, *Independent Review into the National Disability Insurance Scheme*, 2023, p. 53.

> changes so that activities and programs respond to changing needs and circumstances.[110]

2.133 The Independent Review website states that the ‘proposed reforms are the best way to ensure sustainability while also achieving a much fairer system. A system of support for all people with disability, not just those in the NDIS’.[111]

Progress delivering Foundational Supports

2.134 In December 2023, National Cabinet agreed that the Commonwealth and state and territory governments jointly fund additional supports for people with disability, called Foundational Supports.[112]

2.135 In 2024, the Australian Government committed to investing $11.6 million over two years to support work to develop and implement the Foundational Supports Strategy.[113]

2.136 In October 2024, the Department of Social Service released the Foundational Supports for children with developmental concern, delay and/or disability and their families, carers and kin Consultation Paper which addresses some of the actions under recommendation 1 of the NDIS Review.

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[110] NDIS Review, *Foundational supports for all people with disability,* https://www.ndisreview.gov.au/resources/fact-sheet/foundational-supports-all-people-disability (accessed on 12 November 2025).

[111] NDIS Review, *Working together to deliver the NDIS*, https://www.ndisreview.gov.au/resources/reports/working-together-deliver-ndis/ (accessed on 4 December 2025).

[112] Prime Minister of Australia, *Meeting of National Cabinet-the Federation working for Australia*, https://www.pm.gov.au/media/meeting-national-cabinet-federation-working-australia (access 4 December 2025).

[113] Ministers for the Department of Social Services, *Building a strong ecosystem of disability supports*, https://ministers.dss.gov.au/media-releases/13711 (accessed 12 November 2025).

3. Equity and Inclusion

3.1 This chapter reflects the commentary the Committee heard about key areas of concern in relation to equity and inclusion for children with developmental delay and their families.

3.2 Evidence received by the Committee consistently raised issues faced by First Nations and CALD families, and families in rural and remote areas, particularly that these groups 'report limited availability of services or a lack of cultural safety.'[1]

3.3 The chapter also reflects on evidence received about other challenges relating to equity and inclusion, including socio-economic factors and school and community integration.

3.4 The Committee acknowledges the regular intersection and overlap between these issues and how this compounding can impact barriers to children and their carers accessing critical services and support.

3.5 Ms Nicole Avery, Chief Executive Officer of South-West Autism Network (SWAN), drew attention to the compounded barriers that CALD families, regional and remote families and low-income households face. She reported that in a recent national survey conducted by SWAN, 90 per cent of the 360 respondents said that it was 'critical that Thriving Kids address the unique needs of these groups with embedded, locally delivered and culturally safe supports.'[2]

3.6 Various submitters and witnesses emphasised the view that equity and inclusion must be central to the design and implementation of Thriving Kids.

3.7 A submission from the Australian Council of State School Organisations (ACSSO) summarised:

> Equity must sit at the heart of the Thriving Kids initiative. Developmental vulnerability is not evenly distributed across the population: Aboriginal and Torres Strait Islander children, children from culturally and linguistically diverse (CALD) backgrounds, and those living in rural and remote areas are more likely to face barriers in access, affordability, and cultural safety. Without deliberate action, Thriving Kids risks reproducing the same inequities that have long plagued early childhood and disability systems.[3]

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[1] Australian Council of State School Organisations, *Submission 46*, p. 6.

[2] Ms Nicole Avery, Chief Executive Officer, South West Autism Network, *Committee Hansard*, 3 October 2025, p. 34.

[3] Australian Council of State School Organisations, *Submission 46*, p. 7.

3.8 Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association explained:

> Outside the NDIS, access to all allied health is certainly inconsistent, and those inconsistencies are greatest for people in rural settings, Aboriginal and Torres Strait Islander communities, and culturally and linguistically diverse communities. This is why we really need equity focused measures within Thriving Kids to make sure that it doesn't widen those existing gaps and to make sure that it fills those gaps really thoroughly.[4]

3.9 Mr Ross Joyce, Chief Executive Officer, Australian Federation of Disability Organisations advised the Committee:

> Thriving Kids must be culturally safe and responsive. It must work for First Nations families, for children in out-of-home care, and for those from culturally and linguistically diverse backgrounds, inclusive of our deaf community. Community controlled and grassroots organisations should be central partners in that delivery. AFDO and our member organisations are ready to stand with the government and work on this—and with the committee—to ensure that Thriving Kids becomes what it should be: a strong, equitable and inclusive system of foundational supports.[5]

Aboriginal and Torres Strait Islander children and communities

3.10 Aboriginal and Torres Strait Islander Australians experience higher rates of disability compared to Australia’s general population. After factoring in age differences between the Indigenous and non-Indigenous populations, the rate of disability among Aboriginal and Torres Strait Islander Australians is almost double the rate among non-Indigenous people. However, the National Disability Insurance Scheme (NDIS) reports that the total proportion of First Nations participants in the NDIS is 8.2 per cent as of 30 June 2025.[6] Of this, half of First Nations participants on the scheme are aged 14 and below.[7]

3.11 The National Aboriginal Community Controlled Health Organisations (NACCHO) commented on the importance of early intervention programs for Aboriginal and Torres Strait Islander children noting that they ‘in the 2021 Australian Early Development Census were 20 per cent more developmentally vulnerable on one or

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[4] Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 18.

[5] Mr Ross Joyce, Chief Executive Officer, Australian Federation of Disability Organisations, *Committee Hansard*, 20 October 2025, p. 44.

[6] NDIS website, *Quarterly report to disability ministers, Quarter 2024-25 Full report*, p. 21, www.ndis.gov.au/publications/quarterly-reports (accessed 2 October 2025).

[7] Ms Janine Mohamed, Deputy Chief Executive Officer, First Nations, National Disability Insurance Agency, *Committee Hansard*, 21 October 2025, p. 2.

more domains, compared to non-Indigenous children (42 per cent compared with 22 per cent).'[8] They added:

> Aboriginal and Torres Strait Islander people are twice as likely to experience disability than other Australians. Aboriginal children are twice as likely to be developmentally vulnerable at school entry.[9]

3.12 The Committee received evidence about the lived experience of First Nations children with a disability and their carers, including the issues faced by First Nations communities accessing disability services and support, and reflections about the experiences and priorities of First Nations communities inputting into program design.

3.13 A lack of cultural safety in program design, diagnostic tools and disability services was an issue that was raised frequently by stakeholders.

Lived experience of First Nations people with disability

3.14 Mr Damian Griffis, Chief Executive Officer at the First Peoples Disability Network, highlighted it is 'difficult to think of any more disadvantaged Australians than First Nations people with disabilities … because we often experience discrimination based upon indigeneity and disability.'[10] He added:

> Right now, only 33.9 per cent of Aboriginal and Torres Strait Islander children start school developmentally on track—far short of the 2031 target of 55 per cent.[11]

3.15 Associate Professor Clinton Schultz, Director of First Nations Strategy and Partnerships at the Black Dog Institute, suggested that the Aboriginal and Torres Strait Islander young people who experience autism—and their families—could be one of the most marginalised groups in Australian schools.[12] He stated:

> …when we're looking at groups in that school based age. They face all the same challenges with the systems—access et cetera—that we have just spoken about, but we can't deny that there is also that overlay and that intersectionality of discrimination that exists within systems within Australia in the experiences of Aboriginal and Torres Strait Islander people.[13]

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[8] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 6.

[9] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 6.

[10] Mr Damian Griffis, CEO, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 10.

[11] Mr Rhys Howard, National Policy Manager, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 10.

[12] Associate Professor Clinton Schultz, Director, First Nations Strategy and Partnerships, Black Dog Institute, *Committee Hansard*, 10 October 2025, p. 43.

[13] Associate Professor Clinton Schultz, Director, First Nations Strategy and Partnerships, Black Dog Institute, *Committee Hansard*, 10 October 2025, p. 43.

3.16 SNAICC – National Voice for Our Children highlighted the ongoing impacts of colonisation, noting that it results in:

> Aboriginal and Torres Strait Islander people with disability experiencing different forms of discrimination such as racism, ableism and intersectional and structural discrimination, significantly impacting on their rights, health, safety and wellbeing. Aboriginal and Torres Islander people with disability, after experiencing these different forms of discrimination, can often respond with what is known as 'apprehended discrimination'; a fear of encountering prejudice that causes social avoidance and makes them reluctant to access disability supports and participate in the broader community. This intersectional disadvantage and 'double discrimination' leads to major barriers to access in ECEC settings, barriers that results in poorer treatment and outcomes for Aboriginal and Torres Strait Islander children with disability.[14]

Distrust of institutional care

3.17 Several organisations noted a lack of trust in institutional care among Aboriginal and Torres Strait Islander peoples, identifying this as a significant barrier to accessing services.

3.18 Children's Healthcare Australasia commented on the overall distrust of the healthcare system:

> The distrust that many First Nations families have for healthcare services is understandable given that as many as 1 in 10 Aboriginal babies are still being removed at or soon after birth in our maternity hospitals. At the very least, all services that come within the Thriving Kids initiative, whether Child and Family Hubs, Early Childhood Education Centres, or Child Development Services, need to be trained and required to provide culturally safe screening and/or support services.[15]

3.19 NACCHO noted that Aboriginal and Torres Strait Islander people do not access disability services or early intervention supports at a rate commensurate with their level of need. NACCHO said that one of the multiple factors contributing to lower access and utilisation rates for Aboriginal and Torres Strait Islander people was distrust of institutional care as a result of both personal and historical experiences.[16]

3.20 Karitane, a not-for-profit organisation that supports families and children agreed that 'some Aboriginal families avoid mainstream services due to intergenerational experiences of racism, discrimination and judgement about parenting.'[17]

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[14] SNAICC – National Voice for Our Children, *Submission 327*, p. 15.

[15] Children's Healthcare Australasia, *Submission 290*, p. 9.

[16] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 6.

[17] Karitane, *Submission 282*, p. 15.

3.21 The Brotherhood of St Laurence and the Australian Institute of Family Studies also commented on intergenerational trauma and general mistrust of government, health, disability services and providers, education, and other systems and 'fear of child removal if formal supports are sought or accessed.'[18]

3.22 The South West Autism Network and Uniting NSW/ACT, the social services and advocacy arm of the Synod of the Uniting Church in NSW and Australian Capital Territory, both advocated for the work to be led by First Nations communities, adding:

> It is essential that services which deliver supports to First Nations families and communities are aware of systemic failings in mainstream systems such as the overrepresentation of First Nations children in out of home care. Some First Nations families and communities choose not to access mainstream services for children with indicators disability and developmental delay out of a fear of child protection involvement and judgement of their parenting capacity.[19]

Experience with diagnosis

3.23 Several stakeholders raised that identification of disability, neurodiversity, and developmental delays can often occur later than is ideal for First Nations people, for a number of reasons.

3.24 Every Australian Counts highlighted Closing the Gap data that only 34 per cent of First Nations children are developmentally on track at school start, dropping to just 16 per cent in very remote areas.[20]

3.25 One reason is a lack of service availability in First Nations communities. Physical Disability Australia raised that late diagnosis of neurodiversity can occur 'much later than would benefit the child and family, particularly if you're First Nations and particularly if you're living in rural or remote areas…where there is a lack of specialists who can actually make diagnoses.'[21]

3.26 Triple P International agreed that there were 'significant challenges in the diagnosis and support of First Nations children, including lower reported rates of diagnosis due to limited access to services.'[22]

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[18] Brotherhood of St Laurence, *Submission 254*, p. 24; Australian Institute of Family Studies, *Submission 370*, p. 5.

[19] Uniting NSW/ACT, *Submission 258*, pp. 10–11.

[20] Every Australian Counts, *Submission 273*, p. 9.

[21] Mr Jeremy Muir, Chief Executive Officer, Physical Disability Australia, *Committee Hansard*, 3 October 2025, p. 11.

[22] Triple P International, *Submission 310*, p. 13.

3.27 The NACCHO highlighted that there were ‘multiple factors contributing to lower access and utilisation rates for Aboriginal and Torres Strait Islander people’[23] including:

- Limited or no availability of disability services in Aboriginal communities (thin markets)
- The need to provide evidence of disability and the burden on health systems to supply this
- Difficulty navigating the system
- A lack of culturally appropriate and/or trauma informed mainstream disability service provision (culturally thin markets)
- Experiences of systemic and interpersonal racism
- Distrust of institutional care as a result of both personal and historical experiences.[24]

3.28 NACCHO commented that while there is an increase in Aboriginal and Torres Strait Islander people participating in the scheme, overall utilisation of plans was poor:

> While up-take of the NDIS by Aboriginal and Torres Strait Islander people is increasing – NDIS Quarterly reports for 2022-23 show that Aboriginal and Torres Strait Islander people consistently make up more than 9% of new participants to the Scheme - plan utilisation is poor with many Aboriginal and Torres Strait Islander people unable to access vital services and/or culturally safe services.[25]

3.29 Mr Rhys Howard, National Policy Manager, at the First Peoples Disability Network highlighted the gaps between the prevalence of disability with rates of diagnosis and access to service:

> …at the moment, for so many First Nations kids with disability, there is no service, because their diagnosis is made at such a lower rate. And yet, despite that, we know that the prevalence of disability is almost twice that of the mainstream population. So I think that, for kids who fall into this gap where they can't access the NDIS, because they don't have a diagnosis and there aren't mainstream supports available in their local region, especially if they're rural and remote.[26]

3.30 In contrast to this, Associate Professor Schultz from the Black Dog Institute warned that Aboriginal and Torres Strait Islander people across the spectrum of social and

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[23] National Aboriginal Community Controlled Health Organisations, *Submission 154*, pp. 6–7.

[24] National Aboriginal Community Controlled Health Organisations, *Submission 154*, pp. 6–7.

[25] National Aboriginal Community Controlled Health Organisations, *Submission 154*, pp. 6–7.

[26] Mr Rhys Howard, National Policy Manager, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 11.

emotional wellbeing are actually more likely to receive diagnoses, but far less likely to receive treatment and intervention.[27]

3.31 Cultural differences in how disability is defined may also contribute to delayed diagnosis. Associate Professor Schultz from the Black Dog Institute raised that 'for Aboriginal and Torres Strait Islander peoples, the understandings of neurodiversity may not always align with Western diagnostic frameworks,' meaning programs may not be capturing individuals from these groups.[28]

3.32 Speaking on assessment and developmental screening tools, Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi) said that 'current Western assessment tools marginalise our children and lead to misidentification, under identification and the pathologising of cultural differences. Cultural validation must be a design requirement.'[29]

3.33 A lack of cultural safety in diagnostic processes was also raised as an issue by stakeholders. First Peoples Disability Network highlighted that the assessment process required for gaining support services for those with a disability continues to be a barrier for many First Nations individuals, families, and community members, and created an enormous amount of fear.[30] He elaborated:

> There's a real reluctance for parents to come forward and get support for their young child with disability, because they fear removal of the child or being judged as bad parents, for example. These are the bigger picture—understanding that needs to be well established in this system so that we can have the success that we want to see here. There is a greater risk of this becoming more and more medicalised, which will mean that our families, our communities will less engage with that sort of approach. So the critical thing is that our families, our parents, our communities are the ones that drive the program.[31]

3.34 This point was also raised by SNAICC – National Voice for our Children (SNAICC), who told the Committee

> We know that often our families don't look for support because of the intersection with the child protection system. We know that they are misrepresented, we know that they are over analysed, we know that they suffer from oversurveillance, and we know that those things that could have been solved in early childhood are often disregarded and left in tatters.[32]

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[27] Associate Professor Clinton Schultz, Director, First Nations Strategy and Partnerships, Black Dog Institute, *Committee Hansard*, 10 October 2025, p. 43.

[28] Associate Professor Clinton Schultz, Director, First Nations Strategy and Partnerships, Black Dog Institute, *Committee Hansard*, 10 October 2025, p. 41.

[29] Ms Rachel Fishlock, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, 17 November 2025, p. 30.

[30] Mr Damian Griffis, CEO, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 11.

[31] Mr Damian Griffis, CEO, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 11.

[32] Ms Catherine Liddle, Chief Executive Officer, SNAICC – National Voice for our Children, *Committee Hansard*, 17 November 2025, p. 28.

3.35 SNAICC also commented on the impacts of delayed diagnosis on First Nations people. On the experience of First Nations children with disability or developmental delays, SNAICC said:

> What we know is that our children too often enter our school systems with undetected or misidentified developmental challenges and vulnerabilities. Those vulnerabilities persist throughout their lives. We know all too well that, if children start school with a learning gap, that gap gets bigger throughout their entire life journey. We also know that often the first time our children are picked up as needing a little bit of extra support is when they hit the juvenile justice system.[33]

3.36 SNAICC reflected further on the interactions between development delays and the justice system, telling the Committee that in the Northern Territory in 2021, 77 per cent of children in juvenile detention needed cognitive or developmental supports. They said:

> None of them had been identified as needing those supports despite having contact with several systems by the time they hit the child protection system, and there they are, locked up in cells.[34]

Developmental screening

3.37 Several organisations emphasised the value of ensuring that Aboriginal and Torres Strait Islander people be provided culturally appropriate developmental screening tools. Miwatj Health Aboriginal Corporation stated that ‘existing measures of developmental milestones are largely based on Western concepts of progress and fail to recognise First Nations frameworks of child development.’[35]

3.38 SNAICC also noted that ‘definitions of disability and developmental delay varies greatly between mainstream ‘Western’ perspectives and Aboriginal and Torres Strait Islander culture, knowledge and perspectives.’[36] They added:

> This is reflected in the fact that many Aboriginal and Torres Strait Islander languages do not have direct equivalents for the word ‘disability’ and by extension, ‘developmental delay’. This highlights the importance of understanding Aboriginal and Torres Strait Islander definitions of health and wellbeing, anchored in culture and community. This is distinct from the Western perspective that frames disability as a deficit or as a condition to be fixed, rehabilitated, or prevented.[37]

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[33] Ms Catherine Liddle, Chief Executive Officer, SNAICC – National Voice for our Children, *Committee Hansard*, 17 November 2025, p. 28.

[34] Ms Catherine Liddle, Chief Executive Officer, SNAICC – National Voice for our Children, *Committee Hansard*, 17 November 2025, p. 28.

[35] Miwatj Health Aboriginal Corporation, *Submission 288*, p. 1.

[36] SNAICC – National Voice for Our Children, *Submission 327*, p. 15.

[37] SNAICC – National Voice for Our Children, *Submission 327*, p. 15.

3.39 This view that the current system is premised on Western perspectives was echoed by South Burnett CTC and Uniting NSW/ACT.[38]

3.40 Indigenous Allied Health Australia emphasised that the approach should avoid rigid, Western biomedical models and instead reflect holistic, culturally grounded perspectives; that the Thriving Kids initiative must be flexible and culturally responsive. Services should be delivered on Country, draw on culture as a strength for healthy development, and embed social and emotional wellbeing.[39]

3.41 Indigenous Allied Health noted the challenges with current assessment tools for Aboriginal and Torres Strait Islander people:

> Currently assessment tools being used lack cultural responsiveness, they are often prescriptive, deficit-based and developed through a non-Indigenous worldview. The assessment for Aboriginal and Torres Strait Islander children to go on the Thriving Kids Initiative needs to be culturally appropriate, strengths-based and localised. It can't be a 'one fits all approach'.[40]

3.42 South Burnett CTC agreed that 'interventions for the First Nations need to be presented in a way that suits their beliefs and are communicated appropriately.'[41]

3.43 Submitters put forward two main examples of culturally appropriate assessment tools for Aboriginal and Torres Strait Islander children: ASQ-TRAK (Ages and Stages Questionnaire – Talking about Raising Aboriginal Kids) and the Tracking Cube.[42]

ASQ-TRAK

3.44 ASQ-TRAK was developed by Dr Anita D'Aprano, now Principal Research Fellow in Indigenous Health at the University of Melbourne. To develop the tool Dr D'Aprano worked with remote Aboriginal communities in Arnhem Land.[43]

3.45 Organisations were of the view that ASQ-TRAK was strength-based, family centred and develops the skills of caregivers. The Murdoch Children's Research Institute put forward the view that the program was culturally appropriate and could be adopted broadly across the sector:

> ASQ-TRAK is the only culturally adapted developmental screening tool designed specifically for Aboriginal and Torres Strait Islander children aged 2 months to 5.5 years. Co-designed with First Nations communities, it offers a strengths-based, family-centred approach that actively involves caregivers, supporting both early

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[38] South Burnett CTC, *Submission 41*, p. 5; Uniting NSW/ACT, *Submission 258*, pp. 10–11.

[39] Indigenous Allied Health Australia, *Submission 271*, p. 3.

[40] Indigenous Allied Health Australia, *Submission 271*, p. 2.

[41] South Burnett CTC, *Submission 41*, p. 5.

[42] See, for example: Lifestart Disability Services, *Submission 245*, p. 10; Children's Healthcare Australasia, *Submission 290*, p. 9; Monash University, *Submission 291*, p. 7; Occupational Therapy Australia, *Submission 304*, pp. 26–27; University of Melbourne, *Submission 319*, p. 23.

[43] Ms Janice Finlayson, Director, Maternal, Child and Family Health Nurses Australia, *Committee Hansard*, 21 October 2025, p. 26.

> identification and caregiver confidence. ASQ-TRAK enables timely, equitable access to early intervention and is ready for national scale, with training and implementation supports in place. Broader adoption across early childhood services presents a key opportunity for Thriving Kids to embed culturally safe developmental care into universal platforms and support First Nations children to thrive.[44]

3.46 Lifestart Disability Services agreed that ASQ-TRAK was a culturally safe screening tool, elaborating that it could:

> …guide conversations with First Nations families around developmental milestones. This tool uses visuals, flipcharts, and simple language, which is more accessible for families, and ensures they are supported to clearly identify where their child may need support.[45]

3.47 NACCHO commented on how ASQ-TRAK supported caregivers as part of the process:

> It is designed to be administered by interview, and made to be easy-to-use, family centred. It is focussed on highlighting a child's strengths as well as screening for delays. Caregivers are co-observers in the process, and as part of the process they can be supported and taught them about child development and their own child's skills.[46]

3.48 Maternal, Child and Family Health Nurses Australia also spoke of the success of ASQ-TRAK, and raised it as a potential tool to roll out across all of Australia, while acknowledging the challenge of collecting data on its use:

> It makes it translatable to any non-English-speaking family of a non-English-speaking background, because it's full of pictures and plain English. It's brilliant, and it's so easy to use —and yet we've got no way to collect that data… How do you know that your bucket of money is being put to good use when we don't have any common way of collecting that result?[47]

3.49 Several submitters did however express some concerns about the challenges in people accessing culturally appropriate screen tools such as ASQ-TRAK, due to high demand and limited availability of training sessions. NACCHO in particular, stated:

> …the demand for training outpaces NACCHO's current ability to facilitate training – with more than 700 applications for just 200 training places. There remains an urgent need to scale training in child development screening and assessment in the ACCHO sector in a culturally appropriate manner.[48]

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[44] Murdoch Children's Research Institute, *Submission 234*, p. 18.

[45] Lifestart Disability Services, *Submission 245*, pp. 19–20.

[46] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 17.

[47] Ms Janice Finlayson, Director, Maternal, Child and Family Health Nurses Australia, *Committee Hansard*, 21 October 2025, pp. 26–27.

[48] National Aboriginal Community Controlled Health Organisations, *Submission 154*, pp. 12–13.

3.50 NACCHO recommended extension of funding to enable the continued roll-out of ASQ-TRAK training to meet the demand from the ACCHO sector.[49]

3.51 Miwatj Health Aboriginal Corporation also raised concerns about the availability of culturally appropriate developmental screening tools including ASQ-TRAK:

> At present, there is a lack of culturally safe screening tools for developmental delay. While tools such as ASQ-TRAK and the Vanderbilt Assessment exist, they are not widely accessible, nor are there enough qualified professionals to administer them consistently. The ASQ-TRAK training is delivered in Victoria via a 2-day face-to-face workshop that is a significant cost to the organisation, and not a culturally safe or inclusive pathway for First Nations professionals. This makes supporting staff to become qualified ASQ-TRAK Assessors unattainable for many ACCHOs, especially considering the recruitment and retention challenges in remote regions. Parents are also not provided with adequate education or support to understand these tools, nor how to contribute their own observations of their child's development.

The Tracking Cube

3.52 Another developmental screening tool that was mentioned by several organisations as a ‘culturally responsive approach to screening, diagnosing and monitoring neurodevelopment that helps identify disorders such as FASD, ADHD, [and] Autism in primary healthcare and non-health settings’[50] is the Tracking Cube. NACCHO elaborated on the program stating:

> The Tracking Cube can be used to assess children up to 17 years old. The ASQ-TRAK screening tool can be used as part of the assessment process (limited to 0 to 5 years of age).
>
> Through the Yapatjarrathati Project, a bespoke version of the Tracking Cube was co-created for use by the Kalkadoon nation in the Mount Isa region. This ensures it is culturally safe and appropriate.
>
> The Tracking Cube links evidence-based neurodevelopmental screening with risk and protective factors as well as parent/teacher concerns to provide a holistic understanding of at-risk children.
>
> Its digital infrastructure summarises patient data from multiple sources and provides auto-generated referral and report templates to assist triage and support decisions.
>
> It is split into 6 tiers – 5 of which can be carried out by primary health workers such as Aboriginal Health Workers (or workers in schools, childcare and other settings), and the 6th by a specialist. This in effect is able to lower patient wait times and get children the necessary referrals more rapidly.[51]

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[49] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 3.

[50] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 18.

[51] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 18.

3.53 Griffith University endorsed the Tracking Cube as a model for Thriving Kids which could be 'translated into a secure, nationally-scaled platform'[52], highlighting:

> In remote Aboriginal communities, the model has resulted in the identification of 7 times more children with developmental concerns and increased access to local support six-fold. Referrals to specialists stayed the same, because rather than referring all children with a concern (current care model), the right children were referred. The majority of identified children were supported in community and primary care. Staff confidence in supporting children improved and family trust in health care services improved.[53]

3.54 They noted that the Tracking Cube was codesigned with community Elders who 'shaped the Cube's symbols and processes, ensuring cultural resonance and trust'[54] adding that:

> Communities choose the tools they trust based on local expertise, evidence relevant to their region and cultural preferences, ensuring equity but providing a unified national framework for interpretation and outcome.[55]

Culturally safe services and community-led design

Box 3.1 Defining cultural safety

Different sources will have different definitions of cultural safety, but the core principle is that cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.[56] The diversity of First Nations Australians, their perceptions and experiences means that there are a variety of appropriate definitions.[57]

Some of the essential features of cultural safety include an understanding of one's own culture; an acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of this difference; and the ability to recognise, address, and prevent racism.[58] A culturally safe environment is one that is safe for First Nations people, where there is no assault, challenge, or denial of their identity or experience.[59]

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[52] Griffith University, *Submission 222*, p. 2.

[53] Griffith University, *Submission 222*, pp. 2, 6.

[54] Griffith University, *Submission 222*, p. 2.

[55] Griffith University, *Submission 222*, p. 3.

[56] Australian Health Practitioner Regulation Agency, *The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025*, p. 9

[57] Australian Institute of Health and Welfare, *Cultural safety in health care for Indigenous Australians: monitoring framework*, 7 July 2023, www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/background-material (accessed 3 December 2025).

[58] Australian Health Practitioner Regulation Agency, *The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025*, p. 9

[59] Department of Health and Human Services, *Aboriginal and Torres Strait Islander cultural safety framework: Part 1*, 2019, p. 7.

Unsafe cultural practice comprises any action which diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual.[60]

Some important principles of cultural safety that have been put forward in Aboriginal and Torres Strait Islander health and cultural safety strategies are:

- removal of barriers to optimal health, wellbeing, and safety for First Nations people. This includes addressing unconscious bias, racism, and discrimination, and supporting First Nations self-determination[61]
- providers respect and understand First Nations culture and people[62]
- individuals, organisations and systems take responsibility for ensuring their own cultural values do not negatively impact on First Nations peoples[63]
- First Nations people feel safe, connected to culture, and that their cultural identity is respected[64]
- recognition of the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community[65]

Due to the diversity of experiences of First Nations people, this box will not capture the complexity of the issues raised by stakeholders in this inquiry, but aims to provide some context for those who are unfamiliar with the concept.

3.55 The Committee heard evidence about the importance of cultural safety and community-led models in the design of Thriving Kids.

3.56 The NDIA told the Committee that in their experience, ‘when First Nations people experience cultural safety, they're more likely to come back and use the service, and there are more likely to be more First Nations people employed in the service.’[66]

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[60] National Aboriginal and Torres Strait Islander Health Worker Association, *Aboriginal and Torres Strait Islander Cultural Safety Framework*, p. 4.

[61] Department of Health and Human Services, *Aboriginal and Torres Strait Islander cultural safety framework: Part 1*, 2019, p. 7.

[62] Australian Institute of Health and Welfare, *Cultural safety in health care for Indigenous Australians: monitoring framework*, 7 July 2023, www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/background-material (accessed 3 December 2025).

[63] Department of Health and Human Services, *Aboriginal and Torres Strait Islander cultural safety framework: Part 1*, 2019, p. 7.

[64] Australian Institute of Health and Welfare, *Cultural safety in health care for Indigenous Australians: monitoring framework*, 7 July 2023, www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/background-material (accessed 3 December 2025).

[65] Australian Health Practitioner Regulation Agency, *The National Scheme’s Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025*, p. 9

[66] Ms Janine Mohamed, Deputy Chief Executive Officer, First Nations, National Disability Insurance Agency, *Committee Hansard*, 21 October 2025, p. 5.

3.57 The Miwatj Health Aboriginal Corporation told the Committee that there are currently very few culturally safe screening tools that are used in Australia.[67] They explained how their organisation has made these tools work for First Nations children:

> In our model we use Aboriginal health practitioners and community workers—or, in our case, remote community connectors—to support those screening pathways. From our perspective…it's having the ACCHO model and that wraparound team supporting that process that makes it work. There are so many different screening tools around, and so many different screening tools that need to be used with respective disabilities or age demographics, that it is really challenging to make them all accessible and adaptable within language contexts around Australia. The key here is that ACCHO model and having a team to support the implementation of that screening tool, rather than potentially adapting that to all our very complex regions.[68]

3.58 Stakeholders made recommendations on how cultural safety can be more closely embedded into disability services.

3.59 Mr Rhys Howard of the First Peoples Disability Network warned against previous culturally unsafe government programs meant to assist First Nations people.[69] Mr Howard cautioned:

> With a $2 billion investment from July 2026, we cannot afford to repeat the past failures of culturally unsafe and mainstream programs. We urge the committee to hardwire co-design, community controlled delivery and cultural safety into Thriving Kids. This will ensure early identification, family led supports and seamless transitions so that no child falls through the cracks.

3.60 The First Peoples Disability Network emphasised to the Committee that 'Thriving Kids can absolutely close gaps for our children only if it partners with First Nations community at every single stage.'[70] The Early Learning and Care Council of Australia echoed this, speaking of the importance of 'co-design with First Nations people that is led by First Nations controlled organisations.'[71]

3.61 They also reflected on the authority behind their recommendations, stating:

> Our practical recommendations—from mandatory, culturally adapted screening to a First Nations workforce pipeline—are aligned with the disability royal

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[67] Mrs Emily Osborne, NDIS Operations Manager, Miwatj Health Aboriginal Corporation, *Committee Hansard*, 17 November 2025, p. 29.

[68] Mrs Emily Osborne, NDIS Operations Manager, Miwatj Health Aboriginal Corporation, *Committee Hansard*, 17 November 2025, p. 28.

[69] Mr Rhys Howard, National Policy Manager, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 10.

[70] Mr Rhys Howard, National Policy Manager, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 10.

[71] Ms Sally Maddison, Acting Chief Executive Officer, Early Learning and Care Council of Australia, *Committee Hansard*, 28 November 2025, p. 6.

> commission's call for structural reform, as well as the national agreement on Closing the Gap.[72]

3.62 The Executive Director of NACCHO, Dr Sarah Hayton, described why awareness and understanding of cultural safety in a local setting was so important to gain the trust of First Nations people needing support services.[73]

> I think the criticality of this is that it is very important that this is identified as place based. That's because cultural safety is locally placed and oriented towards their own community members. This is why the community-controlled sector is best placed to look after their own people, particularly within this space.[74]

3.63 Ms Lewis from Indigenous Allied Health Australia emphasised First Nations families want services 'on country because country and the environment are healing'[75]. She also emphasised that First Nations families want services provided by First Nations peoples or to be designed with awareness of First Nations issues, and spoke of the need for education and a co-design model:

> They've also said that they want more Aboriginal and Torres Strait Islander workers as well. So they want investment in health and schools and communities. We know that, when the workforce shares culture and history, families feel understood and supported. Our families are saying that the way to do that is by having community co-design—not just the co-design that we talk about in the Western sense; it has to be that proper community co-design. That's to make sure services reflect local priorities and needs.[76]

3.64 Various witnesses spoke about the importance of building connections and trust as an essential part of program design.

3.65 First Nations families want services and professionals to show empathy, genuine care and to share something of themselves, according to Indigenous Allied Health Australia.[77] She stated:

> They want to see and feel that relational accountability to their care and not a transactional account of their health journey. One parent has said to us: 'Professionals need to use story sharing, storytelling, and tell me who you are. It's

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[72] Mr Rhys Howard, National Policy Manager, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 10.

[73] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 13.

[74] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 13.

[75] Ms Tara Lewis, Knowledge Translation Lead, Indigenous Allied Health Australia, *Committee Hansard*, 10 October 2025, p. 14.

[76] Ms Tara Lewis, Knowledge Translation Lead, Indigenous Allied Health Australia, *Committee Hansard*, 10 October 2025, p. 14.

[77] Ms Tara Lewis, Knowledge Translation Lead, Indigenous Allied Health Australia, *Committee Hansard*, 10 October 2025, p. 14.

> not just about me giving. You have to tell me about yourself. What's your story. What's going to make me trust you to tell you these things?'[78]

3.66 Dr Hayton of NACCHO commented:

> It does require a lot of trust. I think that one of the core elements around that is the ability to have a trusting relationship where the Aboriginal family will actually speak openly with you. The reason why those connector roles are so critical…is that, even if they're bringing in clinical teams who are not Aboriginal and may not have deep knowledge of that local community, it is that local person who actually provides that cultural safety for the Aboriginal people and their family when they come into the clinics or if they're sitting in their family homes because they're doing an outreach visit.[79]

3.67 Queenslanders with Disability Network spoke about the importance of continuing connections in the context of ensuring equitable access for First Nations communities, as well as families and communities with other diverse backgrounds:

> I certainly think from our engagement and the families we've talked to that it is very much the importance of cultural safety, trust and engagement with those services on the ground… Families talked about, as different providers come in, having to start all over again. They lose half an hour of the appointment time having to go over everything and retell their story. Cultural safety in the services that are provided is critical.[80]

3.68 Mr Pat Murphy, President of the Australian Government Primary Principals Association, told the Committee that there are often gaps between identification and timely follow-up services for First Nations children, children from remote, disadvantaged communities, and rural and low-SES communities. He called for dedicated funding for schools to employ cultural liaison officers and community connections, 'to ensure families engage early, confidently and continually.'

3.69 NACCHO also advocated support services being 'very trauma informed to be able to work in this space'.[81] Similarly, Ms Lewis reflected that First Nations families want systems and services that retain information to avoid further trauma:[82]

> Families spoke about having to retell their story and their lived experiences with each new health or educational professional, and they don't want that. They want

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[78] Ms Tara Lewis, Knowledge Translation Lead, Indigenous Allied Health Australia, *Committee Hansard*, 10 October 2025, p. 14.

[79] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 13.

[80] Ms Michelle Moss, Chief Executive Officer, Queenslanders with Disability Network, *Committee Hansard*, 3 October 2025, p. 10.

[81] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 13.

[82] Ms Tara Lewis, Knowledge Translation Lead, Indigenous Allied Health Australia, *Committee Hansard*, 10 October 2025, p. 14.

> a system that communicates so that they don't have to relive their trauma every time they see a new health professional or someone new in their schools.[83]

3.70 The Committee heard of some initiatives that are aiming to embed community-led design into disability care.

3.71 The NDIA has established a formal partnership with NACCHO and a First Nations sector policy advisory committee with representatives from SNAICC and FPDN. As well, they are working with Indigenous Allied Health Australia and the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners on growing and retaining a First Nations workforce.[84] The NDIA also started a cultural safety initiative in 2025, with the view to develop a cultural safety plan for the organisation following establishment of this baseline.[85]

3.72 The Committee asked the NDIA whether the government should be doing more to improve the numbers of Aboriginal health and disability workers. NDIA said that there are policies in place to grow this workforce, and that through the actions of NACCHO and the NIAA numbers of Aboriginal health workers throughout the whole care economy are increasing.[86]

3.73 NDIA is also growing an Aboriginal and Torres Strait Islander disability workforce, and placing Aboriginal Disability Liaison Officers (ADLOs) within Aboriginal Community Controlled Health Organisations (ACCHOs) to build trust.[87]

Culturally informed frameworks, initiatives and programs

3.74 Submitters expressed strong support for several frameworks, initiatives and programs that they believe provide culturally informed and responsive approaches to early childhood intervention, particularly for Aboriginal and Torres Strait Islander families. These include the National Best Practice Framework for Early Childhood Intervention, the National Framework for Assessing Children's Functional Strengths and Support in Australia, and ENVISAGE. The following section outlines the evidence received on these programs.

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[83] Ms Tara Lewis, Knowledge Translation Lead, Indigenous Allied Health Australia, *Committee Hansard*, 10 October 2025, p. 14.

[84] Ms Janine Mohamed, Deputy Chief Executive Officer, First Nations, National Disability Insurance Agency, *Committee Hansard*, 21 October 2025, p. 5.

[85] Ms Janine Mohamed, Deputy Chief Executive Officer, First Nations, National Disability Insurance Agency, *Committee Hansard*, 21 October 2025, p. 3.

[86] Ms Janine Mohamed, Deputy Chief Executive Officer, First Nations, National Disability Insurance Agency, *Committee Hansard*, 21 October 2025, p. 9.

[87] Ms Janine Mohamed, Deputy Chief Executive Officer, First Nations, National Disability Insurance Agency, *Committee Hansard*, 21 October 2025, p. 5.

National Best Practice Framework for Early Childhood Intervention

3.75 As discussed in Chapter 2, the National Best Practice Framework for Early Childhood Intervention is aimed at providing:

> …advice on how to support children under 9 years of age who have developmental concerns, delays, or disabilities. It helps families and professionals understand what good support looks like and how to provide it.[88]

3.76 The Framework 'identifies cultural safety and diversity-affirming practice as universal principles of best practice, ensuring that services are rights-based and inclusive of Aboriginal and Torres Strait Islander families, CALD families, and neurodiverse children.'[89]

3.77 The University of Melbourne noted that the Framework was 'developed through a rigorous and comprehensive research collaboration which included consultation with key stakeholders and end-users: that is, young people with disability, their parents, carers and families, Aboriginal and Torres Strait Islander families and community-controlled organisations, and ECI service providers and researchers.'[90]

3.78 Submitters who provided evidence to this inquiry supported the implementation of the Framework 'as the foundational resource for the development of Thriving Kids' believing that it would 'address Aboriginal and Torres Strait Islander families' fear that engaging with ECI practitioners will lead to unwarranted child protection notifications.'[91]

3.79 A significant number of submitters, while not necessarily commenting on the synergy between the Framework and Aboriginal and Torres Strait Islander people, were very supportive of the Framework as a foundation for the Thriving Kids initiative.[92]

National Framework for assessing children's functional strengths and support in Australia

3.80 South Burnett CTC were supportive of the National Framework for assessing children's functional strengths and support in Australia noting that it:

> …has been researched and developed for First Nations people and considers their cultural needs and offers a comprehensive view of different strategies that can be used to assist First Nations families. The framework bases the assistance

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[88] Department of Health, Disability and Ageing, *About the National Best Practice Framework for Early Childhood Intervention*, www.health.gov.au/our-work/national-best-practice-framework-for-early-childhood-intervention/about?language=en (accessed 3 December 2025).

[89] Queenslanders with Disability Network, *Submission 279*, p. 19.

[90] University of Melbourne, *Submission 261*, p. 5.

[91] University of Melbourne, *Submission 261*, pp. 1 and 6; SNAICC – National Voice for Our Children, *Submission 327*, p. 26.

[92] See for example: Child and Family Disability Alliance, *Submission 117*, p. 3; Early Childhood Intervention Australia Victoria, *Submission 199*, p. 7; Murdoch Children's Research Institute, *Submission 234*, p. 4; Queenslanders with Disability Network, *Submission 279*, p. 5; Occupational Therapy Australia, *Submission 304*, pp. 7, 31; Australian Child and Family Services Alliance, *Submission 316*, p. 4; University of Melbourne, *Submission 319*, p. 17; The Australian and Family Supports Alliance, *Submission 357*, p. 4.

> around body structure, activity, forming friendships, family and personal differences.[93]

3.81 Not for-profit organisation Teach Speak Hear agreed that it offered 'genuine partnership with Aboriginal and Torres Strait Islander children, families, and communities'[94] and:

> …emphasises walking alongside families to facilitate culturally informed and responsive approaches to assessment and support. It involves listening, observing and engaging in ways that are developmentally appropriate and respectful. This Framework builds on foundational principles to guide a cyclical process of assessing functional strengths and support needs, differentiating levels of support and informing meaningful reporting.[95]

3.82 When commenting on which frameworks provided guidance on best practice supports in early intervention more broadly, a significant number of submissions put forward the National Framework for assessing children's functional strengths and support in Australia as an example.[96]

ENVISAGE First Peoples program

3.83 The Australian Catholic University put forward the ENVISAGE–Families program and the dedicated ENVISAGE–First Peoples programs noting that they were 'co-designed in partnership with Aboriginal and Torres Strait Islander communities to support families in ways that are culturally sensitive and relevant to context, community, culture and country.'[97]

3.84 Similar to the previous framework, several submitters suggested the ENVISAGE program as an invaluable as starting support as they 'provide evidence-based information, empowerment, peer connection, and practical ideas to help families'.[98]

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[93] South Burnett CTC, *Submission 41*, p. 1.

[94] Teach Speak Hear, *Submission 89*, p. 5.

[95] Teach Speak Hear, *Submission 89*, p. 5.

[96] See for example: Australian Psychological Society, *Submission 160*, p. 11; Australian Physiotherapy Association, *Submission 171*, p. 47; Connectability Australia, *Submission 225*, p. 2; Family Services Alliance, *Submission 316*, p. 6; National Rural and Health Alliance, *Submission 379*, p. 2; Divergent Psychology, *Submission 337*, p. 1; Australian Council for Educational Research, *Submission 394*, p. 2; Autism CRC, *Submission 403*, p. 1.

[97] Australian Catholic University, *Submission 385*, p. 4.

[98] Australian Physiotherapy Association, *Submission 171*, p. 9; Name Withheld, *Submission 393*, p. 5; Connected Kiddos, *Submission 206*, p. 4; Occupational Therapy Australia, *Submission 304*, p. 16; Royal Children's Hospital, *Submission 272*, p. 5.

Additional suggested programs

3.85 Examples of other programs referenced as a positive example of culturally appropriate service provision included:

- Waijungbah Jarjums (which means place of mother and child), 'for mob by mob' at Gold Coast Health 'offers continuity of care by a known Aboriginal and Torres Strait Islander midwife and child health nurse from conception to 5 years.'[99]
- Victorian Aboriginal Child Care Agency's Koorie Families as First Educators program 'employs Koorie Educators to provide in-home support sessions with families or carers of Aboriginal children aged 0 to 5 years.'[100]
- The Victorian Aboriginal Child Care Agency's Koorie Kids Supported Playgroups has delivered 'supported playgroups to Aboriginal and Torres Strait Islander children and their families for over 15 years.'[101]
- Connected Beginnings program 'provides a framework and funding to support the integration of early childhood, maternal and child health, and family support services with schools' for Aboriginal and Torres Strait Islander children.[102]
- National Aboriginal and Torres Strait Islander Early Childhood Strategy 'provides a community-informed and evidence-based pathway to achieve the National Agreement on Closing the Gap targets and outcomes for early childhood.'[103]

3.86 The Minderoo Foundation + Thrive by Five put forward existing and developing parenting resources and programs 'Baby Coming You Ready', 'Bubba Here What Now', 'Maaman Baby Coming You Ready' and ICARE. They elaborated on each noting:

> Culturally appropriate parenting information and resources like 'Baby Coming You Ready' and 'Bubba Here What Now' have helped to close the equity gap for First Nations children and families.
>
> Building on more than a decade of research, Murdoch University's Professor Rhonda Marriott and her team at Ngangk Yira have brought stakeholders

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[99] Children's Healthcare Australasia, *Submission 290*, p. 9; Queensland Government, Gold Coast Health, *Waijungbah Jarjums*, www.goldcoast.health.qld.gov.au/aboriginal-and-torres-strait-islander-service/services/mums-and-bubs (accessed 3 December 2025).

[100] Brotherhood of St Laurence, *Submission 254*, p. 11; Victorian Aboriginal Child Care Agency, *Koorie Families as First Educators*, www.vacca.org/content/Document/KFFE%20Flyer%20for%20Professionals%20-%20Jan2020.pdf (accessed 3 December 2025).

[101] Gayaa Dhuwi (Proud Spirit) Australia, *Submission 99*, p. 5; Victorian Aboriginal Child Care Agency, *Koorie Kids Supported Playgroups*, www.snaicc.org.au/wp-content/uploads/2023/09/220201_7_Early-Intervention-Profile-VACCA-KK-1.pdf (accessed 3 December 2025).

[102] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 15; Australian Council of State School Organisations, *Submission 46*, p. 3; National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 7; Department of Education, *Submission 363*, pp. 9-10; University of Melbourne, *Submission 319*, p. 26; Autistic Self Advocacy Network of Australia and New Zealand, *Submission 181*, p. 30.

[103] Occupational Therapy Australia, *Submission 304*, p. 31; Australian Music Therapy Association, *Submission 274*, p. 3; National Indigenous Australians Agency, *National Aboriginal and Torres Strait Islander Early Childhood Strategy – Summary*, www.niaa.gov.au/sites/default/files/documents/publications/niaa-early-years-summary.pdf (accessed 4 December 2025).

> together to create healthcare supports that truly serve the needs of Aboriginal families they work with.
>
> Their initiatives, such as perinatal assessment tool 'Baby Coming You Ready' and wrap-around maternal health program ICARE have had great success. They are now developing two new programs: 'Bubba Here What Now' to support families in the child's first few years of life and 'Maaman Baby Coming You Ready', which is focussed on preparing First Nations men for fatherhood.[104]

3.87 Miwatj Health Aboriginal Corporation spoke of their adaptation of the Maternal Early Childhood Sustained Home visiting program for the Northern Territory, a program they call Yothuw Mulka. On this program, they said that 'taking the service to the people rather than expecting them to come into clinics' has allowed them to 'address some of the barriers for engagement within those assessments.'[105]

Experience with the NDIS

3.88 The Committee heard from stakeholders that, in the past, the needs of First Nations people have not been considered in the design of reforms to disability schemes.

3.89 Reflecting on previous reforms and the opportunity presented by the Thriving Kids initiative, Mr Griffis explained:

> We are very anxious to ensure that the needs of our young people with disabilities are at the forefront of the Thriving Kids reform. Too often, major social reforms pass us by, or we are an afterthought, or we're not viewed as a priority. Our experience with the NDIS demonstrates this.[106]

3.90 Mr Griffis described the 10-point plan for the successful implementation of the NDIS in its communities that the First Peoples Disability Network prepared in 2013.[107]

> We did this because meeting the needs of our community members should always be a first-order priority. But, regrettably, and predictably, our 10-point plan was largely ignored and, as a result, our people remain at the margins of the NDIS. We cannot allow this to happen again with the Thriving Kids initiative. After all, if the needs of our young people with disability— particularly those living in regional and remote Australia—can be met, then this has the potential to mean greater success, under the Thriving Kids program, for all young Australians with disability.[108]

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[104] Minderoo Foundation + Thrive by Five, *Submission 342*, p. 6.

[105] Mrs Emily Osborne, NDIS Operations Manager, Miwatj Health Aboriginal Corporation, *Committee Hansard*, 17 November 2025, p. 34

[106] Mr Damian Griffis, CEO, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 10.

[107] Mr Damian Griffis, CEO, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 10.

[108] Mr Damian Griffis, CEO, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 10.

3.91 The First Peoples Disability Network believed the current and proposed government policies needed to 'better understand our worldview on disability'.[109]

> In our traditional language, we have no comparable word for disability, and that's a wonderful thing; we've always recognised disability as part of the human experience. Yet the system is heavily labelled. Disability is heavily label ladened, be it autism, acquired brain injury, intellectual disability, cognitive impairment—whatever you want to call it. We are the thought leaders on inclusion, so we actually want to flip things over, if we may, and actually share with the rest of Australia the proper worldview on disability.[110]

3.92 Drawing on its research and consultation, Ms Tara Lewis, Knowledge Translation Lead at Indigenous Allied Health Australia also drew attention to the lack of cultural safety within the current system for First Nations people:

> …whilst we're talking about cultural safety, we have to understand that families are not struggling because of a lack of themselves or because the system is broken; they're struggling to navigate a system that was created to work exactly as it was intended. We know that it was designed to control and marginalise our peoples, and that design still shapes how our children are seen, assessed and supported today.
>
> These systems are built on racialised ideologies that too often see us as problems to be fixed, rather than as families and children with strengths and potential. [111]

3.93 The NDIA, the organisation that administers the NDIS, also reported that, during the Disability Royal Commission and the NDIS review, First Nations communities told them that the system is complex and not culturally safe.[112]

3.94 As was raised when describing the experience of First Nations families in having their children diagnosed, witnesses raised that the fear of child removal negatively impacts their interaction with the NDIS. Gayya Dhuwi said that for First Nations parents, 'the fear of child removal [is] an ongoing fear and it's a very real fear.'[113]

3.95 The NDIA agreed that this is something they have witnessed, saying:

> The historical experience of First Nations people, not just with the agency but with the system, leads First Nations people to be apprehensive, particularly where children are concerned, due to child removal.[114]

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[109] Mr Damian Griffis, CEO, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 11.

[110] Mr Damian Griffis, CEO, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 11.

[111] Ms Tara Lewis, Knowledge Translation Lead, Indigenous Allied Health Australia, *Committee Hansard*, 10 October 2025, p. 13.

[112] Ms Janine Mohamed, Deputy Chief Executive Officer, First Nations, National Disability Insurance Agency, *Committee Hansard*, 21 October 2025, p. 3.

[113] Professor Helen Milroy, Board Chair, Gayaa Dhuwi (Proud Spirit Australia), *Committee Hansard*, 17 November 2025, p. 35.

[114] Ms Janine Mohamed, Deputy Chief Executive Officer, First Nations, National Disability Insurance Agency, *Committee Hansard*, 21 October 2025, p. 9.

3.96 Gayaa Dhuwi emphasised the link between a lack of cultural governance and cultural safety, stating that 'we do not have cultural governance in the non-Aboriginal organisations at present, and we certainly don't have it in the mainstream clinical services.'[115]

Perspectives on Thriving Kids

3.97 The Committee heard from some First Nations stakeholders that Thriving Kids represents an opportunity for reform that could prioritise First Nations individuals and lead to better results for them.

3.98 Gayaa Dhuwi told the Committee that they see Thriving Kids as an opportunity to make the system work better for First Nations people, saying:

> Thriving Kids represents a period of significant structural reform of early childhood developmental and disability support…Together, these reforms create a rare opportunity to build a culturally safe, integrated national system that supports Aboriginal and Torres Strait Islander children across developmental, psychosocial, health and social and emotional wellbeing pathways. These reforms cannot be developed in silos, as they must be culturally grounded and grounded in Aboriginal and Torres Strait Islander concepts of healing and social and emotional wellbeing.[116]

3.99 SNAICC told the Committee that they see Thriving Kids as an opportunity to reverse the disproportionate representation of Aboriginal and Torres Strait Islander children in rates of vulnerability and disability, raising that they might 'for the first time, [be] disproportionately helped by a reform like this one.' They view Thriving Kids as an opportunity to 'work through shared decision-making and in partnership with use and our communities.'[117]

3.100 After telling the Committee about how First Nations families find the current system to be culturally unsafe, Indigenous Allied Health Australia described how Thriving Kids 'represents a vital opportunity to change how we support our families and children, particularly those who have been left navigating fragmented, unsafe and disconnected systems.'[118]

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[115] Professor Helen Milroy, Board Chair, Gayaa Dhuwi (Proud Spirit Australia), *Committee Hansard*, 17 November 2025, p. 35.

[116] Ms Rachel Fishlock, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, 17 November 2025, p. 28.

[117] Ms Catherine Liddle, Chief Executive Officer, SNAICC – National Voice for our Children, *Committee Hansard*, 17 November 2025, p. 28.

[118] Ms Tara Lewis, Knowledge Translation Lead, Indigenous Allied Health Australia, *Committee Hansard*, 10 October 2025, p. 13.

3.101 Miwatj Health Aboriginal Corporation hopes that Thriving Kids will mitigate long waitlists for diagnosis or assessment to support access to the NDIS, and fast-track access pathways.[119]

3.102 Gayaa Dhuwi added that 'Thriving Kids cannot sit as a standalone program; it needs to be embedded within the broader national reform architecture so that Aboriginal and Torres Strait Islander children are not pushed between disconnected systems.' They stressed the importance of integrating the reforms with the National Mental Health and Suicide Prevention Agreement and Closing the Gap reforms, and avoiding fragmentation across portfolios and disconnected systems. They envisage that embedding Thriving Kids across these reforms will create 'a single, connected pathway which ensures consistency in cultural safety, workforce, assessment, navigation and service design.'[120]

3.103 Dr Catherine Wade, representing the Parenting and Family Research Alliance and the Parenting Research Centre, suggested incorporating lessons learned from other programs into Thriving Kids:

> …there are lots of different parenting programs, and they're all valid, and many of them have very good evidence bases behind them. I think there is room for funding for more than one option, because each of those programs looks different, is delivered in a slightly different way, and meets the needs of different families. Some have been adapted to suit Aboriginal and Torres Strait Islander families, and some have been adapted specifically to suit parents with intellectual disability or parents of children with specific disabilities So I think Thriving Kids needs to think about how to keep that flexibility in the offerings that are available because no one size will fit all.[121]

Role of Aboriginal Community Controlled Health Organisations

3.104 The Committee received evidence about the importance and success of ACCHOs in delivering integrated services, and the opportunity to leverage off that model and approach in the design of Thriving Kids.

3.105 ACCHOs are community-run primary healthcare services that provide comprehensive, culturally informed care for Aboriginal and Torres Strait Islander people. These services address not only physical health but also the social, emotional, and cultural wellbeing of individuals, families, and communities.[122]

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[119] Mrs Emily Osborne, NDIS Operations Manager, Miwatj Health Aboriginal Corporation, *Committee Hansard*, 17 November 2025, p. 28.

[120] Ms Rachel Fishlock, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, 17 November 2025, p. 30.

[121] Dr Catherine Wade, Member, Parenting and Family Research Alliance; and Principal, Parenting Research Centre, *Committee Hansard*, 28 November 2025, pp. 36–37

[122] Aboriginal Community Controlled Health Organisations - NACCHO, www.naccho.org.au/aboriginal-community-controlled-health/ (accessed 3 December 2025).

3.106 Reflecting on the challenge of receiving support or accessing the NDIS without a diagnosis, First Peoples Disability Network's National Policy Manager, Mr Rhys Howard noted the service provided by trusted, existing groups:

> …having a tier in between mainstream services and NDIS is really a critical juncture, especially if those services don't require diagnosis to enter them…Largely, for those kids, there are no thresholds, there are no barriers to entry to those services. I think the services that already exist, where relationships and trust are built, are the first step to having people come in and having first contact with that system.[123]

3.107 The Chief Executive Officer of Broome Regional Aboriginal Medical Services (BRAMS), Ms Cassie Atchison, explained why BRAMS needed to be directly involved in the proposed Thriving Kids program, as a large ACCHO delivering fully integrated services across primary health care, aged care, disability, family violence, and social and emotional wellbeing all under one coordinated model of care in Broome, Western Australia.[124] Ms Atchison explained:

> We are not just seen as a service provider by our community; we are seen as their health service, their one-stop shop where people can come and access a service from us without having to navigate external agencies and services. We believe that the Thriving Kids program will only work if Aboriginal community-controlled organisations are involved as partners where we're designing, delivering and doing place based modelling.[125]

3.108 The CEO of BRAMS Ms Cassie Atchison stressed the importance of taking a culturally safe, individual approach to clients, especially school children, as a large ACCHO supporting more than 7,000 people on a regular basis.

> It's really important for us that we don't treat people as numbers and that we identify and work with our families on an individual basis and have that cultural safety. I have lots of examples where cultural safety is lacking in some areas. For example, one for us in Broome is making sure we've got other services on board like the education system. We have lots of kids in our Broome schools with special needs, and the schools still don't seem to be equipped to understand around that person-centredness for children, and children are quite often judged as being naughty or other things when there are developmental delays happening. We do a lot of advocacy in schools and other early childhood providers to ensure that other people have a good understanding of how to look at kids as individuals and not label them with a diagnosis or a developmental...[126]

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[123] Mr Rhys Howard, National Policy Manager, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 11.

[124] Ms Cassie Atchison, CEO, Broome Regional Aboriginal Medical Services, *Committee Hansard*, 10 October 2025, pp. 11–12.

[125] Ms Cassie Atchison, CEO, Broome Regional Aboriginal Medical Services, *Committee Hansard*, 10 October 2025, p. 12.

[126] Ms Cassie Atchison, CEO, Broome Regional Aboriginal Medical Services, *Committee Hansard*, 10 October 2025, p. 13.

3.109 When asked about the benefit of remote community connectors being in an ACCHO for identification and diagnosis, NACCHO's Dr Sarah Hayton highlighted the issues faced in Far North Queensland:[127]

> There are areas where, for example, a local council or a different organisation is looking after those workers, and it's not as coordinated, because they're not necessarily linking into the primary health care system that we manage. That is why we really do advocate that, if community connectors are in an ACCHO, they're much better utilised, they're working much better and it seems to be more of a seamless engagement with our sector. But, when they're sitting in isolation, there's still a disconnect with service delivery. It has had large impacts, for example in Far North Queensland, because they've really struggled to identify children that require some screening and early diagnostics with early intervention. It has been quite difficult to try coordinate that, because they're in a mainstream organisation, and it does make it difficult sometimes to find really good, culturally safe internal referral pathways.[128]

3.110 The Kimberley Aboriginal Medical Services is the peak body for Aboriginal community-controlled health services in the Kimberley, Western Australia. KAMS operates under the auspices of the Kimberley Supports consortium, bringing together eight local Aboriginal community-controlled organisations to improve the outcomes of Aboriginal people living with disability or developmental delay. Senior Manager, Mr Oskar Stenseke explained:

> One of the programs that we do deliver is the Remote Early Childhood Support Program, which is essentially a community designed and led program that leverages the existing relationships and trust of the local Aboriginal medical services to engage with families early, to identify developmental delays and to then provide short-term, culturally safe early intervention services while also providing linkages to longer-term supports where needed. It's kind of like you're looking at the scope of the Thriving Kids program.[129]

3.111 Mr Stenseke elaborated on the advantages of using locally-based consortiums or teams in the major Kimberley hubs of Broome and Kununurra to both address workforce shortages and to deliver culturally-safe outreach services to a rural and very remote area such as the Kimberley. He stated:

> In those communities we have local Aboriginal family support workers as part of the program. They're employed by the local consortium member organisation. It's

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[127] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 16.

[128] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 16.

[129] Mr Oskar Stenseke, Senior Manager, Kimberley Aboriginal Medical Services, *Committee Hansard*, 10 October 2025, p. 12.

> really key, having that local person on the ground making sure that the services are delivered.[130]

3.112 Kimberley Aboriginal Medical Services described its Community Connector Program in the Kimberley as being very successful in finding and encouraging more people to access NDIS services. They explained:

> I think about five years ago when the state of Western Australia transitioned over to the federal NDIS system. They only had the operational NDIS participants. There were only, I think, about a hundred of them in remote communities across the Kimberley—probably less than a hundred. But, since then, over these five years, that number has increased to about 750 participants in the Kimberley region. That just shows that the community can access it. Knowing the community and knowing who to reach out to, to build that awareness, has really worked. The organisations that represent have that trust from community to engage and to assist them with this process.[131]

3.113 Miwatj Health Aboriginal Corporation described the role of ACCHOs in assisting First Nations people to engage with and use the NDIS:

> ACCHOs support the lifespan of community and we've built innate trust within our respective regions…A key message from our remote community connectors is that the NDIS is difficult to explain and interpret in a way that our mob can understand. They've described their role within the NDIS landscape as [Yolngu language not transcribed], which translates to 'taking the weight off' participants, but also 'going home and feeling fulfilled', like they're having an impact on their community.[132]

3.114 The First Peoples Disability Network detailed how Thriving Kids should use ACCHO to 'empower First Nations communities to lead in design and delivery as well' to help their 'kids grow strong in culture and thrive'.[133] Mr Howard told the Committee:

> …what we see as necessary for success for Thriving Kids: a dedicated First Nation stream, co-designed with peaks and delivered through ACCOs and ACCHOs; mandated culturally adapted screening—for example, the ASQ-TRAK tool; funded, parent-mediated, culturally safe, early interventions through ACCHOs; child and family centres with group home visiting and telepractice options; the building of a First Nations workforce pipeline, including scholarships, cadetships, supervised practice, allied health assistant roles with funded clinical supervision, embedded child development navigators, and a consent-based

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[130] Mr Oskar Stenseke, Senior Manager, Kimberley Aboriginal Medical Services, *Committee Hansard*, 10 October 2025, p. 12.

[131] Mr Oskar Stenseke, Senior Manager, Kimberley Aboriginal Medical Services, *Committee Hansard*, 10 October 2025, p. 16.

[132] Mrs Emily Osborne, NDIS Operations Manager, Miwatj Health Aboriginal Corporation, *Committee Hansard*, 17 November 2025, p. 28

[133] Mr Rhys Howard, National Policy Manager, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, p. 10.

> passport—so information follows a child from system to system, reducing the burden on families; a phased implementation with transition safeguards, so absolutely no child loses support during the transition from NDIS to Thriving Kids; a co-commissioned education program to deliver school and ECEC-based inclusion supports; and monitoring, which is aligned with the Closing the Gap priority reform, where published disaggregated results are available within the principles of Indigenous data sovereignty.[134]

3.115 SNAICC were of the view that ACCOs 'set the gold standard in early childhood service delivery' adding that 'integrated early childhood services provide crucial community-based, trusted, culturally appropriate, integrated services in ECEC settings.'[135] They elaborated on the importance of integrated services:

> Aboriginal and Torres Strait Islander children with mild to moderate developmental delays, and their families, should be able to access the requisite developmental supports they need, delivered in a culturally appropriate manner, in an environment where they feel comfortable, surrounded by their own community. Though some Aboriginal and Torres Strait Islander children with more profound disability or developmental vulnerabilities may require specialised, evidence-based early childhood developmental supports, nevertheless screenings, referral and navigation supports, and allied health provision should be delivered in natural early years settings to the degree possible.[136]

3.116 SNAICC noted that 'in several communities, ACCOs/ACCHOs are already providing such integrated, child and family centred, culturally appropriate services.'[137]

3.117 Brotherhood of St Laurence also highlighted the strengths of ACCOs to deliver integrated models.[138] Minderoo Foundation + Thrive by Five believed that ACCOs provided 'holistic wraparound models of care that demonstrate[d] the success of integrated, family-centred care and are instructive for mainstream service design.'[139]

3.118 Murdoch Children's Research Institute were also supportive of First Nations led place-based initiatives commenting that:

> These initiatives [such as Connected Beginnings, ACCOs, Child and Family Hubs] are demonstrating impact via inclusive, holistic, and culturally responsive models. Aboriginal and Torres Strait Islander integrated early years centres, embody these principles by serving as culturally safe community hubs which support early identification and improve access to both universal services and tiered interventions.[140]

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[134] Mr Rhys Howard, National Policy Manager, First Peoples Disability Network, *Committee Hansard*, 10 October 2025, pp. 10–11.

[135] SNAICC – National Voice for Our Children, *Submission 327*, p. 5.

[136] SNAICC – National Voice for Our Children, *Submission 327*, p. 16.

[137] SNAICC – National Voice for Our Children, *Submission 327*, p. 16

[138] Brotherhood of St Laurence, *Submission 254*, p. 14.

[139] Minderoo Foundation + Thrive by Five, *Submission 342*, p. 9.

[140] Murdoch Children's Research Institute, *Submission 234*, p. 18.

Challenges for Aboriginal Community Controlled Health Organisations

3.119 As noted above, submitters believed that ACCHOs play a critical role in delivering culturally safe, community-led health and disability services, but face significant systemic challenges. Short-term and inadequate funding arrangements undermine service continuity and workforce stability, while reliance on fly-in fly-out and agency staff erodes trust and cultural safety. Gaps in staffing expertise, transactional partnerships, and restrictive definitions of family further compound barriers to access and equity for Aboriginal and Torres Strait Islander children and families.

3.120 NACCHO and Miwatj Health Aboriginal Corporation commented that ACCHOs were facing funding and resourcing challenges. NACCHO stated:

> A number of ACCHOs already provide disability and related services, most without adequate funding. When funding is provided, it is often short-term contracts. One member service reported that their contract for the Remote Community Connector program (a program through which community members are employed by local ACCHOs to assist in connecting to services, support workers and the NDIA) was only renewed on the day of its expiry. This makes it very difficult for ACCHOs to retain staff and provide continuous service. ACCHOs also report issues with staff leaving to join mainstream services as they can offer more stability. Understandably, this has a negative impact on outcomes for ACCHOs and for the Aboriginal and Torres Strait Islander communities they support.
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> A research report from Deloitte, coming out of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability found that:
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> ‘Community Controlled and Aboriginal Community Controlled Health Organisations frequently deliver disability services with inadequate funding and resourcing. Partnerships and shared service delivery arrangements between First Nations and non-Indigenous organisations are often transactional and usually favour the non-Indigenous organisation. Allied health providers often aren’t disability specialists and provide inadequate and culturally inappropriate services.’[141]

3.121 NACCHO suggested directing funding to ‘ACCHOs for child-centred, family-focused and culturally safe approaches to: screening and referrals; assessment and diagnosis; and intervention and supports.’[142]

3.122 Miwatj Health Aboriginal Corporation highlighted a gap in staffing and expertise:

> In contrast, the MHAC child health program across six of the seven East Arnhem communities is primarily staffed by short-term agency nurses who are not trained in child health. These nurses cover the 0-17 age group and are also required to participate in acute care and on-call services. This model leaves a significant gap

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[141] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 8.

[142] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 8.

> in the delivery of well child assessments and developmental screening. Families are left uncertain about where to access consistent, reliable well child services, creating inequities in early childhood health and development outcomes.[143]

3.123 Several organisations expressed concerns about the reliance on fly-in fly-out (FIFO) and short-term practitioners in remote and regional communities.

3.124 Queenslanders with Disability Network observed that families prefer providers who understand local contexts and maintain long-term relationships with communities. FIFO and locum models often require families to repeat their stories to new practitioners, eroding trust and continuity. First Nations families emphasised the importance of cultural safety, trust, and continuity in service delivery.[144]

3.125 The Australian Clinical Neuropsychology Association (ACNA) reported that FIFO therapists frequently lack understanding of local cultural norms and community relationships, leading to interventions that do not suit local conditions and result in poor engagement. The ACNA stressed the need to build local capacity and co-design services with families and communities for sustainable outcomes.[145]

3.126 NACCHO advocated for investment in ACCHOs to strengthen local economies, reduce reliance on FIFO services, and deliver services 'with community, not to community.'

3.127 Organisations who submitted to this inquiry also highlighted that Aboriginal and Torres Strait Islander families often face additional barriers when accessing disability supports due to restrictive definitions of family within service design and eligibility criteria.

3.128 The Australian Institute of Family Studies reported that systems such as the NDIS frequently assume that parents are the primary navigators of disability supports. This creates difficulties for other family members—such as grandparents and kinship carers—who often play a significant role in caring for children with disability.[146]

3.129 The Brotherhood of St Laurence noted that current service frameworks articulate family too narrowly, which can prevent Aboriginal and/or Torres Strait Islander kinship carers from accessing the supports they need.[147]

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[143] Miwatj Health Aboriginal Corporation, *Submission 288*, p. 3.

[144] Queenslanders with Disability Network, *Submission 279*, pp. 11, 15.

[145] Australian Clinical Neuropsychology Association, *Submission 152*, pp. 1–2.

[146] Australian Institute of Family Studies, *Submission 370*, pp. 5–6.

[147] Brotherhood of St Laurence, *Submission 254*, p. 24.

Culturally and linguistically diverse communities

3.130 Stakeholders identified a range of intersecting barriers that prevent people with disability and their carers from CALD communities accessing the NDIS and other services, such as:

- language barriers
- lack of culturally safe response services
- barriers to accessing early support
- service affordability
- navigating complex NDIS systems and services
- lack of trust in government and other services
- citizenship and visa considerations.

3.131 This section also discusses evidence received regarding the importance of enshrining a CALD informed design of the Thriving Kids initiative.

Language barriers

3.132 Accessing NDIS services for people from culturally and linguistically diverse communities (CALD) can be challenging. More than 8 million people living in Australia were born overseas – these individuals speak 300 different languages. This language barrier can make it challenging for those families and individuals to navigate and access services and supports.[148]

3.133 Mr Fioramonte of Settlement Services International (SSI), explained it was ‘very, very difficult for people to navigate and understand the systems’, and even harder for those from non-English speaking backgrounds in Australia.[149]

> The NDIS is so complex and so difficult for anyone to manage and navigate. When you're looking at someone who is from a CALD background, where English is not their first language, where there are digital literacy issues, where they're from a lower socioeconomic background, as well as a range of other things, it makes you end up with a situation where there are layers of barriers.[150]

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[148] National Disability Insurance Scheme, *Cultural and Linguistic Diversity Strategy Summary 2024–2028*, p. 7.

[149] Mr Ben Fioramonte, General Manager, Children, Families and Disability Support, Settlement Services International, *Committee Hansard*, 10 October 2025, p. 20.

[150] Mr Ben Fioramonte, General Manager, Children, Families and Disability Support, Settlement Services International, *Committee Hansard*, 10 October 2025, pp. 20–21.

3.134 Multiple stakeholders to this inquiry raised the importance of having accessible information about the NDIS available in their preferred language. Lifestart Disability Services highlighted this point in relation to accessing developmental supports.

> Language barriers and limited access to interpreting services, …can hinder effective communication and erode trust.[151]

3.135 WA Early Childhood Intervention Collaborative also emphasised that besides language barriers, consideration must be given to levels of literacy and dialects.

> A family may not be able to access support in their dialect as resources are translated into a limited number of languages. Consideration of the parent or primary care giver's level of literacy is also needed as they also may not be able to read in their own language.[152]

3.136 Ms Rana Ebrahimi, National Manager, Multicultural Youth Advocacy Network Australia (MYAN) emphasised the need for children with disability to be heard and understood when accessing developmental services.

> …children have the right to be heard in matters that affect their life; language accessibility through multilingual resources, bilingual workers and translated digital and phone based supports; and partnership with local community organisations, such as SSI, who can serve as trusted bridges between government systems and families.[153]

Lack of culturally safe and responsive services

3.137 Some stakeholders told the Committee about difficulties faced when trying to find and access culturally safe and responsive services. SSI suggested that lower levels of access to these services were 'not related to lower levels of need but rather due to difficulties in navigating and accessing services that are culturally responsive.'[154]

3.138 Several submitters, including Marathon Heath, identified that even though children from CALD families are more likely to be diagnosed with a developmental disability, they are less likely to receive early intervention support and services such as allied health.[155]

> Children from culturally and linguistically diverse backgrounds are more likely to be diagnosed with developmental disability, developmental delay or intellectual

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[151] Lifestart Disability Services, *Submission 245*, p.18.

[152] WA Early Childhood Intervention Collaborative, *Submission 128*, p. 26.

[153] Ms Rana Ebrahimi, National Manager, Multicultural Youth Advocacy Network Australia, *Committee Hansard*, 10 October 2025, p. 20.

[154] Settlement Services International, *Submission 73*, p. 13.

[155] See, for example, Australian Council of State Schools, *Submission 46*, p. 8; Autism Spectrum Australia, *Submission 67*, pp. 7, 9; WA Early Childhood Intervention Collaborative, *Submission 128*, p. 26; Marathon Health, *Submission 163*, p. 9; Brotherhood of St Laurence, *Submission 254*, p. 24; Queenslanders with Disability Network, *Submission 279*, pp. 2, 11, 18; Karitane, *Submission 282*, p. 15; The Benevolent Society, *Submission 309*, p. 12; Triple P International Pty Ltd, *Submission 310*, p. 12; Outcomes Therapy, *Submission 312*, p. 3; Australian Institute of Family Studies, *Submission 370*, p. 5.

> disability. In spite of this, families are less likely to receive multi-disciplinary early support and more likely to need help to secure funding for services. Research with diverse families highlights significant barriers to accessing support, including limited awareness of available services, language barriers, stigma around disability and help-seeking, and lack of options for culturally specific care. Parents report feeling like they lack control over the supports they receive and often rely on informal referrals within their communities to find appropriate services.[156]

3.139 The Australian Institute of Family Studies noted that CALD communities found it challenging to engage with existing supports that did not align with cultural values—particularly for parents from culturally diverse backgrounds who care for children with developmental disability and autism.[157]

3.140 Associate Professor Schultz from the Black Dog Institute discussed the need to acknowledge the wide range of cultural diversity for non-Indigenous peoples:

> …you are Aboriginal or Torres Strait Islander, or you are non-Indigenous, and in that non-Indigenous bracket there is a whole bunch of cultural diversity that we tend to just glaze over and not attend to, as if it's not important in terms of how we engage with, respond to and work with families and communities.[158]

3.141 Mr Fioramonte, General Manager, Children, Families and Disability Support at SSI, noted that Sydney has a higher uptake of the NDIS as a percentage due to support services having a more culturally diverse workforce than in other regions. He elaborated:

> …the uptake of CALD people with disability into the NDIS is sitting at around that nine per cent mark, as it has roughly been since the implementation of NDIS. Within Sydney and south-west Sydney, the percentage of people with a CALD background with disability on the scheme sits at around 23 per cent, and we largely attribute that to having that diverse workforce—people that are based in and connected to the communities that we serve. That diverse workforce is definitely key.[159]

3.142 Similarly, Ms Lynette Brodie, Chief Executive Officer at Speech Pathology Australia told the Committee that challenges with languages or cultural differences were being

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[156] See, for example, ADHD Australia, *Submission 221*, p. 1; Multicultural Youth Advocacy Network and 54 Reasons (Save the Children), *Submission 228*, p.1; Every Australian Counts, *Submission 273*, p. 8; Triple P International Pty Ltd, *Submission 310*, p. 12.

[157] Australian Institute of Family Studies, *Submission 370*, p. 5.

[158] Associate Professor Clinton Schultz, Director, First Nations Strategy and Partnerships, Black Dog Institute, *Committee Hansard*, 10 October 2025, p. 43.

[159] Mr Ben Fioramonte, General Manager, Children, Families and Disability Support, Settlement Services International, *Committee Hansard*, 10 October 2025, p. 22.

helped by its speech pathologists coming from diverse backgrounds themselves. Ms Brodie explained:

> When we talk about language barriers, often you can still detect their language in their speech, even if you don't speak the language. But it is about really looking at criteria and where the allied health professionals are coming from. If we've got a good system, we can understand when we've got particular communities that have issues and perhaps find professionals that can meet their needs as well as their language. Of course, translation services alone are maybe not always ideal in this situation. There are speech pathologists who, as I'm sure do other professions, do a lot of play learning as well, and that really does break down a lot of the barriers. And it's not just CALD communities. We also work with very vulnerable Aboriginal and Torres Strait Islander communities.[160]

Barriers to accessing early support

3.143 Multiple submitters gave evidence that CALD children are accessing early childhood education at lower rates.[161] SSI also reported that children from CALD backgrounds are ‘more likely to miss out on critical early intervention for children with developmental concerns.’[162] MYAN suggested ‘This disparity is not about the need; it's about access.’[163]

3.144 A submission from the Murdoch Children’s Research Institute said that the lack of early support leads to reduced opportunities for CALD children to reach their potential:

> Children and families from culturally and linguistically diverse backgrounds often miss out on early identification and support. This is due to current services and supports not designed or delivered for culturally safety or inclusiveness or parents not knowing where to get help or facing stigma in asking for help. This contributes to reduced opportunities for children to reach their potential and inequities in children’s outcomes.[164]

3.145 SSI outlined the barriers that CALD children face in accessing early childhood education and early intervention support:

> People with disability from CALD backgrounds may experience multiple barriers to access such as lack of accessible information in their preferred language; disability services not being culturally responsive; social isolation; lack of

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[160] Ms Lynette Brodie, Chief Executive Officer, Speech Pathology Australia, *Committee Hansard*, 20 October 2025, p. 22.

[161] See, for example, Settlement Services International, *Submission 73*, p. 13; The Occupational Therapy Society for Invisible and Hidden Disabilities (OTSi), *Submission 365*, p. 6; Marathon Health, *Submission 163*, p. 9; Multicultural Youth Advocacy Network and 54 Reasons (Save the Children), *Submission 228*, p. 1.

[162] Settlement Services International, *Submission 73*, p. 13.

[163] Ms Rana Ebrahimi, National Manager, Multicultural Youth Advocacy Network Australia, *Committee Hansard*, 10 October 2025, p. 20.

[164] Murdoch Children’s Research Institute, *Submission 234*, p. 17.

> knowledge about complex service systems and lack of comparable systems in their home country; cultural stigma surrounding disability; and distrust of government agencies due to negative experiences in other countries. These issues are mirrored in part in research with children from CALD backgrounds.[165]

3.146 Mrs Jo Johnson, from the Bathurst Early Childhood Intervention Service, discussed the barriers to early identification for CALD children and stated that it leads to a two-tiered system:

> To be able to have that early identification is good, but we're really struggling to get counsellors within the school to do the work that's already there—having that navigator beforehand that would be there. The students that my special schools cater for are usually well identified beforehand, except for communities of culturally and linguistically but different backgrounds because they will shy away from that lens being cast on them. They won't know how to access. We end up with a two-tier system with the parents who can navigate, advocate for their child, get support and get NDIS packages and those who can't.[166]

3.147 Community Hubs Australia explained how some of the challenges for CALD communities with accessing early childhood support services are exacerbated for newly arrived families to Australia with young children.

> Accessing early childhood education is not always easy, for many culturally and linguistically diverse (CALD) families the Australian school system can be difficult to navigate, especially for those with limited English. For newly arrived families, the settlement process can be intensive and if they are focused on housing and employment, they might not have time to arrange early childhood learning. Additionally, these families are often navigating this without the support of extended family or friends and can be dealing with significant isolation or trauma.[167]

3.148 Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, highlighted the need for integrated systems to support vulnerable CALD communities. She explained: ‘that’s why it's tricky and why they fall through the cracks, there's no easy referral system for GPs into allied health in that very early phase.’[168]

Impact of delayed early support on school readiness

3.149 Some stakeholders highlighted the consequences of delayed early identification for children from CALD families for their school readiness and education milestones later

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[165] Settlement Services International, *Submission 73*, p. 13.

[166] Mrs Jo Johnson, Early Interventionist and Key Worker, Bathurst Early Childhood Intervention Service, *Committee Hansard*, 17 November 2025, p. 6.

[167] Community Hubs Australia, *Submission 364*, p. 6.

[168] Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 23.

on, such as NAPLAN. For example, the Royal Australasian College of Physicians said:

> In refugee communities, children are often not referred until 4-5 years of age, by which time moderate or significant developmental delays are affecting school readiness, representing a critical missed opportunity for early intervention.[169]

3.150 Learning Links described similar issues:

> Systemic inequities are well documented, particularly for First Nations children, culturally and linguistically diverse (CALD) families, and those living in rural and remote communities. These groups are disproportionately represented in both the AEDC data for children starting school, and in NAPLAN results in later years – reinforcing the barriers to early identification and access to developmental supports.[170]

Service affordability

3.151 Some stakeholders discussed the affordability of services for CALD families.[171] The Brotherhood of St Laurence observed intersecting issues such as socio-economic disadvantage, and the cost of private assessments and services that led to potential barriers for CALD communities:

> For some families on temporary visas they may not be eligible for Medicare or other related Government services, which can mean that some families do not access supports for their children due to costs associated with support.[172]

3.152 Ms Sally Maddison, Acting Chief Executive Officer, Early Learning and Care Council of Australia, told the Committee about the importance of access to early childhood education and care, particularly for First Nations and CALD families. She stated:

> We need to invest in greater access for ECEC [early childhood education and care] because many of the children, including those facing vulnerability and disadvantage who would benefit most from ECEC, do not attend. This includes children with additional needs, First Nations children and children from culturally and linguistically diverse backgrounds. We're hoping that the government's introduction of the three-day guarantee at the start of next year will help provide greater access to these children, but that is something we all need to work on.[173]

3.153 Occupational Therapy Australia commented:

> Thriving Kids must recognise and respond to the needs of families who are experiencing economic disadvantage and other complexities… Almost a third of

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[169] The Royal Australasian College of Physicians, *Submission 243*, p. 9.

[170] Learning Links, *Submission 103*, p. 22.

[171] See, for example: Karitane, *Submission 282*, p. 15.

[172] Brotherhood of St Laurence, *Submission 254*, p. 24.

[173] Ms Sally Maddison, Acting Chief Executive Officer, Early Learning and Care Council of Australia, *Committee Hansard*, 28 November 2025, p. 2.

> children from CALD backgrounds living in the most disadvantaged socio-economic areas were developmentally vulnerable compared to 1 in 6 of their peers living in the most advantaged areas.[174]

Navigating complex NDIS systems and services

3.154 On navigating the current care system, Ms Sally Maddison, Acting Chief Executive Officer, Early Learning and Care Council of Australia told the Committee:

> When parents and carers seek help for a child with additional needs, they are often faced with a complex, disconnected network of services involving multiple agencies, application processes and funding streams.[175]

3.155 Ms Maddison continued to discuss the benefit of 'navigation support' for families, stating:

> I think navigation support [for families in the early childhood education and care system] is really important, particularly when we're dealing with really diverse cohorts. It's complicated enough for a mainstream family without additional needs or any additional—
>
> ...language support. It is really quite a fragmented system and it's highly bureaucratic. I think navigation support not only supports families and the child but supports the ECEC workforce, which we know is really dedicated to children and supporting children's participation, ensuring they get every support they can to participate fully in early learning and care.[176]

3.156 Ms Angela Falkenberg, President, Australian Primary Principals Association, was of the view that there is sometimes a disconnect between the work being done at school and the family being excluded, particularly in CALD communities.

> When it comes to building family capability, often, when the support is at school and in school time, that's exclusive of families. The child might be getting some gross motor skills support, but how does the connection with family work? It's left to the teacher. I think the navigator role is key also in keeping the family present for the support.[177]

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[174] Occupational Therapy Australia, *Submission 304*, p.28.

[175] Ms Sally Maddison, Acting Chief Executive Officer, Early Learning and Care Council of Australia, *Committee Hansard*, 28 November 2025, p. 3.

[176] Ms Sally Maddison, Acting Chief Executive Officer, Early Learning and Care Council of Australia, *Committee Hansard*, 28 November 2025, p. 4.

[177] Ms Angela Falkenberg, President, Australian Primary Principals Association, *Committee Hansard,* 17 November 2025, p. 3.

3.157 Mr Hermann, Policy and Advocacy, Allied Health Professions Australia discussed the importance of capacity building in CALD communities in order to provide better access to developmental services.

> …we need to really be focusing on how we are building capacity in communities, and that's why I mentioned CALD communities. The reality is that it's families and perhaps communities, potentially informal playgroups and all those sorts of things that are seeing children constantly. If those families, if those playgroups and whatever else better understand how to identify potential needs that then trigger potentially accessing general practice or allied health services, that's how we do it. Universal approach is a part of the solution, but we need the people who are spending the time with children in the first instance to understand what to look for and how to actually get in and connect to those services.[178]

3.158 MYAN also highlighted the challenge faced by new CALD migrants using the NDIS:

> The people, especially those who are new arrivals, when they get to rural areas, it's really hard for them to navigate a complex system like NDIS or the general system. They have so many other priorities and health will be at the bottom of these priorities.[179]

3.159 Mr Christopher Ouizeman, Director, ADHD Foundation, suggested the need for investment in the literature for CALD communities to support parents and build their health awareness and literacy.

> The information that's provided is very sparse. There's not a lot of good information out there. I think investment needs to be made in literature for CALD communities as well as the English-speaking communities and, to some degree also, the First Nations communities. Tailored information needs to be provided; it's not currently available. The second part is GPs. They need to have access to information that they can provide to their patients. That's not happening at the moment because there isn't any information. The best we can do is refer people to the ADHD Foundation or ADHD Australia or the ADHD professionals association. We do our best to compile best practice information.[180]

Stigma associated with disability

3.160 Children and families from CALD communities may also face cultural stigma around disability when accessing developmental supports. For example, a submission from

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[178] Mr Philipp Herrmann, Policy and Advocacy, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 33.

[179] Ms Rana Ebrahimi, National Manager, Multicultural Youth Advocacy Network Australia, *Committee Hansard*, 10 October 2025, p. 21.

[180] Mr Christopher Ouizeman, Director, ADHD Foundation, *Committee Hansard,* 21 October 2025, p. 23.

Uniting NSW/ACT discussed the negative impact that cultural stigma has on seeking further advice and assistance, and described:

> …an ongoing stigma associated with disability and developmental delay which can prevent some families from accessing support. Our staff report that this is particularly damaging for mothers from culturally and linguistically diverse backgrounds who fear that signs of disability and developmental delay are a reflection on their parenting skills and avoid disclosing their concerns outside the family. This stigma becomes a barrier to seeking help and further information.[181]

3.161 Ms Judy Connell from the Victorian Catholic Education Authority pointed out that the stigma is very real for some cultures. She explained:

> …in some culturally diverse communities there isn't a word for disability. In others, disability is seen as a punishment. We need to work with those families who are really reluctant and not trusting of systems.[182]

3.162 Ms Nicole Rogerson, Chief Executive Officer at the Autism Association of Australia also commented on the issue of stigma being a barrier to accessing early developmental support services.

> We know that for some families, from certain cultural backgrounds, disability is very difficult to talk about ... Often in a family not both parents are on the same page as to where their child is developmentally. One of them might be more prepared to investigate things than the other.[183]

Lack of trust in government and other services

3.163 Trust and collaboration in service delivery is critical to engaging communities, especially for CALD children and families. The Committee heard that some communities have a fear or mistrust towards services, due to previous experiences and therefore are reluctant to engage around their child.[184]

3.164 Ms Connell highlighted the need to invest in time to build trust with CALD children and families:

> …there's a real role for multicultural education aides in supporting that process and engaging with culturally diverse families and building trust. There are soft entry points that we can manage in terms of starting to bring families along those journeys. Examples of where that might have worked previously are in supported play groups, where families attend together with their children. There might be a speech pathologist or an occupational therapist there who develops a

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[181] Uniting NSW ACT, *Submission 258*, p.3.

[182] Ms Judy Connell, Manager, Education Programs and Support, Victorian Catholic Education Authority, *Committee Hansard*, 28 November 2025, p. 14.

[183] Ms Nicole Rogerson, Chief Executive Officer, Autism Association of Australia, *Committee Hansard*, 21 October 2025, p. 38.

[184] WA Early Childhood Intervention Collaborative, *Submission 128*, p. 26.

> conversational relationship with families around a coffee. They then start to work through, once that trust develops, the next stages of referral or support that might be required.[185]

3.165 Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, commented on the complexities for some communities accessing developmental services.

> I think that core to accessing any service is your therapeutic relationship and common values. Given the way our systems are set up at the moment, there are very specific entry points and very specific knowledge needed to enter those systems. You need to know that there is a developmental divergence or difference and, potentially, if you're in a specific community, you might know that, to access services, you need to go outside of your safe and trusted community.[186]

Citizenship and visas considerations

3.166 Some stakeholders discussed challenges regarding citizenship and visa status for children and families trying to access the NDIS and other services. For example, a submission from Uniting NSW/ACT highlighted:

> …while some early connections are available to families living in Australia regardless of their citizenship or visa status, children must meet residency requirements to be eligible for the NDIS. Similarly, asylum seeker families are broadly ineligible for the Child Care Subsidy. They must therefore pay full fees to access early childhood education and care (ECEC).[187]

3.167 The Brotherhood of St. Laurence described similar barriers:

> Families who are seeking a visa renewal, extension or transfer, permanent residency or citizenship may not want to access services or support that might label their children as having a disability due to discrimination in Australia's migration system.
>
> …For some families on temporary visas they may not be eligible for Medicare or other related Government services, which can mean that some families do not access supports for their children due to costs associated with support. …
>
> While there are some services available for families ineligible for the NDIS due to visa status, there can be substantial wait times which delay access to early intervention services.[188]

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[185] Ms Judy Connell, Manager, Education Programs and Support, Victorian Catholic Education Authority, *Committee Hansard*, 28 November 2025, p. 15.

[186] Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 22.

[187] Uniting NSW ACT, *Submission 258*, p.11

[188] Brotherhood of St. Laurence, *Submission 254*, pp. 24–25.

3.168 Acknowledging the persistent gaps that exist for CALD families, National Disability Services recommended that Thriving Kids should ‘ensure that foundational supports are universally accessible regardless of visa status.’[189]

3.169 Early Childhood Intervention Australia Victoria advocated for families to be able to access ‘the right supports, at the right time in the right place regardless of visa status or diagnosis.’[190] Its submission also recommended that Thriving Kids should ‘ensure residency and visa status does not deny access to supports.’[191]

CALD informed design

3.170 Some stakeholders highlighted the need for better CALD-informed design of the Thriving Kids initiative.[192] For example, the national peak body representing young people from refugee and migrant backgrounds, MYAN highlighted the initiative’s importance and emphasised ‘for Thriving Kids to truly achieve its aims, it must be equitable, inclusive and culturally responsive.’[193]

3.171 MYAN recommended ‘a strong commitment to equity and cultural intelligence, cultural competence, across all aspects of the program design and delivery’. MYAN expanded that the Australian Government needed to include comprehensive cultural awareness and intelligence training for all staff to ensure understanding of diverse family experiences and perceptions of disability and developmental delay; and meaningful participation of First Nations and CALD communities in the design, governance and evaluation of Thriving Kids.

3.172 Mrs Nicole Smith, Head of Disability Supports at SSI, emphasised the importance of ensuring inclusion for the CALD community, given it represents a quarter of the Australian population, and explained:

> With more than one in four children entering school in 2024 being from CALD backgrounds …it's imperative that the initiative reflects the true diversity of Australia and that it makes sure that we have equitable access for supports.[194]

3.173 Mrs Smith also shared her personal experience as a mother of a child who is accessing the NDIS. She explained:

> …the benefit for me is that reassurance that I'm not alone on this journey, and I know that many of the supports, and the families from CALD backgrounds that we support, feel the same. That intervention is critical but, as we've heard

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[189] National Disability Services, *Submission 200*, p. 20.

[190] Early Childhood Intervention Australia Victoria, *Submission 199,* p. 10.

[191] Early Childhood Intervention Australia Victoria, *Submission 199,* p. 10.

[192] See, for example: Mrs Nicole Smith, Head of Disability Supports, Settlement Services International, *Committee Hansard*, 10 October 2025, p. 19.

[193] Ms Rana Ebrahimi, National Manager, Multicultural Youth Advocacy Network Australia, *Committee Hansard*, 10 October 2025, p. 20.

[194] Mrs Nicole Smith, Head of Disability Supports, Settlement Services International, *Committee Hansard*, 10 October 2025, p. 19.

> through this reform, the NDIS doesn't need to be that point of call for everything, and I think that's where Thriving Kids has a really key opportunity.[195]

3.174 SSI advocated for a blend of universal and targeted place-based interventions with programs such as community hubs that demonstrate an effectiveness of being culturally responsive and relationships based, which helps 'build trust and facilitate a warm referral process.'

> Thriving Kids needs to incorporate tailored communication strategies to reach CALD families, including translated pictorial resources, and we need to understand the limited English proficiency and digital literacy of these communities, which often results in exclusion from essential information and increases isolation and stigma.[196]

3.175 SSI suggested that an advantage of a national hubs model is that it facilitates an opportunity to connect individuals to a range of services, whether these be health services, settlement services, or disability supports. SSI explained:

> Where families do have that point of contact, we need to remember that trust is very, very important. Trust is important to anyone, but it's especially important for CALD communities who may have recently migrated to Australia. They may be quite isolated, and sometimes they can even be isolated from their own community.[197]

3.176 SSI's general manager Mr Ben Fioramonte highlighted the effectiveness of their Ability Links program working with Vietnamese communities in the Liverpool area.

> …we would find that they would connect with one of our Vietnamese workers and that worker would be the go-to for anything. They would give their number out to their families. That was really positive, but we also had to work quite hard to build their trust with other people, other places and other services so that they could connect and integrate more broadly.[198]

3.177 The Executive Director of the Australian Multicultural Health Collaborative, Ms Priyanka Rai, also highlighted the importance of service providers being trusted and embedded in communities to achieve better outcomes.

> When that information comes from someone who's already a part of that community and who the family trusts, as opposed to an NDIS brochure in a

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[195] Mrs Nicole Smith, Head of Disability Supports, Settlement Services International, *Committee Hansard*, 10 October 2025, p. 22.

[196] Mrs Nicole Smith, Head of Disability Supports, Settlement Services International, *Committee Hansard*, 10 October 2025, p. 19.

[197] Mr Ben Fioramonte, General Manager, Children, Families and Disability Support, Settlement Services International, *Committee Hansard*, 10 October 2025, p. 20.

[198] Mr Ben Fioramonte, General Manager, Children, Families and Disability Support, Settlement Services International, *Committee Hansard*, 10 October 2025, p. 20.

> language they're not familiar with or calling a call centre—those barriers then just start piling up for these families.[199]

3.178 Professor Sharon Goldfeld, Theme Director, Population Health, Murdoch Children's Research Institute, and Director, Centre for Community Child Health, Royal Children's Hospital, spoke about the importance of building community hubs for CALD families:

> We talked about hubs for services, but the other really important thing about hubs is bringing families together. You've got amazing people sitting around the table here, including the people in the room with you, who have already talked about the importance of bringing families together. There are supported playgroups, for example, where families can get together, and they can be culturally appropriate and language specific. Again, that's about putting information in the hands of families.[200]

3.179 Many stakeholders advised against a universal or one-size-fits-all approach to delivering services through Thriving Kids, due to the diversity amongst priority groups such as First Nations and CALD, advocating for a flexible and targeted approach. For example, Professor Goldfield summarised that:

> Universal programs are important but cannot fully address complex and diverse needs. It is important for them to assist alongside individualised support delivered by trained health professionals especially for CALD communities.[201]

Rural and remote communities

3.180 Evidence to the inquiry highlighted the vast and complex equity and inclusion challenges faced by children and their families in rural and remote communities, including:

- inconsistent service availability
- limited telehealth and outreach
- limited infrastructure and internet connectivity
- workforce shortages
- funding and costs.

3.181 The Committee heard that children in rural and remote communities are more likely to experience developmental vulnerability and lower educational outcomes compared

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[199] Ms Priyanka Rai, Executive Director, Australian Multicultural Health Collaborative, *Committee Hansard*, 10 October 2025, p. 21.

[200] Professor Sharon Goldfeld, Theme Director, Population Health, Murdoch Children's Research Institute; and Director, Centre for Community Child Health, Royal Children's Hospital, *Committee Hansard*, 28 November 2025, pp. 52–53.

[201] Mr Kai Reuben Seah, *Submission 130*, p.3.

to those living in cities.[202] A submission from the Regional Education Commissioner reported that only half (around 50 per cent) of children in regional areas and 43 per cent of children in remote and very remote areas are developmentally on track on all five domains measured by the Australian Early Development Census [AEDC].'[203] More information about the AEDC is available in Box 3.2.

Box 3.2 Australian Early Development Census

The AEDC is an Australian Government Initiative that collects nationwide data on early childhood development. The AEDC's results help to identify and monitor trends in childhood development by the time they begin their first year of full-time school—highlighting what works well and what needs to be improved.

The AEDC captures data on five domains of early childhood development:

- physical health and wellbeing
- social competence
- emotional maturity
- language and cognitive skills (school-based)
- communication skills and general knowledge.

Data has been collected via the AEDC every three years since 2009, with the most recent collection taking place in 2024. The 2024 AEDC included 288,483 children and 16,723, teachers in 7,368 schools.[204]

3.182 Ms Susanne Tegen, Chief Executive at the National Rural Health Alliance (NRHA), also gave evidence regarding the AEDC domains, and highlighted that more than 20 per cent of children in rural and remote areas 'are vulnerable in two or more domains.'[205] She elaborated:

> This is not just a statistic. It is a signal that we are failing thousands of children at the very start of their lives purely because we rely on their parents to work in rural, remote and regional Australia, which brings in most of our economic income, brings in the food that Australians eat and also brings in the income from

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[202] See, for example: Australian Multicultural Action Network, *Submission 17*, p. 2; Regional Education Commissioner, *Submission 42*, p. 1; Royal Far West, *Submission 60*, p. 8; Office of the National Rural Health Commissioner, *Submission 195*, p. 3; Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 33.

[203] Regional Education Commissioner, *Submission 42*, p. 1. See also: Noah's Ark Inc, *Submission 311*, p. 11; Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 33.

[204] Australian Early Development Census, *AEDC National Report 2024,* July 2025, www.aedc.gov.au/resources/detail/2024-aedc-national-report (accessed 4 December 2025).

[205] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 33. See also: Royal Far West, *Submission 60*, p. 8.

> tourism. We must not allow this to continue. They're thwarted by the systemic barriers and the fact that they're out of sight and out of mind.[206]

3.183 Ms Nicole Moran, Board Member at Regional Autistic Engagement Network, said that Thriving Kids, as currently proposed, 'will disproportionately impact rural and regional communities.'[207]

3.184 Many submitters and witnesses emphasised the importance of ensuring that Thriving Kids is fair to all children no matter their postcode. For example, Ms Tegen advocated:

> Thriving Kids must be responsive, sustainable and equitable... Getting it right is not only a matter of fairness; it is a national imperative, and it will in fact impact our long-term productivity.[208]

3.185 Similarly, speaking about her experience as a mother of a two-year old boy with a developmental delay living in a regional area, Ms Jessica Paoloni emphasised that 'a postcode should never determine whether a child gets the support they desperately need during their most critical development years.'[209]

Inconsistent service availability

3.186 One of the key challenges affecting children and families in rural and remote communities discussed in evidence to the inquiry was the inconsistent availability of health and disability services, such as paediatricians, allied health professionals, psychologists and psychiatrists.[210]

3.187 A submission from Pop Family Pty Ltd, a national online speech pathology service, highlighted that 'the success of the Thriving Kids initiative is entirely dependent on the availability of a skilled and sufficient workforce, which currently does not exist.'[211]

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[206] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 33.

[207] Ms Nicole Moran, Board Member, Regional Autistic Engagement Network, *Committee Hansard,* 17 November 2025, p. 26.

[208] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 33.

[209] Ms Jessica Paoloni, private capacity, *Committee Hansard*, 7 November 2025, pp. 18–19.

[210] See, for example: Mrs Ashlee Law, *Submission 14*, p. 2; Australian Multicultural Action Network, *Submission 17*, p. 5; Nest Culture Pty Ltd, *Submission 192*, p. 3; Mr Michael Perusco, Chief Executive Officer, National Disability Services, *Committee Hansard,* 20 October 2025, p. 50.

[211] Pop Family Pty Ltd, *Submission 15,* p. 6.

3.188 Dr Sarah Chalmers, President-Elect of the Rural Doctors Association of Australia (RDAA), said that new programs are not designed for the health system in rural and very remote communities, and explained:[212]

> Most people understand the health service as being public and private, that there are primary, secondary and tertiary providers, that there are hospitals with specialists in them, that GPs work out of buildings with all of the resources, and that many of the allied health providers are in private practices that GPs might be able to refer people to. We are in really remote places. We don't have those systems. Often…the system is designed around the urban health system. It simply doesn't work the further away you get from a major capital city.[213]

3.189 In this context, Dr Chalmers warned that without taking 'the differences in availability of resources into account in the initial design, you set particularly the remote communities, rolled into regional and rural communities, up for failure.' She elaborated

> That means they have no chance of any type of equity simply from the design. I would say that taking the remote and rural health system into account as part of designing what happens going forward may assist in equity of access for those children.[214]

3.190 Ms Tegen from the NRHA expressed similar concerns, and added that design 'needs to be covered in a way that takes into consideration the many kilometres that people have to travel and the many costs that rural people have to cover.'[215]

3.191 Ms Carrie Clark, Chief Executive Officer at Kiind, a peer support organisation in Western Australia (WA), pointed out that the NDIS was 'rolled out differently and later than in WA', and shared concerns that Thriving Kids will:

> …end up designed and working for children who live in metro areas and that it will really fail children in regional and remote areas, particularly in WA, where there are significant difficulties in delivering services and huge workforce issues that could potentially create equity problems for families.[216]

3.192 Dr Garth Hargreaves, a General Paediatrician and Member of the Australian Paediatric Society, observed 'a very stark difference in services' between city, regional, rural and very remote areas.' Dr Hargreaves also noted a lack of access to

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[212] Dr Sarah Chalmers, President Elect, Rural Doctors Association of Australia, *Committee Hansard*, 10 October 2025, p. 35. See also: Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 35.

[213] Dr Sarah Chalmers, President Elect, Rural Doctors Association of Australia, *Committee Hansard*, 10 October 2025, p. 35.

[214] Dr Sarah Chalmers, President Elect, Rural Doctors Association of Australia, *Committee Hansard*, 10 October 2025, p. 35.

[215] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 35.

[216] Ms Carrie Clark, Chief Executive Officer, Kiind, *Committee Hansard*, 3 October 2025, p. 32.

therapeutic services and suggested that existing funding models are insufficient to maintain face-to-face services.[217]

3.193 Ms Nicole Avery, Chief Executive Officer at South West Autism Network, told the Committee about service gaps experienced in WA. She said that while:

> …some allied health professionals [are] available through the WA Country Health Service and through primary health care… There might be two years where there is no speech pathologist servicing a community. That is a pretty big chunk of your child's early development. Other issues are that they might be geriatric trained rather than early childhood trained.'[218]

3.194 WA Early Childhood Intervention (ECI) Collaborative noted 'an insufficient number of ECI practitioners with appropriate ECI experience in rural and regional areas'[219] and explained:

> …where rural / remote schools cannot spare the teaching capacity to accommodate children with higher needs, leading to children with more acute sensory or behavioural needs sometimes excluded from school because teachers are not trained or equipped to support them in line with best practice.[220]

3.195 Allied Health Professions Australia suggested a 'hub and spoke model' may improve access to services, where specialised skills are based in metropolitan or regional centres or operate by fly-in models. While Allied Health Professions Australia recognised the importance of building local capacity in the health system, they raised that this may be challenging for highly specialised skills like orthotics or prosthetics.[221]

3.196 However, Autism NT were of the view that you 'can't just walk into any community' but that 'you have to collaborate with our services and people who understand that community.'[222] They also explained that providers in regional centres have expectations for how often clients are available, saying 'If you go to Alice Springs, you have to come every three months. You don't just come when you can. If [you] have funding here and there.'[223]

The role for schools

3.197 Given the limited services available in rural and remote areas, some stakeholders recommended that schools in rural and remote areas be leveraged to provide better

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[217] Dr Garth Hargreaves, Member and General Paediatrician, Australian Paediatric Society, *Committee Hansard,* 17 November 2025, p. 51.

[218] Ms Nicole Avery, Chief Executive Officer, South West Autism Network, *Committee Hansard,* 3 October 2025, p. 36.

[219] WA Early Childhood Intervention Collaborative, *Submission 128*, p. 2.

[220] WA Early Childhood Intervention Collaborative, *Submission 128*, Attachment, p. 25.

[221] Mr Philipp Herrmann, Policy and Advocacy, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 32. See also: Associate Professor David McDonald, Senior Member, Australian Paediatric Society, *Committee Hansard*, 17 November 2025, p. 50.

[222] Mrs Niki Lehmann, Executive Officer, Autism NT, *Committee Hansard*, 3 October 2025, p. 17.

[223] Mrs Niki Lehmann, Executive Officer, Autism NT, *Committee Hansard*, 3 October 2025, p. 17.

support to children and their families. For example, the Regional Education Commissioner suggested consideration be given to:

> …how regional, rural and remote schools could be utilised to provide vulnerable students and families with better access to allied health services, while ensuring that the school is not overburdened coordinating this access. For example, a community allied health services coordinator role could be funded within a school, or across a cluster of schools, to provide the vital linkage between students and allied health services.[224]

3.198 A submission from South Burnett CTC shared an example from Kingaroy, a rural town in Queensland, where an Early Years Service provides in-home support to families with neurodivergent children to prepare them for school:

> This service assists with navigating the pathways for pre and post diagnosis with families for neurodivergent children. The service also assists with behaviours of concern, routines, immunizations, transport to appointments, seeking mental health assistance for the adults. The Early Years Service provides a specialist program that also offers paediatricians, child development service, allied health professionals extensive information on children's developmental differences... Early Years address any concerns parents may have with typical children as well such as toilet training, eating difficulties and many others. This service has been within our community for seven years and … has been very successful in assisting families to have a better understanding of children's development and a bigger toolbox for behaviours of concern.[225]

3.199 Conversely, Dr Hargreaves highlighted the benefits of making therapies available home or clinical settings, as opposed to school settings:

> [O]ver time, we're seeing a lot of kids getting ongoing therapeutic services in school settings, which excludes the parents. I think you get a lot more bang for your buck if therapeutic services include parents—particularly for the conditions that therapists are often working with and the sorts of symptoms and problems that they're seeing. Any reform should be very mindful that … the system has slipped into this model in particular because we fly in and fly out services. It's a lot easier and more convenient to do therapy in school settings, but I don't think it's the most efficacious. So, moving forward, funding models that might allow for clinical spaces outside of schools or in the home really should be part of it.[226]

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[224] Regional Education Commissioner, *Submission 42*, p. 1.

[225] South Burnett CTC*, Submission 41*, p. 3.

[226] Dr Garth Hargreaves, Member and General Paediatrician, Australian Paediatric Society, *Committee Hansard,* 17 November 2025, p. 58.

3.200 South West Autism Network also pointed out equity issues associated with delivering services through schools, including the risk that:

> …they are only available in specific schools rather than every school. That potentially increases segregation if you can't attend the same school as your siblings because you've got some developmental delays and instead you have to attend a school at a town two hours away.[227]

Long travel distances and waiting periods

3.201 Inconsistent service availability means that families may be forced to travel long distances, or face long waiting periods, to access the support their children need.[228] For example, Mrs Law told the Committee 'waitlists for autism assessments are often 1–3 years long. Even when funding is approved, families cannot find providers to deliver the supports.'[229]

3.202 A submission from the Australian Paediatric Society reported 'hospital and private paediatric services in rural areas often carry 6 to 18 month wait times; paediatricians advocate for timely, affordable, and sustainable pathways.'[230]

3.203 South Burnett CTC also highlighted long waitlists for a range of health and disability services:

> The wait list for Allied Health professionals, and Child Development Services are anywhere from 12 -18 months and up to 24 months for Paediatricians in rural areas. This is really limiting the assistance that children with differences are receiving. Even when you have a NDIS plan there is still a 12 month wait list for a speech therapist, and an Occupational Therapist can be longer with many refusing new referrals as their waitlists are full… The paediatrician is only available on certain days and comes from a larger town which isn't enough to service the growing community.[231]

3.204 Ms Tegen, from the NRHA, shared her personal experience travelling long distances from rural South Australia to access NDIS services:

> I travelled 70,000 kilometres during my child's first year… It didn't include my flights. I was living in the south-east of South Australia on a farm. And I'm literate. There are many people that are not health system or health literate, and we are failing those communities. We are failing our children and we are failing those

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[227] Ms Nicole Avery, Chief Executive Officer, South West Autism Network, *Committee Hansard*, 3 October 2025, p. 37.

[228] See, for example: Regional Education Commissioner, *Submission 42*, p. 1; Kids I Can, *Submission 51*, p. 6; Municipal Association of Victoria, *Submission 102*, p. 1; Mrs Michelle Oliver, Chief Occupational Therapist, Occupational Therapy Australia, *Committee Hansard*, 20 October 2025, p. 21.

[229] Mrs Ashlee Law, *Submission 14*, p. 2.

[230] Australian Paediatric Society, *Submission 344*, p. 1.

[231] South Burnett CTC, *Submission 41*, p. 5. See also: Outcomes Therapy, *Submission 312*, p. 2.

> parents and carers. We must not fail rural Australia, because we need rural Australians for our economic wellbeing.[232]

3.205 Services for Australian Rural and Remote Allied Health (SARRAH) expressed concerns that long waiting periods present ‘a missed opportunity to provide interventions that ensure children can start school having reached essential developmental milestones.’[233]

3.206 Given the long travel distances travelled by some families in rural and remote communities, Physical Disability Australia recommended that implementation of Thriving Kids should cover all areas of Australia:

> So that, if I live in a remote part of Queensland, I don't have to travel 500 or a thousand kilometres to get the diagnosis and support that I need. So it's not just about it being rolled out in major centres and major cities; it's about it being rolled out across the states, because otherwise kids are just going to continue to fall through the gaps.[234]

3.207 Community Therapy recommended a system of travel compensation based on the Modified Monash Model (MMM) zones.[235]

3.208 Succeed Healthcare Solutions Pty Ltd also commented on long waitlists for families, but suggested:

> These waitlists are not necessary as there is provider capacity, but there are no consistent, nationally supported mechanisms to match families with available services. Small, responsive providers are ready to deliver, but families often cannot find them, especially in rural and remote areas where trust must be built over time.[236]

3.209 Allied Health Professions Australia highlighted:

> …consideration needs to be given to how support can be provided in natural settings without significantly increasing the costs of services to consumers or reducing significantly the volume of services that can be provided. This is particularly important for rural and remote settings where travel can be considerable.[237]

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[232] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 35.

[233] Services for Australian Rural and Remote Allied Health, *Submission 295*, p. 3.

[234] Mr Jeremy Muir, Chief Executive Officer, Physical Disability Australia, *Committee Hansard*, 3 October 2025, p. 11.

[235] Mrs Kate Southward, Paediatric Speech Pathologist and Clinical Manager, Community Therapy, *Committee Hansard*, 17 November 2025, p. 9.

[236] Succeed Healthcare Solutions Pty Ltd, *Submission 150*, p. 2.

[237] Allied Health Professions Australia, *Submission 176*, p. 10.

3.210 Mrs Meredith Cox, Early Interventionist and Key Worker, Bathurst Early Childhood Intervention Service, told the Committee:

> What works for the city doesn't necessarily work for families in regional and remote areas—for example, the recent changes in travel charges within the NDIS. Some families are travelling further to services, and some providers are now swallowing up those costs to service needs in rural and remote areas. Families need support when they first reach out. We are often the first port of call for families in our regional areas. These families are serviced by what we call Start Strong, and we currently are creating a playgroup to try and capture families when they first reach out for us. We are being supported by another like-minded organisation to fund these programs. Once the playgroup starts early next year, we will be inviting families to come and meet some of our team. We will work with the families to complete ages and stages, identifying areas of concern, and, if Thriving Kids were to be in place, we would happily be a pilot program for it.[238]

Limited telehealth and outreach

3.211 Multiple stakeholders called for improved or expanded telehealth and outreach services as a means to improving access to services for children and families.[239] For example, Pop Family Pty Ltd recommended:

- Funding and regulation for 'telehealth-based developmental screening services to provide timely and equitable access for families in rural, remote, and other isolated and undeserved communities, eliminating prohibitive wait times'.[240]
- Funding for 'telehealth access packages, including subsidies for data and devices, to ensure digital inclusion for all families, particularly those in rural/remote and low-socioeconomic communities.'[241]

3.212 The Australian College of Nurse Practitioners (ACNP) noted that 'families in rural/remote areas … may also experience poverty, transport disadvantage, digital exclusion, or limited workforce availability'. Given this, the ACNP recommended:

- funding for telehealth services to ensure accessibility and affordability
- removing the face-to-face requirement for access to Medicare rebateable telehealth services.[242]

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[238] Mrs Meredith Cox, Early Interventionist and Key Worker, Bathurst Early Childhood Intervention Service, *Committee Hansard,* 17 November 2025, p. 45.

[239] See, for example: Australian Multicultural Action Network, *Submission 17*, p. 4; Aruma, *Submission 113*, p. 9; NursePrac Australia, *Submission 173*, p. 3; Allied Health Professions Australia, *Submission 176*, p. 8; Autistic Self Advocacy Network of Australia & New Zealand, *Submission 181*, p. 17; Australian Orthotic Prosthetic Association, *Submission 189*, p. 2; Nest Culture Pty Ltd, *Submission 192*, p. 3; Believe and Become Pty Ltd, *Submission 381,* p. 5.

[240] Pop Family Pty Ltd, *Submission 15*, p. 3; Australian Physiotherapy Association, *Submission 171*, p. 19.

[241] Pop Family Pty Ltd, *Submission 15*, p. 6.

[242] Australian College of Nurse Practitioners, *Submission 30*, pp. 7–8.

3.213 Similarly, the NRHA recommended:

> Telehealth and hybrid service models supported by local facilitators and outreach programs may complement (not replace) face-to-face contact and address the tyranny of distance, allow timely screening, and facilitate continuity of care, especially for workforce-scarce areas.[243]

3.214 The Regional Education Commissioner suggested that community organisations should be supported 'to provide allied health services through telehealth and outreach [as] another opportunity to extend access to allied health services to regional, rural and remote communities.'[244]

3.215 Royal Far West described telehealth as 'a very effective model of care' that 'doesn't take children out of school.' They shared the example of a student who had to travel to Dubbo to receive care, and, as a result, needed 36 days off school to attend sessions, while her mother had to take those days off work.[245]

3.216 Other stakeholders expressed reservations about the utility of telehealth. For example, although Autism NT agreed that telehealth works for some individuals 'because it takes away the anxiety of that social interaction,' they also noted that healthcare delivered online does not always lead to best results.[246]

3.217 Mrs Ashlee Law noted that 'Telehealth is sometimes available but does not fully replace local, consistent access, and is often incompatible for supporting young children.[247]

3.218 Services for Australian Rural and Remote Allied Health (SARRAH) similarly pointed out that the complexity of some supports mean that they are not suitable to virtual formats. For example:

> Speech pathologists work with children with complex communication needs, supporting participants who have limited speech or are non-verbal to use customised assistive technology. Prescribing the right technology, customising it and training in its use requires face to face input and consistent follow-up to ensure learning sticks. These complexities make virtual modalities impractical. The situation is compounded by poor bandwidth and connectivity issues routinely faced by rural and remote Australians.[248]

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[243] National Rural Health Alliance, *Submission 379*, p. 4.

[244] Regional Education Commissioner, *Submission 42*, p. 1. See also: Australian Council of State School Organisations, *Submission 46*, p. 8.

[245] Ms Jacqueline Emery, Chief Executive Officer, Royal Far West, *Committee Hansard*, 7 November 2025, pp. 3-4.

[246] Mrs Niki Lehmann, Executive Officer, Autism NT, *Committee Hansard*, 3 October 2025, p. 20.

[247] Mrs Ashlee Law, *Submission 14*, p. 2. See also: South Burnett CTC, *Submission 41*, p. 5; Ms Nicole Avery, Chief Executive Officer, South West Autism Network, *Committee Hansard*, 3 October 2025, p. 37.

[248] Services for Australian Rural and Remote Allied Health, *Submission 295*, pp. 3–4.

3.219 The National Organisation for Fetal Alcohol Spectrum Disorder submitted that telehealth ‘functions best as a supplementary model rather than a replacement, as it relies on already overstretched clinic staff and digital infrastructure…’[249]

3.220 Associate Professor David McDonald, Senior Member of the Australian Paediatric Society, said that ‘Telehealth has a place but should not replace face-to-face assessment,’ highlighting ‘very significant limitations in terms of the clinician-to-client interaction.’[250]

3.221 Beyond telehealth, some stakeholders called for improved outreach and digital tools. For example, Succeed Healthcare Solutions Pty Ltd recommended investment in pathways to link families with providers, ‘prioritising long-term relationship-building and cultural safety’ and ‘long-term strategies for rural access, including outreach and relationship-building.’[251]

3.222 Succeed Healthcare Solution’s submission explained its own experience trying to reach rural and remote areas:

> We are willing and able to service rural and remote areas, including through place-based allied health assistant groups and telehealth. However, trust is the first barrier. Families are reluctant to engage when they don’t know us, and there are no effective, nationally maintained systems to connect families with providers who have capacity. As a result, support remains unavailable even when services exist.[252]

3.223 Ms Kylie Irvin, Portfolio Manager, NDIS Western at Marathon Health highlighted the need for continued investment in allied health services operating in regional and rural communities:

> …there are already some excellent allied health services who just need continued investment to be able to deliver more of the services that they're already doing a really great job at doing. We typically travel 400 kilometres to 500 kilometres to provide face-to-face services to children in our patch. We would travel into those communities roughly once a month or sometimes once a fortnight—around about 300 kilometres there and home—and then back again that day or the next day. I think we would view telehealth as something that complements this face-to-face service delivery. And, as I mentioned, adding in those enabling roles, like paediatric linkers and allied health assistance, can really complement that service as well, where families who aren't able to access telehealth—who might live on a remote station an hour from Bourke, which is

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[249] National Organisation for Fetal Alcohol Spectrum Disorder, *Submission 106*, p. 7.

[250] Associate Professor David McDonald, Senior Member, Australian Paediatric Society, *Committee Hansard*, 17 November 2025, p. 50. See also: Square Peg Round Whole, *Submission 318,* p. 9.

[251] Succeed Healthcare Solutions Pty Ltd, *Submission 150,* pp. 4-5.

[252] Succeed Healthcare Solutions Pty Ltd, *Submission 150*, p. 4.

> about 500 kilometres from Dubbo—could have a person in the home, working with them, and then be supported through telehealth as well.[253]

3.224 Colman Education Foundation: Our Place also commented on some of the limitations of digital outreach:

> While digital tools such as apps and websites can extend access, particularly in rural and remote areas, they are not enough on their own. Families experiencing disadvantage are the least likely to engage through these channels, and digital resources cannot provide the reassurance or professional judgement that parents often need when concerns arise.[254]

3.225 Mrs Rachel Green, from SANE Australia, outlined a project funded by the Department of Health on designing digital solutions to improve navigation of the mental health system, and also the role of people helping others navigate the system.[255]

> Those principles from our navigation report are to find me where I am; make it easy to get more help, because no single path works for everyone; help me choose based on what's important to me; value, build and maintain my trust; help others help me; make it easy to move between services; and provide support and resources while I'm waiting—this one is particularly relevant considering the fact that it's not always clear, and it's not always possible, to diagnose certain developmental delays or types of neurodivergence when a kid is simply too young and there could be a lot of factors.[256]

Limited infrastructure and internet connectivity

3.226 Multiple stakeholders identified poor infrastructure and internet connectivity as a barrier affecting children and families in rural and regional communities. For example, MYAN highlighted that poor infrastructure (such as telecommunications, broadband, or electricity) can compound challenges for people with disability living in regional and rural areas.[257]

3.227 A submission from South West Autism Network described poor internet connectivity in parts of regional WA, which can be a barrier to using telehealth.[258]

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[253] Ms Kylie Irvin, Portfolio Manager, NDIS Western, Marathon Health, *Committee Hansard*, 7 November 2025, p. 4.

[254] Colman Education Foundation: Our Place, *Submission 193*, p. 4.

[255] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, pp. 41-42.

[256] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, pp. 41-42.

[257] Ms Rana Ebrahimi, National Manager, Multicultural Youth Advocacy Network Australia, *Committee Hansard*, 10 October 2025, p. 21. See also: Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 35.

[258] Ms Nicole Avery, Chief Executive Officer, South West Autism Network, *Committee Hansard*, 3 October 2025, p. 37.

3.228 Ms Catherine Maloney, Chief Executive Officer, SARRAH, described poor access to high-speed internet in regional, rural and remote Australia as ‘an equity issue for children with disability’. She stated:

> That means you must have all of these options available to families living in rural and remote areas. The evidence tells us that the use of screening models of care with multidisciplinary teams and role substitution methods seems to improve screening, assessment and diagnostic processes, leading to the appropriate identification of children who do require services. But solutions can't rely solely on digital modalities, as there are often reports of technology difficulties, such as not having appropriate equipment or inadequate internet connections.

3.229 In this context, Ms Maloney recommended that consideration be ‘given to ensuring all remote Australians have access to high-speed internet as an essential part of health and education infrastructure.’[259]

Workforce challenges

3.230 The Committee heard about a ‘health workforce crisis’ in rural Australia, where many communities have limited or no access to services and support. Ms Jacqueline Emery, Chief Executive Officer at Royal Far West explained:

> GP access and the availability of allied health, particularly in MMM5, is declining. Bulk-billing rates are falling and locum contracts are unsustainable. Paediatric waitlists can stretch from 18 months to six years, and private assessments cost up to $3,000. We receive consistent reports of a two-year waitlist for allied health. Teachers are managing complex needs without support. Families are under financial and emotional strain. Our rural communities are losing young families because services simply aren't there. Families in thin markets are not getting the help they need at the time when it makes the most difference. This is structural, not situational.[260]

3.231 Stakeholders generally agreed that for Thriving Kids to be delivered successfully, rural and remote communities need more health and disability service workers.[261]

3.232 For example, the National Organisation for Fetal Alcohol Spectrum Disorder (NO FASD) described ‘disproportionate shortfalls in the healthcare workforce’, especially in rural towns. Its submission also highlighted that many communities rely on fly-in fly-out ‘clinicians whose services are prioritised for children with acute or medically complex needs.’ Ultimately, NO FASD concluded: ‘The assumption that Thriving Kids can “scale up” existing services ignores the reality that in many communities, no baseline FASD-informed services currently exist.’[262]

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[259] Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health Ltd, *Committee Hansard*, 10 October 2025, p. 34.

[260] Ms Jacqueline Emery, Chief Executive Officer, Royal Far West, *Committee Hansard,* 7 November 2025, p. 1.

[261] See, for example: South Burnett CTC, *Submission 41*, p. 6; The Benevolent Society, *Submission 309,* p. 14.

[262] National Organisation for Fetal Alcohol Spectrum Disorders, *Submission 106*, p. 7.

3.233 Contemplating funding of Thriving Kids with a focus on workforce, Ms Susanne Tegen, Chief Executive at the NRHA said:

> …clinicians on the ground should be celebrated rather than being made to run through more hoops. We need to build the local workforce and we need to support the local workforce, not treat them as if they are criminals because they're asking for more. They're not even receiving the equitable funding in the first place. That is a really important thing.[263]

3.234 Submitters and witnesses discussed a broad range of sector-specific workforce challenges in rural and regional communities, such as:

- high costs and safety risks for staff driving long distances.[264]
- people studying allied health degrees typically need to relocate to cities, and often don't move back to rural and remote areas after graduation.[265]
- secondary teacher demand is expected to exceed supply, enrolments are rising and workloads are increasing.[266]
- educators do not always have 'the time or the confidence' to make decisions about identifying at-risk children.[267]
- short-term contracts do not incentivise new medical and allied health graduates to relocate or return to rural areas.[268]
- caps on travel limits make it difficult for allied health professionals to provide services.[269]
- pay discrepancies exist between nurses working for a local health district versus in communities.[270]
- rural accommodation shortages.[271]

3.235 Ms Samantha Hunter, Chief Executive Officer at Occupational Therapy Australia, described occupational therapy as 'the fastest-growing allied health profession', and suggested that the increasing number of graduates should assist the availability of supply in rural and remote areas. She also highlighted that 'a number of programs

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[263] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, pp. 35–36.

[264] Mrs Niki Lehmann, Executive Officer, Autism NT, *Committee Hansard*, 3 October 2025, p. 16.

[265] Ms Nicole Avery, Chief Executive Officer, South West Autism Network, *Committee Hansard*, 3 October 2025, p. 35.

[266] Inclusive Educators Australia, *Submission 132*, p. 10.

[267] Ms Kylie Irvin, Portfolio Manager, Marathon Health, *Committee Hansard*, 7 November 2025, p. 3.

[268] Ms Sally Urquhart, Executive Manager of Strategy, HealthWISE, *Committee Hansard*, 7 November 2025, p. 13.

[269] Dr Alexandra Murray, Head, Policy and Research, Australian Psychological Society, *Committee Hansard*, 20 October 2025, pp. 14–15.

[270] Mrs Denise Lyons, President, Australian Primary Health Care Nurses Association, *Committee Hansard*, 21 October 2025, p. 29.

[271] Dr Sarah Chalmers, President Elect, Rural Doctors Association of Australia, *Committee Hansard*, 10 October 2025, p. 38; Australian Council of State School Organisations, *Submission 46*, p. 10; South West Autism Network, *Submission 131*, p. 20;

are being started up over the coming two to three years and will be delivered in regional and remote areas.'[272]

3.236 Mrs Amanda Curran, Chief Psychologist at the Australian Association of Psychologists suggested:

> …a model that we proposed to government where provisional psychologists could be doing placements in those settings if the supervisors were trained and there was some paid work for those provisional psychologists to be out in rural and remote settings. We found that, if people complete their training in those settings, they're more likely to stay in those areas as well. A system like that, where we're getting people there and completing their training, might ease up the burden for those families living in those locations for many more years.[273]

3.237 Additionally, the ACNP argued that nurse practitioners be integrated into the Thriving Kids model to support 'a sustainable, system-wide approach to supporting children to thrive outside of the NDIS.' The ANCP explained:

> Nurse Practitioners are a vital part of the primary care workforce, and are embedded across maternal and child health, general practice, and community health services. With appropriate funding, NPs can strengthen early identification and intervention, ease service demand on specialised behavioral pediatricians, and improve equity of access across metropolitan, rural, and remote settings.[274]

3.238 The Australian Primary Health Care Nurses Association agreed, saying that the 98,000 nurses working in primary care represent a workforce that is embedded in communities and could be trained in screening, early intervention, coaching and supporting parents, which could ease challenges in MM6 and MM7 areas.[275]

3.239 Ms Janice Finlayson from Maternal, Child and Family Health Nurses Australia, echoed this and said that nurses are a mobile workforce which are currently being underutilised.[276]

Relocation and retention incentives

3.240 Many submitters and witnesses advocated for workforce incentives as a means to increase the health and disability service workforce in rural and remote communities.[277] Specifically, stakeholders recommended incentives and other

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[272] Ms Samantha Hunter, Chief Executive Officer, Occupational Therapy Australia, *Committee Hansard*, 20 October 2025, p. 21.

[273] Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists Inc; *Committee Hansard*, 20 October 2025, p. 14.

[274] Australian College of Nurse Practitioners, *Submission 30*, p. 3.

[275] Mrs Denise Lyons, President, Australian Primary Health Care Nurses Association, *Committee Hansard*, 21 October 2025, p. 26.

[276] Ms Janice Finlayson, Director, Maternal, Child and Family Health Nurses Australia, *Committee Hansard*, 21 October 2025, p. 29.

[277] See, for example: Australian Multicultural Action Network, *Submission 17*, p. 4; Australian College of Nurse Practitioners, *Submission 30*, p. 8; Aruma, *Submission 113*, p. 7; Pop Family Pty Ltd, *Submission 156*, p. 7; Australian Physiotherapy Association, *Submission 171*, p. 19; NursePrac Australia, *Submission 173*, p. 4;

supports to attract and retain educators,[278] allied health professionals,[279] and psychologists.[280]

3.241 While stakeholders proposed a range of different incentives, most described financially-based incentives. For example, Ms Louise Ingall, Manager Research and Partnerships at HealthWISE suggested discounting student debt as an incentive for people to relocate to rural areas.[281] She elaborated:

> …we are not expecting people to give up their lives; we would like them to come and have a rural experience for 12 to 18 months. It would make a difference to all our children.[282]

3.242 Similarly, ACSSO recommended 'Relocation and retention incentives should be provided for allied health professionals in rural and remote areas, including housing, travel subsidies, and professional development opportunities.'[283]

3.243 However, the Australian Physiotherapy Association highlighted the need for non-financial incentives:[284]

> Generic incentives have not fully addressed shortages of paediatric physiotherapists in rural and remote locations. Discipline-specific incentives, career development, mentoring and professional learning opportunities are essential to build local workforce capacity.[285]

Funding and costs

3.244 Multiple stakeholders throughout the inquiry referred to the Modified Monash Model / MMM 2019, which is used by the NDIS to determine the location of a participant and cost of a provider. More information about the Modified Monash Model is available in Box 3.3.[286]

Allied Health Professions Australia, *Submission 176*, p. 8; Murrumbidgee Primary Health Network and Murrumbidgee Local Health District, *Submission 191*, p. 7; Dr Jacqui Barfoot, *Submission 194*, p. 1; Australian Paediatric Society, *Submission 344*, p. 3; Queensland Council of Social Service (QCOSS), *Submission 358*, p. 3.

[278] Inclusive Educators Australia, *Submission 132*, p. 11.

[279] South Burnett CTC, *Submission 41*, p. 6; Australian Youth Affairs Coalition, *Submission 334,* p. 3.

[280] Australian Association of Psychologists, *Submission 157*, p. 5; Dr Alexandra Murray, Head, Policy and Research, Australian Psychological Society, *Committee Hansard*, 20 October 2025, pp. 14–15.

[281] Ms Louise Ingall, Manager Research and Partnerships, HealthWISE, *Committee Hansard,* 17 November 2025, p. 13. See also: PRECI (Professionals & Researchers in Early Childhood Intervention), *Submission 203*, p. 5; Australian Paediatric Society, *Submission 344*, p. 3.

[282] Ms Louise Ingall, Manager Research and Partnerships, HealthWISE, *Committee Hansard,* 17 November 2025, p. 13.

[283] Australian Council of State School Organisations, *Submission 46*, p. 10.

[284] Australian Physiotherapy Association, *Submission 171*, p. 21.

[285] Australian Physiotherapy Association, *Submission 171*, p. 21 (citation omitted).

[286] See, for example: Royal Far West, *Submission 60,* p. 4; National Regional, Rural, Remote and Very Remote Community Legal Network, *Submission 264,* p. 2; Developing Ur Life, *Submission 238,* p. 5; Services for Australian Rural and Remote Allied Health, *Submission 295,* p. 2. See also: MyCareSpace, *How to understand the NDIS MMM Pricing*, https://mycarespace.com.au/resources/how-to-understand-the-ndis-mmm-pricing (accessed 29 October 2025).

Box 3.3 Modified Monash Model

Since 1 October 2020, the NDIS has used the Modified Monash Model / MMM 2019 to define whether participants or NDIS providers are located in a city, rural, remote or very remote area. The model measures remoteness and population size on a scale of Modified Monash (MM) category MM 1 to MM 7, with MM 1 being a major city and MM 7 being very remote.

The Modified Monash Model influences the prices charged by a provider and paid by a participant in a specified location. The location of an NDIS service affects its cost: the more remote the service delivery area, the more expensive it is.

The NDIS currently has 3 levels of pricing for each support:

- MMM 1 - 5 is classified as National Non Remote. Services delivered in these regions use the standard (lowest) NDIS price rate
- MMM 6 is classed as National Remote. Services delivered in this region are generally 40 per cent higher than the standard NDIS price rate.
- MMM 7 is classed as National Very Remote. Services delivered in this region are generally 50 per cent higher than the standard NDIS price rate.[287]

3.245 Throughout the inquiry, the Committee was fortunate to hear from support services active in MMM remote locations. For example, in 2024–25, Royal Far West supported more than 30 000 people across 387 communities, with 42 per cent of its services being delivered in MMM 5 locations (small rural towns).[288]

3.246 A submission from SARRAH discussed NDIS funding and pricing in MMM 4-6 areas, and warned that ‘NDIS participants in these areas are at risk of losing access to therapy supports essential for maintaining quality of life.’[289] SARRAH explained:

> The 2025 NDIS Pricing Arrangements which came into effect from 1 July 2025 saw significant changes limiting therapy provider travel, and for many providers will make delivering services into rural and remote communities unsustainable... Recommendations arising from the 2023 NDIS Review have not been implemented, leaving participants with no back-up plan should their current provider withdraw services.[290]

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[287] MyCareSpace, *How to understand the NDIS MMM Pricing*, https://mycarespace.com.au/resources/how-to-understand-the-ndis-mmm-pricing (accessed 29 October 2025).

[288] Royal Far West, *Submission 60,* p. 4.

[289] Services for Australian Rural and Remote Allied Health, *Submission 295,* p. 2. See also: Mrs Niki Lehmann, Executive Officer, Autism NT, *Committee Hansard*, 3 October 2025, p. 16.

[290] Services for Australian Rural and Remote Allied Health, *Submission 295,* p. 2.

3.247 The National Regional, Rural, Remote and Very Remote Community Legal Network said that children were being let down by current supports, particularly in Regional, Rural, Remote and Very Remote (4R) areas:

> Currently the NDIS Act and swathes of Commonwealth legislation fail to visibly support geographic inclusion of children, people and groups in 4Rs areas. This portrays that no major challenges for inclusion, intersectionality and implementation exist, when the reverse is true. The invisibility fails to provide leadership and vision to promote momentum and solutions.
>
> The problems which are letting down children with disability in 4Rs areas – and the complex of failures affecting children and others in 4Rs areas across so many policy and program areas and dimensions – mean that the task must now include establishing a culture of geographic success and inclusion. That is, establishing an enabling, educative and self-improving environment for large scale cultural change which expects and achieves full geographic inclusion of children, people and peoples in 4Rs areas.[291]

Block funding

3.248 Some stakeholders suggested that block funding arrangements (see Box 3.4) could potentially help to address workforce challenges in rural and remote communities. However, other stakeholders raised concerns that this model would unduly impact local providers and subsequently the supports available in those communities.

Box 3.4 Block funding

Government block funding is a funding model where the government provides grants to approved providers to deliver community service programs. This is different to activity-based funding, where funding is determined by the number and type of services provided to patients,[292] and is also different to individualised funding, where consumers of services receive funding and can select their own providers.

Most of Australia's public hospital system is funded using activity-based funding, but some block funding is used to fund small rural hospitals across Australia.[293]

The NDIS uses an individualised funding model, giving funds directly to people on the scheme.[294]

3.249 The Royal Australian College of General Practitioners discussed the 'tremendous potential' of block funding in areas where there are limited specialists available. For

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[291] National Regional, Rural, Remote and Very Remote Community Legal Network, *Submission 264*, pp. 7-8.

[292] National Health Funding Body, *Funding types*, www.publichospitalfunding.gov.au/public-hospital-funding/funding-types (accessed 3 December 2025).

[293] The Front Project, *Funding Models and Levers for Early Childhood Education and Care*, www.thefrontproject.org.au/media/attachments/2022/08/30/ecec-funding-models-and-levers.pdf (accessed 3 December 2025).

[294] National Disability Insurance Scheme, *How the NDIS works*, 2 April 2024, www.ndis.gov.au/understanding/how-ndis-works (accessed 3 December 2025).

example, if ‘multiple general practices pool their block funding to employ…suitable early intervention providers that are community centric.’[295]

3.250 Ms Clark, Kiind, believed that block funding could potentially be one of several alternative models for reaching regional and remote communities, particularly in Western Australia.[296]

3.251 Pop Family Pty Ltd suggested the ‘government could consider funding models such as block funding or national contracts for telehealth-enabled services, which would secure a baseline of access nationally and particularly benefit families in regional and remote communities’[297] as well as enabling ‘providers to invest in the workforce development required to meet demand.’[298]

3.252 The National Rural Health Commissioner noted that block funding could be an option that ‘could support the delivery of services that are no or low cost to clients in rural and remote communities.’[299]

3.253 In contrast, Ms Heidi La Paglia, a Steering Committee Member from Every Australian Counts, said that regional communities are concerned that large block funding contracts will exclude communities that are not serviced by major providers, since local providers may not be NDIS registered, leading to potential collapse or changes to the market in these areas. She also warned that this could lead to workers losing their jobs.[300]

3.254 The Nobody Worse Off Coalition was of the view that if ‘services are block funded small First Nations-led or regional providers may not be eligible, risking service loss.’[301]

3.255 Ms Nicole Moran, Board Member of the Regional Autistic Engagement Network, agreed that block funding ‘will logically disproportionately impact marginalised and intersectional communities, families and children, who cannot afford gap service fees, which we know will remain in rural communities due to the lack of available services and providers.’ She said that her personal experience of block funded disability supports in Tasmania ‘never provided us with adequate support and always fell short of our needs…my family and I were left with out-of-pocket expenses that we could not afford.’ She told the Committee that research supports self-directed, individualised funding packages, such as those currently provided through the NDIS.[302]

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[295] Dr Timothy Jones, Chair, Specific Interests Group, Child and Young Person's Health, Royal Australian College of General Practitioners, *Committee Hansard*, 20 October 2025, p. 25.

[296] Ms Carrie Clark, Chief Executive Officer, Kiind, *Committee Hansard*, 3 October 2025, p. 33.

[297] Pop Family Pty Ltd, *Submission 156*, p. 8.

[298] Pop Family Pty Ltd, *Submission 156*, p. 8.

[299] National Rural Health Commissioner, *Submission 195*, p. 4.

[300] Ms Heidi La Paglia, Steering Committee Member, Every Australian Counts, *Committee Hansard*, 20 October 2025, p. 48.

[301] Nobody Worse Off Coalition, *Submission 242*, p. 8.

[302] Ms Nicole Moran, Board Member, Regional Autistic Engagement Network, *Committee Hansard*, 17 November 2025, p. 17.

Funding and contracting

3.256 The National Rural Health Alliance emphasised the need for adequate and targeted block funding from government as an equitable solution for meeting the higher costs of service delivery of Thriving Kids to participants in regional, rural and remote areas.[303]

> Block funding is one; isolating the funding for rural and remote communities; and,…really investing in your rural workforce. If you've already got people there, it's business 101: if you've got a customer, hang on to them, because it is much more difficult to get new ones. The next thing is rural training: picking rural students, training them in rural—that's a longer-term one. But, at the very beginning, let's start looking at place based solutions for those communities. Let's start looking at ways we can, in the interim, support those people who are on the ground to grow. We've got plenty of communities where the communities have had to raise the funding, and they're expanding, and they're doing it on their own because nobody is willing to help them. In fact, if anything, they have barriers there from the state and federal system, because it's not flexible enough for them to deliver. So work with communities that are doing that. Work with those clinicians that have solutions.[304]

3.257 The Chair of the APA's National Paediatric, Mrs Nicole Pates, outlined that the block funded model had some 'fantastic points, but it was also less accessible'[305].

> There were very long wait lists in Western Australia, where I'm from, for different services, and there continue to be very long waitlists for our child development service. There needs to be an element of choice and control and options. There is not a one-size-fits-all approach. I think we all agree that being able to be funded to have those and not having a family have to choose between professions, because we work so well together in hospitals—in all the hospital systems you see the multidisciplinary teams are together. We want the same in the community as well.[306]

3.258 Occupational Therapy Australia agreed with the APA and saw an opportunity for blending various funded models.

> There is also a great opportunity for us to really invest in our allied health workforce to ensure we are embedded in schools, we are embedded in community health, we are embedded in disability services and we also have a thriving private practice area…but there is absolutely some gaps. This is a great

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[303] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 36.

[304] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 36.

[305] Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 20.

[306] Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 20.

> opportunity for us to reset the scene and create systems and services that enable us to thrive, which will enable the young people and families that we work with to thrive.[307]

3.259 Outside the NDIS, access to allied health services is inconsistent. According to the Australian Physiotherapy Association, those ‘inconsistencies are greatest for people in rural settings, Aboriginal and Torres Strait Islander communities, and culturally and linguistically diverse communities’[308].

> This is why we really need equity focused measures within Thriving Kids to make sure that it doesn't widen those existing gaps and to make sure that it fills those gaps really thoroughly.[309]

3.260 Services for Australian Rural and Remote Allied Health Ltd outlined how recent changes made by the NDIS to allied health professionals claiming for travel impacted on their clients in regional areas.[310]

> This is why we looked at the driving distance to an occupational therapist as a marker of that. The travel caps meant that, if you had an hour’s round trip to visit a child and their family in their home, you were only going to be able to claim for half of that time. So immediately, if you are a small provider located in a Modified Monash Model 4 or 5 town, that's going to limit your capacity to travel to see some of these children in their home context.[311]

3.261 The Department of Social Services highlighted how its financial support for playgroups and toy libraries created opportunities for mutual support as well as ‘conversation that might lead to a referral to a more intensive or targeted service and so forth’.

> Probably the key service offerings are Children and Parenting Support Program—CAPS for short… The other one I'd probably draw attention to is Communities for Children Facilitating Partners, which is a place based initiative where the facilitating partner establishes a committee and a strategic plan based on the needs of the community in respect of children aged nought to 12…complemented by what's needed—reach into the important consultation and engagement with the local schools, preschools, childcare facilities and so forth.[312]

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[307] Mrs Michelle Oliver, Chief Occupational Therapist, Occupational Therapy Australia, *Committee Hansard*, 20 October 2025, p. 20.

[308] Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 21.

[309] Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 21.

[310] Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health Ltd, *Committee Hansard*, 10 October 2025, p. 36.

[311] Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health Ltd, *Committee Hansard*, 10 October 2025, p. 36.

[312] Mr John Riley, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 2.

3.262 NACCHO claimed only some of their member services seek to access the Department of Social Services' Communities for Children funding and other financial support, due to the complexity of application processes onerous reporting requirements.

> Some of them have got up to 72 funding streams that they need to report to. I think Thriving Kids, for it to be incredibly successful, has got this great opportunity at a system level to bring that all together and consider how one funding model could actually integrate a number of different areas. It puts a huge burden on our sector, and they're not funded to manage all the grant guidelines and the constant things that they have to do to receive those pockets of money.[313]

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[313] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 18.

4. Developing the Thriving Kids initiative

4.1 The Committee received a significant volume of commentary about the critical design considerations and components for the development of the Thriving Kids initiative to make it fit for purpose for children and their carers, as well as for people working in the care sector.

4.2 This chapter explores the three issues that were consistently raised in evidence:

- early intervention
- workforce capacity and service delivery
- transition from current systems to Thriving Kids.

Box 4.1 Thriving Kids

The Australian Government announced its commitment to contribute $2 billion over 5 years towards Thriving Kids, commencing from 1 July 2026.

Thriving Kids will focus on identifying developmental concerns earlier, and establishing a national system of supports for children aged 8 and under with mild to moderate developmental delay and autism, and their families. Children with permanent and significant disability will continue to be supported through the NDIS.

The final program design for Thriving Kids will be settled between the Australian Government and state and territory governments. It will be informed by experts and the significant community input received through the Independent Review of the NDIS, and the Thriving Kids Advisory Group co-chaired by Professor Frank Oberklaid AM.[1]

Early identification and intervention

4.3 This section builds on the discussion in Chapter 2 about early intervention processes and supports for children.

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[1] Department of Health, Disability and Ageing, *Foundational supports for people with disability*, www.health.gov.au/our-work/foundational-supports-for-people-with-disability, (accessed 7 October 2025).

4.4 Over the course of the inquiry, multiple witnesses highlighted the importance of screening tools for developmental delays and autism in helping to ensure the timely identification of potential issues.

4.5 Australian families can access developmental screening in multiple different ways, including through maternal and child health services, general practitioner appointments, or within early childhood settings.[2] There is also a variety of different methods and tools that can be used to assist parents and healthcare professionals to identify potential issues. These tools include, for example:

- The Parents' Evaluation of Developmental Status (PEDS), which is a 10-item questionnaire that allows parents to note any concerns in their child's development, health and well-being
- The Ages and Stages Questionnaire (ASQ), which is administered by healthcare professionals and screens across multiple developmental areas
- Raising Children Network, an online milestone checklist and guide for parents that is used to identify development progress.[3]

4.6 Submissions from entities such as Ashar Health, the Australian Primary Health Care Nurses Association (APNA), the Maternal, Child and Family Health Nurses Australia (MCaFHNA), the Australian College of Nurse Practitioners (ACNP), and the AEIOU Foundation, however, noted that the use and access to screening tools across Australia's states and territories tends to be inconsistent.[4] This situation can result in confusion for children and parents, delayed diagnosis and missed opportunities for early support.

4.7 In its submission, ACNP expressed concern at the absence of standardised screening:

> Early recognition of developmental and behavioural concerns is critical to ensuring children receive timely support and intervention. However, these early signs are often overlooked or minimised, often described as "something the child will grow out of" or "just a quirk." Without a consistent approach to a referral, supported by a simplified and universal indicator assessment tool, delays in referral, assessment, and treatment are more likely, and some children may not be identified at all.[5]

4.8 APNA and MCaFHNA further highlighted that the lack of a standardised, national approach can have an adverse impact on professionals working in the field, presenting challenges for training, consistency of care, equitable development

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[2] Ashar Health Pty Ltd, *Submission 16*, p. 1.

[3] Autism Spectrum Australia, *Submission 67*, p. 5; see also AEIOU Foundation, *Submission 70*, p. 5 and Raising Children Network, *Submission 110*.

[4] Australian Primary Health Care Nurses Association and the Maternal, Child and Family Health Nurses Australia, *Submission 74*, p. 5; Ashar Health Pty Ltd, *Submission 16*, p. 1; The Australian College of Nurse Practitioners, *Submission 30*, p. 5; AEIOU Foundation, *Submission 70*, p. 5.

[5] Australian College of Nurse Practitioners, *Submission 30,* p. 3.

surveillance, timely referrals across the country, and overall levels of professional confidence.[6]

4.9 ACNP recommended that a national, standardised approach to screening be developed, as this 'would promote equity, ensure consistency, and enable streamlined assessment and timely referral for a more comprehensive paediatric development evaluation.' This approach, ACNP further explained, would facilitate more consistency in 'recognising red flags' across maternal and child health, early education, and healthcare services, which may include:

> …repetitive play, feeding difficulties, sensory sensitivities, limited food intake and variety, poor or delayed fine and gross motor skills, intense focus or restricted interest, rigid routines, delayed language development (including echolalia), limited eye contact, regression of skills, toe-walking, and unusual pattern of social play.[7]

4.10 ACNP further emphasised the need to integrate screening results into digital systems such as MyHealthRecord or Services Australia platforms, to allow for better monitoring of developmental progress.[8]

4.11 Many submitters also called for a more consistent approach in the level of training required to conduct developmental checks. In its submission, Family Paediatrics Nurse Practitioners noted that health professionals are not always equipped with sufficient knowledge to conduct these checks.[9] For example, practice nurses within general practice environments sometimes conduct the checks, but not all have adequate training in this field. Family Paediatrics Nurse Practitioners recommended establishing a minimum qualification requirement, such as a Graduate Certificate in Child and Family Health.

4.12 In their joint submission, the Australian College of Nursing (ACN), the Australian College of Children and Young People's Nurses (ACCYPN), Maternal, Child and Family Health Nurses Australia, and Professional Association of Nurses in Developmental Disability Australia (PANDDA) similarly noted:

> While nurses working in primary care settings engage with children, particularly during immunisation visits, they are not typically trained in child health or developmental screening. Studies show that practice nurses often struggle to stay current with child health knowledge and lack confidence in advising parents…

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[6] Australian Primary Health Care Nurses and Maternal, Child and Family Health Nurses Australia, *Submission 74*, p. 5.

[7] Australian College of Nurse Practitioners, *Submission 30,* p. 4.

[8] Australian College of Nurse Practitioners, *Submission 30*, p. 5; see also Ashar Health, *Submission 16*.

[9] Family Paediatrics Nurse Practitioners Pty Ltd, *Submission 52*, p. 5; see also Kids I Can, *Submission 51*, p. 2.

> We recommend upskilling primary care nurses in child health and developmental screening and removing barriers to enable more nurse practitioners to work in primary care settings.[10]

4.13 Reflecting on the optimal time for screening, APNA and MCaFHNA drew attention to a recommendation by the American Academy of Pediatrics that all children should be screened for autism at both 18 and 24 months of age, in addition to development monitoring. APNA and MCaFHNA stated that:

> [t]his recommendation supports global best practice and aligns with evidence showing that early intervention during periods of heightened neuroplasticity can lead to significant gains in social communication and cognitive functioning.[11]

4.14 In its submission, Ashar Health recommended implementing screening at key developmental milestones, such as at 6, 12, 18, 24 and 36 months of age.[12] The Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP), and Family Paediatric Nurse Practitioners further highlighted the advantage of integrating developmental checks into immunisation schedules, to leverage the high attendance rates at healthcare settings on these occasions.[13]

4.15 Multiple witnesses highlighted the fact that parents and carers are usually the first to notice issues with a child's development.[14] ACNP noted, however, that sometimes concerns expressed by parents and carers are dismissed. Development of a standardised screening method would help validate their observations.[15]

4.16 At the same time, standardised and regular screening would help to normalise developmental conversations, and reduce stigma associated with developmental delays and disorders. As one submitter observed:

> Current approaches to developmental screening and early identification often perpetuate deficit-driven narratives that can harm rather than help families. We must fundamentally reframe developmental checks as supportive, strengths-based opportunities that celebrate diverse ways of being while identifying areas where additional support might be beneficial.[16]

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[10] Australian College of Nursing, Australian College of Children & Young People's Nurses, Maternal, Child and Family Health Nurses Australia, Professional Association of Nurses in Developmental Disability Australia, *Submission 96*, p. 7.

[11] Australian Primary Health Care Nurses and Maternal, Child and Family Health Nurses Australia, *Submission 74*, p. 7.

[12] Ashar Health Pty Ltd, *Submission 16*, p. 2.

[13] Australian Medical Association, *Submission 209*, p. 1; The Royal Australian College of General Practitioners, *Submission 211*, p. 3 and Family Paediatric Nurse Practitioners, *Submission 52*, p. 5.

[14] See for example, Catholic Schools Parents Australia, *Submission 317*, p. 3; Learning Links, *Submission 103*, p. 10; Dr Jacqui Barfoot, *Submission 194*, p. 3; Monash University, *Submission 291*, p. 8; ADHD Foundation, *Submission 71*, p. 7.

[15] Australian College of Nurse Practitioners, *Submission 30,* p. 4. See also Academy of Child and Adolescent Health, *Submission 76*, p. 1.

[16] Name withheld, *Submission 47*, p. 5.

4.17 Acknowledging the important role of parents and carers in early identification, the Australian Council of State School Organisations (ACSSO) noted that while families often sense developmental issues early, they are unsure what might constitute a 'red flag,' where to go for advice, and what services may be available.[17] The ACSSO recommended the development of clear, accessible, and culturally appropriate resources for parents, along with 'no wrong door pathways' to ensure parents can access support at any touchpoint (including at maternal and child health services, early childhood education and care centres, schools, and community hubs).[18]

4.18 Similarly, Ms Katherine Fotheringham, a mother of a child with autism and a nurse, noted:

> A critical first step is empowering parents with accessible tools for identifying early developmental delays. A simple, stage-appropriate screening tool providing immediate feedback and clear next steps would enable earlier intervention and reduce parental uncertainty.[19]

4.19 In its submission to the inquiry, Healthdirect Australia—a national call centre for health information, advice and triage—submitted that its existing infrastructure could be used to as a 'virtual front door' for families to seek advice on developmental delays. If a child is assessed as needing services, Healthdirect could assist families to find and book appropriate services. As Healthdirect submission explained:

> Using the existing National Health Services Directory which has over 120,000 services listed, new categories of services could be included and pathways created from care plans. …
>
> Furthermore, Healthdirect operates a legacy Pregnancy, Birth and Babies helpline which offers phone based advice from maternal health nurses. This could be repurposed to better reflect contemporary expectations from consumers. It could form an initial step in an integrated service for Australians planning to start a family, moving through the phases of conception and birth, and into early childhood development – including guidance on expected development and how to respond to perceived variations. Integrating this information and advice service with the My Health Record which includes immunisation records would start to provide a holistic record and service experience for families.[20]

4.20 In its submission to the inquiry, Eating Disorders Neurodiversity Australia also highlighted the need for improved support and screening for avoidant/restrictive food intake disorder (ARFID), which involves persistent difficulty consuming adequate amounts and varied types of food. ARFID can cause severe weight loss, nutritional deficiencies, reliance on supplements or enteral feeding and poor psychosocial

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[17] Australian Council of State School Organisations, *Submission 46*, p. 2.

[18] Australian Council of State School Organisations, *Submission 46*, pp. 2-3. See also Australian Primary Principals Association, *Submission 31*, p. 1.

[19] Ms Katherine Fotheringham, *Submission 82*, p. 1.

[20] Healthcare Direct Australia, *Submission 83*, p. 2.

wellbeing, as well as serious impacts on bone, muscle, cardiovascular health, and vision. The organisation recommends incorporating ARFID-specific screening and diagnostic tools into Medicare eligibility assessment for eating disorder care.[21]

4.21 Standardised, systematic developmental screening enhances early diagnosis rates and allows for timely access to early intervention services. Over the course the inquiry, early intervention was consistently recognised as being highly effective in supporting children with developmental differences. In their submission, APNA and MCaFHNA explained that higher levels of neuroplasticity (being the ability of the human brain to change and adapt) in younger children makes them especially responsive to different forms of intervention:

> Neuroplasticity is a vital contributor to early intervention success rates and refers to the brain's innate response to new information of experiences that allows it to restructure neural connections and pathways. Young children's increased neuroplasticity makes them more likely to demonstrate significant gains from intervention compared to those who receive similar services later in development.[22]

4.22 This point was reiterated by a wide range of entities including My Therapy House, the Australian Multicultural Action Network, the Australian College of Nurse Practitioners, the Australian Primary Principals Association, and South Burnett CTC, as well as a number of parents and carers who made submissions to the inquiry.[23] These submissions acknowledge that the first five years of childrens' development are critical, as this is the time when children learn the most and develop important pathways in the brain, laying an intellectual foundation for the future. Early and individualised intervention is, in this context, vital for preventing the need for more complex and costly interventions in the adulthood.[24]

4.23 Autism Spectrum Australia further emphasised that:

> Current and previous programs demonstrate that early and integrated supports can have a significant positive impact on a child's development. The effectiveness is maximised when programs are delivered in natural environments and are deeply embedded in community systems.[25]

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[21] Eating Disorders Neurodiversity Australia, *Submission 23*, p. 1.

[22] Australian Primary Health Care Nurses and Maternal, Child and Family Health Nurses Australia, *Submission 74*, p. 6.

[23] My Therapy House, *Submission 3*; Australian Multicultural Action Network, *Submission 17*; Australian College of Nurse Practitioners, *Submission 30*; Australian Primary Principals Association, *Submission 31*, South Burnett CTC, *Submission 41*; Name withheld, *Submission 33*; Ms Katherine Fotheringham, *Submission 82*, p. 1.

[24] See, for example, Unbound Minds, *Submission 66*.

[25] Autism Spectrum Australia, *Submission 67*, p. 6.

The role of healthcare specialists in early identification and intervention

4.24 The Committee received a substantial amount of evidence regarding the role of healthcare specialists in early identification and intervention, and the importance of building their expertise and experience into the design of the Thriving Kids initiative.

4.25 In their submissions, both the RACGP and the AMA noted that general practice is the most accessible service across Australia, and often the first point of contact for families concerned about their child's development.[26] As such, general practitioners (GPs) play a critical role in early identification and intervention:

> Specialist GPs are usually the first point of contact for families, addressing concerns from parents and providing care through all stages of life. They are well placed to identify children with developmental delay or autism and to coordinate ongoing management, referrals, and supports.[27]

4.26 Nurses, nurse practitioners, and midwives are vital in connecting families to health and developmental services. In their joint submission to the inquiry, ACN, ACCYPN, MCaFHNA, and PANDDA highlighted a recent Flinders University study demonstrating the strong effectiveness of paediatric nurse-led developmental checks for children from birth to five years of age.[28]

4.27 In its submission, ACNP emphasised that nurse practitioners are a critical part of the primary care workforce. They are embedded across key service areas, including maternal and child health, general practice, and community health services. This position enabled them to play a pivotal role in early identification and intervention. Integrating this workforce into the Thriving Kids initiative, ACNP submitted, could help to reduce demand on other specialists and improve equity of access to care.[29]

4.28 A significant portion of the evidence provided to the Committee also focused on the role of allied health care professions, such as exercise physiology, physiotherapy, occupational therapy, speech pathology, feeding and nutrition services, medical and nursing care, and psychology.

4.29 In appearing before the Committee, Mrs Bronwyn Morris-Donovan, Chief Executive Officer of Allied Health Professions Australia (AHPA), noted that the entity represented some 30 professional associations and 200,000 allied health workers—about 35,000 of whom work in regional, rural and remote communities. Many allied health professionals focus on paediatric or early-child care.[30]

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[26] The Royal Australian College of General Practitioners, *Submission 211*, p. 1 and Australian Medical Association, *Submission 209*, p. 1.

[27] The Royal Australian College of General Practitioners, *Submission 211*, p. 5.

[28] Australian College of Nursing, Australian College of Children & Young People's Nurses, Maternal, Child and Family Health Nurses Australia, Professional Association of Nurses in Developmental Disability Australia, *Submission 96*, p. 4.

[29] Australian College of Nurse Practitioners, *Submission 30*, p. 3..

[30] Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 25.

4.30 In explaining the role of this workforce, Ms Morris-Donovan noted:

> Allied health professionals work across the full continuum of care, beginning with early identification of developmental delay either directly or by building capacity of families and other professionals such as early childhood educators. The early-years window is a critical window for development. Timely access to allied health and high-quality assessment and support planning led by allied health practitioners are essential. GPs and nurses play an important role in identification of potential developmental delay, but it is allied health professionals who assess, plan and deliver tailored support programs in close collaboration with families. These assessments are most effective when they happen in natural settings, are multidisciplinary and are seamlessly linked to the support and intervention pathways.[31]

4.31 Occupational Therapy Australia's Chief Occupational Therapist, Mrs Michelle Oliver, described how allied health professionals often have more time than GPs to better understand the early developmental challenges that a child may be facing. She explained:

> The way that allied health works is that we do have the privilege of having an opportunity to really work with individuals and with their families in their natural environments, so we get to understand how they interact, how they communicate and how they engage in their day-to-day occupations.[32]

4.32 Emphasising the importance of the role played by allied health providers in early identification, Ms Lynette Brodie, Chief Executive Officer at Speech Pathology Australia, stated:

> …in the cohort that we're talking about, one in four children are not developed mentally on track with their communication skills when they start school. That's why this is so critically important.[33]

4.33 Ms Brodie further asserted:

> …and we're such a critical part of the workforce, at the end of the day—all of us—around that really early identification that, within our own professions, we are the best placed, in that early identification.[34]

4.34 In discussing the role of speech pathologists, Ms Olga Komadina highlighted Childhood Apraxia of Speech (CAS)—a rare, lifelong neurological speech disorder that affects one to two in 1,000 children. Ms Komadina noted that CAS is not 'speech

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[31] Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 25.

[32] Mrs Michelle Oliver, Chief Occupational Therapist, Occupational Therapy Australia, *Committee Hansard*, 20 October 2025, p. 23.

[33] Ms Lynette Brodie, Chief Executive Officer, Speech Pathology Australia, *Committee Hansard*, 20 October 2025, p. 20.

[34] Ms Lynette Brodie, Chief Executive Officer, Speech Pathology Australia, *Committee Hansard*, 20 October 2025, p. 23.

delay', but rather a 'complex motor-planning disorder' that requires frequent, intense and one-on-one therapy delivered by speech pathologists. She emphasised the critical role of specialised speech pathologists in providing early and ongoing support for this small but highly vulnerable cohort.[35]

4.35 Independent Audiology Australia (IAA) similarly underscored the importance of involving audiologists in identifying and supporting children with developmental difficulties. They explained that middle ear pathology and associated hearing loss can lead to speech and language delays, behaviour concerns, lack of eye contact to speech—presentations that are commonly associated with developmental delays and disorders, but that can be in fact symptoms of remediable hearing loss. Equally, IAA submitted that audiologists are vital in supporting children with autism, who tend to have higher rates of ear disease, Ear Nose and Throat procedures and hospital contacts. IAA recommended that an assessment of a child's hearing profile be undertaken before any further therapies are introduced.[36]

4.36 The Australian Physiotherapy Association (APA), representing Australia's fourth-largest health workforce, told the Committee that physiotherapists also play a vital role in early identification and intervention:

> Before a child speaks or learns to play, they move. Physiotherapists are first-contact movement experts. They identify early developmental concerns in infants, including early markers of autism and neuromotor conditions, often before a diagnosis is made.[37]

4.37 The APA's Chair of National Paediatric, Mrs Nicole Pates, highlighted how the early involvement of physiotherapists can make a difference to a child's development:

> I think embedding physiotherapy within supports that are already available, such as maternal and child health networks, playgroups—particularly, there are a number of playgroups set up that are already connecting and trusted by our CALD and ATSI groups. We can then act as a capacity builder for those systems. We can act as differential diagnostics. We can hopefully provide referrals straight to where they need to go—to speechies or to neurologists, if there are very clear asymmetries and hemiplegia or tone signs.[38]
>
> But, all the while we're doing that detection and assessment, we're capacity building. We're building relationships with that family and looking at that child's strengths. What can they do? What do they want to do?[39]

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[35] Olga Komadina Apraxia Therapy, *Submission 53*, pp. 1-2; See also Name withheld, *Submission 33*.

[36] Independent Audiologists Australia, *Submission 65*, p. 1.

[37] Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 19.

[38] Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 19.

[39] Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 19.

4.38 Understanding a child’s eye health is another key aspect of early identification and intervention. Vision Australia stated that children who are ‘blind or have low vision often require highly specialised supports, and that access to early intervention is critical in ensuring that they can achieve positive long-term outcomes’. The organisation further explained that:

> Many of the young children that we work with currently access NDIS supports through the developmental delay pathway either because there is uncertainty about their exact level of functional vision or because their condition has not yet stabilised and is therefore difficult to diagnose.[40]

4.39 Vision Australia argued that, due to the impact of vision impairment on all areas of development, it is essential that children are able to access vision specific services without delay.

> Access to supports for this cohort also has to be supported by a clear pathway for families. Parents often have limited knowledge of how to identify developmental delay in vision impaired children and also lack knowledge of the services available to them at their child's point of diagnosis. They need to be supported with a referral pathway that operates effectively across both the health and disability sectors.[41]

4.40 Furthermore, Vision Australia warned in the case of very young children, it may be quite difficult to determine visual acuity until the child is either able to communicate or starting to access information in their environment beyond arm’s length.

> For this reason, many children do not meet the permanent disability requirements of the NDIS, but they will access support through the scheme through the early intervention pathway, pending further assessment later in childhood. In the event that these children are transitioned to foundational support programs such as Thriving Kids, it will be necessary to ensure that those programs are sufficiently flexible to meet their unique needs. Regardless of whether these children are later diagnosed with a permanent disability for NDIS purposes, early vision-specific services are crucial in ensuring that they can meet developmental milestones and have access to any strategies that will allow correction of visual function.[42]

4.41 Throughout the inquiry, witnesses emphasised the importance of occupational therapists in supporting children with developmental disorder or delay. Ms Samantha Hunter, Chief Executive Officer of Occupational Therapy Australia, stated:

> Occupational therapy brings a distinctive lens—one that connects health, education and participation—translating developmental progress into everyday activities that matter to children, families and their communities. They bring a participation focused contextual perspective that complements the work of other

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[40] Ms Caitlin McMurrow, Vision Australia, *Committee Hansard*, 10 October 2025, p. 26.

[41] Ms Caitlin McMurrow, Vision Australia, *Committee Hansard*, 10 October 2025, pp. 26-27.

[42] Ms Caitlin McMurrow, Vision Australia, *Committee Hansard*, 10 October 2025, p. 26.

> allied health professionals and help integrate supports across systems. Occupational therapy is always focused on function in context—what does a child need in order to take part in life?[43]

4.42 The Australian Psychological Society highlighted the role of psychologists in this context:

> We already work across health, education, disability and community settings, bringing expertise in how children think, learn and connect with others. This includes providing developmental and cognitive assessments, behaviour and learning support, family coaching and workforce capacity building—all key components of an early intervention system.[44]

4.43 Evidence provided in support of the inquiry consistently highlighted the critical role of diverse health and allied health professionals in the early identification and intervention for children with developmental disorders or delays. Effective coordination across these disciplines is seen as essential to the success of Thriving Kids, and multiple professional groups emphasised the importance of being actively involved in the program's design to ensure comprehensive and integrated support for children.

4.44 Ms Brodie of Speech Pathology Australia stated that the organisation would welcome an opportunity for allied health representatives to have a say in how the NDIS and Thriving Kids might evolve. She further reflected on the success of the collaborative model of allied health care as a useful element in the design of Thriving Kids:

> I think there's a general feeling that, when it comes to the NDIS and perhaps even Thriving Kids at this point, allied health haven't had the voice. ...
>
> So we are very keen, because we do collaborate. You wouldn't necessarily be seeing a child that's just seeing one of our professions; they're seeing multiple. We're used to working in collaborative care models, and, perhaps, a little bit of that has been lost in more recent years compared to pre NDIS. That's not to say—NDIS has been an amazing thing, and we should be very proud of it, but it needs to evolve. We certainly feel that it's key to the success of Thriving Kids to have allied health at the table.[45]

4.45 Speech Pathology Australia recommended leveraging information and communication technology systems to integrate services, providing families with a central database of providers and enabling them to track progress and access support more easily.[46]

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[43] Ms Samantha Hunter, Chief Executive Officer, Occupational Therapy Australia, *Committee Hansard*, 20 October 2025, p. 18.

[44] Dr Linda De George-Walker, Senior Policy Adviser, Australian Psychological Society, *Committee Hansard*, 20 October 2025, p. 11.

[45] Ms Lynette Brodie, Chief Executive Officer, Speech Pathology Australia, *Committee Hansard*, 20 October 2025, p. 23.

[46] Ms Lynette Brodie, Chief Executive Officer, Speech Pathology Australia, *Committee Hansard*, 20 October 2025, p. 20.

4.46 The APA representing Australia’s fourth-largest health workforce, comprising over 44,000 registered physiotherapists working across the health, disability, aged-care and education sectors in metropolitan, regional and remote settings, welcomed the Thriving Kids initiative.

> The APA believes that thriving kids has the potential to be transformative for children with developmental delay and autism and their families by establishing a national system of supports that enables earlier identification and intervention. It can move us from a system that leaves families waiting during the critical first thousand days to one that acts early and equitably.[47]

4.47 The APA’s Chair of National Paediatric, Mrs Pates, supported Thriving Kids taking a multipronged approach. She described an example of the collaboration between specialists in early intervention:

> Paediatric physiotherapists are movement analysis experts, but also our differential diagnostic skills are amazing…So getting in early and being able to understand what is causing it—is it the hip dysplasia? Is it CP [cerebral palsy]? Is there something going on? Are there early communication signs referring on to speech pathologists?[48]

4.48 The AMA submitted that the initiative represented a recognition of the need for additional foundation support outside existing systems. AMA noted that its members consistently ‘raise concerns that they cannot support children and families to access the necessary allied health and medical input for mild to moderate developmental delay unless the child is enrolled with the NDIS.’ The organisation highlighted, however, that the Thriving Kids initiative ‘must build on existing systems rather than creating parallel systems and programs,’ including by leveraging existing structures in general practice.[49]

4.49 Occupational Therapy Australia’s Chief Occupational Therapist, Mrs Michelle Oliver, reflected on the opportunity to use the Thriving Kids initiative to better embed allied health models in critical locations:

> That's why this is where this is a really great opportunity to set up a system in Australia that enables us to engage early. So let's embed our allied health in the community in places where our children already engage and don't require having to step out of that community or their day-to-day activities or occupations to seek that early interventional support or to build that knowledge. GPs are definitely a pathway, but, as you were saying, it's not the only pathway and it's not necessarily working now. So, if we can have our allied health embedded in our community centres, in our childcare services, in our kindergartens and in our

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[47] Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, pp. 18-19.

[48] Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 19.

[49] Australian Medical Association, *Submission 209*, p. 1; p. 3.

> preschools, we're going to be able to work, to be able to observe, to engage and work collaboratively to ensure that those children are picked up at intervention.[50]

4.50 Ms Samantha Hunter, Occupational Therapy Australia’s Chief Executive Officer, outlined the three fundamentals that the Thriving Kids system must get right:

- inclusion and equity—so no child misses out simply because their needs don’t fit a diagnosis;
- services that are culturally safe and responsive to community needs; embedding supports where children live and learn—in classrooms, early learning centres and in community; and
- a capable and connected workforce with occupational therapists central to the design and delivery of foundational supports—an anchor in the multidisciplinary teams that are required for success.[51]

Concerns

4.51 Multiple submitters raised a range of design and implementation concerns related to the proposed Thriving Kids initiative. These concerns tended to relate to language describing types of disability (such has mild and moderate), concerns regarding a loss of control and access to individualised support, and concerns regarding possible impact on pathways for some specific cohorts. The following section provides a snapshot of selected issues raised during the inquiry.

4.52 The AEIOU Foundation cautioned against using broad diagnostic labels such as *mild*, *moderate*, or *severe* autism, noting that these terms fail to reflect functional needs and can stigmatise individuals. Families often report that so-called mild autism still presents significant barriers to participation and communication. AEIOU argued that severity labels are deficit-based, misrepresent needs, and risk overlooking children with less visible challenges. The organisation recommended removing severity labels and adopting a strengths-based, neuro-affirming approach that recognises diversity and prioritises individualised support.[52]

4.53 In reflecting on the importance of individual choice and control when accessing support, Mr Neil Turton-Lane, the Convener of the Australian Psychosocial Disability Collective (APDC), noted that the experience of being neurodiverse and caring for children diagnosed with autism:

> …can be a very lonely, isolating, challenging experience, where receiving recognition and accessing affirming support can be very, very hard. School refusal caused by rigid neurotypical education systems have further traumatised many children and have weakened our trust in our government’s willingness and

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[50] Mrs Michelle Oliver, Chief Occupational Therapist, Occupational Therapy Australia, *Committee Hansard*, 20 October 2025, p. 23.

[51] Ms Samantha Hunter, Chief Executive Officer, Occupational Therapy Australia, *Committee Hansard*, 20 October 2025, p. 18.

[52] AEIOU Foundation, *Submission 70*, p. 14.

> commitment to supporting our kids in any real, meaningful way. For many parents, the choice and control offered by the NDIS has been a real game changer, providing opportunities to access targeted supports that are person- and family-centred at the right time and in the right way.[53]

4.54 The APDC remained deeply concerned about the capacity of the Thriving Kids program to provide 'early foundational supports to the Australian community safely, inclusively and in ways that reflect the individual needs of children and of families'.

> We worry about the impact of these changes on children and families and the uncertain future that lies ahead when a shift in major social policy appears rushed. We ask: is Thriving Kids primarily a cost-saving measure? If so, what will end up being the cost to children and families—children who will be shifted from trusted, individualised, person-centred supports delivered by skilled practitioners to a block-funded, heavily manualised, one-size-fits-all, short-term, behaviouralist intervention.[54]

4.55 When accessing support from the allied health workers, the APDC cautioned that choice and control were essential for people with disability:

> Choice and control for parents and their children, whether it's for an OT, a speech therapist, a form of art or music therapy—anything that builds that connection for that child and develops their capacity to communicate more broadly. I feel we need a range of approaches.[55]

4.56 The APDC acknowledged the importance of building ongoing relationships with specific service providers or practitioners:

> I agree that there are barriers, particularly those introduced around travel, but I would say that psychology, OT, speech, music and art therapy, and anything else that supports the development of that child, builds that bridge and builds their own individual capacity, as well as supporting the family—it's very important that the family trusts the services that they receive. Many families are very wary of entering into that support with their child, the most precious person in their life. It's a huge leap of faith to put your trust in a practitioner.[56]

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[53] Mr Neil Turton-Lane, Convener, Australian Psychosocial Disability Collective; *Committee Hansard*, 20 October 2025, p. 13.

[54] Mr Neil Turton-Lane, Convener, Australian Psychosocial Disability Collective; *Committee Hansard*, 20 October 2025, p. 13.

[55] Mr Neil Turton-Lane Convener, Australian Psychosocial Disability Collective, *Committee Hansard*, 20 October 2025, p. 15-16.

[56] Mr Neil Turton-Lane Convener, Australian Psychosocial Disability Collective, *Committee Hansard*, 20 October 2025, p. 16.

4.57 Some witnesses raised concern about the proposed scope of the initiative. Vision Australia cautioned, for example, that crucial opportunities for early visual development could be lost if dedicated provisions are not included:

> So we're concerned that the scope of Thriving Kids does not seem to anticipate the support of children with developmental delay arising from low-incidence disability, such as vision impairment. It will be important for this initiative to have a funding stream that enables specialist vision providers to work within mainstream settings to build the capacity of children with vision impairment and developmental delay. If this isn't within the scope of Thriving Kids, then a similar initiative must be developed to support children with vision impairment outside the NDIS.[57]

4.58 Without a dedicated approach, Vision Australia feared children with vision impairment and developmental delay will not have access to supports outside the NDIS to the same degree as children with more prevalent conditions:

> These programs must also be sufficiently flexible to allow services to be delivered across both home and community settings in order to maximise the benefits of specialised intervention services.[58]

4.59 Vision Australia further observed that the lack of exposure most schools have of working with children with vision impairment typically means they do not have the necessary experience, knowledge and skills to provide appropriate supports for those students:

> Almost every classroom in Australia will have a child with autism or a child who is neurodiverse, but the same school generally will not see a child who is blind or has low vision more than once in a decade. It’s therefore feasible for education settings to build the expertise in relation to high-prevalence disabilities; however, this is rarely possible with low-incidence cohorts, such as blindness and low vision. To address developmental delay and encourage good, functional vision skills, these children require a more individualised and specialised approach.[59]

4.60 The APA, representing Australia’s fourth-largest health workforce, saw an important role for physiotherapists in Thriving Kids. The APA advised that motor screening identifies concerns and flows directly into funded, evidence-based therapy in children's natural environments. It cautioned:

> …but embedding physiotherapy is not enough unless the broader model supports it with funding for case conferencing, non-face-to-face coordination, in situ environmental adaptations, outreach travel and telehealth. These components make early intervention work in real settings.[60]

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[57] Ms Caitlin McMurrow, Vision Australia, *Committee Hansard*, 10 October 2025, p. 27.

[58] Ms Caitlin McMurrow, Vision Australia, *Committee Hansard*, 10 October 2025, p. 27.

[59] Ms Caitlin McMurrow, Vision Australia, *Committee Hansard*, 10 October 2025, p. 27.

[60] Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 19.

4.61 The APA outlined proven domestic and international models and case studies to support its recommendations to embed a role for physiotherapists in the Thriving Kids assessments and capacity building:

> When motor divergence is identified and addressed early, it unlocks a cascade of gains in language, cognition and social participation. Physiotherapy in the first thousand days of life can change developmental trajectories. It can improve school readiness, strengthen family confidence and reduce reliance on higher tier supports. This is the vision of Thriving Kids. The government has signalled a new Medicare funded child health check and allied health items under Thriving Kids. Physiotherapy, we believe, must be named explicitly in those universal supports. Integrated physiotherapy across a range of universal platforms—including maternal and child health, early learning and schools—enables a genuine, no-wrong-door approach. With this, screening and early detection can occur at standard touchpoints, families avoid having to opt in or navigate multiple systems, and transitions to school or the NDIS are smoother because developmental history and supports travel with the child, ideally enabled by the expansion of My Health Record.[61]

4.62 The Australian Association of Psychologists Inc shared its deep concern about the current gaps in developmental support services and the urgent need for reform:

> Despite clear evidence that early intervention and identification dramatically improve developmental outcomes, access to psychological assessment and treatment remains severely limited, particularly for children with mild to moderate developmental delays.[62]

4.63 The Australian Psychological Society welcomed Thriving Kids as an opportunity for children who fell behind under the existing NDIS system, ‘particularly those with development delays or low to moderate support needs, without a clear pathway to help’:

> Psychologists are a critical part of that picture. Their inclusion is fundamental to ensuring Thriving Kids achieves its goals and delivers better outcomes for children and families.[63]

4.64 Psychologists' expertise in early intervention, however, is often overlooked and narrowly interpreted as relating only to mental health, according to the Australian Psychological Society:

> In recent policy design, including early Thriving Kids information, psychologists have been grouped under broad or imprecise categories such as psychosocial

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[61] Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 19.

[62] Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists Inc; *Committee Hansard*, 20 October 2025, p. 12.

[63] Dr Linda De George-Walker, Senior Policy Adviser, Australian Psychological Society, *Committee Hansard*, 20 October 2025, p. 11.

> therapy, which risks diminishing recognition of their unique contributions to child development, assessment and family support. This pattern appears to have continued in the current composition of the Thriving Kids Advisory Group, where, unlike other key disciplines, psychologists do not appear to have direct representation. To deliver on its promise, Thriving Kids must explicitly recognise and include psychologists in all aspects of design, governance, workforce planning, and evaluation and review. This is not about professional boundaries. It's about ensuring that children and families have access to the full spectrum of skills needed for early identification and intervention to work.[64]

4.65 The Australian Psychological Society's Dr Linda De George-Walker outlined a number of key priorities to ensuring Thriving Kids realises its promise, beginning with the 'need to explicitly recognise psychologists and their role in delivering effective early support'.

4.66 Beyond this, Dr De George-Walker detailed several other priorities essential for success of the Thriving Kids initiative:

- First is establishing genuine consultation and co-production from the outset with families, children, practitioners and researchers in the broader disability sector.
- Second is ensuring Thriving Kids provides a continuum of support, from universal and low-intensity help to targeted and specialist intervention, delivered at the right intensity and right time in the settings where children and families already are.
- Third is embedding cultural safety and equity at every level by partnering with Aboriginal and Torres Strait Islander communities, investing in bicultural workforces and translation support, and ensuring rural and disadvantaged families are not left behind.

4.67 Dr De George-Walker was concerned that Thriving Kids may confuse parents and fail to help the children who will need it.

> If not done well, Thriving Kids risks adding another layer of complexity to an already fragmented system, one that confuses families, increases inequity and fails to reach the children and families who need support.[65]

4.68 Mrs Rachel Green of SANE Australia noted there was an opportunity for governments to develop strategies or interventions to support children.

> We're talking about little kids here. We've got to bear in mind that the data shows us that, for example, people who are autistic have a much higher incidence of anxiety and depression. So some of the things that could benefit young people while they're maybe still going through the process of receiving support and getting strategies, and while families are working on stuff…One of the big

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[64] Dr Linda De George-Walker, Senior Policy Adviser, Australian Psychological Society, *Committee Hansard*, 20 October 2025, p. 11.

[65] Dr Linda De George-Walker, Senior Policy Adviser, Australian Psychological Society, *Committee Hansard*, 20 October 2025, p. 11.

> problems I think we've got with the way the system functions currently is that schools feel almost prevented from doing anything at all—even the basics like calm corners and fidget spinners—until there's been a diagnosis done, so we're losing extraordinary amounts of time.[66]

4.69 The Australian Association of Psychologists Inc. recalled how the advent of the NDIS and changes to funding impacted on where psychologists chose to work.

> I think with the addition of the NDIS a lot of the workforce that was embedded in not-for-profit organisations and community health moved out of those settings because funding changed. So we've got a situation now where a lot of psychologists are in private practice. But that actually works really well for families in that psychologists can be where families need them to be, whether that's going into schools, going into childcare settings or going into homes and doing these assessments. It makes them much more accessible for young children to participate. I think you see a very different picture of a child when you're observing them in a natural setting than you do if they're coming into a clinic or a community based organisation.[67]

4.70 The APA saw an opportunity for more allied health professionals to work closer locally with early childhood centres, to assist families of all backgrounds.

> With the new model of care coming into free child care that the government is working towards, I think that that's an opportunity to embed allied health within early childhood centres. Those centres are usually set up in local areas and families are accessing those as they fit with their family values. But the early childhood educators that I speak to do not feel confident on having discussions around potential delays or differences and they lack the knowledge and the skills to enrich the environments in a specific way if something is noted, so we—myself and my speechie and my OT colleagues—do a lot of coaching and capacity building.[68]

Universal screening

4.71 Universal screening can play a critical role in early childhood health and development. These assessments are designed to identify potential delays or concerns in areas such as communication, motor skills, social-emotional development, and cognitive abilities. Several submissions to the inquiry indicated support for universal screening.[69]

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[66] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 42.

[67] Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists Inc; *Committee Hansard*, 20 October 2025, p. 14.

[68] Mrs Nicole Pates, Chair, National Paediatric, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 22.

[69] National Organisation for Fetal Alcohol Spectrum Disorder, *Submission 106*, p. 13; Lion and Mouse Australia Ltd, *Submission 140*, p. 4; Kid Link Occupational Therapy, *Submission 169,* p. 4; National Catholic Education

4.72 A National Framework for Universal Child and Family Health Services, agreed between the Commonwealth and each of the states and territories, recommends regular health and developmental checks from birth to school age.[70] Ms Janice Finlayson, Director, MCaFHNA noted that these checks have not been implemented at the same ages consistently in each state and territory, although each state does an 18-month development check:

> I think I can probably say, with some level of certainty, that all jurisdictions would have a key 'age and stage' at 18 months. They would offer to a parent the opportunity to come to us so we can do an assessment on their child at 18 months. What you were talking about before—eye tests and things like that—is usually done at the 3½-year-old assessment time. Hearing used to be done at the 3½-year-old assessment time, but we don't do that anymore. There are similarities in the ages at which children are brought back in to be assessed, or when these assessments are offered to parents. Some jurisdictions offer more. The Territory certainly offers more. Some offer less. I know Western Australia has cut down the occasions of service that they offer. You'd probably need to start with: at what point do you bring them back? Eighteen months is also key because it's also a key immunisation time. If you can link something with immunisation, you're more likely to get people attending.[71]

4.73 Childhood screening checks are generally undertaken by child health nurses. Family Paediatrics Nurse Practitioners noted that the shift away from community-based delivery has resulted in children missing out on critical supports:

> Australia has an opportunity to fundamentally reshape how we identify and support children with developmental needs in the early years. Despite decades of evidence that the first five years are critical to long-term outcomes, child health and development services remain fragmented, inequitable, and inconsistently delivered across jurisdictions. Families frequently miss out on timely support because maternal and child health services have shifted away from community-based delivery, workforce standards vary nationally, and access to specialist services is defined more by waiting lists than by children's needs.
>
> A new approach is required, one that re-establishes place-based services in the community, integrates developmental checks with immunisation schedules, and creates a clear progression from universal screening to targeted interventions and specialist care. Nurse Practitioners and Child & Family Health Nurses are ideally positioned to deliver these services in childcare centres, kindergartens,

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Commission, *Submission 183*, p. 3; Mission Australia, *Submission 217*, p. 12; Autism Association of Australia, *Submission 232*, p. 3; Triple P International Pty Ltd, *Submission 310*, p. 5;

[70] Australian Health Ministers' Advisory Council, *National Framework for Universal Child and Family Health Services*, July 2021.

[71] Ms Janice Finlayson, Director, Maternal, Child and Family Health Nurses Australia, *Committee Hansard,* 21 October 2025, p. 29.

> and schools, building relationships with parents, supporting educators, and reducing unnecessary referrals to overburdened hospital systems.[72]

4.74 Children's Healthcare Australasia suggested that the Thriving Kids initiative should build on this capability:

> With a consistent national framework and local flexibility, Thriving Kids can reduce wait times, improve access, and ensure all children, regardless of background, have the opportunity to thrive. It will be critical to ensure the public health sector remains the spine of such reform with a universal screen and respond function building on existing child health nursing services to ensure seamless transition through generalised and more targeted supports.[73]

4.75 APM noted that a lack of universal screening checks results in missed opportunities to ensure success in all children. APM suggested:

> While systems exist across the states and territories, for example national hearing screening at birth or free vision screening for pre-schoolers, there are no nationally consistent programs or approaches dedicated to speech, communication, and motor functioning. This is not only out of step with other OECD nations but also misses key opportunities to consistently identify children with developmental delays or disabilities early in life when we know interventions are most effective.[74]

4.76 The Australian Clinical Neuropsychology Association strongly supported the focus on universal screening:

> We strongly support the focus on universal screening, and emphasise that this must be backed by access to thorough, multidisciplinary diagnostic assessments, including comprehensive neuropsychology assessment for identification of cognitive disabilities, to ensure equitable identification and support for all children.[75]

4.77 The William Campbell Foundation recommended that universal screening be embedded in family support, foster care and early childhood programs.[76]

Workforce capacity and development

4.78 Throughout the course of the inquiry, witnesses stressed that the success of any health initiative depended on a skilled and well supported workforce. Persistent shortages, limited training pathways, retention challenges, and the impact of the

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[72] Family Paediatrics Nurse Practitioners, *Submission 52*, p. 3.

[73] Children's Healthcare Australasia, *Submission 290*, p. 2.

[74] APM, *Submission 322*, p. 10

[75] Australian Clinical Neuropsychology Association, *Submission 152*, p. 2.

[76] William Campbell Foundation, *Submission 159*, p. 3.

NDIS on service delivery often hinder equitable access to health and developmental services for children and their families.

Medical, nursing, and allied health workforce

4.79 The AMA highlighted that a strong workforce will be critical for the success of the Thriving Kids program. The organisation called for a sustained support of the existing workforce strategies, such as the National Medical Workforce Strategy 2021-31 and National Mental Health Workforce Strategy 2022-2032, to address shortages in general practice, paediatrics, and child and adolescent psychiatry.[77]

4.80 Evidence to the inquiry consistently highlighted shortages of practitioners in psychiatry and psychology. Some witnesses suggested alleviating this pressure by expanding the scope of duties for allied health professionals. Associate Professor Clinton Schultz from the Black Dog Institute, for example, noted that:

> At times, what happens is that, within systems and within certain initiatives that are put in place, certain professions are only capable of working with certain diagnoses or certain conditions, which I think at times limits the scope, the opportunity or the breadth of practitioners that we have available to us to actually open up access to more people in terms of working. I think that's quite common across most of the mental health space. We tend to really look towards psychologists and psychiatrists, and we often don't pay as much attention or give as much support to all the other practitioners that work within the allied health space in the fields of mental health or whatever the certain condition may actually be. I think that, by broadening our perspective on who we include in certain initiatives and empower to work within spaces and making sure that they actually have the training, the skills and the knowledge available to them to work in those spaces, we can more greatly increase access.[78]

4.81 Mrs Amanda Curran, Chief Psychologist at the Australian Association of Psychologists, recommended strengthening workforce capacity through:

- targeted training and incentives and prioritising utilising appropriately skilled and trained allied health professionals, including psychologists
- funded parenting support
- expanded access to funded psychological assessments via Medicare so that children can receive the assessments they require
- ensured coverage for collaborative care
- Medicare rebates that cover the actual cost of assessment so that those who need it most are not locked out of access due to financial barriers

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[77] Australian Medical Association, *Submission 209*, p. 3.

[78] Associate Professor Clinton Schultz, Director, First Nations Strategy and Partnerships, Black Dog Institute, *Committee Hansard*, 10 October 2025, pp. 45-46.

- elimination of unnecessary referral and diagnostic barriers, such as are seen in complex neurodevelopmental disorders and Better Access Medicare items
- embedding of neurodiversity-affirming, culturally safe and family centred models
- seamless transitions across mainstream systems through integrated partnerships.[79]

4.82 In their joint submission ACN, ACCYPN, MCaFHNA and PANDDA highlighted the critical workforce shortages and gaps in nursing education and retention:

> Australia is projected to face a shortfall of 79,473 nurses by 2035, with primary healthcare, including child and family nursing, among the most affected. Many nurses reconsider their careers around seven years post-graduation due to burnout, poor conditions, and limited career pathways. Despite the need for specialised training, structured support for child and family health nurses remains inadequate.[80]

4.83 ACN, ACCYPN, MCaFHNA, and PANDDA recommended upskilling primary care nurses in child health and developmental screening, as well as removing barriers to enable more nurse practitioners to work in primary care settings. These measures, they argued, would strengthen the capacity of the primary health workforce to support early childhood development.[81] Additional recommendations included:

- implementing all recommendations from the Nurse Practitioner Workforce Plan, the Primary Care and Workforce Reviews, and the National Nursing Workforce Strategy
- expanding access to the Medicare Benefits Schedule, including nurse practitioner-led practices in MyMedicare, and removing regulatory and funding barriers that prevent nurse practitioners from working to their full scope of practice.[82]

4.84 ACN, ACCYPN, MCaFHNA, and PANDDA also reflected on the state of the allied health workforce:

> The allied health workforce, essential for children requiring therapy, is currently stretched thin, largely due to the impact of the NDIS, which has diverted resources away from mainstream services. Equitable access must be prioritised

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[79] Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists Inc; *Committee Hansard*, 20 October 2025, p. 12.

[80] Australian College of Nursing, Australian College of Children & Young People's Nurses, Maternal, Child and Family Health Nurses Australia, Professional Association of Nurses in Developmental Disability Australia, *Submission 96*, p. 4.

[81] Australian College of Nursing, Australian College of Children & Young People's Nurses, Maternal, Child and Family Health Nurses Australia, Professional Association of Nurses in Developmental Disability Australia, *Submission 96*, p. 7. See also Ashar Health, *Submission 16*.

[82] Australian College of Nursing, Australian College of Children & Young People's Nurses, Maternal, Child and Family Health Nurses Australia, Professional Association of Nurses in Developmental Disability Australia, *Submission 96*, p. 7.

> to ensure children with developmental delays have the opportunity to thrive, regardless of their location or socioeconomic background.[83]

4.85 Autism Spectrum Australia similarly noted the prevalence of workforce shortages in allied health:

> Australia faces a national shortage of key allied health professionals, including speech pathologists, occupational therapists, and psychologists. These shortages are most acute in the public health system and in regional and remote areas.[84]

4.86 Mrs Ashlee Law, a mother of children with autism, reflected on her experience accessing services in regional New South Wales. She noted that there were few professionals available, with many rural towns having one or no paediatricians, and psychiatry services even harder to access. Families often struggle to find providers and are forced to wait between one to three years for autism assessments.[85]

4.87 In its submission, the Therapy Room NQ reported similarly great challenges in rural and regional areas in Northern Queensland, where families wait for weeks for an appointment with a GP, and have limited access to community services and only occasional outreach from city-based providers.

4.88 The Therapy Room NQ further explained that since the NDIS reduced travel fees on 1 July 2025, outreach providers had to cut down their services, with many North Queensland services cancelling their outreach programs to rural and remote communities:

> Delivering outreach carries significant overheads—including room hire in small towns, staff wages, superannuation, insurances, registrations, and rising fuel costs. With travel feeds halved, continuing to deliver outreach is becoming almost impossible … If providers pull back further, children in rural and regional towns will lose access to early intervention and ongoing therapy, widening the already significant gap between metropolitan and rural areas.[86]

4.89 AHPA outlined the progress of the development of its allied health workforce strategy aimed at countering the staff shortages:

> …the first National Allied Health Workforce Strategy is currently in the final stages of approval and that, with more than half of the allied health workforces in a national workforce shortage, the strategy needs to be adequately funded to ensure we secure the undergraduate pipeline, build a workforce that is equipped

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[83] Australian College of Nursing, Australian College of Children & Young People's Nurses, Maternal, Child and Family Health Nurses Australia, Professional Association of Nurses in Developmental Disability Australia, *Submission 96*, p. 6. See also Australian Primary Principals Association, *Submission 31*, p. 3.

[84] Autism Spectrum Australia, *Submission 67*, p. 8.

[85] Mrs Ashlee Law, *Submission 14*, p. 2.

[86] The Therapy Room NQ, *Submission 6*, p. 2.

> to work in the disability sector and establish better placement pathways that adequately fund the undergraduate sector via paid placements.[87]

4.90 The Australian Psychological Society's Dr Linda De George-Walker highlighted the importance of building up the capacity of the allied health workforce for families and to support their children as young as possible:

> What's really important is also not underestimating the allied health workforce capacity to build the capabilities of early childhood educators—for example, educators in schools. Those trust points that families are going to naturally be in front of on a daily basis—child maternal health nurses are also very well skilled in these areas—are all working together to support and train each other in what to look for and how to support a family that is maybe not at the point of being quite able to articulate what their concerns are—how to work with them and support them at those early stages. That workforce capacity building and capability building is a really important part of this puzzle too.[88]

4.91 The extent of staff shortages remained an ongoing issue according to Indigenous Allied Health Australia. As Mr Paul Gibson, the organisation's CEO, explained:

> I can share that we know that, across allied health, for most professions the workforce is probably about 0.8 per cent Aboriginal and Torres Strait Islander. If we take occupational therapists, for example, there are 199 nationally out of a workforce that's about 27,000 strong. So that's 0.75 per cent, I believe, of the workforce there. So underrepresentation and workforce challenges are really significant concerns.[89]

4.92 The Kimberley Aboriginal Medical Services also raised the challenges of finding enough suitable staff to cover 200 communities in such a vast remote part of Western Australia:

> There are never enough of them. I think in the Kimberley currently we've got 12 family support workers. That's not nearly enough for the around 200 communities we have in the region. We have them placed in the major communities and towns. But, to really reach out and to provide an equitable service that really services everyone, we would need to increase that workforce.[90]

Education workforce

4.93 The Thriving Kids initiative positions schools as central hubs for supporting children with developmental disorders or delays. Multiple submitters, however, expressed

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[87] Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, pp. 25-26.

[88] Dr Linda De George-Walker, Senior Policy Adviser, Australian Psychological Society, *Committee Hansard*, 20 October 2025, p. 17.

[89] Mr Paul Gibson, CEO, Indigenous Allied Health Australia, *Committee Hansard*, 10 October 2025, pp. 12-13.

[90] Mr Oskar Stenseke, Senior Manager, Kimberley Aboriginal Medical Services, *Committee Hansard*, 10 October 2025, p. 12.

concern regarding the capacity of schools to deliver the program. Inclusive Educators Australia cautioned, for example, that:

> Simply layering new expectations on top of existing demands will undermine both teacher wellbeing and the effectiveness of the program.[91]

4.94 Inclusive Educators Australia further noted that workforce shortages remain one of the most significant challenges for schools and early childhood education, with rural and regional areas especially affected:

> The *Review of Best Practice in Early Childhood Intervention* identifies these shortages, alongside variable capability and lack of regulation, as major barriers to best practice. Thriving Kids must therefore treat workforce reform as a central pillar of its design.[92]

4.95 Independent Schools Australia highlighted that both teaching and non-teaching school staff are currently required to provide a range of supports for students that extend beyond the traditional role of schools. This is particularly evident in regional and remote areas, where schools often function as community hubs providing students with disability or developmental delay support before, during, and after diagnosis and medical intervention.[93]

4.96 Independent Schools Australia further expressed concern that:

> Blurring the lines between education and therapy not only undermines professional boundaries but also places unrealistic expectations on teachers. Without dedicated funding to embed allied health professionals within school settings, collaboration remains ad hoc and inconsistent.[94]

4.97 The Australian Primary Principals Association (APPA) submitted that 'any increased expectations of schools must be matched with increased human resources on the school site.'[95] Among its key recommendations, APPA called for funding to support administrative and leadership roles in schools to coordinate services and manage staffing pressures; professional development for educators on early identification, trauma-informed practice, referral processes, and family engagement; and incentives to train teacher assistants to effectively respond to children's needs.[96]

4.98 In its submission to the inquiry, ACSSO observed that while educators are often the first to raise developmental concerns with families, many feel underprepared to identify the red flags, make referrals, or supporting children with additional needs in inclusive classrooms.[97]

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[91] Inclusive Educators Australia, *Submission 132*, p. 10.

[92] Inclusive Educators Australia, *Submission 132*, p. 10.

[93] Independent Schools Australia, *Submission 68*, p. 10.

[94] Independent Schools Australia, *Submission 68*, p. 10.

[95] Australian Primary Principals Association, *Submission 31*, p. 3.

[96] Australian Primary Principals Association, *Submission 31*, p. 3.

[97] Australian Council of State School Organisations, *Submission 46*, p. 9.

4.99 To strengthen the capacity of the education workforce, ACSSO recommended embedding nationally consistent training within the Thriving Kids initiative. This training would equip teachers, early childhood educators, and school leaders with practical skills in:

- Identifying developmental differences
- Using neurodiversity-affirming language
- Making reasonable adjustments in learning and play environments
- Communicating effectively with families
- Navigating referral processes.[98]

4.100 The Early Learning and Care Council of Australia similarly stressed that building the knowledge and capacity of the early learning and care workforce is essential to the success of the Thriving Kids initiative. The organisation highlighted the importance of embedding time for planning and developing inclusion strategies; providing opportunities to learn about disability and developmental delay, effective communication, and cultural safety; and fostering stronger collaboration with training providers and universities to promote best practice and innovation.[99]

4.101 The Home Education Network noted that some children with developmental delays or disorders are home-schooled, yet professionals often lack awareness of home education pathways. Many families are left to rely on their own research to navigate this option. The organisation recommended developing training for the education workforce—and other professionals—on home education pathways as a key component of upskilling.[100]

Service design and delivery models

4.102 The Acting Group Manager of the Family Wellbeing Group at the Department of Social Services, Ms Jacqueline Hrast, saw an opportunity for government to rebuild an intermediary service system.

> While we fund the broad based mainstream, who absolutely have an obligation to be accessible and to deliver a valuable service to people with disability and developmental delay, there is a need for an in-between space. The community sector can only do so much. You won't receive intensive one-on-one speech therapy through the programs we [DSS] fund.[101]

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[98] Australian Council of State School Organisations, *Submission 46*, pp. 9-10.

[99] Early Learning and Care Council of Australia, *Submission 166*, p. 4.

[100] Home Education Network, *Submission 143*, p. 3.

[101] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 3.

4.103 Ms Hrast believed there was a ‘missing middle that Thriving Kids will provide’ for:

> The ability for a service provider who is working with a family in a group setting to have a quiet conversation with that family and say: 'Hey, you know what? I think there's something else here that's worth looking at. How about you go and have this next level of intensive services?'—that's still to be designed, but it is things like 10 sessions with a speech therapist. That's something that won't be delivered within the community sector, and it's not yet something that requires all-the-way access to the NDIS. I think that's really critical and important.[102]

Integrated and multidisciplinary care

4.104 AHPA claimed the NDIS has currently placed ‘significant barriers to collaborative care’.

> For example, practitioners often lack access to a participant's plan and the broader care team. Families may believe that more individual therapy is the solution, when in fact coordination and collaboration often drive better outcomes. The NDIS has also fundamentally changed where and how allied health professionals work. The market based approach has pushed many into private practice, with providers setting up services where they are financially sustainable and not necessarily where they are needed most. navigate.[103]

4.105 Despite sector advocacy, the AHPA continues to ‘lack mechanisms to identify where allied health professionals are located, where they are needed, and workforce or funding initiatives to address distribution gaps’.

> Private provision will remain an important part of our system, but we must strengthen how private allied health professionals can work collaboratively across both the health and disability system. There are clear opportunities to improve service delivery through new block-funding models; new Medicare items that reflect the real cost and time involved in high-quality service provision; support for team based, multidisciplinary, family focused interventions; referral and access pathways that are streamlined; and delivery of services in natural settings.[104]

4.106 The National Aboriginal Community Controlled Health Organisation outlined the key elements of a preferred integrated service delivery model for Thriving Kids to best suit First Nations children and their families.

> I really do think it’s a very integrated approach that really supports trauma informed early screening, therapeutic intervention and diagnosis, enhanced and streamlined referral pathways, and improves service integration for children with

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[102] Ms Jacqueline Hrast, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 3.

[103] Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 25.

[104] Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 25.

> developmental delays and the concerns. We're really urging government to fund, within that, the cultural supports required for us to streamline the navigation roles that we discussed just now, and invest in workforce development to ensure sustainable community led services.[105]

4.107 Dr Sarah Hayton, from NACCHO, recalled how the South West Aboriginal Medical Service in Bunbury, WA, highlighted to her the opportunities playgroups and maternal and early childhood centres provide families and children to discuss about any concerns they may have.

> The medical service spends so much time educating the families and demystifying some of the misinformation that's out there about early developmental delay. They spend a lot of time rebuilding that trust as well, because parents blame themselves for this and they feel very isolated. So then they do that, and then they're walking along that journey with the family, so the child's got continuity of care. They talked a lot about how they just move the family from that group to another group within the art show, so they don't need to repeat their stories all the time. They don't need to keep telling everyone what they do do and what they don't do. It's that very holistic model that is probably one of the most important areas for consideration.[106]

Navigator role

4.108 Navigating complex systems such as the NDIS can be particularly challenging for families. Submitters emphasised the need for government-funded, locally based navigators—individuals who may not be health professionals but who understand community needs and can guide families through interconnected education, health, and disability systems.

4.109 Medhealth Pty Limited suggested that 'the Thriving Kids initiative presents an ideal opportunity to introduce the navigator function as recommended by the NDIS review'.[107]

4.110 The Independent Review into the National Disability Insurance Scheme recommended a navigator function, stating:

> Navigators should act as the central points of entry for linkages and referrals to foundational supports, mainstream services and community supports and activities for all people with disability (not just participants). Navigators must have the capability to:

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[105] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 17.

[106] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 17.

[107] MedHealth Pty Ltd, *Submission 399*, p. 6.

> - Support people with disability to determine their own goals and participate in activities in their community
> - Connects and link people with disability to mainstream services, community supports and activities as well as foundational supports
> - Develop working relationships with mainstream services, community organisations and foundational support organisations.[108]

4.111 The National Rural Health Alliance believed the government should fund and support locally-based navigators, who may not necessarily be a therapist, doctor, or nurse, to help families in rural or remote communities navigate or manage a complex system such as Thriving Kids, and look for solutions that best suit their circumstances.[109]

> We must fund navigators or local coordination roles and help families navigate complex systems and access the right support at the right time.[110]
>
> They (navigators) will also understand the challenges that people face. And there won't be that shame of, 'I don't know how it works, so I'm not going to access it.' Sometimes people are so overwhelmed they don't know how to do it. You almost find it hard to help yourself because it's so overwhelming. They're already struggling with the education system and all the other challenges. It's not because they're not intelligent. They just don't understand the system. And so a fund navigator or local coordinator that is linked up to the education system, health system and disability system is a way of supporting those people who cannot do it themselves.[111]

4.112 Mrs Rachel Green, the Chief Executive Officer of SANE Australia, believed having people helping families navigate the system would be helpful, but 'only if there's something to navigate to, and only if it's possible to find good, trustworthy information'.

> [The Digital Navigation Project is] a solid piece of research and found that, for example, something like 85 per cent of directories—the kind of directories you might search if you were a navigator helping someone—are manually updated, and 37 per cent of the ones we looked at are Excel spreadsheets. Navigators can be helpful, but only if they've got a system and a set of information that's easily navigable.[112]

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[108] Independent Review into the National Disability Insurance Scheme, Final Report, 30 July 2025, p. 20.

[109] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 38.

[110] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 35.

[111] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, pp. 38-39.

[112] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 42.

4.113 ACSSO supported families receiving practical, timely support through family navigators:

> …independent, trained staff who walk alongside families, helping them understand resources, make referrals, and coordinate plans across health, education, and community sectors.[113]

4.114 Karitane, First Peoples Disability Network, Alliance of Registered Therapy Providers, Australian Rehabilitation and Assistive Technology Association and Amaze all advocated for establishing navigators to support families through complex health care and education systems.[114]

4.115 National Rural Health Alliance commented on the importance of foundational supports and early intervention for children with developmental concerns or disabilities, stating that the navigator role should:

> …be complemented by foundational supports, and expansion of universally available child development checks. These would ensure early identification of children with developmental concerns and disability and enable early intervention. Navigators will also have an important role in amplifying and giving voice to people with disability.
>
> The Navigator should be appropriately funded and at a minimum include:
>
> - Helping families navigate complex systems and providing accessible information and advice on the right support, whether to mainstream services, foundational supports or NDIS-funded services, thereby bridging the gap between families and services.
> - Importantly for rural and remote areas, be locally embedded with strong knowledge and connections of existing support and services and understanding of the local context including barriers to access, e.g. services, education system.
> - Coordinating the right mix of support and provide continuity of support as children move between services or life stages. This includes an understanding of federal vs state funded programs.
> - Assisting people before they access the NDIS, through proactive screening, outreach and support, including accessing mental health services.
> - Report on demand for services and unmet need, including gaps in local service systems.[115]

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[113] Australian Council of State School Organisations, *Submission 46*, p. 11.

[114] Karitane, *Submission 282*, p. 7; First Peoples Disability Network, *Submission 294*, p. 1; Alliance of Registered Therapy Providers, *Submission 301*, p. 2; Australian Rehabilitation and Assistive Technology Association, *Submission 398*, p. 5; Amaze, *Submission 129*, p. 3.

[115] National Rural Health Alliance, *Submission 379*, p. 6.

4.116 Lifestart Disability Services highlighted the central role of navigators in the new connected system of support, through:

> …helping all people with disability, including those not eligible for the NDIS, find and access the right supports at the right time. Positioned across mainstream services, foundational supports, and the NDIS, navigators will provide tailored guidance, connect families to local services, and support coordination of care. Different types of navigators will be available, including general navigators, specialist navigators for people with complex needs, and lead practitioners for children and families. Their role is to ensure no one falls through the cracks by bridging service systems and supporting early, inclusive, and community-based responses. Navigation supports should also be provided digitally, which are more scalable, streamlined and accessible for families and people with a disability or developmental concern.[116]

4.117 The Front Project believed that service navigators were a crucial component for supporting families, especially those with complex needs.

> Service navigators were identified as playing an important role in supporting families, particularly those with complex needs. Navigators could provide valuable, individualised assistance by helping families navigate multiple services, connecting them with the right supports, and advocating on their behalf. Even in systems working towards greater integration, service navigators can help ensure that vulnerable families receive coordinated, timely care. Their role can be particularly beneficial in reducing the burden on families who may find it difficult to engage with multiple, sometimes disconnected, services on their own.[117]
>
> However, some cautioned against relying too heavily on navigator roles. While navigators can provide valuable support in some cases, there was concern that this could lead to an over-reliance on individuals to guide families through complex systems, rather than addressing the underlying issues of fragmentation.[118]

4.118 Disability Advocacy Network Australia pointed out that navigators not only assist families but also provide valuable feedback to government:

> Families having access to navigation support within Thriving Kids is critical to the success of the initiative. Navigators can provide tailored information and link families with local supports, reduce the administrative and emotional burden on families by finding and referring to them to services, and can capture and map the needs of the local communities they support.
>
> Equally, Navigators can provide a critical role for Government in collecting intelligence and data on what supports are needed and how systems are working on the ground. There will be significant conflicting information about the

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[116] Lifestart Disability Services, *Submission 245*, p. 8.

[117] The Front Project, *Submission 109*, pp. 12-13.

[118] The Front Project *Submission 109*, p. 13.

> performance of Thriving Kids as it ramps-up – whether it is truly meeting need, whether it can be improved, or whether a totally different approach is needed. This needs to be provided by Navigators who are alongside people – embedded in their communities – helping to navigate different systems. Navigators who won't benefit financially from Thriving Kids or children or families.[119]

4.119 Brisbane Children's Therapy called on navigators to provide accessible information and early training programs to empower families:

> …these navigators should also provide evidence-based information and resources to help parents recognise developmental differences early and understand practical next steps. This could include milestone checklists, early signs of autism and developmental delay presented in neuroaffirming, parent-friendly language, and guidance on how to support their child at home while waiting for services. Navigators should also be able to link families to early training programs such as Early Days workshops, which empower parents to understand their child's developmental profile, build practical strategies at home, and feel more confident when engaging with therapists and educators.[120]

4.120 National Aboriginal Community Controlled Health Organisation highlighted the increasing necessity of the navigator role:

> Specialist Navigators should also be available for people with more complex support needs, certain population groups and people at key life transitions, such as preparing for education, employment and independent living. These Navigator roles will be increasingly necessary as Thriving Kids rolls out and the system becomes more complex and potentially fragmented.[121]

4.121 Australian Psychological Society recommend embedding the key worker and navigator roles across various settings:

> Key worker and navigator roles will be critical to ensuring continuity of care. These roles, embedded across hospitals, schools, maternal and child health, early childhood education, and community health centres, can act as first-line connectors and guides for families. Unlike case managers, they provide navigation, coordination and support, ensuring children access the right programs at the right time. Thriving Kids can build on existing international and domestic models that demonstrate the effectiveness of this approach, particularly for families who may face additional barriers, such as those in rural and remote areas or Aboriginal and Torres Strait Islander and culturally and linguistically diverse families.[122]

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[119] Disability Advocacy Network Australia, *Submission 251*, p. 5.

[120] Brisbane Children's Therapy, *Submission 85*, p. 2.

[121] National Aboriginal Community Controlled Health Organisations, *Submission 154*, p. 2.

[122] Australian Psychological Society, *Submission 160*, p. 14.

4.122 Children's Healthcare Australasia, however, questioned the purpose of the navigator role:

> The rationale for the NDIA to have replaced care coordinators with 'navigators' remains unclear and from the point of view of Child Development Services trying to assist families to access support. Our members support the return of a "support coordinator type role" to assist the streamlining of supports for a family as they journey the system, simplifying the framework for families to move through with consistent, accessible support.[123]

Key worker role

4.123 Similar to the navigator role, 'a key worker is an early childhood professional who works alongside the family to support the child and helps coordinate a team of early childhood therapists and professionals. Key workers practice from a family-centred approach, supporting and empowering families.'[124]

4.124 Early Childhood Intervention Coordination Program (ECICP – Inner West) stated that key workers:

> - Hold professional qualifications in areas such as speech pathology, occupational therapy, psychology, social work, or early childhood education
> - Work within a transdisciplinary team, drawing on the expertise of multiple professionals while providing consistent, relationship-based support to the family
> - Build trust with parents and caregivers, coach them in evidence-based strategies, and coordinate services to avoid duplication and fragmentation
> - Ensure interventions are tailored, goal-focused, and responsive as the child's needs change.[125]

4.125 Noah's Ark Inc provided a description of the foundational elements of the Key Worker model:

> Primary components of the Key Worker model include supports to families that recognise the complexity of having a child with a disability. These include emotional support, information and advice, identifying and addressing needs, advocacy, and service coordination. These components form the basics of a family-centred approach and enable services to be individualised to unique family circumstances.
>
> Key Workers are educational and allied health professionals with specialist knowledge of child development; they are family-focused, strengths-based and

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[123] Children's Healthcare Australasia, *Submission 290*, p. 12.

[124] Independent Review into the National Disability Insurance Scheme, Final Report, 30 July 2025, p. 411.

[125] Early Childhood Intervention Coordination Program (ECICP – Inner West), *Submission 314*, p. 4.

> work in a child's natural environments and routines to build the capacity of parents, educators, and other important people in the child's life (Alexander & Forster, 2012). While the NDIA recommend the Key Worker model (National Disability Insurance Agency, 2023), there is an absence of education, incentive, or regulation to support the implementation of the model.[126]

4.126 Lifestart Disability Services outlined the practical role of key workers in everyday settings:

> Working in everyday settings, the key worker builds the family's capacity to support their child, coordinates services, and delivers responsive, goal oriented support. Key workers also provide emotional guidance, practical strategies, and help families develop advocacy skills and navigate systems to ensure their child's needs are met holistically.[127]

4.127 The APA put forward the Key Worker model as a proven approach for ensuring continuity of care:

> One proven mechanism for continuity is the Key Worker model, also known as a lead practitioner or care coordinator. In this approach, one professional becomes the single point of contact for the family, coordinating services across health, education, and social sectors.
>
> The key worker guides the family, helping them navigate the often complex system of appointments and supports.[128]

4.128 The APA added that the role can be filled by professionals from various disciplines:

> A key worker can come from various disciplines – frequently social work or nursing, but physiotherapists, occupational therapists, psychologists and teachers are also often in this role. A paediatric physiotherapist who knows the child well could act as the key worker, especially if the child's primary needs are motor or physical. As key worker, the physiotherapist would not only deliver therapy but also liaise with speech therapists, educators, paediatricians, and any other involved providers to create a single integrated plan. This prevents fragmentation.[129]

4.129 The APA identified research on the benefits of the key worker role, stating:

> Research on key working shows families experience better coordinated and comprehensive care, quicker access to necessary services, and less stress when a key worker is involved. For example, a case coordinator might set up a joint case conference with the child's preschool teacher, physiotherapist, and speech therapist to agree on shared goals and who will do what. They might help the

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[126] Noah's Ark Inc., *Submission 311*, p. 12.

[127] Lifestart Disability Services, *Submission 245*, p. 8.

[128] Australian Physiotherapy Association, *Submission 171*, p. 35.

[129] Australian Physiotherapy Association, *Submission 171*, p. 35.

> parents prioritize goals (e.g. improving balance to join playground games) and then make sure each provider supports that aim in their own domain.
>
> Studies find that parents strongly prefer having one go-to person rather than a multitude of contacts. This approach reduces the battle parents face in accessing information and services, thereby lowering family stress.[130]

4.130 The APA believed that the key worker model could essentially act as a safety net:

> For children with mild to moderate needs, a key worker model can ensure they stay on the radar even if they don't qualify for intensive case management. The physiotherapist as key worker can periodically check on the child's progress across settings and prompt referrals or supports as new needs arise, effectively bridging gaps between systems.[131]

4.131 According to Koorana Child & Family Services Ltd '[the] Key Worker Model is well-evidenced and demonstrates excellent outcomes in practice.'[132]

4.132 Multiple submitters to this inquiry put forward the view that the Key Worker model represents best practice and called for funding for key workers to support families across systems.[133]

4.133 Occupational Therapy Australia acknowledged that while the Key Worker model is widely regarded as best practice, its implementation can sometimes fall short:

> Key worker models are seen by many early childhood providers as best practice, and may be utilised as a default method of providing early childhood services. However, there is evidence to suggest that overreliance on these may jeopardise outcomes. In practice, the programs being delivered do not always align with the evidence underpinning a key worker approach. This may be due to several factors.
>
> It may be that providers do not understand when and how to implement key worker models based on the needs and preferences of the child and family; or that staff working in key worker roles may lack the scope, training and professional characteristics to work effectively in interdisciplinary key worker roles, or similar roles. Perhaps most critically, key worker models may be offered as independent services rather than as part of a team; which is contrary to the intent underlying the model.

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[130] Australian Physiotherapy Association, *Submission 171*, p. 35.

[131] Australian Physiotherapy Association, *Submission 171*, p. 35.

[132] Koorana Child & Family Services Ltd, *Submission 345*, p. 13.

[133] See, for example: National Child and Family Hubs Network, *Submission 402*, p. 12; Autism Queensland, *Submission 346*, p. 18; APM, *Submission 322*, p. 3; National Disability Services, *Submission 200*, p. 18; Speech Pathology Australia, *Submission 224*, p. 8; Learn My Way, *Submission 125*, p. 1; Learning for Life Autism Centre, *Submission 88*, p. 3; Bathurst Early Childhood Intervention Service, *Submission 240*, p. 3; MedHealth Pty Limited, *Submission 399*, p. 25; NDIS Independent Advisory Council, *Submission 248*, p. 2.

> The Desktop Review of Best Practice in Early Childhood Intervention noted the scarcity of vigorous research about collaborative practice, including key worker models.[134]

Funding and contracting

4.134 This section builds on evidence outlined in Chapter 3 about funding arrangements, where evidence related to the experience of First Nations people and those living in rural and remote communities was discussed.

4.135 Noah's Ark Inc suggested a 'block funding approach supports the engagement of high-quality providers and ensures equity and consistency of service delivery for all families.'[135] They suggested that block funding could be a simpler funding model, stating:

> The call is not for more funding but rather for existing funds to be channelled into best practice and earlier intervention through a simpler funding model such as block funding for best practice service providers or transdisciplinary key worker packages.[136]

4.136 Learning Links stated that 'evidence from programs such as Communities for Children and HIPPY shows that block-funded, place-based, and co-designed approaches strengthen families and communities, build parent confidence, and improve access to supports in ways that are locally relevant and trusted.'[137]

4.137 Teach Speak Hear noted the benefits of establishing a block funding approach:

> ….block funding or tender-based approach, with robust reporting requirements and accountability measures, would ensure sustainability and allow us to focus on what we do best – supporting children with mild to moderate needs and their families. Without this financial commitment, we are increasingly reliant on nonguaranteed and uncertain funding to meet growing demand and to ensure equitable access to essential services.[138]

4.138 Disability Advocacy Network of Australia believed that the block funding of services contained both opportunities and risks. The benefits of this model included:

> - Government has better oversight of commissioned organisation[s] who deliver services
> - Potential for more collaboration between different services and therapists as they are not competing in the market.[139]

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[134] Occupational Therapy Australia, *Submission 304*, p. 39.
[135] Noah's Ark Inc, *Submission 311*, p. 24.
[136] Noah's Ark Inc, *Submission 311*, p. 29.
[137] Learning Links, *Submission 103*, p. 22.
[138] Teach Speak Hear, *Submission 89*, p. 6.
[139] Disability Advocacy Network of Australia, *Submission 251*, p. 4.

4.139 Potential risks they identified included:

> - Significant shift away from the consumer directed care evolution that NDIS introduced
> - Gives significant power to service providers as the contract holders compared to service users
> - Funding and availability of the service is typically estimated which may not reflect actual need on the ground (creating service gaps or waitlists).[140]

4.140 Every Australian Counts believed that 'block funding leads to a lack of choice and reduced safety - where children and families are only able to access support through a single provider.'[141] Nobody Worse Off Coalition, Succeed Healthcare Solutions Pty Ltd, RAEN Tasmania, and Occupational Therapy Society for Invisible and Hidden Disabilities were also of the view that the block funding model risks reducing the choice of provider or professional support.[142]

4.141 Dietitians Australia noted concerns raised by its members that:

> …sole traders and small providers struggle to access block funding due to limited time, resources, and expertise in competitive applications, leaving most of the funding to flow to larger organisations. This risks smaller providers being pushed out, reducing choice and local access.[143]

4.142 Occupational Therapy Australia agreed with the APA and saw an opportunity for the blended funded models.

> There is also a great opportunity for us to really invest in our allied health workforce to ensure we are embedded in schools, we are embedded in community health, we are embedded in disability services and we also have a thriving private practice area…but there is absolutely some gaps. This is a great opportunity for us to reset the scene and create systems and services that enable us to thrive, which will enable the young people and families that we work with to thrive.[144]

4.143 Outside the NDIS, access to all allied health services can be inconsistent, and according to the APA, those 'inconsistencies are greatest for people in rural settings,

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[140] Disability Advocacy Network of Australia, *Submission 251*, p. 4.

[141] Every Australian Counts, *Submission 273*, p. 10.

[142] Nobody Worse Off Coalition, *Submission 242*, p. 11; Succeed Healthcare Solutions Pty Ltd, *Submission 150*, p. 7; RAEN Tasmania, *Submission 389*, p. 12; Occupational Therapy Society for Invisible and Hidden Disabilities, *Submission 365*, p. 6.

[143] Dietitians Australia, *Submission 329*, p. 22.

[144] Mrs Michelle Oliver, Chief Occupational Therapist, Occupational Therapy Australia, *Committee Hansard*, 20 October 2025, p. 20.

Aboriginal and Torres Strait Islander communities, and culturally and linguistically diverse communities'.

> This is why we really need equity focused measures within Thriving Kids to make sure that it doesn't widen those existing gaps and to make sure that it fills those gaps really thoroughly.[145]

4.144 Services for Australian Rural and Remote Allied Health Ltd outlined how recent changes made by the NDIS to allied health professionals claiming for travel impacted on their clients in regional areas.

> This is why we looked at the driving distance to an occupational therapist as a marker of that. The travel caps meant that, if you had an hour's round trip to visit a child and their family in their home, you were only going to be able to claim for half of that time. So immediately, if you are a small provider located in a Modified Monash Model 4 or 5 town, that's going to limit your capacity to travel to see some of these children in their home context.[146]

4.145 The Department of Social Services highlighted how its financial support for playgroups and toy libraries created opportunities for mutual support as well as 'conversation that might lead to a referral to a more intensive or targeted service and so forth'.

> Probably the key service offerings are Children and Parenting Support Program—CAPS for short… The other one I'd probably draw attention to is Communities for Children Facilitating Partners, which is a place based initiative where the facilitating partner establishes a committee and a strategic plan based on the needs of the community in respect of children aged nought to 12…complemented by what's needed—reach into the important consultation and engagement with the local schools, preschools, childcare facilities and so forth.[147]

4.146 The National Aboriginal Community Controlled Health Organisation claimed only some of their member services seek to access the Department of Social Services' Communities for Children funding and other financial support due to the complexity of applying and onerous reporting requirements.

> Some of them have got up to 72 funding streams that they need to report to. I think Thriving Kids, for it to be incredibly successful, has got this great opportunity at a system level to bring that all together and consider how one funding model could actually integrate a number of different areas. It puts a huge burden on our sector, and they're not funded to manage all the grant guidelines

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[145] Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association, *Committee Hansard*, 20 October 2025, p. 21.

[146] Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health Ltd, *Committee Hansard*, 10 October 2025, p. 36.

[147] Mr John Riley, Family Wellbeing Group, Department of Social Services, *Committee Hansard*, 10 October 2025, p. 2.

> and the constant things that they have to do to receive those pockets of money.[148]

Education and school-based supports

4.147 The Committee heard evidence that mainstream education settings, which are attended by nearly all children including those with developmental delays or disabilities, play a vital role in fostering inclusion and enabling early identification of developmental challenges. When accessible and supported by appropriate interventions, these environments can promote positive developmental outcomes.

4.148 Occupational Therapy Australia set out that:

> There is emerging evidence from current mainstream education programs that embedding occupational therapists within education systems leads to positive outcomes and is the most effective way to support children with developmental delay and disability in those settings. Occupational therapists are well established in many mainstream education settings and there is significant capacity to ensure consistent access to occupational therapists across jurisdictions and settings.[149]

4.149 AHPA acknowledged that mainstream education settings have played a crucial role in the early identification of children who need support, and that Thriving Kids will need to be integrated with schools and early childhood centres.

> Mainstream education settings…not only support early identification but also provide a consistent base for delivering services. However, access to allied health professionals in these settings varies significantly by location. In some places, it is non-existent. We need a nationally consistent approach to embedding allied health supports into mainstream education with a multidisciplinary model that enables educators to deliver day-to-day support backed by allied health professionals. Mainstream education is only one part of the equation. Children also develop and thrive in their homes and communities. A successful Thriving Kids initiative must create an ecosystem of supports outside of schools that is well integrated across systems, including education; family inclusive; and easy to navigate.[150]

4.150 The Australian Psychological Society believed there would be great demand for the presence of more psychologists in schools and early childhood settings.

> And for school psychologists, their broader workforce issues aside, that ratio is about one to 1,500 students. Ideally it would be about one to 500. So at this point we need to build capacity and to resource school psychologists so they can do

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[148] Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, 10 October 2025, p. 18.

[149] Occupational Therapy Australia, *Submission 304*, p. 22.

[150] Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 25.

> just that, so they can act on one part of the problem—certainly not the whole offset. So yes—very much so. We also need some resourcing, not just for the broader workforce issues but also for the aspects that can make a real difference to kids in their everyday settings.[151]

4.151 The APDC warned provision also needed to be made for access to psychologists for children not attending schools.

> While school psychologists are a great idea, if your child is not attending school—which many children aren't; they're refusing school—then what do you do? From my own personal experience, from the age of 11 my child stopped attending school for six months. So all those kinds of things have a huge impact on families, on the child, and the child feeling less than, when really they basically haven't had the support when they've needed it within the school system.[152]

4.152 SANE Australia saw a significant role for schools and the education system, in helping to identify students with challenges that Thriving Kids could support with appropriate services.

> …services that will be funded under it from the principle of making it as easy as possible to get more help without relying on families being able to spot that there's an issue or get themselves help, then it means we need to be looking at all the possible settings.[153]

4.153 Mrs Green recalled a history of counselling services being under-funded at most public schools.

> For me, that means looking at schools—investment in school-accessible or school-located services or practitioners. For example, in schools around Australia, most schools would be lucky to have one or maybe two counsellors available. That's in a public school system. We should be looking at how we actually group services and interventions together around the school. That should include strategies like place based approaches to how this intervention is rolled out and things like getting the primary health networks working together with the local health districts or the state-run health infrastructure with private providers.[154]

4.154 Noting the success of some great pilot programs in schools already such as the Murdoch children's mental health professionals in schools and doctors in schools,

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[151] Dr Linda De George-Walker, Senior Policy Adviser, Australian Psychological Society, *Committee Hansard*, 20 October 2025, p. 14.

[152] Mr Neil Turton-Lane Convener, Australian Psychosocial Disability Collective, *Committee Hansard*, 20 October 2025, p. 14.

[153] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 40.

[154] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 40.

SANE Australia supported packaging together all supports that could make a difference, including psychosocial support for families and carers.

> Because, more often than not, if you're trying to support a child or a young person with developmental or mental health issues or disability, then there's often work that needs to be done with the whole family, yet most services are still offered and delivered in a model that's driven by the way they're funded rather than the way people might need them. So they're delivered as this one over here and that one over there, and the people will run between.[155]

4.155 Mrs Green saw an opportunity for Thriving Kids to provide more packaged care options at schools to help with the early identification of children with an issue needing support.[=]

> …to envisage a future where, at the earliest point that someone in the school system in early childhood or a parent or a caregiver might realise there’s an issue, you want the help to appear as fast as possible and you want it to be as comprehensive as possible, because that's the essence of early intervention.[156]

4.156 Aware of past issues with earlier programs for mental health support, SANE Australia warned that schools and their staff will need plenty of government support if they are to play a useful role.

> Schools are a particularly challenging environment because there are still a lot of snake-oil programs sold into schools, and schools don't necessarily have the resources to do an evidence review. And then you need to have local delivery arrangements, local coordination on how to best put these things together based on the local context, which might be very different in terms of whether there is a workforce available and whether there is housing available for a workforce.[157]

4.157 Associate Professor Schultz from the Black Dog Institute cautioned against having unfair expectations of school teachers having the necessary experience or the time to deal with the different challenges presented by neurodiverse students.

> I fully support that teachers are integral in outcomes of children and the way that we work with any child, and they do an amazing job. What I would suggest is that with the range of neurodiverse experiences that may present within a classroom, teachers are unlikely to have the professional capacity to be able to pick up and necessarily distinguish between different presentations or diagnoses that kids may be presenting with. For instance, if we look at some of the well-spoken-about neurodivergent conditions, like FASD versus ASD versus ADHD, each may have some overlaps in terms of behaviours and presentations, but each is unique in terms of (1) the way it is diagnosed and the history that has led to that, and (2) the responses that are best practice for ensuring we get the best outcomes for

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[155] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 41.

[156] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 41.

[157] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 41.

> that particular person. Early intervention is absolutely required, and a lot more training and support could be provided to teachers and to schools to bolster that everyday serviceability and support for children, but I wouldn't suggest that teachers are best placed to be necessarily picking up on diagnoses and, therefore, coming up with treatment plans et cetera.[158]

4.158 The Australian Council for Education Research explained that international research and reviews highlight that:

> …effective provision for children with mild to moderate support needs within mainstream education settings relies on a highly coordinated and responsive system of prevention, targeted support, and intensive intervention.[159]

4.159 Queensland Catholic Education pointed out that:

> Lack of dedicated funding for allied health services in education settings leads to inconsistent and informal collaboration.[160]

4.160 Emerging Minds cautioned against using any program as a one size fits all to address the 'complex and interconnected needs of children and families.' They explained that Thriving Kids:

> …should be positioned not as a standalone initiative, but as a strategic enabler within a broader ecosystem of support. This framing helps avoid the perception that programs alone can resolve systemic challenges, particularly within education settings, and instead highlights the importance of integrated, developmentally informed approaches.[161]

Inclusive education

4.161 The Inclusive Educators Australia (IEA) 'considers that inclusive education, as an educational practice, means that all students with disability.'

> - learn in a regular education environment (that has been sufficiently transformed to be accommodate all learners), alongside their same-age peers
> - access the core curriculum, with appropriate adjustments and supports
> - fully and effectively participate in their school community as valued members.[162]

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[158] Associate Professor Clinton Schultz, Director, First Nations Strategy and Partnerships, Black Dog Institute, *Committee Hansard*, 10 October 2025, p. 44.

[159] Australian Council for Education Research, *Submission 394*, p. 2.

[160] Queensland Catholic Education, *Submission 246*, p. 3.

[161] Emerging Minds, *Submission 306*, p. 5.

[162] Inclusive Educators Australia, *Submission 132*, p. 5.

4.162 IEA suggested that the following elements were critical to the success of inclusive education:

> - Shared understanding amongst all stakeholders of inclusive education, including its guiding philosophy, fundamental concepts, frameworks and practices
> - System-level support from state/territory and regional stakeholders and Departments of Education
> - School leadership and commitment from principals and broader leadership teams
> - Strategic planning to develop a robust plan for achieving inclusive education in the school's unique context
> - Professional development opportunities for teachers and support staff to become more confident in providing inclusive education, with sufficient time allocated to enable this
> - Community education of the broader school community about inclusive education and the benefits for all students
> - Family collaboration with parents/carers and supporters in planning and decision-making
> - Inclusive culture that actively fosters inclusive attitudes and behaviours and building a school culture based on respect for diversity
> - Empowering the leadership and voice of students with disability
> - Ongoing, continuous review and monitoring of inclusive education implementation.[163]

4.163 Submitters suggested that embedding inclusive education principles within Thriving Kids could enhance mainstream capacity and lead to better outcomes for all children.

4.164 Square Peg Round Whole commented that inclusive education requires a variety of teaching methods to remove barriers to learning, i.e., Universal Design for Learning:

> A cornerstone of workforce development must be Universal Design for Learning (UDL). UDL provides teachers with the tools to design learning environments that are inclusive from the outset, reducing reliance on retrofitted adjustments and one-to-one supports. Embedding UDL across professional standards and teacher training creates systemic capacity for inclusion, benefitting all students while particularly addressing inequities faced by neurodivergent and disabled children.
>
> The UN Committee on the Rights of Persons with Disabilities (CRPD General Comment No. 4, 2016) identifies UDL as a requirement for inclusive education.[164]

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[163] Inclusive Educators Australia, *Submission 132*, pp. 6-7.

[164] Square Peg Round Whole, *Submission 318*, p. 11.

4.165 JFA Purple Orange believed that the Thriving Kids initiative could act as a catalyst for Australia to commit to a comprehensive Inclusive Education Strategy:

> …we strongly believe the development of the Thriving Kids initiative creates another impetus for Australia to commit to develop, fund, and implement an Inclusive Education Strategy across all education settings and to embrace the opportunities this would provide for all children to receive a high-quality inclusive education throughout their years of schooling. This is in line with the recommendations of all the Disability Royal Commission commissioners with lived experience of disability.[165]

4.166 Autistic Self Advocacy Network of Australia and New Zealand called for adopting programs that have been independently evaluated for effectiveness and safety:

> Anchor Thriving Kids in inclusive education and family centred models, rejecting segregation/normalisation, and only adopt programs once independent, long-term evaluations confirm effectiveness and no net harm.[166]

4.167 The Australian Childcare Alliance was of the view that, while support for children with additional needs has been underfunded for a substantial amount of time, the Thriving Kids initiative had the potential to be a turning point in improving outcomes:

> Inclusive education is a core and critical component of our sector. The commitment and support required for children with additional needs has been underfunded and has failed to address children's and families' material needs for nearly a decade. We have been advocating for such changes to improve inclusive education for many years and hope Thriving Kids could be a domino in fixing all the systems aimed at improving child outcomes.[167]

4.168 Children and Young People with Disability Australia commented that research shows that inclusive education delivers equal or better outcomes for all children, families, teachers, and society.[168]

4.169 I CAN Network Ltd noted steps being taken by the Victorian Government to inclusive education:

> Government-led initiatives such as the Victorian Disability Inclusion Reform offer a strong foundation of co-design. This reform is enhancing inclusive education by providing schools with additional resources, a tiered support model, and a stronger workforce trained to meet the needs of students with disability. Aligning Thriving Kids with these efforts through co-design ensures policy cohesion and program sustainability.[169]

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[165] JFA Purple Orange, *Submission 376*, pp. 20-21.

[166] Autistic Self Advocacy Network of Australia and New Zealand, *Submission 181*, p. 3.

[167] Mr Paul, President, Australian Childcare Alliance, *Committee Hansard*, 28 November 2025, p. 1.

[168] Associate Professor Kathy, Associate Director, Children's Voices Centre, Charles Sturt University, *Committee Hansard*, 28 November 2025, p. 20.

[169] I CAN Network Ltd, *Submission 285*, p. 8.

4.170 The National Rural Health Alliance believed the education system needed to work closer with the mainstream health and disability services, to help identify children needing support.

> The first thing is that there needs to be an integration of the education system into mainstream health and disability services so that school and early childhood centres become active partners in identifying and supporting children with development needs and those people that look after them are also supported. The intervention needs to start early with coordinated, family centred care, and investment in workforce capacity has to occur. As you heard before, we need to invest in rural and remote multidisciplinary teams.[170]

4.171 Settlement Services International, Mrs Smith, supported providing greater access to supported classrooms for CALD students at their primary schools.

> If there is such a big gap in access to therapists, for example, and the cost of the NDIS is so high, I do that blue-sky thinking around imagining if that was available in those settings alongside the educators, alongside the families, and even more so in CALD communities, where you can build the capacity of that support around that child as well. So it's not that hour of therapy that you get once a fortnight just with that child, which is often the model we're seeing at the moment. It's really embedding in the system, alongside education and also those community supports, so that it's working collectively rather than in a siloed fashion.[171]

4.172 Services for Australian Rural and Remote Allied Health Ltd explained schools can play a role in referring a student for further checks, but the education system can also raise obstacles.

> Referrals into some of these checks and screening programs come from everywhere. They can come from family members or from schools, but there are significant challenges to being able to use school infrastructure to provide services to children who have these needs. For example, we understand that some of our members are being charged to go into schools to provide disability services.[172]

4.173 Ms Maloney highlighted that some schools may charge allied health professionals to come in to see children who might be being funded under a disability program.

> I think that just speaks to the lack of communication between health and education. And if the service is being targeted to the child and not supporting the school community—not uplifting the skills and capacity of the teachers and the

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[170] Ms Susanne Tegen, Chief Executive, National Rural Health Alliance, *Committee Hansard*, 10 October 2025, p. 34.

[171] Mrs Nicole Smith, Head of Disability Supports, Settlement Services International, *Committee Hansard*, 10 October 2025, p. 25.

[172] Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health Ltd, *Committee Hansard*, 10 October 2025, p. 37.

> assistant workers within that school—then I can see that there might be that cultural question of, 'What's this person doing coming in and seeing this child?' There's a lot of work to be done to improve the way that health and education work together.[173]

4.174 The Department of Education noted that the Autism CRC is leading the development of National Guidance for Best Practice in Inclusive Education for Autistic Students:

> The Autism CRC is developing National Guidance for Best Practice in Inclusive Education for Autistic Students and will draw on both domestic and international policy experience and practice. The guidance will be developed through a co-production model involving over 20 community, professional, and government organisations and will integrate systematic reviews of global research evidence with insights from Australian educators, health professionals, autistic individuals, and families.[174]

Challenges providing inclusive education

4.175 Ms Karavolos, Disability Advocacy and Complaints Service of South Australia, noted that despite progressive policies and government support for autism inclusion in South Australia, there remains a significant gap between policy and practice.

> South Australia has one of the most forward thinking governments in the country. We have a premier and ministers who have strongly backed autism inclusion, established an office for autism and invested in autism inclusion teachers. We have the minister for autism. However, at the grassroots, families report a different reality. Teachers and schools still too often interpret behaviours of distress as naughty or defiant, reinforcing stigma and exclusion. In the past year alone, advocacy services have seen a threefold increase at our organisation in requests for support due to vilification and discrimination in schools. With a statistic of autistic children being expelled permanently from preschool 10 times more often than their peers, it says a lot. So often behaviour is a concern in education settings. They are still reported as being defiant rather than having a disability. These stories aren't isolated.
>
> So here is the paradox. We've got progressive policy at the top but discrimination at the classroom level. It shows us what is at stake.[175]

4.176 Ms Nicole Avery, CEO of South West Autism Network, was of the view that availability and quality of autism training for school staff varied:

> There needs to be a lot of upskilling. There's no mandatory training on autism in schools. It's entirely optional. I don't know about other states, but, in WA,

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[173] Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health Ltd, *Committee Hansard*, 10 October 2025, p. 38.

[174] Department of Education, *Submission 363*, p. 16.

[175] Ms Jenny Karavolos, Chief Executive, Disability Advocacy and Complaints Service of South Australia; and Independent Co-Chair, Australian Autism Alliance, *Committee Hansard*, 3 October 2025, pp. 25-26.

> professional development for school staff on autism is entirely optional. It's very much luck of the draw whether you attend a school that is very inclusive and understanding of autism and developmental delays or you don't. Because of catchment areas, you might just happen to be living on the wrong side of the street and wind up in a school that is not supportive, whereas if you were on the opposite side of the street, you could go to a school that is.[176]

4.177 Broome Regional Aboriginal Medical Service noted that, in Broome, schools are ill-equipped to provide adequate support:

> We have lots of kids in our Broome schools with special needs, and the schools still don't seem to be equipped to understand around that person-centredness for children, and children are quite often judged as being naughty or other things when there are developmental delays happening. We do a lot of advocacy in schools and other early childhood providers to ensure that other people have a good understanding of how to look at kids as individuals and not label them with a diagnosis or a developmental delay and how we have a strength based approach to working.[177]

4.178 Mrs Green, from SANE Australia, while very supportive of teachers, suggested that schools often felt constrained from implementing basic support strategies:

> Yes, we have amazing teachers, and they have a whole classroom of kids. It's a bit like the emergency department in that the resources can often get drawn to the most acute need. And so kids that have a softer signal or a flag that they might benefit from some support are going to be less in line to be able to be supported that way because there aren't enough resources. Sure, let's look at how we're training teachers and make sure that they're getting great professional development around the best ways to support children and young people with different needs, but I think you've still got one teacher in a classroom and maybe one counsellor in a school and a whole lot of kids in a public school with needs. And so those resources, that time, that planning, that making of the plan—that goes to the kids with the most acute needs. And so, if you've got a kid who's presenting a bit—maybe there are some signs of autism, maybe there's some ADHD—and they're struggling to make friends, but they're not the most noticeable behaviourally, then at least my experience has been that schools are not going to get you to the front of that queue, because there's only one counsellor.[178]

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[176] Ms Nicole Avery, Chief Executive Officer, South West Autism Network, *Committee Hansard*, 3 October 2025, p. 37

[177] Ms Cassie Atchison, Chief Executive Officer, Broome Regional Aboriginal Medical Service, *Committee Hansard*, 10 October 2025, p. 13.

[178] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 44.

4.179 Children and Young People with Disability Australia provided information on two education surveys they had conducted for young people and one for families which found:

- 72 per cent of students with a disability said they'd been excluded from school activities or events in the last 12 months
- 75 per cent of the students who responded to the survey reported being bullied in the last year
- fewer than two in five students had been involved in shaping their own individual education plan
- 72 per cent of parents of children with disabilities said that care of the children lacked any kind of personalisation or effective execution.[179]

4.180 Mrs Catherine McAlpine, from Inclusion Australia, commented that acceptance of students with intellectual disabilities remains a persistent challenge:

> In terms of acceptance in school, it's been an ongoing issue. We've got a review of the Disability Discrimination Act at the moment, where we need to look at acceptance into school and the subtle pressure that's put on families to go elsewhere. I think one of the things that's lost in the debate is, we would say very strongly, that the resources currently in special school systems need to not be stopped; they need to be transitioned across into schools so that we have inclusive strategies. We know there are a whole lot of inclusive education strategies that work well for all students if they are implemented.[180]

4.181 Ms Nicole Rogerson, from Autism Association of Australia pointed out that school expulsion and exclusion remain significant issues for children on the autism spectrum, often stemming from a lack of understanding and inadequate teacher training.[181]

4.182 Ms Lynette Brodie, from Speech Pathology Australia, noted that service availability in schools is inconsistent across states and territories, with some employing speech pathologists and others not. They called for a more uniform approach to support services in education.[182]

4.183 Mr Jonathon Guy, from the Australian Education Union, held the view that scarce funding limits the ability to make necessary changes

> …in order for a student to receive adjusted funding under the NCCD, the school must demonstrate they had made that adjustment for 10 weeks in the previous year. We have a situation in public schools where funding is very scarce. They

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[179] Ms Skye Kakoschke-Moore, Chief Executive Officer, Children and Young People with Disability Australia, *Committee Hansard*, 20 October 2025, p. 40.

[180] Mrs Catherine McAlpine, Chief Executive Officer, Inclusion Australia, *Committee Hansard*, 20 October 2025, p. 36.

[181] Ms Nicole Rogerson, Chief Executive Officer, Autism Association of Australia, *Committee Hansard*, 21 October 2025, p. 36.

[182] Ms Lynette Brodie, Speech Pathology Australia, *Committee Hansard*, 20 October 2025, p. 20.

> don't have the money to make the adjustment and then they can't demonstrate that they've made it to get the money to make the adjustment in the future.[183]

Transitioning between programs

4.184 There was widespread concern about the transition from the NDIS to the Thriving Kids initiative, particularly regarding the risk of exclusion and loss of supports for children and families. Submissions emphasised the need for a clear timeline for the Thriving Kids rollout and transparent communication to reduce anxiety and confusion.

4.185 Highlighting the importance of a clear transition for young children with ongoing diagnoses, Inclusion Australia emphasised the need for government collaboration with the disability sector.

> We mention the need for young children that will go on to have an ongoing diagnosis to have a clear pathway onto the NDIS, particularly from age nine, and it's critical that the government works with the disability sector to determine which cohorts of children may be at the highest risk of losing supports or may be left worse off in any way in the transition to Thriving Kids. This process can assess community need to determine what safeguards and alternative arrangements are required to ensure sufficient supports are in place before and after the transition.[184]

4.186 Children and Young People with Disability Australia stressed the need for transparent communication from all levels of government, so families can understand and trust the transition to Thriving Kids:

> Families have been bombarded over the last few years with messaging that change is coming and change is happening, but each time change it's announced it is not accompanied by any level of detail. You marry that with families who are experiencing NDIS eligibility reassessments, having plans cut or having children removed from the scheme, the cost-of-living crisis—families are in a really uncertain state at the moment. The more communication that federal, state and territory governments can provide to families about what Thriving Kids will be in their area and how families can access them—that will help, as well as making sure that the community is able to see what they've told the government they need reflected back to them.[185]

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[183] Mr Jonathon Guy, Federal Strategic Research Officer, Australian Education Union, *Committee Hansard*, 28 November 2025, p. 40.

[184] Mrs Catherine McAlpine, Chief Executive Officer, Inclusion Australia, *Committee Hansard*, 20 October 2025, p. 35.

[185] Ms Skye Kakoschke-Moore, Chief Executive Officer, Children and Young People with Disability Australia, *Committee Hansard*, 20 October 2025, p. 38.

4.187 Drawing on results from its national survey, the South West Autism Network voiced widespread concern among families that children currently supported by the NDIS may lose access under proposed changes:

> 92.5 per cent of respondents were concerned that kids currently supported by the NDIS could lose access under the proposed changes, and 77.4 per cent of those were very concerned. Only 5.1 per cent believed Thriving Kids should replace NDIS supports for autistic kids and kids with developmental delay. So 84 per cent of families are not confident that Thriving Kids will deliver timely, affordable or appropriate support in their community, especially outside metropolitan areas.[186]

4.188 Ms Karavolos, from the Disability Advocacy and Complaints Service of South Australia, pointed out that a safe and well-communicated transition period was essential, stating:

> The reality is that if families know there is a safe transition period, we can actually build in some safeguards.
>
> I believe that we could do it in a way so that there's a transition. You're still in the NDIS. While you're transitioning over this period, the government picks up the responsibility for education or community settings. It builds a transition plan to be funded so that there's a transition of knowledge over a period of time. We've then got a much bigger chance of success. We're not relying on the child to transfer knowledge or the parent and overburdening the parent.[187]

4.189 The AEIOU Foundation expressed anxiety about the potential loss of vital supports for children and families during the handover period between NDIS and Thriving Kids, calling for a tiered, interconnected model:

> AEIOU supports a tiered and interconnected model, where children are not permanently locked into one stream. If a child accessing Thriving Kids is not making progress, they must be able to transition into NDIS-funded intensive supports. Likewise, children making gains in intensive programs should be supported to transition into Thriving Kids, with continuity of care and transition planning embedded across pathways.[188]

4.190 ACSSO believed that:

> …seamless transitions are not an optional extra. They are the defining feature that will determine whether families experience Thriving Kids as a supportive reform or as another system that fails them.[189]

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[186] Ms Nicole Avery, Chief Executive Officer, South West Autism Network, *Committee Hansard*, 3 October 2025, p. 33.

[187] Ms Jenny Karavolos, Chief Executive, Disability Advocacy and Complaints Service of South Australia; and Independent Co-Chair, Australian Autism Alliance, 3 October 2025, p. 26.

[188] AEIOU Foundation, *Submission 70*, p. 4.

[189] Australian Council of State School Organisations, *Submission 46*, p. 14.

4.191 ACSSO was supportive of phased implementation, including pilot programs and an overlap period, to ensure families are not left without support, including:

- Pilot programs in selected regions, co-designed and independently evaluated, before scaling nationally.
- A 12–18 month overlap period where both NDIS and Thriving Kids operate concurrently, giving families time to transition at their own pace.
- Clear public timelines with milestones for workforce recruitment, service commissioning, and family resource development.[190]

4.192 Monash University highlighted the need for families to experience seamless transitions across services:

> For Thriving Kids to succeed, families must experience seamless transitions across services — moving from first concerns to identification, to support within mainstream settings, and, where necessary, referral to specialist care. Too often, families face fragmented pathways and long waits across health, education, and community systems.[191]

4.193 Pop Family Ltd believed that there were significant risks if children are transitioned from the NDIS before robust mainstream supports are established:

> …there are significant risks in transitioning children from the NDIS before equivalent, funded, and robust mainstream supports and regulatory frameworks are in place. Without these safeguards, the Thriving Kids initiative risks creating a service vacuum that will fail the very children and families it intends to support.[192]

4.194 The South West Autism Network emphasised the importance of bridging services for effective transition through systems:

> To enable a seamless transition through mainstream systems for children with low (mild) support needs, it is essential for Thriving Kids to bridge services across early childhood, school, community health, and the NDIS using clear referral pathways, integrated planning, and wraparound communication.[193]

4.195 SNAICC recommend establishing transition safeguards to avoid any disruptions to supports:

> …utmost care needs to be taken to ensure that parents and children currently accessing the NDIS do not face any disruption in their supports. This can be done through transition safeguards, including pausing adverse reviews until the Thriving Kids Initiative is live.[194]

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[190] Australian Council of State School Organisations, *Submission 46*, p. 15.

[191] Monash University *Submission 291*, p. 17.

[192] Pop Family Ltd, *Submission 156*, p. 2.

[193] South West Autism Network, *Submission 131*, p. 22.

[194] SNAICC – National Voice for our Children, *Submission 327*, p. 24.

4.196 Inclusive Educators Australia called for 'nationally consistent transition planning frameworks, ensuring every child and family has a structured plan for key points of change.'[195]

4.197 MedHealth Pty Ltd called for a clear transition process stating:

> We strongly recommend that the Department ensures that the NDIA is not exiting children requiring ongoing supports from the scheme until a new ecosystem of Thriving Kids supports and services are funded and readily available nationally.
>
> Additionally, on commencement of Thriving Kids services there must be a clear transition process for children who are exiting the scheme.[196]

4.198 The Australian Youth Affairs Coalition echoed concerns from the Australian Autism Alliance about vulnerabilities of children who don't fit the new criteria:

> There is risk of some children falling through the cracks during the transition between NDIS and the Thriving Kids Initiative, as voiced by Australian Autism Alliance (2025). Older children, those with unclear diagnoses, those who don't fit new criteria, or families with who would experience financial strain in acquiring a review of their diagnoses in order to access the initiative, are most at risk.[197]

4.199 The National Centre of Excellence in Intellectual Disability Health suggested preparation, crossover periods, and a focus on children's strengths were key to ensuring successful changes:

> I think transition is a really important concept for lots of different changes. It's the change into kindy. It's the change from kindy or pre-primary into school. It's the change from one developmental and disability support into another. I think the fundamental components are being clear on strengths—not just weaknesses and impairments—needs and gains and having a crossover period so that there is introduction before the change and then follow-up. So there's preparation for the change. They're touchpoints that are extremely stressful for both children and families. I can imagine that the crossover, the meeting and the preparation before changes actually happen are critical ingredients to that success that includes strengths and preferences.[198]

4.200 The APA recommended that Thriving Kids include protocols for referral to the NDIS when needed 'and also to coordinate if a child is small supports from both the Scheme and initiative – those should be complementary, not working at cross-purposes.'[199]

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[195] Inclusive Educators Australia, *Submission 132*, p. 15.

[196] MedHealth Pty Ltd, *Submission 399*, p. 6.

[197] Australian Youth Affairs Coalition, *Submission 344*, p. 2.

[198] Professor Jenny, Consortium Member Lead, National Centre of Excellence in Intellectual Disability Health, *Committee Hansard*, 21 October 2025, p. 46.

[199] Australian Physiotherapy Association, *Submission 171*, p. 33.

4.201 The Disability Advocacy Network Australia sought clarity on whether Thriving Kids will be aligned with the NDIS or embedded as a mainstream model, and whether ‘grandfathering’ provisions will be used to support a smooth transition.[200]

4.202 The Australian Federation of Disability Organisations suggested that no child or family should be transitioned off the NDIS until Thriving Kids supports are fully accessible:

> Crucially, no child or family should be transitioned off the NDIS until the Thriving Kids foundational supports are fully operational and accessible across all relevant jurisdictions. This includes completion of the phased rollout, establishment of sufficient service capacity, workforce readiness, and the resolution of policy and procedural arrangements across Commonwealth and state/territory governments. Premature transition risks gaps in essential supports and disrupts care continuity, undermining families' trust, and well-being.[201]

4.203 The Autistic Self Advocacy Network of Australia and New Zealand caution against rigid criteria, stating:

> Children who are not eligible for the NDIS should be able to access free, high-quality, trauma-responsive, neuroaffirming, culturally safe supports through Thriving Kids, including short-term transition “bridge” supports delivered via health or education. Rigid criteria can inadvertently cause regressions; flexible support based on actual needs at transition points is better and must not involve moving eligible autistic children out of the NDIS.[202]

4.204 The William Campbell Foundation called for a guarantee in continuity between Thriving Kids and the NDIS, including:

- Stage NDIS eligibility changes only after Thriving Kids rollout.
- Establish clear transition protocols and escalation pathways.
- Provide safety nets for children with higher support needs.[203]

4.205 The Murrumbidgee Primary Health Network and Murrumbidgee Local Health District put forward several key requirements for a seamless transition:

- Clear systems and referral pathways
- Care navigators to guide families and clinicians
- Integration between health, education, and social services
- School readiness programs that align with early intervention efforts
- Removal of cost barriers to access services.

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[200] Disability Advocacy Network Australia, *Submission 251*, p. 6.
[201] Australian Federation of Disability Organisations, *Submission 275*, p. 7.
[202] Autistic Self Advocacy Network of Australia and New Zealand, *Submission 181*, p. 31.
[203] William Campbell Foundation, *Submission 159*, p. 3.

> A tiered model supports these factors by allowing children to move between levels of care based on need. However, successful implementation depends on investment in Tier 1 and Tier 2 workforce, care coordination, and access to allied health.[204]

4.206 Lifestart Disability Services emphasised the need for a coordinated, inclusive, and flexible ecosystem of support:

> A seamless transition through mainstream systems for children with mild to moderate support needs requires a coordinated, inclusive, and flexible ecosystem of support, one that recognises the diversity of children's cultural backgrounds, experiences and needs, and supports them across multiple environments, including health, education, and community settings.[205]

4.207 Inclusion Australia reiterated the need for government collaboration with the disability community:

> It is critical that government works with the disability community to determine which cohorts of children may be at highest risk of losing supports or being left worse off in any way in the transition to Thriving Kids.[206]

Co-design and lived experience

4.208 Mrs Rachel Green the Chief Executive Officer of SANE Australia highlighted some of the challenges faced by families seeking help from the current system for high needs children with autism.

> There is good data to show that people who are autistic and people who have an intellectual disability have a higher prevalence of anxiety and depression. They also have a much harder time accessing mental health support. We also know that families and parents who are the primary caregivers, trying to essentially fight a system to get help for their kids, are, in turn, also facing high levels of stress, anxiety, depression and relationship issues.[207]

4.209 Mrs Green recalled a family that SANE Australia supported and engaged with who had a son with very high needs.

> He didn't fit the criteria for NDIS, and they were spending $30,000 to $40,000 a year out of pocket. Some of that was for the compounding effect of trying to support their son, who had very difficult behavioural issues. He was a lovely boy, but they were experiencing significant depression and anxiety themselves. Imagine what that's like for a family… They had the experience of regularly being

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[204] Murrumbidgee Primary Health Network and Murrumbidgee Local Health District, *Submission 191*, pp. 7-8.

[205] Lifestart Disability Services, *Submission 245*, p. 26.

[206] Inclusion Australia, *Submission 55*, p. 3.

[207] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 43.

> let go by private psychologists and psychiatrists for having a kid whose needs were too difficult and did not fit the mould of any particular program.[208]

4.210 Ms Wade also cautioned how reviews of the NDIS are conducted.

> I think that review plays a very important role in that, though, when we do review the NDIS, we must do so in a way that is respectful of people with disability and their families and their sense of self in the scheme. It's unfair when we review the NDIS and lose sight of that and cause distress, uncertainty or unpredictability in the lives of people with disability.[209]

4.211 The Australian Psychosocial Disability Collective, an independent group of NDIS psychosocial participants, acknowledged problems with the operation and sustainability of the NDIS but urged caution when making changes.

> …in the interests of the disability community, we ask that great care be taken in how any reforms to the NDIS are carried out. We believe that the decision by the Australian government to remove children with mild to moderate neurodevelopmental delays—their term, not ours—and autism from the NDIS and place them in the newly hatched Thriving Kids program is poor and ill considered.[210]

4.212 The Chief Psychologist at the Australian Association of Psychologists Inc, Mrs Amanda Curran, warned that the 'current funding models, including Medicare and NDIS pathways, are fragmented, restrictive and inequitable'.

> Many families are left navigating long waitlists, prohibitive costs, inappropriate referral requirements and inadequate session caps, while children miss out on timely support. Psychologists play a vital role not only in assessment but in empowering parents, supporting educators and delivering therapeutic interventions that build resilience and developmental capacity, yet our workforce is constrained by underfunding, lack of incentive for rural and remote practice and barriers to collaborative care.[211]

4.213 The APDC warned that for children with neurodevelopmental delays and autism and their families, there was much at stake in the NDIS process.[212]

> There is much evidence that children with neurodevelopmental delays and autism who fail to receive appropriate support run a much higher risk of experiencing mental ill health later in life. Many of the concerns voiced by

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[208] Mrs Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, 10 October 2025, p. 43.

[209] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 8.

[210] Mr Neil Turton-Lane, Convener, Australian Psychosocial Disability Collective; *Committee Hansard*, 20 October 2025, p. 12.

[211] Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists Inc; *Committee Hansard*, 20 October 2025, p. 12.

[212] Mr Neil Turton-Lane, Convener, Australian Psychosocial Disability Collective; *Committee Hansard*, 20 October 2025, p. 12.

> members of the autistic community about autistic people being subject to coercive practices resonate with the APDC.[213]

Role of families and people with disability

4.214 The Chief Psychologist at the Australian Association of Psychologists Inc; Mrs Amanda Curran, described 'a lot of support for parents as currently ad hoc'.[214]

> We provide it as we go, often unpaid. Parents are highly distressed by the time they get to us. They're very concerned about their child and what their life is going to look like. They've often raised concerns with multiple people by the time somebody's listened to them and actually gone through and done an assessment. Often, there's a need for them to be really well supported as well. There are high levels of carer burnout.[215]

4.215 Mrs Curran described children's support needs as not being adequately covered currently, even within the NDIS.

> Parents are doing a lot; they're stretched absolutely thin. I've had parents who have given up their own meal in order to feed their child and try to save for the cost of assessment. There's a need for them to be given a lot of support, a lot of assistance, in finding their way and being confident in how they might need to change parenting practices to better support their children, advocate and navigate very complex health and disability and education systems.[216]

4.216 As a start for improving the situation for parents and the children, the Australian Association of Psychologists Inc believed that the government needed to provide parents with Medicare-funded psychology sessions:

> Currently, they can get parenting support only if they've got a diagnosed mental health condition and they're receiving parenting training under Better Access. There needs to be a better support system to help them learn how to support their children and to provide them emotional support as well embedding lived experience in leadership.[217]

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[213] Mr Neil Turton-Lane, Convener, Australian Psychosocial Disability Collective; *Committee Hansard*, 20 October 2025, p. 12.

[214] Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists Inc; *Committee Hansard*, 20 October 2025, p. 16.

[215] Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists Inc; *Committee Hansard*, 20 October 2025, p. 16.

[216] Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists Inc; *Committee Hansard*, 20 October 2025, p. 16.

[217] Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists Inc; *Committee Hansard*, 20 October 2025, p. 16.

Governance and complaints process for the NDIS

4.217 The NDIS is governed through shared arrangements with the Commonwealth and the states and territories. The Disability Reform Ministerial Council (DRMC) comprises the state and territory ministers responsible for disability policy, the Minister for Health and Ageing, and the Minister for the NDIS.[218]

4.218 The NDIS provides quarterly reports to the disability ministers, with information (including statistics) about participants in each jurisdiction and the funding or provision of supports by the NDIA in each jurisdiction. These quarterly reports are reviewed by the Board, then published on the NDIS website.[219]

4.219 The NDIA is governed by a Board consisting of 11 members. The Board assists with the NDIA's statutory requirements, manages risk and ensures the agency achieves best-practice governance. The membership of the board and its work is published in the NDIA Annual report.[220]

Complaints system available to NDIS participants

4.220 Complaints about the NDIS can be made by participants in the scheme, or their representatives, and others including members of the public. Complaints can also be referred by parliamentarians, other government agencies and community organisations.[221]

4.221 The most recent quarterly report noted that the volume of complaints had increased

> During the September 2025 quarter, there was an increase in complaints from participants to 14,061, compared to 12,161 in the June 2025 quarter. While we received a small number of complaints from participants about the Annual Pricing Review this quarter, the growth reflects a general increase in contacts from participants about all complaint topics.[222]

The report also noted the most common focus of complaints

> When exploring both participant and provider and other complains, participant plans are the most common focus of complaints, in particular:
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> - the type and amount of funding approved

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[218] Department of Health, Disability and Ageing, *Disability Reform Ministerial Council,* 28 August 2025, https://www.health.gov.au/committees-and-groups/disability-reform-ministerial-council?language=en (accessed 4 December 2025)

[219] National Disability Insurance Scheme, *Quarterly Reports,* www.ndis.gov.au/publications/quarterly-reports, (accessed 1 October 2025).

[220] National Disability Insurance Scheme, *Board*, 6 May 2025, www.ndis.gov.au/governance/board#board-members-of-the-ndia (accessed 30 September 2025).

[221] National Disability Insurance Scheme, *Quarterly Report to Disability Ministers,* Q1 2025-26, Full Report, September 2025, p. 47.

[222] National Disability Insurance Scheme, *Quarterly Report to Disability Ministers,* Q1 2025-26, Full Report, September 2025, p. 47.

- communication about changes to participant plans
- the plan review process
- delays in receiving payment.[223]

4.222 NDIS Quality and Safeguards Commission Commissioner Ms Louise Glanville confirmed that the Commission received thousands of complaints, and codifies them under various categories such as ‘provider practice, worker conduct and capability, alleged abuse and neglect, provider policies and procedures, and others’.[224]

> We received over 30,000 complaints in the 2024-25 financial year, which is a significant number, and it continues to grow as the number of participants in the scheme grow and people know that they can come to us to raise concerns around the delivery of NDIS services.[225]

4.223 Associate Commissioner Ms Natalie Wade, from the NDIS Quality and Safeguards Commission, detailed how the complaints system worked as a statutory function carried out by the Commission:

> It is available to people with disability, their families and the public more broadly, where complaints can be made about NDIS providers. They can be unregistered or registered providers. If a complaint is made, we have specific powers, as the regulator, to respond to those complaints. We can decide to take it as intelligence and refer the matter out or continue to keep it in our intelligence holdings, right through to bringing the complaint for investigation and compliance and enforcement action. This is a really key way in which we receive information about NDIS services and the way in which they're delivering for people.[226]

4.224 Ms Wade explained that the breadth and width of the nature of complaints that the Commission receive about the NDIS was quite significant.

> It might be something like a person with a disability not receiving their support service on time, and they may complain to us about that, right through to serious allegations of physical and sexual assault. Our role in that, as opposed to the police or an ombudsman or otherwise, is to regulate the NDIS market. We are the only body that has the power in response to a complaint to ban a worker or ban a provider, to stop them from providing those services once those allegations have been made.[227]

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[223] National Disability Insurance Scheme, *Quarterly Report to Disability Ministers,* Q1 2025-26, Full Report, September 2025, p. 48.

[224] Ms Louise Glanville, Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 3.

[225] Ms Louise Glanville, Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, pp. 2-3.

[226] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 2.

[227] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 2.

4.225 The complaints system is the key way in which the Commission received information and what regulatory tools to use, according to Ms Wade.

> Really importantly, they apply to both registered and unregistered providers, and, with respect to early childhood supports, families can make complaints to us. Children could too, although it probably would be families who make those complaints. Providers might also make complaints about the quality and safety of the services.
>
> Most prudently, it's important to highlight that we only have jurisdiction for providers, so not with respect to other allegations of abuse of other family members or things like that.[228]

Other review mechanisms

4.226 An NDIS participant may also request a plan reassessment or variation at any time; a reassessment is a complete review of the plan, whereas a variation is often a minor adjustment to a plan.

4.227 Participants can request a review of a reviewable decision (RoRDs). The NDIS reported that the proportion of plan reassessments that became RoRDs increased from 8.5 per cent (5,860 RoRDs) in the September 2023 quarter to 10.7 per cent (5,835 RoRDs) in the March 2025 quarter.[229]

4.228 If a person is not satisfied with the outcome of their review by the NDIA, they may apply to the Administrative Review Tribunal (ART) for review of a decision made by a reviewer. The NDIA reported there were 2,481 new ART cases in the September 2025 quarter, relating to 2,441 participants. The number of new ART cases (as a proportion of active participants) increased from 0.67 per cent in the September 2023 quarter to 1.33 per cent in the September 2025 quarter. The September 2025 quarter saw an increase from 0.89 per cent recorded in the June 2025 quarter.[230]

NDIS worker-screening checks

4.229 Deputy Commissioner at the NDIS Quality and Safeguards Commission Ms Alisa Chambers outlined that the NDIS worker-screening check was a check that's 'only required for workers who are in risk assessed roles' with a registered provider.

> The only requirement for a worker-screening check is if you are working with a registered provider, but we do encourage all participants who might be self-managed and who are engaging workers to ask their worker to go through that worker screening. It runs a range of different criteria over the person—a criminal

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[228] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 2.

[229] National Disability Insurance Scheme, *Quarterly Report to Disability Ministers*, Q1 2025-26, Full Report, September 2025, p. 53.

[230] National Disability Insurance Scheme, *Quarterly Report to Disability Ministers*, Q1 2025-26, Full Report, September 2025, p. 54.

> record check and a check for any adverse findings about that person—and it flags that in the system. We run the database, but the worker-screening check itself occurs in the states and territories.[231]

4.230 Ms Wade wanted to stress, however, that 'whether you are registered or unregistered, you are regulated by us through the code of conduct'.

> There is no NDIS provider in the market that is not regulated. Everyone is by us. When we look at when there are increased numbers of unregistered providers behaving poorly proportionately to the market—if 93 per cent of the market is them and seven per cent is registered—then of course we see significant numbers of unregistered providers being subject to complaints and coming through our door in various ways.[232]

4.231 The Commission had identified that risk occurs according to the service delivery and the service type, which would be important to mitigate in any programs for children.

> We know from the Disability Royal Commission that, when people receive certain types of services, they are statistically more likely to be subject to violence, abuse, neglect and exploitation. There are absolutely risk-proportionate elements of service delivery that a registration system needs to respond to and recognise, because, ultimately, registration does two things for us as a regulator. It gives us visibility and it gives us an ability to set standards in quality and safety of service delivery… So that's an example where you look to the highest service delivery and then overlay registration, but there is already mandatory registration in place now with regard to specialist disability accommodation and also behaviour support for restricted practice, which is very pertinent for children with regard to restricted practice.[233]

Data, regulation and quality assurance

4.232 Submissions to the Committee spent some time focusing on the importance of data in shaping effective health policy and funding models for neurodivergent children and people with disability.

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[231] Ms Alisa Chambers, Deputy Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 4.

[232] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 6.

[233] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 6.

Data collection and transparency

The importance of data collection

4.233 The importance of data collecting was identified by AHPA, which highlighted the need to share improved data to help guide the provision of services and with the Thriving Kids initiative.[234]

> …the importance of shared digital infrastructure to ensure that allied health clinical data is freely exchanged across the health and disability interface. If there is the expectation of operating in a multidisciplinary team, we need to ensure all members of that care team upload and share their clinical data.[235]

4.234 The Murdoch Children's Research Institute stated that:

> Thriving Kids should be underpinned by a consistent national data framework that includes consistent definitions of lead indicators for service quality, quantity, and participation, alongside impact and outcome measures. Lead indicators are essential to enable data-driven decision making to make inequities visible and guide early action. Clear, consistent definition and indicators developed in consultation with priority groups is also needed to ensure Thriving Kids can monitor reach, participation, equity and progress. System-wide delivery requires services to be equipped with the tools and capabilities to collect and act on these data routinely.[236]

4.235 Similarly, Amaze set out that 'measuring the success of the Thriving Kids initiative is crucial to ensuring it delivers meaningful, lasting benefits for children with disability and their families and carers' and that 'Thriving Kids must be anchored by a comprehensive Outcomes Framework that prioritizes robust and reliable data collection.'[237] Amaze stated that this framework should:

> …track progress towards meaningful short- and long-term outcomes such as education, employment, mental health, and overall wellbeing. This data must be broken down by disability type, including autism, and priority cohorts to ensure equity in service delivery and outcomes for all eligible children.[238]

4.236 The Bryan Foundation stated that a proper support structure should include:

> Robust data and monitoring to guide design, delivery, improvement, and evaluation, including multidisciplinary data frameworks and data sharing protocols.[239]

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[234] Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 26.

[235] Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 26.

[236] Murdoch Children's Research Institute, *Submission 234*, p. 24.

[237] Amaze, *Submission 129*, p. 24.

[238] Amaze, *Submission 129*, p. 24.

[239] The Bryan Foundation, *Submission 333*, p. 6.

4.237 As a mother of a child who received early intervention on the NDIS, Ms Priyanka Rai, from the Australian Multicultural Health Collaborative highlighted the importance of governments collecting more suitable data from CALD families to give more insight on whether a child's language skills may indicate any possible developmental delay.

> One of the issues for us, because we are obviously a multilingual household, was that, during his pre-kindy days, they didn't know if he wasn't socialising because there was a language difference—there wasn't; he was born in Canberra—or because it was a developmental delay.[240]
>
> There are obviously children from multilingual households who take a bit longer to start speaking because they're trying to pick up different languages. But then there's also the issue that we don't actually know what percentage of multicultural children have developmental delays because we're not collecting that data. In general, ethnicity data is not collected across Australia.[241]

4.238 Ms Rai claimed the NDIS doesn't know how many of those children with a disability are from an ethnically diverse background.

> What we know is that one-in-four children who go to school is from a family that speaks a different language. We're assuming that that filters through, but we don't have the granularity of data to actually tell us what the inequity really is.[242]

4.239 Ms Rai also pointed to the benefits data collection has brought in other areas of health inequality:

> One of the things we've learnt from other areas where we're trying to bridge inequity, like with Closing the Gap, the first step was collecting that data—actually seeing where our Indigenous communities were falling back in terms of health outcomes or other metrics. When we didn't have that data, we heard anecdotally that communities were falling behind but we didn't know it. Now, when we have those metrics, which we benchmark and check, we have more-granular information about where they're falling behind and what we need to step up. It's the same with multicultural communities, and more so because we know that the fabric of Australia is going to be more diverse. It just makes sense to collect this data. If you look at comparable countries, like the US and the UK, the UK has its own health observatory such that it's looking at multicultural data specifically. So if we want Australia to continue to be seen as the bastion of universal health care, that's definitely a step we need to take.[243]

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[240] Ms Priyanka Rai, Executive Director, Australian Multicultural Health Collaborative, *Committee Hansard*, 10 October 2025, p. 23.

[241] Ms Priyanka Rai, Executive Director, Australian Multicultural Health Collaborative, *Committee Hansard*, 10 October 2025, p. 23.

[242] Ms Priyanka Rai, Executive Director, Australian Multicultural Health Collaborative, *Committee Hansard*, 10 October 2025, p. 23.

[243] Ms Priyanka Rai, Executive Director, Australian Multicultural Health Collaborative, *Committee Hansard*, 20 October 2025, p. 24.

4.240 The National Rural Health Alliance pointed out that:

> Thriving Kids will require meaningful data to facilitate insights and inform policy, reform and evaluation. The disability ecosystem, more broadly, needs to be supported by comprehensive disability data and data improvements that reflect the experience of all people with disability. As noted by the NDIS Review, investment in integrated and longitudinal data is needed now so we can respond to the needs of children with developmental needs. This will also require cross-portfolio understanding and collaboration in the health, disability and education sectors.[244]

4.241 An important component of data collection is the collection of data on complaints. Ms Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, stated that:

> Complaints are a key way in which we receive information and determine the statutory use of our regulatory tools. Really importantly, they apply to both registered and unregistered providers, and, with respect to early childhood supports, families can make complaints to us. Children could too, although it probably would be families who make those complaints. Providers might also make complaints about the quality and safety of the services.[245]

4.242 Ms Ailsa Chamber, Deputy Commissioner, Regulatory Policy, Insights and Review, NDIS Quality and Safeguards Commission, informed the Committee that the Commissions had:

> …received about $164 million in budget uplift for us to implement the data and regulatory transformation program, which is allowing us to better capture data and better use the data so that we can construct risk profiles. That will enable us to capture more information about children and other cohorts, and we will understand those risks that we're seeing through the system in a much better way.[246]

4.243 Mr Philipp Hermann also from Allied Health Professionals Australia set out that data collection need not be expensive. When asked what data should be captured, he explained that:

> …we have massive data gaps and we need to invest in developing solutions to those. I don't think those are necessarily enormously expensive solutions. I think there are things we can start doing if we put at least a little bit of money into thinking about: What are minimum data sets? What's the information that we actually need? How are we using it? That's work that really needs to progress,

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[244] National Rural Health Alliance, *Submission 379*, p. 7.

[245] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 2.

[246] Ms Alisa Chamber, Deputy Commissioner, Regulatory Policy, Insights and Review, NDIS Quality and Safeguards Commission, *Committee Hansard*, 10 October 2025, p. 2.

> and that will be the next step, actually saying, 'How do we develop an implementation plan off the back of the strategy?[247]

Current data collection and issues arising

4.244 Ms Winslow, a First Assistant Secretary from the Department of Education set out the existence of the Australian Early Development Census and the usefulness of the information it collects:

> We have the Australian Early Development Census, and that is a population measure of early childhood development. It's collected in the first year that children attend full-time schooling, and it is undertaken every three years. The latest results were with respect to the 2024 collection. That is a really comprehensive analysis of how all children are tracking across five key developmental areas. I'm certainly happy to go into what those areas are. We look very closely at those results as an indicator for school readiness. It collects information with respect to physical health and wellbeing, emotional maturity, social competence, language and cognitive skills—which is critical in school settings—and communication skills and general knowledge. That is collected every three years and that is supported through our department.[248]

4.245 Ms Sadikshya Dulai, a Project and Policy Officer from the National Ethnic Disability Alliance, explained to the Committee that a lack of disaggregation of data impacted on the Alliance's ability to ascertain if promised outcome were being met.

> In terms of the data collection, we fail to see disaggregation of data, which is, again, what makes it difficult for us to identify whether the inclusion outcomes, the equity outcomes, that were promised were met. There's nothing we can measure that against—not what was done but also not what was set out in the beginning. So there's no baseline for us to compare that to.[249]

4.246 Dr Esmeralda Rocha, an Assistant Secretary from the Department of Education, set out information in relation to the Disability Standards for Education (DSE), which apply to all schools which ensures that schools make adjustments for students so that they can access and participate. Dt Rocha then set out the importance of data collection to assist with ensuring DSE outcomes are being met:

> The way that we ensure that the adjustments are being provided is through something called the nationally consistent collection of data for students with disability—I'm going to call that the NCCD for short. In the NCCD what happens, essentially, is that we base our student with disability loading contributions from the Commonwealth on that data. Every school in Australia completes a survey

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[247] Mr Philipp Hermann, Policy and Advocacy, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 32.

[248] Ms Alana, Winslow Acting First Assistant Secretary, Early Learning, Programs and Youth Division, Department of Education *Committee Hansard*, 10 October 2025, p. 57.

[249] Ms Sadikshya Dulai, Policy and Project Officer, National Ethnic Disability Alliance *Committee Hansard*, 10 October 2025, p. 28.

> each year for census. That's how we get the total recurrent funding. The NCCD is a part of that.[250]

4.247 Importantly, Dr Rocha explained that adjustments are based on a child's needs in the classroom and are not diagnosis-dependent:

> As soon as a child's functional need becomes apparent, they can document it. They need to have evidence of the child's disability, but it can be something like an individual learning plan, for example. They document the level of adjustment that has been required. There are four levels of adjustment. Three of them attract different levels of funding and one is unfunded—we call that the quality differentiated teaching practice level of adjustment. Then, based on the information that's been provided, it goes through to our system, and that's how we calculate how much student with disability loading is required each year.[251]

4.248 For the non-government sector, Dr Rocha explained that there is a post-enumeration census process where every non-government school is not audited but there is a:

> …quality assurance mechanism, which is risk based to some extent, and then there are just random schools that we will go and audit each year to make sure that the evidence is in place and that the adjustments were in alignment with the level of adjustment that is being claimed.[252]

4.249 Achieving Health Equality for All Australians with Disability stated that the:

> …research and data infrastructure surrounding the NDIS is not fit for purpose and this poses a significant barrier in engaging in evidence-informed reform. The NDIS data currently has information on budget allocation and payments but lacks rigorous information on the types and quality of services provided and outcomes achieved. Furthermore, while the NDIA is now making data available to external researchers, which theoretically should enable greater oversight, there are still major issues in terms of information about the data so researchers are 'in the dark' about the meaning of data items and whether all the information is in the dataset. Moreover, beyond the NDIS there is a complex infrastructure of different evidence sources across different sectors that is not always joined up making it difficult to understand how children and their families navigate service systems.[253]

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[250] Dr Esmeralda Rocha Assistant Secretary, Inclusion and Disability Branch, Department of Education *Committee Hansard*, 10 October 2025, p. 56.

[251] Dr Esmeralda Rocha Assistant Secretary, Inclusion and Disability Branch, Department of Education *Committee Hansard*, 10 October 2025, p. 56.

[252] Dr Esmeralda Rocha Assistant Secretary, Inclusion and Disability Branch, Department of Education *Committee Hansard*, 10 October 2025, p. 56.

[253] Achieving Health Equality for All Australians with Disability, *Submission 235*, p. 4.

Indigenous Data Sovereignty

4.250 Indigenous Data Sovereignty (IDS) is:

> …the right of Indigenous peoples to govern the collection, ownership and application of data about Indigenous communities, peoples, lands, and resources. Its enactment mechanism Indigenous data governance is built around two central premises: the rights of Indigenous nations over data about them, regardless of where it is held and by whom; and the right to the data Indigenous peoples require to support nation rebuilding.[254]

4.251 SNAICC commented that ‘existing administrative datasets often reinforce deficit-based narratives, framing Aboriginal and Torres Strait Islander children and families through lenses of deficiency and disadvantage. As noted in national health reporting, such data frequently perpetuates a narrative of ‘negativity, deficiency, and failure.’’[255]

4.252 The principles of IDS must be acknowledged when collecting data with SNAICC – National Voice for our Children emphasising the importance of ‘giving Aboriginal and Torres Strait Islander people ownership over data so they can exercise sovereignty in relation to data creation, collection, access, analysis, interpretation, stewardship, dissemination, reuse and infrastructure.’[256] They added:

> To be effective, data collected through Thriving Kids must be co-designed with communities. Codesign enables the generation of insights that reflect holistic understandings of child development, encompassing connection to culture, Country, kinship, and language.[257]

4.253 Indigenous Allied Health Australia stated that data should be ‘accessible to community and be co-designed with relevant communities that centre around Indigenous data sovereignty and cultural intellectual property.’[258]

4.254 Referring to sharing data and information to support decision making as a priority area of reform, the National Aboriginal Community Controlled Health Organisation noted that it ‘supports principles of Indigenous Data Sovereignty’.[259]

4.255 Northcott linked IDS to the need to ‘disaggregate outcomes for Aboriginal and Torres Strait Islander children.’[260] Griffith University also mentioned to the importance of IDS principles.[261]

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[254] Associate Prof Gawaian Bodkin-Andrews, Prof Maggie Walter, Dr Vanessa Lee, Prof Tahu Kukutai, Dr Ray Lovett, *Delivering Indigenous Data Sovereignty*, https://aiatsis.gov.au/publication/116530 accessed 1 December 2025.

[255] SNAICC – National Voice for our Children, *Submission 327*, pp. 28-29.

[256] SNAICC – National Voice for our Children, *Submission 327*, p. 8.

[257] SNAICC – National Voice for our Children, *Submission 327*, p. 28.

[258] Indigenous Allied Health Australia, *Submission 271*, p. 6.

[259] National Aboriginal Community Controlled Health Organisation, *Submission 154*, p. 5.

[260] Northcott, *Submission 133*, p. 8.

[261] Griffith University, *Submission 222*, p. 4.

Data interoperability

4.256 An important aspect of data collection, the ability to provide that data to a central area so that it can be accessed by other was addressed Mrs Morris-Donovan, Chief Executive Officer of the AHPA, who stated that one of the barriers to collaborative care is:

> …a barrier towards the sharing of an uploading of appropriate clinical data across the health-disability interface. Private practitioners and allied health work in private practices and create literally thousands of individual data silos, none of which can be shared with each other, nor with the broader health ecosystem. In my view, that's a significant barrier to collaborative care, regardless of setting.[262]

4.257 Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health Ltd, pointed out the importance of data interoperability; being able to access data from a range of health services and states and territories:

> When we're talking about families who are at the interface between health, education and disability, the inability to access information across those systems is a significant one. An example of that is that a child might be born on a remote station in one state but is having to access services in another. It's next to impossible for that health service to access the data on that child. Trying to fix that interoperability issue would be our priority.[263]

4.258 Ms Glanville, Commissioner, NDIS Quality and Safeguards Commission, speaking to the budget uplift mentioned above to implement the data and regulatory transformation program also spoke to the data interoperability aspect – informing the Committee that this should help with sharing data with other organisations.[264]

4.259 Indigenous Allied Health Australia identified data interoperability as an important part of a system that should allow for seamless transition through mainstream systems for all children with mild and moderate support needs.[265]

4.260 Speech Pathology Australia elaborated on its claim that an Australian study reveals one in four children are not on track in terms of their development goals, and to data showing differences between children from regional, rural, remote and metropolitan areas.

> The stat that I was using is that they're not developmentally on track with their communication skills…But we're talking about children who potentially don't have that opportunity. They can't actually understand the language around them and

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[262] Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 20 October 2025, p. 27.

[263] Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health Ltd, *Committee Hansard*, 10 October 2025, p. 37.

[264] Ms Louise Glanville, Commissioner, NDIS Quality and Safeguards Commission, Committee Hansard, 20 October 2025, p. 3.

[265] Indigenous Allied Health Australia, *Submission 271*, p. 5.

> they need the opportunity to get their message across in a way that suits them best of all.[266]

4.261 Occupational Therapy Australia's Mrs Michelle Oliver identified that a core part of what OTs and other allied health professionals do, is working with the child but also with the family members.

> When we're talking about early identification and early intervention, it is about working with that child but also with the really important people who sit around that child: the caregivers, the educators and the community who support that child and that family to thrive as well. So we can use technology to assist us with that, whether it be in building databases, in community education or in developing an app that enables families to improve their own knowledge of or access to services. This is really a great opportunity for us and for the allied health workforce to really help support, drive and lead a pathway to better access to disability services, particularly in our regional and remote areas.[267]

Provider registration and oversight

4.262 The Committee received many submissions setting out that provider registration and oversight are fundamental pillars in ensuring the integrity, equity, and effectiveness of health policy and funding for neurodivergent children, people with disability and their families.

4.263 MedHealth Pty Ltd (MedHealth) noted that it saw an opportunity at the outset with Thriving Kids to ensure the regulatory framework learns from the experiences of the NDIS stating that:

> This would ensure it is proportionate, consistent and responsive to the needs of children, families, and providers when supporting these children. It should include
>
> - Mandatory registration of all providers.
> - Appropriate registration requirements and obligations- clear guidelines to reduce subjectivity and ensure a focus on outcomes rather than administrative preferences.
> - National consistency regardless of state led programs. This should include transition to a National Working with Children Check.
> - Timeliness and efficiency: minimise administrative delays in regulatory processes by reviewing internal workflows and resourcing to ensure timely decision-making.[268]

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[266] Ms Lynette Brodie, Chief Executive Officer, Speech Pathology Australia, *Committee Hansard*, 20 October 2025, p. 21.

[267] Mrs Michelle Oliver, Chief Occupational Therapist, Occupational Therapy Australia, *Committee Hansard*, 20 October 2025, p. 21.

[268] MedHealth Pty Ltd, *Submission 399*, p. 20.

4.264 MedHealth made the following recommendations in relation to registration:

> - Registration should be simple, centralised and follow a transparent process that is consistent across the board yet is not onerous from a governance perspective. In doing so it will achieve the necessary quality and safeguarding for participants whilst reducing the cost burden.
> - Concessions should be explored to reduce registration requirements for organisations holding ISO 9001 certification ensuring overlapping audit requirements require one review.
> - Worker Registration: where duplications exist with professional registrations these should have mutual recognition.
> - WWCC - we strongly recommend the introduction of a national Working with Children Check especially as a national organisation we frequently have staff working across multiple states and territories.
> - Panel Arrangements: improvements in quality regulation and pricing to reward quality would result in a reduction in volume of poor providers and result in better outcomes for participants and financial viability of the scheme. The introduction of panel arrangements would improve quality focus and enhance participant informed choice and control.[269]

4.265 Ms Glanville also commented on the importance of a registration system:

> …that tells you who's in your market and where they are, it's very difficult to not only see what's happening but also be able to shape the market to perhaps attend to places where there are thin markets or areas where there is a lack of services in some spaces.[270]

4.266 Ms Wade made it clear to the Committee that being unregistered did not mean conduct was unregulated:

> I think it's prudent to highlight that, whether you are registered or unregistered, you are regulated by us through the code of conduct. There is no NDIS provider in the market that is not regulated. Everyone is by us.[271]

4.267 Lifestart Disability Services told the Committee that there is inconsistency between registered and unregistered providers. They stated that:

> Registered providers are required to adhere to the NDIS Practice Standards and are subject to oversight by the NDIS Quality and Safeguards Commission. In contrast, unregistered providers are not held to the same standards, creating variability in service quality and safety. For *Thriving Kids* to be a trusted and

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[269] MedHealth Pty Ltd, *Submission 399*, p. 21.

[270] Ms Louise Glanville, Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 3.

[271] Ms Natalie Wade, Associate Commissioner, NDIS Quality and Safeguards Commission, *Committee Hansard*, 20 October 2025, p. 6.

> effective initiative, clear guidelines around workforce registration and external quality assurance are essential. All providers delivering services under *Thriving Kids* should be subject to a unified quality framework, regardless of their professional background, whether in allied health, education, or disability services.[272]

4.268 Autism Spectrum Australia highlighted the importance of registration for 'oversighting best practice' to 'ensure provider accountability in service provision and maintain the safety and wellbeing of vulnerable children and families'[273] The Whole Child explained to the Committee that the 'the NDIS registration framework has often been complex and difficult to interpret' whilst:

> …systems such as CAETI, Better Start, Helping Children with Autism, and CheckUp applied proportionate, workable registration that recognised existing regulation of allied health professionals.[274]

4.269 Similarly Occupational Therapy Australia commented on the need for a registration scheme stating that any scheme should ensure that:

> …registration requirements across early childhood settings are proportionate and recognise existing Australian Health Practitioner Registration Authority (AHPRA) registration requirements. Current NDIS registration requirements are financially prohibitive and administratively onerous and there is little evidence to suggest they increase the safety or quality of the services provided by AHPRA-registered occupational therapists. Governments must commit to ensuring registration processes are fit for purpose, and balance participant safety with access to quality service provision in all geographic settings through the development of requirements that are proportionate and complementary to existing regulatory requirements. In addition to imposing registration requirements, governments must ensure that early childhood supports are delivered by suitability qualified and experienced professionals.[275]

Committee comment

4.270 The Committee acknowledges the strong and consistent message from stakeholders that genuine co-design is essential to the success of the Thriving Kids initiative. Witnesses emphasised that co-design must go beyond consultation to embed lived experience in leadership and decision-making. This includes partnering with disability advocates, and First Nations communities ensuring cultural safety, and incorporating CALD, regional, rural and remote communities voices in governance and evaluation.

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[272] Lifestart Disability Services, *Submission 245*, p. 21.

[273] Autism Spectrum Australia, *Submission 67*, p. 4. See also Autism Advisory and Support Services, *Submission 180*, p. 6.

[274] The Whole Child, *Submission 355*, pp. 11-12.

[275] Occupational Therapy Australia, *Submission 304*, p. 4.

4.271 Families and advocacy groups expressed concern about rushed timelines and the risk of moving children into generic, under-resourced services. They called for transparency in distinguishing consultation from true co-design and recommended phased implementation to safeguard continuity of supports. Witnesses highlighted the need for place-based flexibility, family-led approaches, and integration with existing evidence-based programs rather than creating parallel systems.

4.272 The Committee notes that workforce development and governance structures are critical enablers of co-design. A national workforce strategy, clear standards of practice, and pathways for Aboriginal governance and peer workers were identified as priorities. The Committee supports embedding navigators and peer workers to assist families and reduce complexity, and leveraging local partnerships to ensure Thriving Kids reflects community needs.

4.273 It is critical to include early childhood education and care and primary education providers to ensure that inclusive education is captured in the co-design process.

4.274 The Committee considers genuine co-design—rooted in cultural safety, family leadership, and community control—to be a non-negotiable foundation for Thriving Kids. Without these elements, the initiative risks failing to deliver equitable and effective outcomes for children and families.

4.275 The Committee therefore recommends that Thriving Kids Advisory Group undertakes a genuine co-design process and sets up an ongoing Thriving Kids Advisory Council to continue to ensure that the initiative drives actions and improvements for children with disability.

4.276 The Advisory Council could be modelled on Australia’s Disability Strategy Advisory Council. Its role would be to advise Australian governments and disability ministers on the implementation of Thriving Kids. It would also be responsible for reviewing and advising on its progress.

4.277 The Advisory Council should be established before the commencement of the Thriving Kids initiative.

Recommendation 1

4.278 The Committee recommends that the Thriving Kids Advisory Group undertake an inclusive co-design process and embed evidence-based policies and interventions, as well as the ability to formally review progress on these processes.

4.279 Included in this process should be recognised organisations and peak bodies with an established history in providing services and support for children with physical or psychosocial disabilities and intellectual disability, as well as individuals with lived experience of disability or care of persons with disability, First Nations, and culturally and linguistically diverse backgrounds.

Recommendation 2

4.280 The Committee recommends that the Australian Government establish a Thriving Kids Advisory Council, to advise Federal, State and Territory governments, and disability ministers, on the implementation of the Thriving Kids initiative.

4.281 The Committee notes the evidence that there is strong support for a phased and flexible approach to implementation, including pilot programs, as well as overlap periods where both NDIS and Thriving Kids operate concurrently, and clear public timelines for workforce and service development. Such measures are seen as critical to ensuring that no family is left without support during the transition.

4.282 The Committee also recognises calls for government collaboration with the disability sector and the broader community to identify cohorts most at risk of losing supports, and to ensure that Thriving Kids foundational supports are fully operational and accessible before any transition occurs.

4.283 The Committee recommends that the transition to the Thriving Kids initiative be underpinned by:

- transparent and ongoing communication with families and stakeholders
- phased implementation with overlap and pilot periods
- robust safeguards to prevent loss of support
- clear referral pathways and integrated planning across services
- full operational readiness of Thriving Kids supports before changes to NDIS eligibility
- ongoing collaboration with the disability sector to monitor and address emerging risks.

4.284 The Committee urges all levels of government to prioritise the needs and voices of children and families throughout this process, ensuring that no child is worse off as a result of these reforms.

4.285 The Committee therefore recommends the transition period only commence once foundational supports are fully operational and accessible. The Committee also recommends that families and carers have the option to request a review of decisions about a child participant of the NDIS. The Committee recommends that the *National Disability Insurance Scheme Act 2013* be amended to provide that a decision made under a specified provision of the rules associated with the Thriving Kids initiative be a reviewable decision.

Recommendation 3

4.286 The Committee recommends that the Thriving Kids initiative be implemented in phases and that the Thriving Kids Advisory Group consider appropriate safeguards to prevent loss of supports for children.

4.287 The Committee also recommends that the *National Disability Insurance Scheme Act 2013* be amended to ensure that foundational supports are appropriately implemented.

4.288 In addition to the concerns outlined above, the Committee notes that the number of complaints about the NDIS is increasing. The Committee also notes the evidence by the NDIS Quality and Safeguards Commission about the volume and type of complaints it receives about providers and other matters.

4.289 The Committee acknowledges the current governance and oversight arrangements in place for the NDIS. Robust governance and oversight arrangements provide a framework that supports informed decision-making, improve the quality and standards of services to Australians and provide assurance that the NDIS and related supports are functioning as intended.

4.290 The Committee considers that the current oversight system can appear fragmented or siloed and could benefit from a holistic oversight body able to monitor governance and compliance, examine trends in complaints, and provide guidance on improving practices to better meet the expectations of Australians in participating in the NDIS.

4.291 The Committee recommends the Australian Government appoint an Inspector-General of the NDIS. The Inspector-General would have the ability to coordinate the complaints system currently managed by the NDIA and the NDIS Quality and Safeguards Commission, provide guidance on practice and process improvements, and have visibility of the quality and integrity of the NDIS. The Inspector-General could also be charged with improving data collection and transparency, discussed further below.

Recommendation 4

4.292 The Committee recommends the Australian Government establish an Inspector-General of the National Disability Insurance Scheme.

4.293 The Committee notes that a structured registration system establishes clear standards for qualifications, service delivery, and accountability, creating a trusted network of providers who meet evidence-based and ethical requirements.

4.294 The Committee considers that any registration requirements and processes must be streamlined and proportionate to the objectives of the *Thriving Kids* initiative. Specifically, the system should:

- minimise administrative burdens by avoiding unnecessary complexity or duplication, ensuring registration is not overly onerous for providers.

- recognise existing registrations for providers already registered under the NDIS and similar schemes.
- be designed to encourage participation by capable providers, thereby supporting timely and effective service delivery to families and children who need additional support.

4.295 The Committee recommends that the Thriving Kids initiative include a provider registration process that is streamlined and proportionate, ensuring it is not overly onerous for providers. The process should recognise and leverage existing registrations under other schemes for similar services, reducing duplication and administrative burden while maintaining appropriate safeguards and quality standards. This approach will encourage participation by qualified providers and support timely delivery of services to families and children in need.

Recommendation 5

4.296 The Committee recommends that Thriving Kids initiative include a provider registration process that is streamlined and proportionate. The process should recognise and leverage existing registrations under other schemes for similar services, reducing duplication and administrative burden while maintaining appropriate safeguards and quality standards.

4.297 Block funding presents a compelling solution for addressing the unique challenges faced by service providers and communities, particularly in regional, rural, and remote areas.

4.298 Evidence to this inquiry highlighted that block funding enables more equitable and targeted resource allocation, helping to meet the higher costs of service delivery in areas where market-based models often fall short. By supporting high-quality providers and simplifying funding models, block funding can foster consistency and equity in service delivery for families, while also enabling earlier intervention and best practice approaches.

4.299 Block funding arrangements can also help address workforce challenges by supporting workforce retention and growth, particularly of professionals in rural and regional areas, supporting investment in local training, and enabling communities to develop solutions tailored to their needs.

4.300 Block funding also offers the government better oversight of commissioned organisations and encourages collaboration between services, reducing competition and fostering multidisciplinary teamwork. This model can help ensure sustainability and allow providers to focus on supporting children and families, rather than relying on uncertain or fragmented funding streams.

4.301 The Committee therefore recommends that that the government adopt a commissioned service model for the Thriving Kids initiative.

Recommendation 6

4.302 The Committee recommends that that the government adopt a commissioned service model for the Thriving Kids initiative to ensure appropriate and quality services are delivered across all jurisdictions. Wherever possible already existing services with appropriate regulation and safeguards should be used.

4.303 As discussed in Chapter 3, the Committee notes the challenges faced by rural, regional and remote communities in accessing support services. Despite the growth, advancement and improved access to telehealth services, especially over the past five years, the Committee heard the evidence provided by witnesses that access to remote supports still needs improvement. The Committee also notes the evidence that remote supports will not suit all participants in the Thriving Kids initiative.

4.304 However, the Committee notes that access to technology-based supports can be of significant benefit to those with disability, developmental delay and autism, including for those who are based in cities and regional centres which generally have better access to health, including allied health, supports. The Committee considers that the opportunity to access online and telehealth supports improves choice and self-determination for people with disability, developmental delay and autism.

4.305 The Committee acknowledges that the need to overcome the tyranny of distance in Australia is not unique to the health or disability sector and is a consistent theme in public policy. However, when considering the development of the Thriving Kids initiative and other foundational supports, the Committee considers that the Australian Government consider how access to remote support services could be improved.

4.306 The Committee recommends that the Australian Government consider funding and implementing improvements to technology for online and telehealth services. The Committee considers that it is appropriate that these efforts support people in cities and regional centres to access online health supports. The Committee also recommends that the Australian Government provide additional funding to implement improvements to access technology and telehealth services in regional, rural and remote areas.

Recommendation 7

4.307 The Committee recommends that the Australian Government fund and implement improvements to technology for access to online and health advice services, with additional focus on improving these services in regional, rural and remote areas.

4.308 The Committee notes that it received consistent evidence in the course of its inquiry about the need for access to accurate and comprehensive data to support the delivery of services through the NDIS.

4.309 The Committee considers that accurate and comprehensive data enables policymakers to identify needs, allocate resources equitably, and monitor outcomes, while regulation ensures that services adhere to ethical standards and evidence-based practices. Robust data provides safeguards for consistency and accountability, promoting interventions that genuinely improve health and developmental outcomes. Together, these elements form the foundation for sustainable, transparent, and inclusive health strategies that address the unique challenges faced by people with disability, developmental delay and autism, as well as their families.

4.310 The Committee acknowledges that the *National Disability Insurance Scheme Act 2013* already requires the NDIS to provide regular reporting. However, the Committee also considers that there is an opportunity to enhance the integrity and effectiveness of data collection to support the delivery of the NDIS, the Thriving Kids initiative and other foundational supports.

4.311 The Committee recommends that dedicated staffing and funding be allocated to ensure the effectiveness and integrity of data collection to support the Thriving Kids initiative. Consideration should be given to expanding focus on data management to the NDIS and other foundational supports. The Committee recommends that in implementing this recommendation, the Australian Government should ensure robust and verifiable data collection, interoperability, and that the overall purpose of data collection to assist in informing decision-making and improve outcomes for Australian families. The Committee also recommends that the principles of Indigenous Data Sovereignty be considered in implementing this recommendation.

Recommendation 8

4.312 The Committee recommends that dedicated funding and staffing be allocated in the development of the Thriving Kids initiative to ensure the integrity and effectiveness of data management. Specifically:

- **Adequate resources should be provided to implement systems and processes that guarantee data accuracy, reliability, transparency and adherence to Indigenous Data Sovereignty principles.**
- **Data infrastructure must support interoperability, enabling seamless sharing and integration across relevant platforms and agencies to avoid duplication and enhance efficiency.**
- **Data collection and analysis should be structured to inform decision-making and drive best possible outcomes for families and children in need.**

4.313 The Committee notes the concerns raised by witnesses to the inquiry that accessing existing non-NDIS related supports and programs can preclude an individual from accessing support through the NDIS at a later time. It is the view of the Committee that participating in the Thriving Kids initiative should not preclude a person from being able to participate in the NDIS should they require additional and individualised supports not provided by the initiative.

4.314 The Committee considers that just as a child who is accessing early childhood supports can transition to the NDIS where a diagnosis is received and there is a requirement for significant support, a child who is or has participated in the Thriving Kids initiative should be able to participate in the NDIS where their needs change. This should also be considered for other foundational support programs.

4.315 The Committee therefore recommends that the Thriving Kids Advisory Group ensure that participation in the Thriving Kids initiative will not preclude a child from participating in the NDIS once their participation in the initiative has concluded.

Recommendation 9

4.316 The Committee recommends that there should be a single portal of entry with multiple referral pathways for all children with developmental concerns whether they are in the NDIS or not.

4.317 The Committee also recommends that the Thriving Kids Advisory Group ensures that participation in the Thriving Kids initiative will not preclude an individual from seeking to participate in the National Disability Insurance Scheme, once their time in the Thriving Kids initiative has concluded.

4.318 The Committee considers that a transparent, independent rapid review after twenty-four months of operation is essential to assess whether the Thriving Kids initiative is meeting its stated objectives across early identification, integrated supports and culturally safe, evidence-based delivery; to test implementation in school and community settings; and to ensure the program complements—rather than displaces—the NDIS.

4.319 It is essential that the review:

- measures outcomes for children and families, and compares delivery across jurisdictions, sectors and school settings
- assesses workforce availability, capability and local delivery arrangements (including digital and place-based models)
- assesses inequities (particularly for Aboriginal and Torres Strait islander, culturally and linguistically diverse, and regional, rural and remote communities)
- assesses the provider registration process
- examines integration with the NDIS and other foundational supports to avoid duplication or substitution effects
- includes structured co-design with parents, carers and people with lived experience, and reports on participation and findings
- identifies risks of non-evidence-based practices and proposes accountability mechanisms, including fraud and quality safeguards.

4.320 The Committee therefore recommends, that to enable timely parliamentary and public scrutiny, the Australian Government refer an inquiry to the Committee to undertake a rapid review of the Thriving Kids initiative after twenty-four months in operation.

Recommendation 10

4.321 The Committee recommends that the Australian Government refer an inquiry to the Committee to undertake a rapid review of the Thriving Kids initiative after twenty-four months in operation. The Committee further recommends that the review be presented to the House in accordance with Standing Orders.

Recommendation 11

4.322 The Committee recommends that a consultative group of professional organisations (including allied health peak bodies, paediatricians, child psychiatrists, child & family nurses, early childhood educators, and school educators) and parents involved in the system themselves, be part of the review process.

4.323 The Committee recognises that the key transition points in a child's education—entering early childhood education, moving from early education into primary school, and progressing from primary to secondary—are periods when families often face fragmented services, unclear referral pathways and gaps in funded supports. Strengthening navigation assistance and continuity of care at these junctures would reduce drop-offs, improve participation and outcomes, and lessen stress on parents and carers.

4.324 Evidence to the inquiry consistently emphasised the value of co-ordination across jurisdictions and systems. Coordinated frameworks ensure that policies complement rather than conflict, and that families experience seamless support when moving between systems.

4.325 The Committee therefore recommends that the Federal, State and Territory governments work collaboratively to fund practical improvements for children and families during times of transition, including:

- family-centred navigation and case coordination
- place-based, multidisciplinary teams that can operate in mainstream settings
- culturally safe and inclusive services, with focused attention to Aboriginal and Torres Strait Islander children, children from culturally and linguistically diverse communities, and those in regional, rural and remote areas
- shared data and referral protocols between health, education and community services, and
- clear performance measures to track outcomes and equity across jurisdictions.

Recommendation 12

4.326 The Committee recommends that the Australian Government works with the States and Territories to fund support improvements for children and families during times of transition. These would support families when children is transitioning into early education, from early education into primary education, or from primary education to higher education, as appropriate.

4.327 A lack of specialised support, inconsistent service availability, limited telehealth and outreach and workforce shortages in regional, rural and remote areas, was identified as a significant problem by most submitters to this inquiry.

4.328 Submitters suggested that Thriving Kids can meet demand for access to diagnostic services, particularly allied health services in regional and remote areas by utilising a hub-and-spoke model in which, specialists provide consultation where there are geographic or workforce challenges, while generalists manage cases locally.

4.329 This approach facilitates access for children in rural and remote communities to an experienced allied health team and a paediatrician, working collaboratively with families within their local context. The fully integrated healthcare model ensures that the paediatrician arrives equipped with detailed information, enabling timely care and accurate diagnosis.

4.330 Each child receives an individualised care plan and is connected to their general practitioner and ongoing local supports. This continuity of care ensures that children receive the assistance necessary to succeed both academically and socially. The service provides access to a broad range of supports, including specialist health professionals, ongoing allied health services, and tailored educational support within the school environment.

4.331 The ‘Hub-and-Spoke’ model is a service delivery framework where:

- a central ‘Hub’ provides specialised, multidisciplinary services (e.g., allied health, early intervention, autism-specific programs)
- the ‘Spokes’ are local sites—such as mainstream childcare, schools, or community clinics—linked to the hub, extending the hub’s services into surrounding regions, and
- support is delivered by training local staff in mainstream sites, augmented with regular supervision, visits, telehealth, and ongoing consultation from the hub creating equitable access across regions.

4.332 The Committee recommends that the Federal government work with States and Territories to increase funding and resources to already existing organisations able to deliver supports through ‘hub and spoke’ systems.

Recommendation 13

4.333 The Committee recommends that the Australian Government use both existing and new resources to work with the States and Territories to support children and their families in regional, rural and remote areas.

4.334 This is particularly important for children in regional, rural, and remote areas who have developmental issues and who can be supported through various means, such as using multidisciplinary teams using a hub and spoke system in regional, rural and remote areas.

4.335 By increasing funding and resources to already existing organisations who can deliver through a hub-and-spoke system, these supports can be made more readily available and therefore can improve equitable access for these children and their families, thereby ensuring that cost and distance is not a barrier.

4.336 The NDIS is a highly complex system involving multiple pathways (early childhood, mainstream services, foundational supports, and NDIS-funded supports). Families often struggle to understand eligibility, funding categories, and service coordination. Without comprehensive resources across all areas, families risk falling through gaps or duplicating efforts, which leads to confusion and poorer outcomes.

4.337 Families from diverse backgrounds—such as First Nations, culturally and linguistically diverse communities, and those in rural or remote areas—face additional barriers. Developing resources across all support areas ensures equitable access and culturally safe practices, reducing systemic disadvantage and promoting inclusion

4.338 Children and families often move between different systems. Developing resources that span all areas will help maintain continuity of care during transitions, preventing service gaps and ensuring that supports remain aligned with best practice standards.

4.339 Comprehensive resources empower families to make informed decisions, advocate for their needs, and manage plans effectively. This includes practical tools, clear communication, and strategies for goal setting, which reduce stress and improve outcomes for children with disabilities.

4.340 The Committee recommends that resources be developed across all areas of support for families to navigate the health and education systems; and that support be provided by a range of workers to ensure equitable access for all.

Recommendation 14

4.341 The Committee recommends that workforce and resources be developed across all areas of support for families to navigate an extremely complex system and that, wherever possible, support should be provided by a range of workers to ensure equitable access for all, including:

- **regional, rural and remote areas, CALD and Indigenous communities, children in out-of-home care, parents and carers with disabilities themselves, and other high-risk communities.**

4.342 The Committee recommends the introduction of a separate Medicare Benefits Schedule (MBS) item number for paediatricians to conduct an annual comprehensive review of their patients, mirroring the process currently available to geriatricians. This measure is essential to ensure continuity of care for children with complex health and developmental needs.

4.343 A yearly review, combined with structured case conferencing, will enable paediatricians to collaborate effectively with allied health professionals, educators, and other specialists involved in the child's care. Such multidisciplinary engagement promotes holistic planning, reduces duplication of services, and ensures that interventions remain aligned with the child's evolving needs.

4.344 The Committee notes that paediatric patients often require coordinated input across health, education, and social systems. Embedding this review within the MBS framework will incentivise best practice, improve communication between providers, and deliver better outcomes for children and families.

Recommendation 15

4.345 The Committee recommends that a separate item number, identical to the yearly review process available to geriatricians, be made available to paediatricians to conduct a yearly review for their patients, with case conferencing with other health professionals and educators involved.

4.346 The Committee also recommends that a child development check item number be available for GP's and allied health professionals, as well as similar childhood development checks be made available for early childhood educators, child and family nurses and community nurses in regional, rural and remote areas. This way, all children can have this as another portal of entry into the Thriving Kids initiative.

Recommendation 16

4.347 The Committee recommends that the Australian Government work with state and territory governments and the non-government school sector to increase transparency of the Nationally Consistent Collection of Data and the Schooling Resource Standard (SRS) – Students with Disability loading to better identify the need for this funding and ensure it is effectively targeted and used as intended.

Dr Mike Freelander MP
Chair

A. Submissions

1	A C McArthur Services
2	Mrs Phillippa Smoker
3	My Therapy House
4	Eat Speak Learn - Allied Health Services
5	*Name Withheld*
6	The Therapy Room NQ
7	Mr Robert Heron
8	*Name Withheld*
9	*Name Withheld*
10	Mr Shane Scriven
11	Mrs Shona Redmile
12	*Name Withheld*
13	*Confidential*
14	Mrs Ashlee Law
15	All About Autism
16	Ashar Health Pty Ltd
17	Australian Multicultural Action Network
18	*Name Withheld*
19	*Name Withheld*
20	*Name Withheld*
21	Prof Richard Bruggemann
22	Ms Cath Fernando

23	Eating Disorders Neurodiversity Australia
24	*Name Withheld*
25	*Name Withheld*
26	Can Speak Canberra Speech Pathology
27	*Name Withheld*
28	Ms Alana Beeson
29	*Name Withheld*
30	The Australian College of Nurse Practitioners
31	Australian Primary Principals Association
32	Dr Carol Tran
33	*Name Withheld*
34	*Confidential*
35	*Name Withheld*
36	*Name Withheld*
37	Ms Samantha Duffy
38	Playgroup WA
39	Mr Jarrod Sandell-Hay
40	Ocean Kids Health
41	South Burnett CTC
42	Regional Education Commissioner
43	*Name Withheld*
44	Mental Health for Young & Families
45	Conquip Consulting Pty Ltd - T/AS Continence at Conquip
46	Australian Council of State School Organisations
47	*Name Withheld*
48	Australian Parents Council

49 *Name Withheld*

50 Audiology Australia

51 Kids I Can

52 Family Paediatrics Nurse Practitioners Pty Ltd

53 Olga Komadina Apraxia Therapy

54 Dads Group

55 Inclusion Australia

56 Extended Families Australia

57 Dr Saga Arthursson

58 Down Syndrome Association of NSW

59 *Name Withheld*

60 Royal Far West

- 60.1 Supplementary to submission 60

61 *Name Withheld*

62 *Name Withheld*

63 *Name Withheld*

64 Spectrum Space

65 Independent Audiologists Australia

66 Unbound Minds

67 Autism Spectrum Australia

68 Independent Schools Australia

69 Mito Foundation

70 AEIOU Foundation

71 ADHD Foundation Australia Ltd

72 Disability Employment Australia

73 Settlement Services International (SSI)

74	Australian Primary Health Care Nurses Association (APNA) and Maternal, Child & Family Health Nurses Australia (MCaFHNA)
75	Be Space
76	Academy of Child and Adolescent Health
77	Easy Access Psychology
78	MHNP Consulting
79	Ashton's Place
80	*Name Withheld*
81	*Confidential*
82	Ms Katherine Fotheringham
83	Healthdirect Australia
84	Peninsula Plus
85	Brisbane Children's Therapy
86	Children and Young People with Disability Australia
87	*Name Withheld*
88	The Learning for Life Autism Centre
89	Teach Speak Hear (TSH)
90	First Steps Count Incorporated
91	Siblings Australia
92	Micah Projects
93	The Kids Research Institute Australia • 93.1 Supplementary to submission 93 • 93.2 Supplementary to submission 93
94	NeuFocus
95	Dr Matthew Hale
96	Australian College of Nursing
97	Australian Research Alliance For Children and Youth

98	Mrs Christina Mildren
99	Gayaa Dhuwi (Proud Spirit) Australia
100	Brisbane North Primary Health Network (PHN)
101	Women's Alcohol and Drug Service- First Thousand Days Clinic
102	Municipal Association of Victoria
103	Learning Links
104	Social Ventures Australia
105	Heale Collab
106	National Organisation for Fetal Alcohol Spectrum Disorders
107	Uniting Communities
108	IEU
109	The Front Project
110	Raising Children Network
111	AnglicareSA
112	*Confidential*
113	Aruma
114	Through the Unexpected
115	Brisbane South Primary Health Network
116	Ms Heather McKay
117	Children and Family Disability Alliance
118	Women's and Girls' Emergency Centre
119	*Name Withheld*
120	Queensland Independent Disability Advocacy Network (QIDAN)
121	Peninsula Health
122	Wanslea
123	A Growing Understanding

124	Mrs Jessica Smith
125	North Ryde Community Preschool and Learn my Way
126	*Name Withheld*
127	Miss Jesse Raczynski-Dogaru
128	WA Early Childhood Intervention Collaborative
129	Amaze
130	Mr Kai Meng Reuben Seah
131	South West Autism Network (SWAN)
132	Inclusive Educators Australia
133	Northcott
134	Kiind
135	Miss Aimee Schook
136	Mx Teneille Williams
137	Flying Fox Services Limited.
138	*Name Withheld*
139	*Name Withheld*
140	Lion and Mouse Australia Ltd
141	Rare Voices Australia
142	Dr Kate Renshaw
143	Home Education Network
144	*Confidential*
145	National Eating Disorders Collaboration
146	Mr Dylan Alexander
147	*Confidential*
148	*Confidential*
149	*Name Withheld*

150 Succeed Healthcare Solutions Pty Ltd

151 The Play Way

152 Australian Clinical Neuropsychology Association

153 Access Health and Community

154 National Aboriginal Community Controlled Health Organisation (NACCHO)

  - 154.1 Supplementary to submission 154

155 FASD Research Australia NHMRC Centre of Research Excellence

156 Pop Family Pty Ltd

157 The Australian Association of Psychologists Inc

158 Vision Australia

  - 158.1 Supplementary to submission 158

159 William Campbell Foundation

160 Australian Psychological Society

161 *Name Withheld*

162 Tregear Presbyterian Preschool

163 Marathon Health Ltd

164 Australian Association of Social Workers

  - 164.1 Supplementary to submission 164

165 The Smith Family

166 Early Learning and Care Council of Australia

167 *Name Withheld*

168 *Name Withheld*

169 Kid Link Occupational Therapy

170 Toy Libraries Australia

171 Australian Physiotherapy Association

172 Down Syndrome Australia

173 NursePrac Australia

174 The Hive - United Way Australia

175 SCN2A Australia

176 Allied Health Professions Australia

  - 176.1 Supplementary to submission 176

177 Playgroup Australia

178 Learn Through Play

179 Australian Multicultural Health Collaborative

180 Autism Advisory and Support Service

181 Autistic Self Advocacy Network of Australia & New Zealand

  - 181.1 Supplementary to submission 181

182 Mr Matthew Frost

183 National Catholic Education Commission

  - 183.1 Supplementary to submission 183

184 Joint submission - Disability Advocacy Victoria and Disabled Peoples' Organisations Victoria

185 Latrobe Community Health Service

186 SDN Children's Services

187 Olga Tennison Autism Research Centre

188 PLACE Australia

189 Australian Orthotic Prosthetic Association

190 Exercise & Sports Science Australia

191 Murrumbidgee Primary Health Network and Murrumbidgee Local Health District

192 Nest Culture Pty Ltd

193 Colman Education Foundation: Our Place

194 Dr Jacqui Barfoot

195 Office of the National Rural Health Commissioner

196 AEU Federal Office

197 Autism Association of Western Australia

198 Jewish Care (Victoria) Ins

199 Early Childhood Intervention Australia VIC/TAS

- 199.1 Supplementary to submission 199

200 National Disability Services

201 Parenting and Family Research Alliance

202 Smiling Mind

203 PRECI (Professionals & Researchers in Early Childhood Intervention)

204 Dr Danielle Einstein

205 Ms Shirley Humphris

206 Connected Kiddos

207 Institute of Special Educators

208 Dr. Maryrose Hall

209 Australian Medical Association

210 Stroke Foundation

211 The Royal Australian College of General Practitioners (RACGP)

212 EnhanceABILITY

213 Carers WA

214 cohealth

215 Carers Tasmania

216 *Name Withheld*

217 Mission Australia

218 First Voice

219 Australasian ADHD Professionals Association

220 Genetic Epilepsy Team Australia

221 ADHD Australia

222 Griffith University

223 CATSINaM

224 Speech Pathology Australia

- 224.1 Supplementary to submission 224

225 ConnectAbility Australia

226 Mrs Meran Byleveld

227 Women's and Children's Health Network

228 Joint MYAN and 54 Reasons

229 Community Therapy

230 Australian Literacy and Numeracy Foundation & Raising Literacy Australia

231 Early Childhood Intervention Best Practice Network

232 Autism Association of Australia

233 Anglicare Victoria

234 Murdoch Children's Research Institute

235 Achieving Health Equity for all Australians with Disability

236 Mental Health Carers NSW

237 Inner West Paediatrics

238 Developing Ur Life

239 Ability First Australia

240 Bathurst Early Childhood Intervention Service

241 *Name Withheld*

242 Nobody Worse Off Coalition

243 Royal Australasian College of Physicians

244 NECP: PlayConnect+ Project

245 Lifestart Disability Services

246 Queensland Catholic Education Commission

247 Queensland Foundational Supports 0-9 Working Group

248 Independent Advisory Council to the NDIS

249 Australian Podiatry Association (APodA)

250 Australian, New Zealand and Asian Creative Arts Therapies Association (ANZACATA)

251 Disability Advocacy Network Australia (DANA)

252 Mr David Edelman

253 *Name Withheld*

254 Brotherhood of St. Laurence

255 Brain and Mind Centre, University of Sydney

256 Health Care Consumers' Association

257 Yellow Ukulele

258 Uniting NSW.ACT

- 258.1 Supplementary to submission 258

259 Beyond Blue

260 Dr Tristan Nickless

261 University of Melbourne

262 Kimberley Aboriginal Medical Services

263 United Workers Union

264 National Regional, Rural, Remote and Very Remote Community Legal Network

265 Child Development Sub-Network

266 Community Health First

267 Ms Kate Chaney MP, Federal Member for Curtin

268 Bendigo Community Health Services

269 Australasian Society for Developmental Paediatrics (ASDP)

270 Mr Jack Davenport

271 Indigenous Allied Health Australia

272 The Royal Children's Hospital

273 Every Australian Counts

274 Australian Music Therapy Association

275 Australian Federation of Disability Organisations (AFDO)

276 Holstep Health

277 Miracle Babies Foundation

278 Bellarine Community Health

279 Queenslanders with Disability Network

  - 279.1 Supplementary to submission 279

280 Australian Association for Infant Mental Health

281 Australian College of Midwives

282 Karitane

283 Eating and Feeding Pty Ltd

284 Centre for Excellence in Child and Family Welfare

285 I CAN Network Ltd

286 *Name Withheld*

287 IPC Health

288 Miwatj Health Aboriginal Corporation

  - 288.1 Supplementary to submission 288

289 *Name Withheld*

290 Children's Healthcare Australasia

291 Monash University

292 Prelude Australia

293 Mansfield Autism Statewide Services

294	First Peoples Disability Network
295	Services for Australian Rural and Remote Allied Health
296	Council of Catholic School Parents NSW/ACT
297	*Name Withheld*
298	Neurodiversity Special Interest Group of Australasian Society of Developmental Paediatrics (ASDP)
299	Sensational Start Occupational Therapy P/L
300	Kindship
301	Alliance of Registered Therapy Providers
302	*Name Withheld*
303	*Name Withheld*
304	Occupational Therapy Australia
	• 304.1 Supplementary to submission 304
305	Hope in Colour Advocacy
306	Emerging Minds
307	Ms Toni Hassan
308	Senator Jordon Steele-John
309	The Benevolent Society
310	Triple P International Pty Ltd
311	Noah's Ark Inc
312	Outcomes Therapy
313	Play Matters Australia
314	Early Childhood Intervention Coordination Program (Inner West)
315	Sydney Local Health District
316	Australian Child and Family Services Alliance
317	Catholic School Parents Australia

318 Square Peg Round Whole

319 The University of Melbourne

320 Mrs Giarne Ashby

321 Mrs Kereth Harris

322 Advanced Personnel Management (APM)

323 54 Reasons

324 Journey 2 Learn Ltd

325 Batten Disease Support and Research Association Australia

326 Mrs Satinderjit Kaur

327 SNAICC - National Voice for Our Children

328 Diverse Learning

329 Dietitians Australia

330 *Name Withheld*

331 Best Life Therapy Company

332 Ms Monika Schofield, Phoenix Therapy & Inclusion

- 332.1 Supplementary to submission 332

333 The Bryan Foundation

334 Australian Youth Affairs Coalition

335 EARLY CHILDHOOD AUSTRALIA

336 Light Occupational Therapy

337 Divergent Psychology

338 Mrs Nicole Pates

339 Special Teaching and Research (STaR) Ltd

340 *Name Withheld*

341 Parenting Research Centre

- 341.1 Supplementary to submission 341

342 Minderoo Foundation + Thrive by Five

343 *Name Withheld*

344 Australian Paediatric Society

345 Koorana Child & Family Services Ltd

346 Autism Queensland Ltd

347 *Name Withheld*

348 Ms Melissa North

349 Early Education (EarlyEd) Inc

350 Intellectual Disability Rights Service

351 Yellow Ladybugs

352 Autism Aspergers Advocacy Australia (A4)

353 Dr James Carter

354 Central Goldfields Shire Council

355 The Whole Child

356 Bolshy Diva

357 Australian and Family Supports Alliance (ACaFSA)

358 Queensland Council of Social Service (QCOSS)

359 Australian Nursing & Midwifery Federation (ANMF)

360 Australian Neurodivergent Parents Association

361 *Name Withheld*

362 Playgroup NSW

363 Department of Education

- 363.1 Supplementary to submission 363

364 Community Hubs Australia

365 the Occupational Therapy Society for Invisible and Hidden Disabilities (OTSi)

366 CREATE Foundation

367 Plumtree

368 Ms Nicolette Boele MP, Federal Member for Bradfield

369 International Council on Development and Learning

370 Australian Institute of Family Studies (AIFS)

371 Family & Relationship Services Australia (FRSA)

372 *Name Withheld*

373 Multicultural Disability Advocacy Association

374 Lived Experience Australia

375 Department of Social Services

376 JFA Purple Orange

377 NDIS Quality and Safeguards Commission

378 Helen Said

379 National Rural Health Alliance

380 National Disability Insurance Agency

381 Believe and Become Pty Ltd

382 Health Services Union

383 Gheorg

384 Illawarra Disability Alliance

385 Australian Catholic University

386 Ms Allegra Spender MP, Federal Member for Wentworth

387 Developmental Coordination Disorder Australia Inc

388 Isolated Children's Parents' Association

389 RAEN Tasmania

- 389.1 Supplementary to submission 389

390 Reimagine Australia

391 The Royal Australian and New Zealand College of Ophthalmologists

392	Targeted Motor Control
393	*Name Withheld*
394	Australian Council for Educational Research
395	National Indigenous Australians Agency
396	*Name Withheld*
397	Australian College of Rural and Remote Medicine (ACRRM)
398	Australian Rehabilitation and Assistive Technology Association (ARATA)
399	MedHealth
400	HealthWISE
401	Berry Street Yooralla
402	National Child and Family Hubs Network
403	Autism CRC
404	Claire Shellam

B. Public hearings

Friday 3 October 2025 – Canberra

Department of Health, Disability and Ageing

- Dr Elizabeth Develin, Deputy Secretary, Department of Health, Disability and Ageing
- Ms Lisha Jackman, Assistant Secretary, Foundational Supports and Childhood Reforms Branch, Department of Health, Disability and Ageing
- Mr Luke Mansfield PSM, Acting Deputy Secretary, Department of Health, Disability and Ageing

Roundtable 1

- Ms Michelle Moss, Chief Executive Officer, Queenslanders with Disability Network
- Mr Jeremy Muir, Chief Executive Officer, Physical Disability Australia

Roundtable 2

- Mrs Niki Lehmann, Executive Officer, Autism

Roundtable 3

- Ms Jenny Karavolos, Chief Executive, Disability Advocacy and Complaints Service of South Australia; and Independent Co-Chair, Australian Autism Alliance
- Professor Sharon Lawn, Executive Director, Lived Experience Australia

Roundtable 4

- Ms Nicole Avery, Chief Executive Officer, South West Autism Network
- Ms Carrie Clark, Chief Executive Officer, Kiind
- Mrs Sophie Harrington, Chief Executive Officer, National Organisation for Fetal Alcohol Spectrum Disorders

Friday 10 October 2025 – Canberra

Department of Social Services

- Ms Janaya Cox, Acting Branch Manager, Early Childhood and Parenting Wellbeing Branch, Family Wellbeing Group, Families and Communities Stream, Department of Social Services
- Ms Jacqueline Hrast, Acting Group Manager, Family Wellbeing Group, Families and Communities Stream, Department of Social Services

- Mr John Riley, Branch Manager, Child and Family Programs, Family Wellbeing Group, Families and Communities Stream, Department of Social Services

Roundtable 1

- Ms Cassie Atchison, Chief Executive Officer, Broome Regional Aboriginal Medical Service
- Mr Paul Gibson, Chief Operating Officer, Indigenous Allied Health Australia
- Mr Damian Griffis, Chief Executive Officer, First Peoples Disability
- Dr Sarah Hayton, Executive Director, Policy and Programs, National Aboriginal Community Controlled Health Organisation
- Mr Rhys Howard, National Policy Manager, First Peoples Disability Network
- Ms Tara Lewis, Knowledge Translation Lead, Indigenous Allied Health
- Mr Oskar Stenseke, Senior Manager, Kimberley Aboriginal Medical Services

Roundtable 2

- Ms Rana Ebrahimi, National Manager, Multicultural Youth Advocacy Network Australia
- Mr Ben Fioramonte, General Manager, Children, Families and Disability Support, Settlement Services International
- Ms Priyanka Rai, Executive Director, Australian Multicultural Health Collaborative
- Mrs Nicole Smith, Head, Disability Supports, Settlement Services International

Roundtable 3

- Ms Sadikshya Dulal, Policy and Project Officer, National Ethnic Disability Alliance
- Ms Caitlin McMurrow, NDIS and Aged Care Funding Specialist Lead, Vision Australia

Roundtable 4

- Dr Sarah Chalmers, President Elect, Rural Doctors Association of Australia
- Ms Catherine Maloney, Chief Executive Officer, Services for Australian Rural and Remote Allied Health Ltd
- Ms Susanne Tegen, Chief Executive, National Rural Health Alliance

Roundtable 5

- Mx Priscilla Brice, Chief Executive Officer, National Mental Health Consumer Alliance
- Mrs Rachel Green, Chief Executive Officer, SANE Australia
- Associate Professor Clinton Schultz, Director, First Nations Strategy and Partnerships, Black Dog Institute

Roundtable 6

- Ms Samantha Page, Chief Executive Officer, Early Childhood Australia
- Mr David Tonge, Chief Executive Officer, Amaze

Department of Education

- Dr Esmeralda Rocha, Assistant Secretary, Inclusion and Disability Branch
- Ms Alana Winslow, Acting First Assistant Secretary, Early Learning, Programs and Youth Division

Monday 20 October 2025 – Melbourne

NDIS Quality and Safeguards Commission

- Ms Louise Glanville, Commissioner
- Ms Natalie Wade, Associate Commissioner
- Ms Alisa Chambers, Deputy Commissioner, Regulatory Policy, Insights and Review

Roundtable 1

- Mrs Amanda Curran, Chief Psychologist, Australian Association of Psychologists
- Mr Neil Turton-Lane, Australian Psychosocial Disability Collective
- Dr Alexandra Murray, Head of Policy and Research, Australian Psychological Society
- Dr Linda De George-Walker, Senior Policy Advisor, Australian Psychological Society

Roundtable 2

- Ms Jessica Landers, Chief Executive Officer, Australian Orthotic Prosthetic Association
- Ms Diana Poole, Board Chair, Australian Orthotic Prosthetic Association
- Ms Katherine Utry, General Manager, Policy and Government Relations, Australian Physiotherapy Association
- Mrs Nicole Pates, Australian Physiotherapy Association National Paediatric Chair, Australian Physiotherapy Association
- Ms Lynette Brodie, Chief Executive Officer, Speech Pathology Australia
- Mrs Michelle Oliver, Occupational Therapy Australia
- Ms Samantha Hunter, Occupational Therapy Australia

Roundtable 3

- Mrs Bronwyn Morris-Donovan, Chief Executive Officer, Allied Health Professionals Australia

- Mr Philipp Herrmann, Policy and Advocacy, Allied Health Professionals Australia
- Dr Michael Wright, President, Australian College of General Practitioners
- Dr Timothy Jones, Chair, RACGP Specific Interests group - Child and Young Person's Health, Australian College of General Practitioners

Roundtable 4

- Ms Skye Kakoschke-Moore, Chief Executive Officer, Children and Young People with Disability Australia
- Mrs Catherine McAlpine, Chief Executive Officer, Inclusion Australia

Roundtable 5

- Mr Ross Joyce, Chief Executive Officer, Australian Federation of Disability Organisations
- Mr Jarrod Sandell-Hay, Specialist Advocate, Disability Resource Centre
- Ms Heidi La Paglia, Steering Committee Member, National Disability and Carer Alliance
- Ms Nicole Avery, Codesign Lead, National Disability and Carer Alliance

Roundtable 6

- Mr Michael Perusco, Chief Executive Officer, National Disability Services
- Ms Emily Forrest, Deputy CEO and Director of Policy and Advocacy, National Disability Services
- Mr John Forster, Chief Executive Officer, Noah's Ark, National Disability Services
- Ms Cherry Baylosis, Director of Policy and Advocacy, Disability Advocacy Network Australia
- Mr Liam Thatcher, Policy and Advocacy Advisor, Disability Advocacy Network Australia

Tuesday 21 October 2025 – Sydney

National Disability Insurance Agency

- Ms Amity Durham, Deputy Chief Executive Officer, Children, Specialised Services and Scheme Interfaces
- Ms Janine Mohamed, Deputy Chief Executive Officer, First Nations
- Ms Cassie Hammond, Branch Manager, Scheme Eligibility

Roundtable 1

- Ms Karen Dimmock, CEO, Association for Children with Disability
- Ms Stacey Touma, Co-chair/member, Disability, Child and Family Disability Alliance
- Mr Edgar Julian Laurens, Senior Policy Officer, People with Disability Australia

Roundtable 2

- Ms Melissa Webster, CEO, ADHD Australia
- Mr Matthew Tice, Chair/Director, ADHD Australia
- Ms Kelly Dargan, Non-Executive Director, ADHD Australia
- Mr Christopher Ouizeman, Director, ADHD Foundation

Roundtable 3

- Ms Denise Lyons, President, Australian Primary Health Care Nurses Association
- Ms Janice Finlayson, Director, Maternal, Child and Family Health Nurses Australia

Roundtable 4

- Mrs Vicki Gibbs, Head of Research, Autism Spectrum Australia
- Ms Nicole Rogerson, Chief Executive Officer, Autism Awareness Australia
- Mrs Jacki Borland, Chair Australian Advisory Board on Autism
- Ms Laurence Cobbaert, Chairperson, Autism and Eating Disorders Neurodiversity Australia
- Ms Natasha Lane, Support person for Laurence Cobbaert, Autism and Eating Disorders Neurodiversity Australia

Roundtable 5

- Professor Jenny Downs, National Centre of Excellence in Intellectual Disability Health
- Ms Sophie Howlett, National Centre of Excellence in Intellectual Disability Health
- Mr Julian Trollor, National Centre of Excellence in Intellectual Disability Health,
- Mr Darryl Steff, CEO, Down Syndrome Australia

Friday 7 November 2025 – Canberra

Roundtable 1

- Ms Jacqueline Emery, CEO, Royal Far West
- Ms Kylie Irvin, Portfolio Manager, NDIS Western, Marathon Health
- Ms Kylie Falciani, General Manager – Operations, Marathon Health

Roundtable 2

- Ms Jennifer Lewis, Social Policy and Advocacy Officer, Australian Association of Social Workers
- Ms Sally Urquhart, Executive Manager of Strategy, HealthWISE
- Ms Louise Ingall, Manager Research and Partnerships, HealthWISE

Roundtable 3

- Mrs Margaritha Raxworthy, CEO, Dietitians Australia
- Mrs Nicole Donnelly, Chair of Disability Sector Reference Group, Dietitians Australia
- Mr Scot MacDonald, General Manager Policy and Advocacy, Exercise and Sports Science Australia
- Mrs Elyse Hocking, Policy and Advocacy Manager, Exercise and Sports Science Australia
- Ms Eliza Smith, Accredited Exercise Physiologist, Exercise and Sports Science Australia
- Ms Jessica Paolini, Personal capacity, Exercise and Sports Science Australia

Roundtable 4

- Ms Clare Lawrence, Principal Policy Officer, Uniting NSW.ACT
- Mrs Lisa Kinsey-Smith, Head of Operations Disability and Child Youth and Families, Uniting NSW.ACT
- Ms Wendy Field, Head of Evidence and Impact, The Smith Family
- Ms Sulabha Pawar, Group Manager, Programs and Strategic Initiatives, The Smith Family

Monday 17 November 2025 – Canberra

Roundtable 1

- Ms Angela Falkenberg, President, Australian Primary Principals Association
- Mr Pat Murphy, President, Australian Government Primary Principals Association
- Mr Matthew Johnson, President/CEO, Australian Special Education Principals Association

Roundtable 2

- Mrs Kate Southward, Paediatric Speech Pathologist/Clinical Manager, Community Therapy
- Mr Jordan McGuire, Head of Clinical Operations, Community Therapy
- Mr Edward Birt, Senior Policy Specialist, Illawarra Disability Alliance

Roundtable 3

- Mrs Cheryl Koch, President, Autistic Self Advocacy Network Australia and New Zealand
- Ms Alexandra Bignell, Deputy Chair/Governance and Strategy Officer, Autistic Self Advocacy Network Australia and New Zealand
- Ms Cheryl Mangan, Chief Innovation Officer, Autism CRC

- Professor David Trembath, Project Lead, Autism CRC
- Ms Heidi La Paglia, Vice President, Regional Autism Engagement Network Tasmania
- Ms Nicole Moran, Board Member, Regional Autism Engagement Network Tasmania
- Ms Sarah Langston, President, Australian Neurodivergent Parents Association

Roundtable 4

- Ms Rachel Fishlock, Chief Executive Officer, Gayaa Dhuwi Australia
- Professor Helen Milroy, Board Chair, Gayaa Dhuwi Australia
- Ms Catherine Liddle, Chief Executive Officer, SNAICC
- Mrs Emily Osborne, NDIS Operations Manager, Miwatj Health Aboriginal Corporation
- Ms Kathryn Freeman, Chief Operating Officer, Miwatj Health Aboriginal Corporation

Roundtable 5

- Ms Sylvana Mahmic, Chief Executive Officer, Plumtree
- Mrs Clare Brennan, Director, First Steps Count Incorporated
- Dr Roslyn Baxter, Chief Executive Officer, Goodstart Early Education
- Ms Karen Weston, Chief Executive Office, Gowrie Victoria

Roundtable 6

- Ms Sally Moore, Chief Executive Officer, Early Childhood Intervention Australia VIC/TAS
- Mrs Jo Johnson, Early Interventionist/Key Worker, Bathurst Early Childhood Intervention Service
- Ms Lucinda Jones, Key Worker; Early Interventionist; Sector Capacity Building Project Officer, Bathurst Early Childhood Intervention Service
- Mrs Meredith Cox, Early Interventionist Key Worker, Bathurst Early Childhood Intervention Service

Roundtable 7

- Dr Danielle McMullen, President, Australian Medical Association
- Associate Professor David McDonald, Senior Member, Australian Paediatric Society
- Mr Garth Hargreaves, Member, General Paediatrician, Australian Paediatric Society
- Mr Peter Goss, Treasurer, Australian Paediatric Society

Friday 28 November 2025 – Canberra

Roundtable 1

- Mr Paul Mondo, President, Australian Childcare Alliance
- Ms Sally Maddison, Acting Chief Executive Officer, Early Learning and Care Council of Australia

Roundtable 2

- Ms Jacinta Collins, Executive Director, National Catholic Education Commission
- Dr Jacqueline Frost, Governance and Communications, National Catholic Education Commission
- Mr Graham Catt, Chief Executive Officer, Independent Schools Australia
- Mr Jacob Hanley, Assistant Director, Policy and Research, Independent Schools Australia
- Ms Tracey Taylor, Executive Director, Association of Independent Schools of the ACT
- Professor Elizabeth Labone, Chief Executive Officer, Victorian Catholic Education Authority
- Ms Judy Connell, Manager, Education Programs and Support, Victorian Catholic Education Authority

Roundtable 3

- Mrs Denise Luscombe, Chair, Professionals and Researchers in Early childhood Intervention
- Ms Alice Lans, Member, ECI Best Practice Network
- Ms Kerry Dominish, Co-Chair, ECI Best Practice Network
- Associate Professor Kathy Cologon, Associate Director, Children's Voices Centre, Charles Sturt University

Roundtable 4

- Mrs Leanne Varga, Systemic Advocacy and Campaigns Manager, Family Advocacy
- Mr Rob Ryan, Chief Executive Officer, Parenting Research Centre
- Dr Catherine Wade, Member, Parenting and Families Research Alliance and Parenting Research Centre
- Ms Erica Kelly, NDIS Action Circle Representative, Parenting and Families Research Alliance
- Dr Jacqui Barfoot, NDIS Action Circle Representative, Parenting and Families Research Alliance

Roundtable 5

- Ms Cara Nightingale, Vice President, Early Childhood Australian Education Union
- Mr Jonathon Guy, Federal Strategic Research Officer, Australian Education Union
- Ms Veronica Yewdall, Assistant Federal Secretary, Independent Education Union
- Ms Lisa James, Early Childhood Organiser, Independent Education Union
- Ms Lisa Judge, Public Sector Coordinator, United Workers Union
- Mr Kevin Davey, Education Assistant, United Workers Union
- Ms Claire Shellam, Centre Director, United Workers Union
- Ms Bronwyn Kays, Member, United Workers Union

Roundtable 6

- Dr Christine Johnston, School of Education, Western Sydney University
- Dr Lisa McKay-Brown, Associate Dean, Diversity and Inclusion, University of Melbourne
- Dr Matthew Harrison, Associate Professor (Learning Intervention), Co-Lead of the University of Melbourne Neurodiversity Project, University of Melbourne
- Professor Sharon Goldfeld, Theme Director – Population Health and Director, Centre for Community Child Health, Murdoch Children's Research Institute

C. Survey into the Thriving Kids initiative

Overview

1.1 The Committee conducted a public survey to gather views and experiences from parents, carers, service providers and community members about the availability and effectiveness of the current services available to support children with disability, including developmental delay and autism.

1.2 The survey comprised of nine questions, each offering respondents a choice from five response options on a fixed scale. The final question in the survey was a free text box, meaning respondents could write anything they wished. The free text box had no character or word limit.

1.3 The Committee notes the concerns from many organisations and individuals about the accessibility of the survey, particularly for people with disability, from culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait islander communities.

1.4 The Committee notes that there are several types of surveys which could have been administered as part of this inquiry. Given the relatively short timeframe for this inquiry the Committee resolved to use a self-administered questionnaire which was designed to gain a quick snapshot about the current support services available to help children with disability including developmental delay and autism. This style of survey offered several advantages including saving time; reduced interviewer bias; provided greater anonymity and privacy; respondents were able to complete questionnaires at their own pace and preferred time; could be delivered via multiple channels; and was suitable for geographically dispersed or remote populations.

1.5 The survey was designed to provide contextual insights to complement written submissions and other evidence gathered for this inquiry; it was not intended to inform broader policy development.

1.6 The Committee acknowledges that engaging in public consultation processes may be especially difficult for parents and carers of children with autism and developmental delays, given the additional responsibilities and complexities they often manage. The Committee expresses its sincere appreciation to those who took the time to contribute, providing valuable insights that have helped inform the Committee’s broad understanding of the issues under examination.

1.7 Participation in the survey was voluntary. The Committee received 1,194 responses in total.

1.8 The survey was launched on 21 August 2025 and remained open for 50 days. The survey closed on 10 October 2025.

1.9 The survey was accessible on the Committee's website, via the homepage for the inquiry.

1.10 The Committee published a media release for the inquiry which included a description and link to the survey, as well as the closing date. The media release was published on the Parliament of Australia webpage and social media.

Breakdown of Key Statistics

Summary of results

1.11 Participants were requested in question 3 to specify their geographical base (remote, rural, regional, or metropolitan).

Ease of access to information about available supports

Figure C.1 How easy or difficult was it to find information about the supports available?

Source: Survey on support services for people with disabilities

1.12 Respondents were asked to rate how easy or difficult it was to find information about the supports available to help children with disability including developmental delay and autism. A rating of 1 indicated they found it very difficult to find the supports available, while a rating of 5 indicated they found it very easy to find the supports available.

1.13 Most people who answered the survey said it was very difficult or difficult to find information about available supports.

1.14 Almost a third of people said it was very difficult to find information about available supports (326 respondents).

1.15 A further third of people said it was difficult to find information about available supports (346 respondents).

1.16 Almost a third of people said that they did not find it particularly difficult or particularly easy to find information about available supports (336 respondents).

1.17 Far fewer people said it was easy or very easy (51 respondents) to find information about available supports.

1.18 Just over 1 in 10 people said they found it easy to find information about available supports (135 respondents).

1.19 Just 1 in 25 people said they found it very easy to find information about available supports (51 respondents).

Ease of understanding the information received

Figure C.2 Was the information you received easy to understand?

Source: Survey on support services for people with disabilities

Figure C.2 are responses to the question: Was the information you received easy to understand? 172 respondents said "very difficult"; 360 said "difficult"; 403 chose the "neutral" option; 195 said "'easy"; and 64 pick "very easy" as their answer.

1.20 Respondents were asked to rate how easy they found it to understand information they received about supports available to them. A rating of 1 indicated they found it very difficult to understand the information they received, while a rating of 5 indicated they found it very easy to understand the information they received.

1.21 Many respondents said that they found information difficult to understand or very difficult to understand (173 respondents). Close to half of survey respondents chose one of these ratings.

1.22 A third of people said it was difficult to understand the information they received (360 respondents).

1.23 Over 1 in 10 said that it was very difficult to understand the information they received (173 respondents).

1.24 Over a third people did not find it particularly easy or particularly difficult to understand the information they received (404 respondents). This was the most popular answer to this question.

1.25 Only about 1 in 5 people found the information easy to understand or very easy to understand (64 respondents).

1.26 Sixteen per cent of people found it easy to understand the information they received (195 respondents).

1.27 One in 20 found it very easy to understand the information they received (64 respondents).

Explanation of decisions and outcomes

Figure C.3 Were decisions and outcomes explained to you?

Source: Survey on support services for people with disabilities

Figure C.3 is a snapshot of the responses to the question: Were decisions and outcomes explained to you? 8% (101) respondents said “always”; 25% (222) said “often”; 453 (38%) responded with “sometimes”; 303 (25%) said "“rarely”; and 10% (115) survey participants picked “never.”

1.28 Respondents were asked to rate how frequently decisions and outcomes were explained to them. Respondents could choose never, rarely, sometimes, often or always.

1.29 About 1 in 10 people said that they never had decisions and outcomes explained to them (115 respondents).

1.30 About 1 in 4 people said that they rarely had decision and outcomes explained to them (304 respondents).

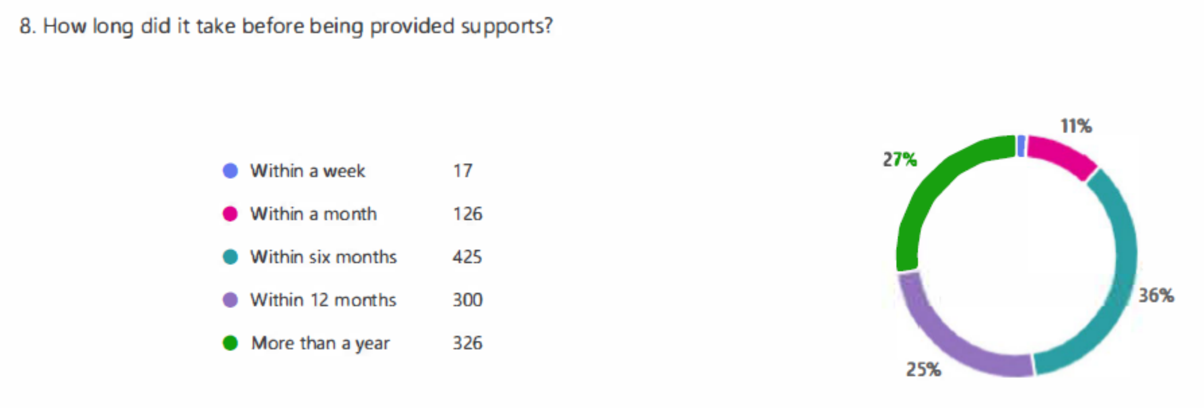
1.31 The most popular answer was that decisions and outcomes were sometimes explained (454 respondents). This represents two-fifths of people.

1.32 About 1 in 5 people said they often had decisions and outcomes explained to them (222 respondents).

1.33 Almost 1 in 10 people said they always had decisions and outcomes explained to them (101 respondents).

Timeliness of being provided supports

Figure C.4 How long did it take before being provided supports?



Source: Survey on support services for people with disabilities

Figure C.4 is a captures respondents' responses to the question: How long did it take before being provided supports? Only 17 survey participants said supports were provided "within a week"; 126 said "a month"; 425 respondents said "within six months"; 300 chose the "within 12 months option; 326 responded with "more than a year."

1.34 Respondents were asked how long it took until they were provided with supports. Respondents could choose within a week, within a month, within 6 months, within 12 months, or more than a year.

1.35 Very few people were provided supports within a week, about 1 in 100 (17 respondents).

1.36 About 1 in 10 people were provided supports within a month (127 respondents).

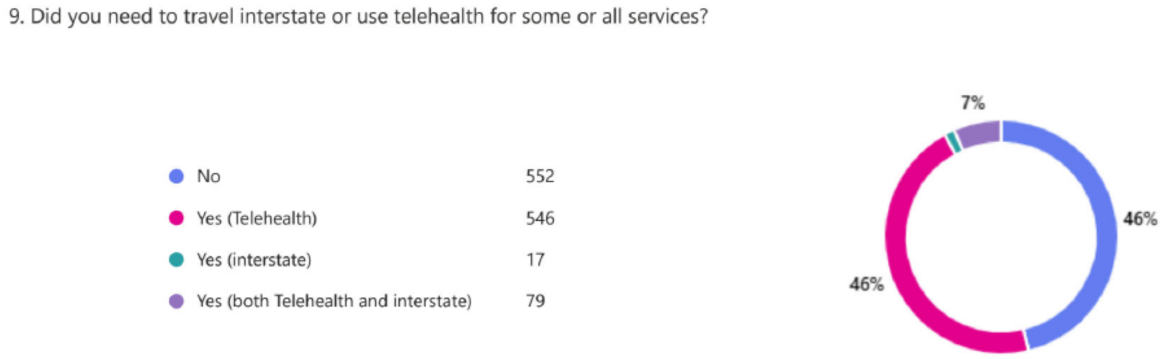
1.37 Over a third of people were provided supports within 6 months (425 respondents). This was the most popular answer to this question.

1.38 About a quarter of people were provided supports within 12 months (300 respondents).

1.39 Almost a third of people were provided supports after more than a year (327 respondents).

Travelling interstate or using telehealth for services

Figure C.5 Did you need to travel interstate or use telehealth for some or all services?



9. Did you need to travel interstate or use telehealth for some or all services?

● No	552
● Yes (Telehealth)	546
● Yes (interstate)	17
● Yes (both Telehealth and interstate)	79

Source: [Source]

Figure C.5 are responses to the question: Did you need to travel interstate or use telehealth for some or all services. 552 respondents said "no"; 546 said "yes- to having had to access telehealth"; 17 respondents said they had to travel interstate to access services; 79 participants said they had to use both telehealth and travel interstate to access some or all services.

1.40 Respondents were asked if they needed to travel interstate or use telehealth for some or all services. Respondents could answer that they did not need to use telehealth or travel interstate, that they did need to use telehealth (but not travel interstate), that they needed to travel interstate (but they did not need to use telehealth), or that they needed to use telehealth and also needed to travel interstate.

1.41 Almost half of people said they did not need to travel interstate or use telehealth (552 respondents).

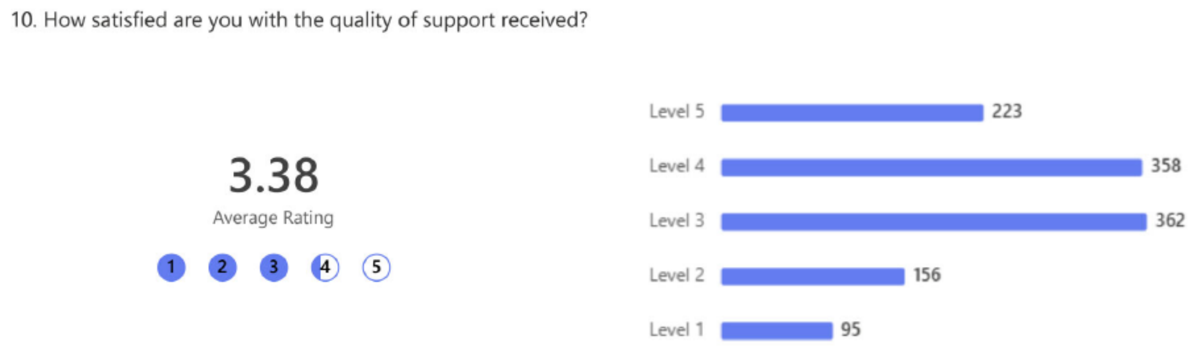
1.42 Almost half of people said they needed to use telehealth, but did not need to travel interstate (546 respondents).

1.43 Almost 1 in 10 people said they needed to travel interstate and also needed to use telehealth (81 respondents).

1.44 Only 1 in 100 people said they needed to travel interstate but did not need to use telehealth (17 respondents).

Satisfaction with quality of support

Figure C.6 How satisfied are you with the quality of support received?



10. How satisfied are you with the quality of support received?

Source: [Source]

Figure C.6 shows responses to the survey question: How satisfied are you with the quality of support received? A total of 95 respondents selected "not satisfied at all"; 156 respondents chose the "slightly satisfied option"; 362 survey participants were "moderately satisfied", while 358 expressed being "very satisfied"; 223 selected level 5 or the "extremely satisfied" option. The average satisfaction rating was 3.38.

1.45 Respondents were asked how satisfied they were with the quality of support they received. Respondents could answer on a scale from 1 to 5, where 1 is very dissatisfied with the quality of support they received, and 5 is very satisfied with the quality of support they received.

1.46 Almost half of people said that they were satisfied or very satisfied with the quality of support they received.

1.47 About a third of people said that they were satisfied with the quality of the support they received (358 respondents).

1.48 Almost 1 in 5 people said that they were very satisfied with the quality of the support they received (223 respondents).

1.49 A third of people said that they were neither satisfied or dissatisfied with the quality of the support they received (363 respondents).

1.50 About 1 in 10 people said that they were dissatisfied with the quality of the support they received (157 respondents).

1.51 About 1 in 10 people also said that they were very dissatisfied with the quality of the support they received (95 respondents).

Appropriateness of current supports to meet individual or family needs

Figure C.7 Figure C.7 How well do current supports meet the needs for you or your family?

Source: [Source]

Figure C.7 captures the responses to the question: How well do current supports meet the needs for you or your family? A total of 113 respondents selected level 1 i.e., “not at all well”; 252 selected “slightly well”; 319 chose the “moderately well” option; 289 said “very well”; and 221 selected extremely well.

1.52 Respondents were asked how well the current supports meet the needs of the person answering the survey and their family. Respondents could give a rating from 1 to 5, where 1 was not at all, and 5 was very well.

1.53 1 in 10 people said that current supports did not meet their needs at all (114 respondents).

1.54 1 in 5 people said that current supports mostly did not meet their needs (253 respondents).

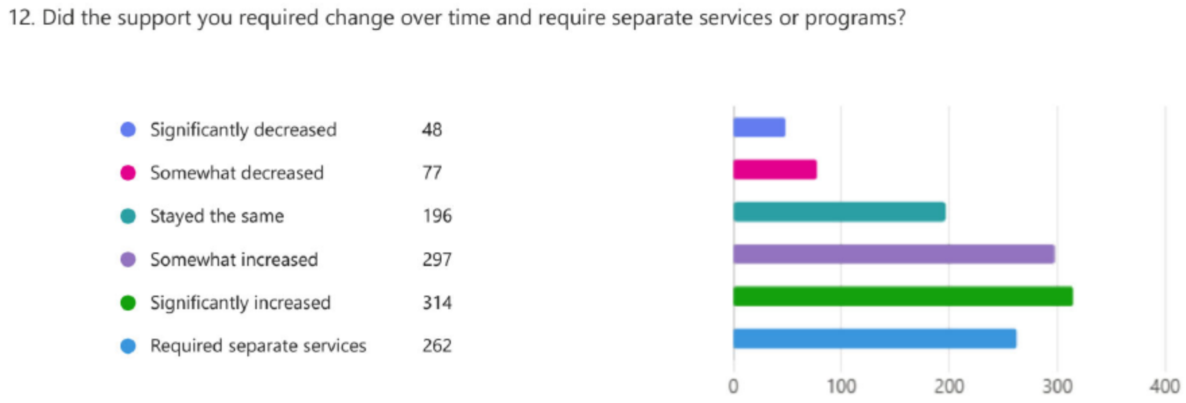
1.55 Almost a third of people said that current supports neither were nor were not meeting their needs (319 respondents).

1.56 Almost a quarter of people said that current supports were mostly meeting their needs (289 respondents).

1.57 Almost 1 in 5 people said that current supports were meeting their needs very well (221 respondents).

Change to required supports over time

Figure C.8 Did the support you required change over time and require separate services or programs?



Source: [Source]

Figure C .8 shows responses to the question: “Did the support you required change overtime and require separate services or programmes?” A total of 48 respondents said their support needs had “significantly decreased”; 77 said they had “somewhat decreased”; 196 reported that their support needs had “stayed the same.” Conversely 297 respondents said their support needs had “somewhat increased” and 314 said they had “significantly increased.” A further 262 respondents indicated that they had required separate services or programs overtime.

1.58 Respondents were asked if the support they required changed over time and required separate services or programs. Respondents could answer that their support significantly decreased, somewhat decreased, stayed the same, somewhat increased, significantly increased or required separate services.

1.59 Only a few people said that the support they required significantly decreased – just 1 in 25 (48 respondents).

1.60 Similarly, only 1 in 20 people said that the support they required decreased somewhat (77 respondents).

1.61 A minority of people, less than 1 in 5, said that their support needs stayed the same (196 respondents).

1.62 The majority of people, almost three quarters, said that their support needs increased or needed separate services.

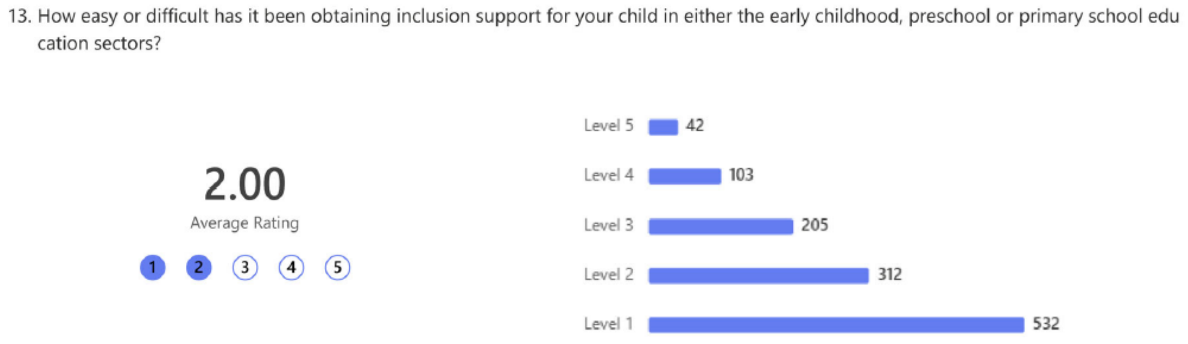
1.63 A quarter of people said their support needs increased somewhat (297 respondents).

1.64 Slightly more than a quarter of people said their support needs increased significantly (314 respondents).

1.65 Just over 1 in 5 people said that they required separate services (264 respondents).

Obtaining inclusion support in early childhood, preschool, or primary school sectors

Figure C.9 How easy or difficult has it been obtaining inclusion support for your child in either the early childhood, preschool or primary school education sectors?



13. How easy or difficult has it been obtaining inclusion support for your child in either the early childhood, preschool or primary school education sectors?

Source: [Source]

Figure C .9 shows responses to the question: “How easy or difficult has it been obtaining inclusion support for your child in either the early childhood, preschool or primary school education sectors?” 532 respondents selected “very difficult” as their preferred option; 312 selected “somewhat difficult”; 205 selected “neutral”; 103 selected “somewhat easy”, while 42 selected “very easy” as their response. The average rating was 2.00 indicating that most respondents found it difficult to obtain inclusion support within early childhood, preschool or primary education settings.

1.66 Respondents were asked how easy or difficult it has been for them to obtain inclusion support for their child in either the early childhood, preschool or primary school education sectors. Respondents could answer on a scale from 1 to 5, where 1 was very difficult and 5 was very easy.

1.67 Concerningly, almost half of people answered that it was very difficult to obtain inclusion support (534 respondents).

1.68 A further quarter of people said that it was difficult to obtain inclusion support (312 respondents).

1.69 About 1 in 5 people said that it was neither easy nor difficult to obtain inclusion support (205 respondents).

1.70 Less than 1 in 10 people said that it was easy to obtain inclusion support (103 respondents).

1.71 Very few people said that it was very easy to obtain inclusion support, just 1 in 25 (42 respondents).

Summary of themes

1.72 As noted above, the final question in the survey was a free text box where survey respondents were asked if there was anything else they would like to share about their experience about support services available to help children with disability including developmental delay and autism.

1.73 The following section explores the views of survey respondents who highlighted:

- the complexity of navigating the NDIS, the administrative burden placed on parents and carers, and the emotional toll of acting as case managers
- concerns about inadequate inclusion practices, insufficient staff training, and the risks associated with positioning schools as central hubs for intervention
- concerns that shifting services into schools will reduce choice and control, create service gaps, and rely on under-resourced systems
- the need for individualise supports and neuro-affirming, trauma-informed approaches
- disparities in access to disability support, particularly for families in regional areas, those with lower incomes, and culturally diverse communities
- profound impact of navigating the disability support system on families' mental health and financial stability
- calls for co-designed reforms, expanded supports, and continuity of care beyond early childhood
- concerns about allegations of misuse of NDIS funding.

NDIS as a Lifeline

1.74 A significant number of respondents emphasised that access to the NDIS has been crucial in securing support for children with autism. This includes services such as occupational and speech therapy, psychological sessions, and physiotherapy.

1.75 Families report that their children have made substantial developmental progress as a direct result of the support provided through the NDIS.

1.76 Respondents particularly value the current NDIS model for enabling choice and control over the services they engage. This flexibility allows parents and carers to select programs that best align with their children's individual circumstances. The ability to personalise support is seen as essential in meeting diverse and often complex needs.

1.77 Survey responses indicate that without the NDIS, many families would face significant financial hardship and debt. Parents and carers express concern that losing access to the Scheme would prevent them from providing necessary support, potentially leading to regression and increased demand for services later in life.

Systemic Barriers and Navigation Challenges

1.78 While survey respondents acknowledge the benefits of the NDIS, many report that accessing and navigating the Scheme is often extremely complex. This challenge is experienced broadly across the cohort, including individuals with high levels of education and professional expertise in relevant fields.

1.79 Some respondents note that it has taken them years to fully understand or even become aware of the available services. They emphasise that caring for a child with disability is highly demanding, leaving limited time for the research and administration required to effectively engage with the NDIS.

1.80 Families frequently take on the roles of case managers, service coordinators, and researchers, with respondents describing system navigation as equivalent to a full-time job. The survey reveals that this added pressure – combined with caregiving responsibilities – can result in significant distress and burnout.

1.81 Respondents report significant difficulties communicating with the NDIS, describing the information provided as confusing, incomplete, or poorly conveyed – particularly when program changes occur. Communication via phone and email is slow and challenging, creating additional barriers to accessing and effectively using services.

1.82 Inconsistency in decision-making is identified as a major issue. Parents report submitting applications for children with the same diagnosis, only to receive vastly different outcomes. This lack of transparency is a significant source of frustration and fatigue.

1.83 Such inconsistency is compounded by the absence of shared definitions for key terms such as ‘child’ and ‘disability’ across different services.

1.84 Families consistently report long wait times – ranging from six months to four years – for assessments and therapies, even in urgent cases. Given the importance of early intervention, these delays pose a serious barrier to effective support.

1.85 Uneven distribution of services remains a key concern, with some families reporting the need to travel for hours to reach a service provider. The situation is particularly challenging in rural and remote areas. While telehealth appointments are sometimes offered, respondents note that this format is often unsuitable for children with autism.

1.86 The Scheme’s inflexibility is also a concern. Families report that children, tweens and teens experience rapid developmental changes, yet the NDIS does not adequately respond to their evolving needs for care and support.

1.87 The review process for individual NDIS plans is frequently described as bureaucratic and burdensome. As a result, some families choose to retain their existing plans – even when they no longer meet their needs – rather than face the complexity and stress of initiating a review.

Education System Failures

1.88 Survey respondents consistently express concern about the proposal under the Thriving Kids initiative to position schools as the central hub for support and intervention programs.

1.89 Many highlight that schools are not adequately equipped to support children with autism. They lack the capacity to provide the individualised assistance these children require, and staff often struggle to identify and manage developmental delays that warrant intervention.

1.90 Inclusion practices within the education system are frequently described as inadequate. Teachers, often under-resourced and insufficiently trained, are placed in roles related to special education without the necessary support or expertise.

1.91 Respondents also note that knowledge of neurodivergent children among school staff tends to be limited. Where support is available, it is often outdated and not aligned with evidence-based best practices.

1.92 Children with autism may engage in masking at school – concealing their challenges to fit in socially. While these struggles often go unnoticed in the classroom, masking can lead to increased emotional strain, with symptoms surfacing more intensely at home. Parents of girls with autism in particular frequently report this behaviour, noting that their children’s difficulties are often entirely overlooked in the school setting.

1.93 For some children with autism, the school environment can be a source of trauma. Families report repeated experiences of bullying and discrimination, raising concerns that embedding support services within such settings may not yield positive outcomes.

1.94 Group therapy in school settings may not be suitable for all children, with some finding the environment overwhelming or stigmatising. Many respondents emphasised the benefits of home-based therapy, where children feel safer and more receptive, and families can observe and actively participate in the process.

1.95 Some children with disability are homeschooled and not part of the mainstream education system. It remains unclear how these families would access support if services were restricted to school-based settings.

1.96 While there are cases where school-based support would be beneficial, respondents note that schools are often resistant to integrating external therapists. As a result, parents and carers are required to schedule appointments during school hours, disrupting both education and work commitments.

1.97 While some families schedule therapy appointments outside of school hours, accommodating these sorts of arrangements can be challenging. Children may perceive these sessions as additional work, and the timing can be exhausting. As a result, they may struggle to engage meaningfully, which can limit the overall effectiveness of the support.

1.98 Respondents acknowledge that attending therapy in childcare or school settings may benefit some cohorts, offering a more natural environment than isolated external appointments. They note that scheduling therapy during school hours can ease the burden of managing appointments alongside school and work commitments. Families emphasise, however, that in-school support must involve a range of specialised professionals, rather than relying on generalist services.

Criticism of the Thriving Kids initiative

1.99 Survey respondents expressed several key concerns regarding the Thriving Kids initiative.

1.100 A central issue is the proposed shift of support services into the school setting, which respondents describe as under-resourced and lacking adequate expertise. Participation in school-based programs may also be stigmatising and, in some cases, a source of further trauma.

1.101 Respondents emphasise that the initiative reduces the choice and control currently afforded to families under the NDIS. It moves away from an individualised approach – widely recognised as the most effective – towards more generic, standardised models of support.

1.102 Families also express concern about the lack of clarity surrounding the new program and the transition process from the NDIS. They fear potential service gaps during this phase and highlight the unpredictability of the initiative as a major source of distress, particularly for children with autism who rely on consistency and routine.

1.103 Families recommend that announcements regarding changes to the NDIS and the Thriving Kids initiative be more effectively managed and clearly communicated. They emphasise the need for detailed information to help reduce anxiety within the affected community.

1.104 Respondents consistently stress that autism is a lifelong condition. Children with autism will grow into adults with autism, and families are uncertain about what support will be available once their children are no longer eligible for the Thriving Kids initiative. Any disruption in services poses a risk of regression.

1.105 Some respondents view the Thriving Kids initiative as regressive and primarily driven by cost-cutting measures. A key concern is the lack of meaningful consultation with families, communities, and autism specialists. Many argue that greater emphasis should have been placed on co-designing the program with those directly impacted.

1.106 Families also raise issues with the language used to describe and promote the initiative. Terms such as ‘mild’ or ‘moderate’ autism are criticised for oversimplifying the complexity and dynamic nature of neurodiversity.

1.107 Additionally, respondents highlight that communication around the program has, at times, implied that autism is a condition one may ‘grow out of’. This lack of sensitivity in language has been deeply distressing for many families, who emphasise that autism is a lifelong neurodevelopmental condition.

Importance of Early and Individualised Intervention

1.108 Survey respondents consistently highlight the critical importance of early identification and tailored intervention in effectively supporting neurodivergent children. These approaches are viewed as foundational to achieving positive long-term outcomes.

1.109 Families strongly reject one-size-fits-all models, describing them as not only ineffective but potentially harmful. Instead, they advocate for maintaining targeted, individualised support that is neuro-affirming and trauma-informed, aligning with best practice principles.

1.110 Many respondents describe early therapy as life-changing for their children, emphasising that such support should extend beyond the age of 7 or 8 to accommodate ongoing developmental needs.

Equity and Access Issues

1.111 Survey respondents repeatedly highlight the significant difficulties associated with accessing and navigating the NDIS, including long wait times and complex administrative processes, as outlined earlier.

1.112 These challenges are especially pronounced for families in regional areas and those with lower incomes, who face additional barriers due to service shortages, geographic isolation, and prohibitive costs.

1.113 Cultural and linguistic diversity further complicates access, with families from diverse backgrounds often encountering systemic obstacles and a lack of culturally responsive support.

1.114 Respondents also note that conditions such as ADHD and co-occurring diagnoses are frequently under-recognised and under-supported within the current framework, leaving many families without adequate assistance.

Emotional and Financial Toll

1.115 Families describe the diagnostic process as both lengthy and expensive, creating significant barriers to timely support.

1.116 To avoid extended waitlists, many families opt to pay privately for assessments required to access the NDIS. Some respondents report waiting years before resorting to out-of-pocket funding. During these delays, families must also self-fund therapies to ensure their children do not miss out on critical early intervention.

1.117 For families unable to afford private assessments and therapies, the consequences can be severe, with children at risk of experiencing greater developmental delays due to lack of timely support.

1.118 Respondents also highlight that Medicare rebates often fall short of covering the full cost of therapy, resulting in substantial out-of-pocket expenses. This creates significant equity barriers, with disadvantaged families at risk of being priced out of essential services.

1.119 The current system places a heavy burden on parents and carers, who are often responsible for sourcing, coordinating, and managing their children’s therapies. Many are forced to reduce their work hours to meet these demands, compounding financial stress.

1.120 Beyond the financial strain, families report a profound emotional toll from caring for children with a disability within the NDIS. The constant need to advocate for their children and secure appropriate support from the Scheme, is described as exhausting and traumatic, leading to burnout and declining mental health.

1.121 Families also report experiences of bullying and feeling dismissed by both the education and health systems. Many describe being forced to repeatedly justify their children’s needs, particularly when symptoms are perceived as mild, resulting in inadequate recognition and support.

1.122 Greater support should be provided to parents and carers of children with disability, as well as to siblings who often take on informal caregiving roles. All are significantly impacted and should receive targeted assistance to help manage their responsibilities effectively.

Policy and Advocacy Recommendations

1.123 A central recommendation from survey respondents is to preserve and strengthen the support provided through the NDIS, which is viewed as essential for families of children with autism and other neurodivergent conditions.

1.124 Families also call for better integration across the health, education, and disability sectors to enable holistic, multidisciplinary support. Stronger collaboration between teachers, psychologists, occupational therapists, speech pathologists, and paediatric physiotherapists is seen as critical to optimising children’s developmental outcomes.

1.125 Greater transparency and consistency in decision-making processes are urgently needed. Respondents express frustration with the lack of clarity and fairness in how decisions are made.

1.126 The plan reassessment process is frequently described as overly complex and discouraging. Families report that detailed assessments from qualified professionals are often disregarded, highlighting the need for improved recognition of professional evidence in reassessments.

1.127 Respondents advocate for NDIS decisions to be transparent, consistent, and clearly linked to the professional evidence provided. This would allow families and practitioners to work collaboratively and effectively to meet individual needs.

1.128 Families emphasise that autism is a lifelong condition and should be recognised and treated as such. Support must extend beyond childhood and adapt to changing needs over time.

1.129 Many respondents advocate for the inclusion of items such as sensory tools and specialised swimming lessons within NDIS-funded supports. They also call for better integration of mental health social workers, who play a vital role in recognising and addressing the psychological impacts of autism.

1.130 The survey reveals a clear need for co-design reforms involving neurodivergent individuals and their families. Respondents stress that lived experience should inform the development of policies and programs.

1.131 Finally, families recommend expanding Medicare coverage and foundational supports beyond the age of nine, ensuring continuity of care and access to essential services as children grow.

Concerns About Misuse and Fraud

1.132 Some respondents allege instances of potential misuse of NDIS funding, noting that funds may occasionally be directed toward leisure activities or household tasks rather than approved supports.

1.133 Concerns were raised about providers inflating appointment costs by exploiting NDIS pricing structures. For example, some families reported that providers adjusted their charges in other areas after travel-related pricing was reduced.

1.134 Some respondents called for stricter diagnostic protocols and more rigorous audits to ensure appropriate use of funding, although these views were not universal.

D. Comparable international programs and initiatives

1.1 The terms of reference for this inquiry directed the Committee to examine international policy frameworks and identify best practice models. Evidence presented to the Committee referenced jurisdictions such as Canada, New Zealand, Ireland, and the United Kingdom, which have established programs and services to support children with developmental delay or autism. These international approaches provide valuable insights that may inform the design and implementation of the Thriving Kids initiative and strengthen the broader support architecture within Australia.

1.2 These programs and initiatives typically incorporated several common elements, including:

- health check-ups and developmental screening
- early intervention for developmental delay and disability
- education for parents and caregivers, including training for supporting an individual child’s specific development and goals
- education for teachers and early childhood educators, including training for supporting an individual child’s specific development and goals
- maternal and children’s health programs
- transition to mainstream school
- integration of support into mainstream schools
- culturally sensitive programs
- support coordination services
- multi-disciplinary support teams
- payments and individualised funding.

1.3 The following tables below provide a brief overview of the programs and services provided by the governments of Canada, New Zealand, Ireland and the United Kingdom. This summary is intended to provide illustrative examples and does not constitute a comprehensive analysis of all available programs or services.

Canada

1.4 As noted in the table below, Canada offers a range of programs designed to support children with disabilities and their families, addressing both financial needs and developmental support. At the federal level, the Child Disability Benefit provides a tax-free monthly payment to families caring for a child under 18 with a severe and prolonged impairment in physical or mental functions. This benefit is available to families who qualify for the Canada Child Benefit and whose child is eligible for the Disability Tax Credit, helping to ease the financial burden associated with caring for a child with significant disabilities.

1.5 In addition to federal support, provinces and territories offer specialised programs tailored to local needs. For example, Ontario's Infant Child Development Program provides free, home-based early intervention for children from birth to school entry who have a developmental disability or are at risk of developmental delay—no medical diagnosis is required. The Ontario Autism Program offers a comprehensive suite of services for children and youth on the autism spectrum, including family mentoring, caregiver workshops, and targeted early years programs. Other provinces, such as Manitoba and Quebec, have their own initiatives like Children's disABILITY Services and the Agir tôt (Act Early) program, which focus on early identification, intervention, and support for children with developmental challenges. These programs are often free and voluntary, emphasising early screening, culturally sensitive support, and individualised services to help children reach their full potential.

Program name	Description
Child Disability Benefit[1]	Addresses developmental delay and takes the form of a tax-free monthly payment made to families who care for a child under the age of 18 with a severe and prolonged impairment in physical or mental functions. Available only if the parent qualifies for the Canada Child Benefit and the child qualifies for the Disability Tax Credit.
Maternal Child Health (MCH) program[2]	This program includes components related to developmental delays, case management; screening, assessment and referrals, and health promotion strategies to improve maternal and infant mental health issues. The First Nations and Inuit Health Branch funds the program, which is delivered by First Nations and Inuit communities. Communities determine what aspects of the program they will deliver based on needs and capacity.

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[1] Government of Canada, *Child Disability Benefit*, 16 June 2025, https://www.canada.ca/en/revenue-agency/services/child-family-benefits/child-disability-benefit.html (accessed 18 September 2025).

[2] Government of Canada, *Evaluation of the Healthy Child Development Program*, 23 July 2024, https://www.isc.gc.ca/eng/1720810446684/1720810497806 (accessed 19 September 2025).

Healthy Babies Healthy Children Program (Ontario)[3]	A free and voluntary preventative program that can help families learn about having a healthy pregnancy and birth and information on child growth and development.
Infant Child Development Program (Ontario)[4]	This is a free early child development program that serves children from birth to school entry who have a developmental disability and/or risk of developmental delay. It is primarily a home-based early intervention program delivered to children and their parents/caregivers with the aim of building skills through routines in their daily environment. No medical diagnosis is required for children to access the program.
Ontario Autism Program (Ontario)[5]	The program offers support to families of children and youth on the autism spectrum. To access the Ontario Autism Program (OAP), a child must be under the age of 18 and have a professional autism diagnosis. The OAP provides 'foundational family services' for free to all families registered in the program. These services aim to give families the tools to work with their children. Services include family and peer mentoring, caregiver workshops and coaching sessions, brief targeted consultations, transition supports, family resource and clinic days.[6] Most children in the OAP who are aged 12 to 48 months are eligible for the Caregiver-Mediated Early Years Programs. These programs, which are free through the OAP, teach parents and caregivers therapeutic strategies and specific techniques so they can support their child's skill development in areas such as social interaction, play, communication, emotional development. They are play-based and child-led.[7] Some children in the OAP are eligible for the entry to school program, which helps children develop school-readiness skills in preparation for starting kindergarten or Grade 1. This program is free through the OAP. This is a group-based program delivered by multi-disciplinary staff with expertise in ASD, applied behaviour analysis, speech-language pathology, occupational therapy and early childhood. The entry to school program staff also provides individual transition supports to each child as they enter school, including consultation services for their family and educators.[8]

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[3] Government of Ontario, Healthy Babies Healthy Children program, https://www.ontario.ca/page/healthy-babies-healthy-children-program

[4] Government of Ontario, *Infant Child Development Program*, 29 September 2025, https://www.ontario.ca/page/infant-child-development-program (accessed 29 September 2025); Aruma, *Submission 113*, p. 8.

[5] Government of Ontario, *Ontario Autism Program*, 21 July 2025, https://www.ontario.ca/page/ontario-autism-program (accessed 19 September 2025).

[6] Government of Ontario, *Ontario Autism Program: foundational family services*, 11 September 2025, https://www.ontario.ca/page/ontario-autism-program-foundational-family-services (accessed 29 September 2025).

[7] Government of Ontario, *Ontario Autism Program: caregiver-mediated early years programs*, 24 October 2024, https://www.ontario.ca/page/ontario-autism-program-caregiver-mediated-early-years-programs (accessed 29 September 2025).

[8] Government of Ontario, *Ontario Autism Program: entry to school program*, 2 May 2025, https://www.ontario.ca/page/ontario-autism-program-entry-school-program (accessed 29 September 2025).

	The OAP also provide urgent response services when children are experiencing high-risk factors which may cause harm to themselves, others or property.[9] Core clinical services such as applied behaviour analysis and occupational therapy are available depending on the assessment of the child's needs. Parents are given funding to pay for these services based on their child's needs.[10]
Children's disABILITY Services (Manitoba)[11]	Delivered by the Manitoba Department of Families program, this program supports families raising children with physical or developmental disabilities by helping to meet additional needs. Children under the age of 18 living in Manitoba are eligible if they have a medical diagnosis of intellectual disability, developmental delay, autism spectrum disorder, a lifelong physical disability with significant mobility limitations, or a high probability of developmental delay due to a pre-existing condition. Services provided include early intervention child development and autism services, programming to help school-age children maintain their skills during school holidays, respite care, therapy and others.
Agir tôt program (Act Early Program – Quebec)[12]	The Agir tôt program supports children from birth to age 5 and their families. The goal of the program is to identify early signs of developmental difficulties in children and ensure their quickly referred to appropriate services. Participation in the program is free and voluntary. Is available through all integrated health and social services centres an integrated University Health and social services centres across Quebec.
Aboriginal Infant Development Program (British Columbia)[13]	The Aboriginal Infant Development Program (AIDP) in British Columbia support families of children (birth to age 3) who are at risk of or diagnosed with developmental delay. Participation is voluntary and includes culturally sensitive home visits, play groups, family support, and parent-to-parent links.

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[9] Government of Ontario, *Ontario Autism program: urgent response services*, 30 March 2023, https://www.ontario.ca/page/ontario-autism-program-urgent-response-services (accessed 29 September 2025).

[10] Government of Ontario, *Ontario Autism Program: core clinical services*, 28 June 2024, https://www.ontario.ca/page/ontario-autism-program-core-clinical-services (accessed 29 September 2025).

[11] Government of Manitoba, *Children's disABILITY Services*, https://www.gov.mb.ca/fs/cds/services.html (accessed 19 September 2025).

[12] Government of Quebec, Agir Tot Program, https://www.quebec.ca/en/famille-et-soutien-aux-personnes/enfance/developpement-des-enfants/outils-ressources-developpement-enfants/the-agir-tot-program-early-screening-to-better-address-childrens-needs (accessed 23 October 2025).

[13] Aboriginal Infant Development Programs, *AIDP Programs*, https://www.aidp.bc.ca/aidp-programs (accessed 19 September 2025).

New Zealand

1.6 The table provides an overview of key programs and services available in New Zealand for children with disabilities and their families. New Zealand offers a comprehensive suite of programs and services to support children with disabilities and their families, focusing on early intervention, education, and holistic family support. The Well Child Tamariki Ora programme, provided by Health New Zealand, for example, delivers a series of free health visits for all families with children from around six weeks up to five years old. These visits are designed to monitor child development, provide health education, and connect families with additional resources as needed.

1.7 For children on the autism spectrum, New Zealand offers specialised programs such as the Incredible Years Autism program for parents and the Incredible Years Helping Children with Autism program for teachers and early childhood educators. These group-based, government-funded initiatives aim to build the capacity of caregivers and educators to support children's emotional regulation, social interactions, and language development. In addition, Disability Support Services, part of the Ministry of Social Development, provides a range of targeted supports, including Autism Parent Education, Autism Behavioural Support Services, and Autism Developmental Coordination support. These services offer courses, positive behaviour support, and a single point of contact for families to access therapy and allied health services, aimed at ensuring that children receive individualised and coordinated care. The Child Development Services (CDS) further facilitate access to occupational therapy, speech language therapy, and other allied health supports, helping children with disabilities reach their full potential.

Program name	Description
Well Child Tamariki Ora programme[14]	A series of health visits free to all families for children from around 6 weeks up to 5 years.
Incredible Years Autism program[15]	The Incredible Years Autism program is a free, government funded group-based program for parents of children aged 2–5 on the autism spectrum. The program builds the capacity of parents to support their children's emotional regulation, positive social interactions, language development and relationships with others.

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[14] Health New Zealand, *Well Child Tamariki Ora programme*, https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/specific-life-stage-health-information/child-health/well-child-tamariki-programme (accessed 25 September 2025).

[15] Te Kete Ipurangi, *The Incredible Years Autism (for caregivers)*, https://pb4l.tki.org.nz/Incredible-Years-Autism/The-Incredible-Years-Autism-for-caregivers (accessed 25 September 2025); Ministry of Education, *Supporting your child if they need extra help with their learning*, 5 September 2025, https://www.education.govt.nz/parents-and-caregivers/schools-year-0-13/learning-support/supporting-your-child-if-they-need-extra-help-their-learning (accessed 25 September 2025).

Incredible Years Helping Children with Autism program[16]	This group-based program for teachers and early childhood educators of children aged 2-5 on the autism spectrum builds their capacity to support children's emotional regulation, positive social interactions and language development.
The following are services available through Disability Support Services, which is a part of New Zealand's Ministry of Social Development.	
Autism Parent Education[17]	Provides a range of courses provided nationally for family and caregivers and delivered in person or remotely. The courses, such as Exploring Autism (ages 0 – 9) and Teen life help family and caregivers to understand their children's needs and how to support them. Each program is targeted to supporting children in different life stages. These courses can be accessed through self-referral, through a health professional, or through a government support coordinator (Needs Assessment and Service Coordination).
Autism Behavioural Support Services[18]	The service is based on a 'positive behaviour support' model, and is tailored to the needs of each person being supported.
Autism Developmental Coordination support[19]	The Developmental Coordinator provides a single point of contact for the child and family and supports them to access appropriate support and therapy services.
Child Development Services (CDS)[20]	This service facilitates support pathways, such as referral to Allied Health supports such as Occupational Therapy and Speech Language Therapy.

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[16] Te Kete Ipurangi, *The Incredible Years Helping Children with Autism (for kaiako)*, https://pb4l.tki.org.nz/Incredible-Years-Autism/The-Incredible-Years-Helping-Children-with-Autism-for-kaiako, accessed 29 September 2025).

[17] The Ministry of Social Development - Disability Support Services (New Zealand), *Autism support services,* 23 October 2024, https://www.disabilitysupport.govt.nz/disabled-people/support-and-services/specific-disability-services/autism-support-services (accessed 19 September 2025).

[18] The Ministry of Social Development - Disability Support Services (New Zealand), *Autism support services,* 23 October 2024, https://www.disabilitysupport.govt.nz/disabled-people/support-and-services/specific-disability-services/autism-support-services (accessed 19 September 2025).

[19] The Ministry of Social Development - Disability Support Services (New Zealand), *Autism support services,* 23 October 2024, https://www.disabilitysupport.govt.nz/disabled-people/support-and-services/specific-disability-services/autism-support-services (accessed 19 September 2025).

[20] The Ministry of Social Development - Disability Support Services (New Zealand), *Autism support services,* 23 October 2024, https://www.disabilitysupport.govt.nz/disabled-people/support-and-services/specific-disability-services/autism-support-services (accessed 19 September 2025).

Ireland

1.8 Ireland has established several programs and legislative supports aimed at addressing the needs of children with disability and their families, as summarised in the table below. Central to this is the Autism Innovation Strategy (2024), developed by the National Disability Authority. This strategy focuses on addressing the unique challenges faced by autistic individuals, promoting inclusion, and enhancing understanding across society and public services. It outlines specific actions to better support autistic children and their families, ensuring these efforts complement broader disability policies such as the forthcoming National Human Rights Strategy for Disabled People 2025–2030.

1.9 Children's Disability Network Teams (CDNTs) deliver multidisciplinary services—including therapy, parent training, and school participation support—for children up to age 18 with complex needs. Practical guidelines are designed to assist educators to create inclusive environments, and specialised clinics like Kidscope offer free developmental assessments for young children.

1.10 Legislation such as the *Education for Persons with Special Educational Needs Act 2004* and the *Education (Provision in Respect of Children with Special Educational Needs) Act 2022* ensures the right to inclusive, quality education and mandates reasonable accommodations in schools. The *Equal Status Act 2000* prohibits discrimination in educational services, further protecting the rights of children with disabilities. Ireland's National Human Rights Strategy for Disabled People 2025–2030 reinforces these commitments by focusing on reducing waiting lists and improving access to specialised supports

Program name	Description
Autism Innovation Strategy (2024)[21]	The Autism Innovation Strategy focuses on tackling the specific challenges faced by autistic people and enhancing understanding and inclusion across society and public services. It outlines government actions to better support autistic individuals and their families, complementing broader disability policies such as the National Human Rights Strategy for Disabled People 2025–2030, while addressing autism-specific needs.
Children's disability network teams (CDNTs)[22]	CDNTs provides services for children and young people up to the age of 18 with complex needs. Each team consists of members that specialise in different areas of child development. CDNT members may work with a child together or separately depending on the child's needs and the priorities agreed with the parent.

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[21] National Disability Authority, Ireland, *Autism Innovation Strategy 2024*, 2025, https://nda.ie/disability-policy/national-disability-strategies/autism/about-the-autism-innovation-strategy (accessed 23 October 2025).

[22] Health Service Executive, *Children's disability services*, 16 September 2022, https://www2.hse.ie/services/disability/childrens-services/services/overview/ (accessed 25 September 2025).

	CDNTs have occupational therapists, psychologists, physiotherapists, social workers, speech and language therapists. Some CDNTs also have access to dietitians, family support workers, nurses, social care workers. CDNTs can offer a range of services depending on the child's needs such as individual or group therapy, parent training such as information sessions and workshops, support for the child's full participation in pre-school and school, and advice on financial entitlements, housing and transport. Children with less complex needs do not access services through CDNTs.
Introductory Guidelines to Support the Meaningful Inclusion of Autistic Children in Early Learning and Care & School Age Children[23]	These guidelines provide practical guidance for operationalising Ireland's Access and Inclusion Model (AIM) and Autism Innovation Strategy (2024). The guidelines help educators implement neurodiversity-affirming practices through strategies for creating inclusive environments, supporting play, using respectful language, and managing transitions for autistic children.
Education for Persons with Special Educational Needs (EPSEN) Act 2004[24]	The EPSEN Act 2004 sets out how children with special educational needs (SEN) in Ireland should be supported. It states that, wherever possible, children with SEN should be educated in inclusive mainstream settings, unless this is not in the best interests of the child or other pupils. The Act guarantees equal rights to access and benefit from education, increases parents' involvement in decisions about their child's education, and formally established the National Council for Special Education. However, some parts of the Act have not yet been fully implemented.
Education Acts 1998 - 2022 [*Education (Provision in Respect of Children with Special Educational Needs) Act 2022*][25]	Primarily aims to ensure that all children, especially those with disabilities and special educational needs, can access their constitutional right to an appropriate and quality education. The legislation places a duty on schools to use State resources to make reasonable provisions and accommodations and outlines the funding and support services available for these students, including a provision for directing schools to establish special classes.

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[23] Department of Children, Equality, Disability, Integration and Youth, *Introductory Guidelines to Support the Meaningful Inclusion of Autistic Children in Early Learning and Care & School Age Childcare,* https://aim.gov.ie/app/uploads/2024/10/91746-Department-of-Children-Equality-Autism-Guidelines-Booklet-v5-online-1.pdf (accessed 23 October 2025).

[24] Irish Statue Book, *Education for Persons with Special Educational Needs Act 2004*, 19 July 2004, https://www.irishstatutebook.ie/eli/2004/act/30/enacted/en/html, (accessed 23 October 2025).

[25] Houses of the Oireachtas, *Education (Provision in Respect of Children with Special Educational Needs) Act 2022,* https://data.oireachtas.ie/ie/oireachtas/act/2022/22/eng/enacted/a2222.pdf, November 2022 (accessed 23 October 2023)

Equal Status Act 2000[26]	Prohibits direct and indirect discrimination across various areas of life, including educational services such as private schools, on grounds including disability, race, gender, and religion. Under the Act, schools are required to make reasonable accommodations for students with disabilities, provided the cost is nominal or it does not severely impact services for other students
Kidscope Paediatric Clinic[27]	Serving children aged 0- 6 years in Cork city northwest, Kidscope is a free, consultant-led community paediatric clinic dedicated to holistic health and developmental assessment. By leveraging the expertise of various local services and practitioners, Kidscope seeks to ensure every child receives high-quality care and appropriate onward referrals.
National Human Rights Strategy for Disabled People 2025-2030[28]	The newly released strategy brings "*a necessary focus to the areas of specialised disability supports that must enhance and improve – reducing waiting lists to ensure that children and families can access the right care at the right time, for example*".

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[26] Citizens Information, *The Law on Special Education Needs*, 25 June 2024, https://www.citizensinformation.ie/en/education/special-education-needs/the-law-on-special-educational-needs/ (accessed 23 October 2025).

[27] Department of Children, Equality, Disability, Integration and Youth- Infant & Childhood Partnership CLG, *Kidscope Paediatric Clinic*, https://letsgrowtogether.ie/programmes-services/kidscope-paediatric-clinic/ (accessed 23 October 2025).

[28] Government of Ireland, *National Human Rights Strategy for Disabled People 2025- 2030*, September 2025, https://thenationalplatform.ie/wp-content/uploads/2025/09/National_Human_Rights_Strategy_for_Disabled_People_2025-2030_English_Final.pdf (accessed 24 October 2025).

United Kingdom

1.11 Across the United Kingdom, a mix of national and regionally administered programs are provided to support children with developmental delay, disability or autism.

1.12 In England, Special Educational Needs (SEN) support and Education, Health and Care (EHC) plans form the core mechanisms for informing, delivering and addressing children's developmental and educational needs through schools and local authorities. These frameworks enable tailored assistance, including access to specialist bases that focus on communication, learning or sensory needs. Families may also access financial support through the disability living allowance for children. Earlier initiatives, such as the Sure Start program, established the foundation for integrated early years engagement, while current programs like the Healthy Child Programme continue to embed parent participation within universal health checks. Elements of Sure Start were frequently cited by submitters as potentially instructive for strengthening early-childhood and developmental support frameworks in Australia.

1.13 In Scotland, the Autism Toolbox program provides educators with practical resources to support inclusion and classroom adaptation.

1.14 The programs listed in the table below demonstrate how the United Kingdom combines several entitlements with regionally delivered initiatives across health, education and social care systems.

Program name	Description
Special education needs support (SEN support) and Education Health and Care plans (EHC plans)[29]	Children can get special educational needs support (SEN support) through their school or university. This can include support such as a special learning program, extra help from a teacher or assistant, help communicating with other children, and support with physical or personal care difficulties.[30] For primary and secondary schooling, some mainstream schools have a specialist base or unit on site. These are generally accessed by children with Education Health and Care plans, who have more complex

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[29] Department for Education (GOV.UK), *Children with special educational needs and disabilities (SEND): Overview*, https://www.gov.uk/children-with-special-educational-needs (accessed 19 September 2025)

[30] Department for Education (GOV.UK), *Children with special educational needs and disabilities (SEND): Overview*, https://www.gov.uk/children-with-special-educational-needs (accessed 19 September 2025).

	needs. Schools receive funding to provide the support the child is entitled to according to their EHC plan.[31] Each specialist base tends to focus on a specific need such as speech, language and communication needs, moderate learning disabilities, deafness/hearing impairment or autism.[32] The proportion of time a student spends in mainstream classes compared to in the specialist unit depends on the needs of the student and the program they are in.[33] Other children with EHC plans may attend non-mainstream schools. Some local authorities offer specialised autism provision, such as Mainstream Autism Bases and Enhanced Mainstream Autism Bases. These bases allow students to get support at the base and access mainstream lessons according to their needs.[34]
Disability living allowance[35]	Disability Living Allowance (DLA) for children helps with the extra costs of looking after an eligible child who is under 16 and has difficulties walking or needs much more looking after than a child of the same age who does not have a disability.
Sure Start (launched, 1999 – largely phased out between 2010 - 2022)	Sure Start is an early intervention program for children under four and their families in the United Kingdom, which was announced in July 1998 and introduced in April 1999. There are separate programs for Wales, Scotland and Northern Ireland. There are a number of core services which all local programs are expected to provide, such as visits to all new parents within two months of a child's birth, and access to good quality

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[31] SCOPE, *If school is not following an EHCP*, 23 July 2025, https://www.scope.org.uk/advice-and-support/school-not-following-ehcp (accessed 25 September 2025).

[32] Hammersmith and Fulham Council, School admissions and SEND, https://www.lbhf.gov.uk/children-and-young-people/family-hub/education-and-learning/applying-schools/school-admissions-and-send/additionally-resourced-provision-sen-units-and-special-schools (accessed 25 September 2025); Leicestershire County Council, *An introduction to Enhanced Resource Bases*, https://www.leicestershire.gov.uk/sites/default/files/2023-08/Introduction-to-enhanced-resource-bases.pdf (accessed 29 September 2025).

[33] Hertfordshire County Council, Specialist Resource Provision for Pupils with Speech, Language and Communication needs and Autism, https://www.hertfordshire.gov.uk/microsites/local-offer/education-support/education-options/specialist-resource-provision-for-pupils-with-speech-language-and-communication-needs-and-autism.aspx (accessed 25 September 2025), Department of Education (UK), *Area guidelines for SEND and alternative provision*, December 2015, https://assets.publishing.service.gov.uk/media/5f23ec4e8fa8f57ac968fb11/BB104.pdf (accessed 25 September 2025), p. 11.

[34] Worcestershire County Council, *Specialist Education provision in Worcestershire*, March 2023, https://www.worcestershire.gov.uk/sites/default/files/2024-09/specialist_ed_provision_in_worcs.pdf (accessed 25 September 2025).

[35] National Autistic Society (UK), *Benefits for autistic children, 14 December 2020,* https://www.autism.org.uk/advice-and-guidance/Topics/benefits-and-money/benefits/benefits-you-can-get/benefits-for-autistic-children (accessed 19 September 2025).

	play and early learning opportunities; but there is also an emphasis on developing projects that respond to locally identified needs, in recognition that "one size doesn't fit all".[36]
Healthy Child Programme[37]	"*Builds parent engagement into universal health reviews, ensuring families leave each check-up with information on what to look for and where to seek help."*[38]
The Autism Toolbox - Scotland[39]	A flexible resource designed to help practitioners deepen their understanding of autism and develop practical strategies to support children and young people on autism spectrum. Contents of the toolkit include practical frameworks for practitioners on issues such as helping pupils with managing sensory issues, transitions, etc.

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[36] Australian Institute of Family Studies, The UK Sure Start program, https://aifs.gov.au/sites/default/files/js_1.pdf

[37] UK Government, *Healthy Child Programme,* 27 June 2023, https://www.gov.uk/government/collections/healthy-child-programme (accessed 23 October 2025).

[38] ADHD Australia, *Submission 221*, p.5.

[39] Education Scotland, *The Autism Toolbox,* August 2023, https://education.gov.scot/resources/neurodiversity/the-autism-toolbox/; Australian College of Nurse Practitioners, *Submission 30*, p. 9

Additional Comments by Deputy Chair of the Committee

One in six Australians live with disability; 4.4 million people. For many, the National Disability Insurance scheme has been life-changing - it has provided supports essential to living an included life in our society. However, the recent 10-year anniversary of the Scheme coincided with uncertainty and concern about its future.

The fundamental principles of Medicare, our universal healthcare insurance scheme, are equity, efficiency, simplicity and fairness. The NDIS has never achieved those lofty ideals – it's the problem child in our social welfare system.

Many issues with the NDIS relate to its structure. It was established as an insurance scheme; it was expected that early intervention would decrease the cost of the future care of Australians with permanent and significant deficits. Those individuals were to be provided with personalised individual support packages; it was anticipated that fewer than 500 0000 would be required. The plan was that the remaining 3.9 million Australians with disability would continue to receive mainstream (generally state-based) services.

This has not played out. Almost from inception the NDIS has been the main service provider for most children and adults, as other disability supports and programs – particularly those funded by state and territory governments – have been defunded or removed. Loss of community-based block-funded services has left a void for those with milder developmental delay and physical deficits. This has caused significant inequity; those on the scheme receive much more support than non-participants.

In the absence of alternatives, all needing disability support have had to fight for NDIS packages. That's led to a situation where 11 per cent of Australian five- to seven-year-old boys, and 5 per cent of five- to seven-year-old girls, are NDIS participants. This is unsustainable. More than 750,000 NDIS participants have an average plan size of $82,500. It's a huge investment from a generous nation, but we've still managed to leave many with no plan and no access to the support they need.

The NDIS was established as a market-based system; it was assumed that supply would be generated in response to increased demand for providers. But you can't conjure up experienced therapists overnight. There are persisting shortages of psychologists, speech pathologists, and other allied health disciplines. Many participants simply can't find the help they need.

Federal and state governments have not adequately monitored disability services to ensure that there's back-up in regional or rural settings and that the services billed are actually provided.

And the Scheme is challenging for providers. The policy and compliance framework can be challenging, worker screening slow, and cashflow an issue. Not-for-profits caring for high-needs and complex participants struggle to compete for staff and to provide their services competitively.

Plan utilisation is higher for those in metropolitan than regional settings. Many participants have, in the course of this inquiry, described confounding inconsistencies in the size of support packages provided to people with the same level of need. The quality of advocacy by planners and parents has mattered, disadvantaging those with less familiarity with bureaucracy and those from culturally and linguistically diverse backgrounds. Lower levels of plan utilisation among Indigenous people reflect thin markets for providers in rural and regional settings, but also difficulties with case management for those dealing not only with disability, but also with other social challenges such as homelessness and poverty.

Cost has been a perennial concern. The NDIS is a demand-driven scheme with no limits on spending. Fraud is an issue, as with all government systems, but the extent and prevalence of system abuse is unclear. The NDIS is projected to cost more than $100 billion/year by 2032 – more than Medicare, or even defence. That figure, however, ignores the original assumption of the scheme: that it would generate revenue and productivity by facilitating employment and engagement of people with disabilities, and by freeing up carers to return to the workforce. The multiplier effect of the NDIS is significant – every dollar spent generates an economic contribution of $2.25. It’s an investment in Australians’ futures.

As a paediatric neurologist, I found the NDIS opaque, frustrating and cumbersome. As a Member of Parliament, I hear often from constituents of their anger and distress with the system. Things have to change.

I’ve long felt that, rather than the individual supports provided by the NDIS, we should create a dual system, with defined packages for those with more significant needs, and community-based programs for infants and young children with developmental delay, autism and neurodivergence. Services which increase community and mainstream supports for people without severe disability, and which provide group therapy for all able to benefit from them, will not only result in better use of resources but might also promote inclusion. This model should be more cost-effective and create increased capacity.

The Thriving Kids initiative is a means to that end. It marks a commitment from the federal government to a new system of evidence-based early intervention services, providing equity of access for all young Australian children with emerging developmental delay and disability.

Thriving Kids was announced less than four months ago; it needs the social licence which will be won only from its demonstrated effectiveness. There has been much anxiety within the disability community about these changes. For Thriving Kids to work it has to obtain the social licence which will be won only from its demonstrated effectiveness. For that reason, it’s really important that it be rolled out only when the state and territory government are ready and the necessary systems and staff in place.

There’s much to do, and this short inquiry has not addressed all of the issues and questions around Thriving Kids; but some things have been clear.

We must address the issue of who should receive foundational supports and when. We must determine how much therapy is enough for children with emerging developmental delays. We must make it easier for parents to navigate a system which has often proven hostile and defensive. We must collect better data about participants’ experiences and outcomes and the quality, safety and effectiveness of their treatment. We have to determine where these services should be provided; in the home, childcare centre, kindergarten, school, or clinic. Children should always receive therapies in a place where they feel comfortable and safe, and it's best that their carers participate in those interventions where possible, but the challenges of home visits and services provided in school settings are significant.

In designing the Thriving Kids initiative, we must use inclusive codesign processes in collaboration with peak bodies and parents experienced in the care of children with disabilities. We have to actively include individuals representing First Nations, and culturally and linguistically diverse backgrounds. The Thriving Kids program should be subjected to regular review, and should have an independent Inspector General. It has to be adequately staffed and funded from the start, to enable both its effective administration and the integrity and effectiveness of data management for the scheme.

The vast majority of providers in the NDIS are not registered providers: this must change, but we also have to improve the registration process to make it less burdensome and more streamlined. We must improve access to online health services, particularly for regional, rural, and remote services.

We need more providers able to support children with emerging developmental delay. There is a significant gap in our health care workforce strategy. We have no channel or mechanism for identifying current or future workforce deficiencies, for setting policy direction and priorities around these, for coordinating actions required across the jurisdictional health systems at a national level and within the National Registration and Accreditation Scheme (NRAS), or for reporting on delivery of agreed priorities.

The NRAS registers 16 health professions in Australia; each of these also has a national board overseeing professional registration, standards, codes, and guidelines. An independent national health workforce planning agency and reduction in registration red tape would help shape a more targeted workforce, identify future demand, and streamline registration processes for healthcare and disability providers.

We’re also failing to capitalize on investment in education by excluding students from the professional workforce due to barriers to practice placements. Prac placements can be very burdensome for students via both direct and indirect costs. The burden falls inequitably on those with caring responsibilities and rural students. The government should extend financial support for practice placements to students from all health care disciplines based on the existing workforce shortages. It’s a false economy to have young people deferring their studies, or going part-time to cover their living costs, at a time when we’re desperate for their skills.

It's been a privilege to work on this inquiry with Dr Mike Freelander, the chair of the health committee, throughout this inquiry. Mike is the kindest of men, who brings decades of experience as a general paediatrician to his leadership of a parliamentary committee aiming to improve the health of all Australians. He led a group of parliamentarians who put aside their political differences to work together constructively and hard on an issue of interest and importance to all our electorates. The committee secretariat also worked incredibly hard over a very intense period, to bring together a report which summarises very well the generous and considered contributions of the almost 500 groups and individuals who made submissions or appeared at public hearings.

The Thriving Kids program need us to resile from the premise that disabled people must self-manage their care, and that all should receive support individually. Some things are better done together - for efficiency, economy and enjoyment. Success of the model demands that, as a society, we accept our responsibility to include and support all children, create a system responsive to their varying capacities and needs, and commit to creating and supporting the workforce and infrastructure required to maximise their independence and inclusion.

Dr Monique Ryan MP
Deputy Chair

Additional Comments by Coalition Members of the Committee

Coalition members support the intent of strengthening early support for children with developmental delay, autism and disability, and we note the Committee’s recommendations are broadly sensible and constructive. We also recognise the importance of reform that protects the long-term sustainability of the National Disability Insurance Scheme (NDIS) while ensuring children and families receive timely, appropriate support.

However, Coalition members are concerned that the Thriving Kids initiative has been announced with insufficient detail in the public domain. Families, clinicians, service providers, educators and state systems still lack clarity on fundamental design and delivery questions, including eligibility, referral pathways, assessment settings, scope of supports, workforce requirements, service standards, safeguards, complaints and review mechanisms, and how outcomes will be measured.

Coalition members further note that the Government has not adequately explained how Thriving Kids will co-exist with, complement, and interface with the NDIS. It remains unclear how children will be supported to transition between foundational supports and the NDIS where necessary, and how the Government will ensure that children do not fall between the cracks during the implementation period.

Coalition members remain concerned that, without a clear implementation plan, the initiative risks replicating existing system failures, such as inconsistent decision-making, poor communication, long wait times for assessment and therapy, and inequitable access for families in rural, regional and remote Australia. Workforce shortages across the care and allied health sectors remain a major barrier to equity of access and must be addressed as a matter of urgency if Thriving Kids is to succeed.

Coalition members acknowledge the Government’s stated commitment to NDIS reform. But it is time for the Government to move beyond announcements and provide real, practical detail, guided by strong clinical advice and a clear commitment to long-term budget sustainability, so the Scheme and the broader ecosystem of supports remain fit for purpose for generations to come.

The Coalition will work constructively on sensible NDIS reforms, including working towards putting the NDIS on a sustainable growth trajectory, to secure its future. This stands in contrast to Labor’s previous record in opposition of politicising NDIS reform for short-term political gain. At the same time, Coalition members will continue to hold the Government to account to ensure Australians living with disability receive the services they need, and that no child is worse off as a result of these changes.

Additional Recommendation

The Minister for the NDIS, Mark Butler, has stated the cost of the scheme will be shared 50/50 with the States and Territories however to date there has been little inclination the jurisdictions will support this proposed funding arrangement. This calls into question the operation and commencement dates that have been outlined. In order for the details of the scheme to be progressed a funding agreement needs to be finalised.

Coalition members recommend that the Australian Government finalise, as a matter of urgency, an agreement with State and Territory governments on the design, funding, roles and responsibilities, and implementation timeline for the Thriving Kids initiative (including foundational supports), to provide certainty to families and service providers and to ensure consistent access and safeguards nationwide.

Mr Cameron Caldwell MP

Mr Sam Birrell MP