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12/09/2025

Committee Secretary
House of Representatives Standing Committee on Health, Aged Care and Disability
Parliament House
Canberra ACT 2600

Subject: Submission to the Thriving Kids Inquiry

Dear Committee Secretary,

Please find attached my written submission to the *Thriving Kids Inquiry*.

This submission is prepared solely for the purposes of the Inquiry. It draws on my personal experience as a parent of a child with mild to moderate support needs, as well as my professional expertise as an educator and academic specialising in inclusive education across early childhood through to adult settings.

I am happy for my submission to be published in full on the Inquiry's website though that my name and location be withheld from publication.

Thank you for the opportunity to contribute to this important work.

Yours sincerely,

[redacted]

Submission to the House Standing Committee on Health, Aged Care and Disability: Thriving Kids Inquiry

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Executive Summary

This submission is written from the perspective of both a parent of a child with mild to moderate support needs and a professional in inclusive education. My son was born in 2021 and is four years old at the time of this submission.

Overarching message: Thriving Kids must avoid replicating the failures of the NDIS early childhood pathway. Current systems rely on deficit-based models, rigid funding rules, and unpaid parental advocacy or expertise. These harm children, exhaust families, and waste public resources.

Key findings:

- **Deficit-based models harm children.** Compliance-heavy programs such as ABA are linked to trauma and poor long-term outcomes (Kupferstein, 2018; Royal Commission, 2023).
- **Parents carry unsustainable loads.** Families are pressured to coordinate services, cover essential costs privately, and reduce paid work.

- **Siblings and carers are disadvantaged.** Economic studies show lifelong impacts for carers and clear return on investment for sibling support (Carers Australia, 2022; Siblings Australia, 2024).
- **Funding models are incoherent.** Diagnostic assessments are excluded, consumables underfunded, and service access rules contradictory.
- **Better models exist.** Pregnancy care, the NDSS, and past respite programs show anticipatory, flexible, values-based care can be delivered nationally.
- **Teachers are leaving.** Demonstrations of challenging behaviour drive attrition and reduce teacher confidence (AITSL, 2022).
- **Policy obligations are clear.** The NDIS Act 2013, Disability Standards for Education 2005, CRPD, and Disability Royal Commission findings set a rights-based framework. Thriving Kids must not dilute these protections.

Recommendations (condensed):

1. Replace deficit language such as *developmental delay* with *developmental divergence*.
2. Make funding flexible and coherent — include diagnostic assessments and realistic consumables allocations.
3. Embed supports for siblings and carers.
4. Reinstate flexible, subsidised respite.
5. Invest in autistic-led, trauma-aware, neuro-affirming training across sectors.
6. Align with the NDIS Act, Disability Standards, CRPD, and Royal Commission findings.
7. Fund culturally safe, community-controlled programs.
8. Design transitions that adapt to children, not the reverse.

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1. Personal and Professional Knowledge

I am both the parent of a neurodivergent child with "mild to moderate support needs", recorded for the purposes of NDIS as "Developmental Delay"; and a professional academic with a Masters degree in inclusive education and decades of public school-based teaching experience. I now train graduate and postgraduate educators from early childhood through to secondary contexts in my region's largest Initial Teacher Education program, in my university's Education Faculty.

This dual perspective provides a unique vantage point: I have navigated the contradictions of current systems as a parent and witnessed their consequences for teachers, families, and children as an educator.

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2. Evidence-Based Resources for Parents

At age three, my child attended an early learning centre under the expanded three-year-old preschool program. Despite daily contact with qualified early childhood educators, no concerns were raised. It was I, as a parent with expertise in developmental diversity, who initiated assessment.

This reflects **masking**, where autistic children suppress or conceal differences. At school, my child masked successfully, but at home the mask fell away, leaving him exhausted and dysregulated.

By the time he commenced at a local government preschool, I was supplying teachers with support materials I created myself. These drew on my professional expertise and intimate knowledge of his neurological, sensory, behavioural, and developmental profile. Most parents cannot do this, yet the system implicitly requires it.

Evidence: Masking delays diagnosis and increases stress (Hull et al., 2019). Australian parents report confusion and burden in diagnostic pathways (Raynes-Greenow et al., 2022).

Recommendation: Develop resources co-designed with autistic adults and families, framed around divergence not deficit, and train educators to recognise high-masking presentations.

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3. Effectiveness of Current and Previous Programs

In early childhood programs, approaches to inclusion focused on compliance, and conformity with routines. This created meltdowns, and contributed to family strain. When sensory needs and neurodivergence were suggested, advocated for, and respected, my child thrived.

Evidence: Compliance-based programs such as ABA are linked to trauma (Kupferstein, 2018). A systematic review of interventions in Australia found little evidence of benefit, calling instead for pedagogical reform (Graham & Tancredi, 2019). The Disability Royal Commission (2023) concluded **normalisation approaches cause lifelong harm**.

Economic impact: Programs that fail to deliver inclusion increase family costs, raise teacher attrition, and waste public funds.

Recommendation: Fund neuro-affirming, play-based, family-centred supports.

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4. Equity and Intersectional Issues

First Nations and CALD families often find mainstream supports culturally unsafe. They experience systemic racism and reduced access to diagnosis and services (Bennett et al., 2011; Priest et al., 2012).

Recommendation: Fund culturally safe, community-controlled supports.

5. Workforce Support and Training

As one of the few cross-sector experts in my region, I train educators working across all school-aged settings. Many report their anticipation of meeting the needs of diverse children as causing levels of distress, or that the idea of the scope of challenges presented by unsupported children is overwhelming, and they feel unsupported and underprepared.

Evidence: Teacher attrition and declining confidence are linked to workload and complexity (AITSL, 2022; Australian Government, 2023). Unsupported demonstrations of challenging behaviour intensify this burden.

Recommendation: Embed autistic-led, trauma-aware, monotropism-informed training across teacher education, allied health, and child health.

6. Domestic and Policy Experience

Better models already exist, even in my own limited experience:

- **Pregnancy/GDM care**: When I developed gestational diabetes, I was supported by an endocrinologist and the NDSS. Consumables were subsidised, and care was anticipatory and flexible.
- **NDSS**: Demonstrates national provision of subsidised consumables and flexible, multi-disciplinary, specialist support.
- **Respite services**: Twenty years ago, I worked as a respite care worker, supporting children in ordinary activities and giving families needed breaks. Respite reduced stress and improved wellbeing.

Evidence: UNSW studies confirm respite improves family quality of life and is cost-effective (Dow et al., 2020).

Recommendation: Model Thriving Kids on anticipatory, flexible care. Reinstate subsidised respite.

7. Mechanisms for Seamless Transitions

My child has had to restart with every new provider, as context was lost. This destabilises families and wastes resources.

Evidence: Research shows poor coordination increases trauma and burdens families (Gibbs et al., 2021).

Recommendation: Fund personalised planning, relational continuity, and cross-sector collaboration.

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8. Inconsistencies and Systemic Barriers

NDIS planning reveals contradictions:

- **Contradictory access**: Families told to reduce one service to access another, such as accessing School Readiness Programs during existing school terms.
- **Consumables allocation**: My child’s plan provides $300 annually. Overnight continence aids alone cost $405 per year. Add to this the “disability tax”: $50 for sensory-based literacy aides, $30 for safe and robust chewelery, $60+ for games. Food variation adds hundreds to weekly bills.
- **Diagnostic exclusion**: Autism assessments excluded, forcing families to wait under Medicare and lose opportunities for early support.
- **Silencing parent expertise**: Plans directed me to seek advice from professionals in roles I train myself, while dismissing my voice.
- **Siblings and carers**: My older child is disadvantaged by reduced opportunity. Carers lose long-term income (Carers Australia, 2022). Sibling support offers 28:1 return on investment (Siblings Australia, 2024).

Scaling example: If even 50,000 families each absorb $2,000 annually in unfunded costs, this equates to $100 million in hidden household burden.

Recommendation: Make funding coherent and flexible, cover diagnostics and consumables, and embed sibling/carer support.

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9. Parent Advocacy Burden and Family Impact

My child’s inclusion has depended almost entirely on my advocacy. I can do this because of my professional expertise and flexible work. Most families cannot.

Case vignette: A week in our family

We are a family of four in suburban Canberra. Both parents work full time in education — one in a local high school, the other in higher education. Both children attend school or early education full time.

- One parent manages 9am drop-offs and 3pm pick-ups. Outside school hours care is inaccessible.
- Lunch boxes often return uneaten due to sensory overload. Appointments are scheduled after hours when possible, but therapy access usually disrupts routines.
- At home, my child requires constant co-regulation. Outbursts frequently injure family members. He is at risk of harm due to low danger awareness and pain threshold, leading to emergency department visits.

- Separate meals must be prepared to meet sensory and nutritional needs. Shower time includes injury checks and communication support.
- Bedtime requires one-to-one co-regulation. Nights are broken by distress or night terrors.
- Parents alternate supervision and complete household tasks late at night.
- During work breaks, parents coordinate therapy providers, negotiate appointments, and design materials such as visual schedules and social stories. This unpaid labour consumes hours each week.

This is not extraordinary. It is the daily reality of raising a child with support needs, even in a family with privilege. For families without this privilege, the inequity is starker.

Recommendation: Reduce reliance on unpaid parental advocacy. Systemic inclusion must be the baseline.

10. Policy Obligations

The NDIS Act 2013, Disability Standards for Education 2005, and CRPD Article 24 enshrine rights to inclusion. The Disability Royal Commission (2023) found deficit models harmful.

Recommendation: Thriving Kids must strengthen, not dilute, these obligations.

11. Condensed Recommendations

1. Replace deficit language with *developmental divergence*.
2. Fund consumables and diagnostic assessments at realistic levels.
3. Reduce reliance on parental advocacy.
4. Embed sibling and carer supports.
5. Reinstate subsidised respite and family support.
6. Invest in autistic-led, trauma-aware training.
7. Fund culturally safe, community-controlled programs.
8. Align with NDIS Act, Disability Standards, CRPD, and Royal Commission findings.
9. Design transitions that adapt to children.