Submission to Inquiry into the Thriving Kids Initiative

Response to consultation

October 2025

Recipient

House Standing Committee on Health, Aged Care and Disability

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Dietitians Australia acknowledges all traditional custodians of the lands, waters and seas that we work and live on across Australia. We pay our respect to Elders past, present and future and thank them for their continuing custodianship.

About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 9000 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for the profession and the people and communities we serve. Dietetics is a foundational disability support for children with developmental delays and children on the autism spectrum.

Dietitians Australia's credentialing program, the Accredited Practising Dietitian program, provides an assurance of safe, quality practice, and it is the foundation of self-regulation of the dietetic profession in Australia.

Accredited Practising Dietitians (APDs) are uniquely trained to provide essential support for children with disability by assessing and managing swallowing difficulties, ensuring safe mealtime practices, addressing tube feeding and complex nutrition needs, and preventing malnutrition. They also guide families in managing allergies, intolerances, and specialised diets that can affect growth, learning, and participation. Recognising dietitians as part of the disability workforce will ensure children receive safe, timely, and holistic care.

APDs are also uniquely trained to provide one-on-one medical nutrition therapy to patients in a clinical context across a broad range of disease and health conditions. Dietitians must hold the APD credential and meet continuing professional development and recency of practice standards annually to access Medicare, Department of Veterans Affairs, National Disability Insurance Scheme, worker's compensation schemes and most private health insurers.

Dietitians are essential providers of functional capacity-building supports in disability and mental health. In this submission, we highlight the critical role of APDs across the care economy and cross-sectoral experience, in disability support, primary health care, early childhood education and care (ECEC) and prevention initiatives to improve care quality, efficiency and long-term cost-effectiveness

Overview of Recommendations

Thriving Kids will only succeed if it recognises nutrition and feeding as foundational to learning, participation and health. APDs provide essential therapeutic supports across autism, global developmental delay (GDD) and for varying levels of support needs. Current NDIS practice too often overlooks dietetics, leading to preventable harms. Dietitians Australia urges the House Standing Committee on Health Aged Care and Disability to adopt the recommendations listed in the table below to enable safe food and meal time practices, and to reduce the risk of preventable harm that directly undermines school attendance and therapy progress (e.g. growth faltering or excess weight, micronutrient deficiencies, food selectivity/ARFID, swallow safety risks, tube-feeding needs).

Thriving Kids framework main pillar focusses on food and nutrition

Dietitians Australia recommends the Australian Government:

1.	**Recognises:** • **food and nutrition care as a priority area, and explicitly include it as a core component of the Thriving Kids Program and Foundational Supports across all settings** • **nutrition is foundational to all Australian children's long-term capacity and wellness,** • **and fully utilises APDs as essential contributors to care quality and safety.** Explicit inclusion will ensure nutrition is not overlooked in regulatory reforms and that APDs' expertise is consistently embedded to uphold safety, prevent malnutrition, and improve health and functional outcomes for all children. Governments should explicitly embed nutrition and dietetics in Thriving Kids arrangements to reduce fragmentation and improve outcomes across primary, acute, and health and community care.
2.	**Thriving Kids governance must explicitly embed APDs' expertise in functional nutrition outcomes across all care settings to safeguard quality and safety, prevent inappropriate role substitution, and ensure consistent, efficient, and child-centred-care.** Embedding dietetic expertise ensures that regulation reflects the complexity of nutrition care, maintains professional standards, and avoids dilution of quality through inappropriate delegation or substitution.
3.	**Make it explicit that APDs are included in all governance processes, relevant regulation, accreditation, registration, monitoring frameworks and audits to provide clarity for allied health professionals and APDs.** Clear inclusion will remove ambiguity, align regulatory expectations across sectors, and ensure that the unique skills and expertise of APDs are appropriately utilised and benefits are fully realised by consumers.
4.	**Recognise APDs as core therapy supports providers: Dietetics is an evidence-based profession and a crucial component of disability and autism supports**

Co-design with APDs

Dietitians Australia recommends:

1.	**Allocate an APD to the Thriving Kids Advisory Committee given the significant impact of food and nutrition on the quality of life, functional capacity and cost-savings to society.** APDs are trained to work across sectors, including but not limited to health, disability, aged care, education, and agriculture and food systems, making them well-suited for the cross-sectoral work in Thriving Kids
2.	**Collaborate with Dietitians Australia and our members to inform policy and practice on the unique role and scope of practice of APDs supporting children when developing the Thriving Kids new joint governance arrangements to support functional nutrition outcomes.** Governments should collaborate with Dietitians Australia and APD members to co-develop policy documents, operational guidelines, and training that reflect the unique role and scope of practice of APDs. This will improve consistent application of legislative requirements and strengthen nutrition and dietetic supports across care settings **for children with developmental delays and mild to moderate autism**.

3.	**Dietitians Australia has State and Territory branches as well as locally-based members who are readily available and willing to be formally engaged in designing Thriving Kids nutrition-related programs.** Engaging our distributed network ensures that governance and service design processes benefit from on-the-ground expertise, strong existing regional knowledge, and direct links to communities. This strengthens the consistency, cultural safety, and effectiveness of nutrition initiatives across diverse care settings for children, while also being able to tailor programs to address local considerations?

Dedicated Funding for APDs in programs

1.	**Long-term economic benefits of nutrition interventions for children with developmental delays and mild to moderate autism must be recognized in budget processes.**
2.	**Provide dedicated, flexible funding for nutrition-focused Thriving Kids Programs** The Australian Government should provide dedicated flexible funding streams within PHNs and other existing or new structures to ensure nutritional needs of children are met
3.	**Review pricing so that hourly rates and travel allowances reflect the real cost of providing services**.
4.	**The Thriving Kids Advisory Committee to meaningfully work with Dietitians Australia and its members on any future pricing arrangements.**
5.	**Design commissioning and panel arrangements that support and protect smaller dietetic providers**, including reserving panel places for local dietetic practices and simplifying tender requirements.
6.	**Ringfence dedicated funding pools for rural dietetic supports programs.**

1) 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.

1.	Develop national parent-facing resources to help families recognise developmental and nutrition concerns early.
2.	Establish self-referral mechanisms for parents concerned about feeding and nutrition.
3.	Embed mandatory nutrition screening and referral pathways in child health milestone checks.
4.	Address barriers to screening by ensuring time, skills, and prioritisation for nutrition in frontline settings.

5.	Strengthen recognition of dietitians in early intervention alongside occupational therapists and speech pathologists.

2) Examine the effectiveness of current (and previous) programs and initiatives that identify children with developmental 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.

Medicare

1.	Create a **mixed funding structure** e.g. the funding envelope should include a balance of fee for service and block funding to allow for varied circumstances and settings?
2.	**Ensure no-gap access and appropriate consult length** by funding dietetic care with adequate rebates and evidence-based appointment durations.
3.	**Guarantee adequate annual hours** of dietetic support (20–25 per child, tiered by need), with separate travel funding.
4.	**Introduce a single flexible funding block** to reduce administrative burden and cover all dietetic services.
5.	**Support travel and rural access** through quarantined travel funding, hybrid telehealth/outreach, and regional loadings.
6.	**Embed equity guardrails** to prioritise access for First Nations, CALD, and low-income families, including automatic fee-free status.
7.	**Streamline reporting and payments** with brief templates, acceptance of professional reports, and fast bulk-bill style processing.
8.	**Enable direct commissioning to dietitians** to avoid delays and inefficiencies from intermediaries.
9.	**Strengthen data collection and continuous improvement** through national datasets, public dashboards, and rapid-cycle evaluation.

Community Programs

1.	Leverage Existing Strengths in Frontline Services
2.	Address Service Gaps that Limit Access
3.	Embed Standard Referral Prompts in GP/ECEC Templates

4.	Fund School/ECEC, and Case Conferencing for Dietitians
5.	Commission Accessible, Community-Based Group Programs led by APDs
6.	Update eligibility for allied health treatment programs to include dietitians
7.	Fund food-centric, family/child-led community programs (home-based routines, food play, kitchen-based education).
8.	Scale up programs like the Stephanie Alexander Kitchen Garden
9.	Program funding must ensure low or no out-of-pocket cost to families to avoid inequities

Early childhood and school settings

1.	That Accredited Practising Dietitians (APDs) are embedded in early childhood, play groups, maternal and child health services, school settings and allied health play groups as part of the "mainstream, community settings" structure to provide consistent nutrition support, build capacity of staff and families, and improve mealtime and dietary outcomes for children.

Funding and access to PHNs

1.	Give dietitians direct access to funding
2.	Standardise and expand inclusion of APDs in allied health programs
3.	Ensure equity and consistency across regions
4.	Safeguard against monopolisation by large providers in collaborative commissioning

3) Identify equity and intersectional issues, in particular, children who identify as First Nations and culturally and linguistically diverse.

1.	Embed workforce planning for APDs in Thriving Kids
2.	Explicitly name APDs in Thriving Kids service guidelines and tenders
3.	Build multidisciplinary models with dietitians as core members
4.	Provide national billing/claims guidance and helpline
5.	Train assessors/planners on dietetic scope, risk, and standard hour needs
6.	Fund supervision and mentoring networks, including rural outreach rotations

4) Workforce support and training gaps

1.	**Workforce readiness actions:** • Publish a practical Medicare/claiming guide for disability dietitians • Provide targeted micro-credentials to build expertise in developmental nutrition, restrictive/fussy eating, and sensory feeding • Invest in supervision & mentoring programs, particularly in rural/remote areas.
2.	Ensure dietitians (APDs) and other professionals are trained in trauma-informed, neurodiversity-affirming practice, with assessment processes co-designed with people with disability
3.	**Ensure all stages of the workforce planning cycle** for Thriving Kids explicitly **includes APDs** to strengthen access to nutrition care and build a sustainable workforce.
4.	**Skilled screening & referral:** Upskill **maternal & child health nurses, GPs, ECECs and schools** with a simple red-flag screening tool and **clear referral pathways** to APDs.
5.	**Assessor and planner training:** Mandatory training for assessors/planners on **nutrition and disability** (what dietitians do, who benefits, typical hour needs, safety risks when support is delayed).
6.	Explicitly name APDs in Thriving Kids service guidelines and tenders
7.	Build multidisciplinary models with APDs as core members
8.	Provide national billing/claims guidance and helpline
9.	Fund supervision and mentoring networks, including rural outreach rotations
10.	Simplify billing, reporting, and compliance systems

5) Draw on domestic and international policy experience and best practice.

1.	Fund and scale food-centric, play-based approaches
2.	Adopt/adapt proven food education initiatives in public systems
3.	Embed nutrition support in schools and early learning centres
4.	Develop multidisciplinary feeding clinics led by APDs
5.	Ensure continuity of dietitian involvement across pathways
6.	Adopt principles from best-practice early childhood systems

6) Identify mechanisms that would allow a seamless transition through mainstream systems for all children with mild to moderate support needs.

Dietitians Australia recommends:

1.	A single child record and care coordinator role that follows the child across settings (home–ECEC–school–primary care), with handovers at each step by the same care coordinator
2.	Ensure dietitians are part of multidisciplinary teams that serve children with mild-moderate developmental support needs outside the NDIS.
3.	Ensure confirmation is sought regarding the government's ongoing commitment to delivering foundational supports
4.	Single point of entry with shared child record
5.	Care coordinator and warm handovers at key transition points
6.	Stage-based reassessments linked to developmental transitions
7.	Embed dietitians in collaborative models and transition points
8.	Recognise nutrition in all future national and state policy frameworks related to children with developmental delay and autism

Background

Australian children with development delay, autism or both, with mild to moderate support needs deserve to be supported to live healthy and well, with access to APDs when needed. Providing dietetic support at the right time, in the right place and led by APDs would allow more Australian children who are eligible for Thriving Kids, to enjoy improved quality of life, improved functioning and growth, as well as stronger families and communities, leading to improved social and economic participation benefiting society in the long-term.

Nutrition must be a cornerstone of the Thriving Kids strategy, as it underpins child health, learning, and development while intersecting with education, disability, and social policy. Many families face additional barriers such as food insecurity, rising costs, and unequal access to services, which further compounds the impact on children's nutrition and growth. APDs are essential in translating these challenges into practical, evidence-based interventions, from supporting families with feeding and mealtime practices to shaping community programs that promote equity across mainstream services. Embedding APDs across Thriving Kids prevention and early intervention portfolios ensures approaches are clinically sound, culturally safe, and capable of delivering both immediate support for families and sustainable long-term benefits for children.

In line with the Allied Health Professions Association (AHPA), Dietitians Australia notes the Early Childhood Targeted Action Plan, under Australia's Disability Strategy 2021-2031, explicitly commits to "early

identification of disability or developmental concerns and develop clearer pathways and timely access to appropriate supports" (Early Childhood TAP, p. 3)[1]. The success of the Thriving Kids initiative will depend on:

- children being screened appropriately for nutrition related issues early on in life
- clear and fast pathways for referral to APDs to avoid delays in seeing a dietitian and avoid negative growth and development related issues due to malnutrition.

There is a lack of clarity about how Foundational Supports and Thriving Kids interrelate, and whether the government will continue to progress the development of Foundational Supports as previously promised. Also, at present, there is no reference to nutrition, diet, or the role of APDs, despite these being integral to supporting the health and wellbeing of children with developmental delays and autism. Our submission provides guidance on how to deliver effective supports under the Thriving Kids program.

Substantial economic ramifications of poor infant and young child feeding

The **UNICEF "Feeding Profit**" (2025)[2] describes that 1 in 10 children globally is obese. **Child malnutrition** has three dimensions: undernutrition (stunting and wasting), overweight/obesity and hidden hunger or micronutrient deficiencies. The Australian Government and key stakeholders need to understand and be informed about these important dimensions as they determine the capacity and wellbeing of Australia's future generations. The report underscores the **substantial economic ramifications** of poor infant and young child feeding practices, revealing that suboptimal nutrition in early life not only leads to long-term health and developmental costs, but also **impairs productivity and economic potential**. This finding reinforces the prioritisation of investments in dietitian-led early feeding interventions, which can yield high net benefits by mitigating both immediate and intergenerational fiscal and social burdens (Box 1). This further underscores the high return on investment from effective child-centred nutrition interventions. Nutrition should therefore be recognised as a cornerstone of any **National Prevention Investment Framework and Thriving Kids framework**, ensuring that APD-led programs are prioritised alongside other preventive strategies to deliver sustained health and fiscal benefits.

[1] https://www.disabilitygateway.gov.au/sites/default/files/documents/2021-12/1886-tap-early-childhood.pdf

[2] UNICEF (2025). Feeding Profit. How food environments are failing children. 2025 child nutrition report. Report brief. English version. https://www.unicef.org/media/174026/file/CNR%202025%20-%20Feeding%20Profit%20-%20Brief%20-%20English%20-%20Final.pdf, 3 October 2025.

"*Governments:*

- *Strengthen national monitoring and accountability systems through regular data collection on children's diets and nutrition, the implementation of legal measures and policies, and industry practices impacting children's food environments."*

Box 1 UNICEF "Feeding Profit" (3 October, 2025)[3]

Lastly, according to the World Bank (2024), every $1 invested in nutrition returns $23, while failure to act on undernutrition and obesity is projected to cost $41 trillion over 10 years (Box 2).

*"For every $1 invested in addressing undernutrition, $23 are returned, and an estimated $2.4 trillion is generated in economic benefits. The economic benefits associated with these investments far outweigh the costs of inaction, which run around **$41 trillion over 10 years**, including $21 trillion in economic productivity losses due to undernutrition and micronutrient deficiencies and **$20 trillion in economic and social costs from overweight and obesity."***

Box 2 '*World Bank Investment Framework for Nutrition 2024*' [4]

Understand the critical requirement of dietetic supports in Thriving Kids

Nutrition is foundational to healthy development, and it must be recognised as a major cornerstone of both the 'Thriving Kids' and Foundational Supports Programs. Kids must explicitly have access to dietetics to ensure children with feeding difficulties, growth concerns, and chronic conditions don't fall through the gaps.

Key Benefits of embeddings APDs into Thriving Kids are:

- **Preventing illness & hospitalisations:** proper nutrition can reduce the risk of chronic health issues in autistic children, lowering hospital visits and creating cost savings for families, the health system and the economy.
- **Better quality of life:** by improving access to APDs, we can support children with developmental delays to eat better, manage health more independently, and promote stronger development and wellbeing.

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[3] UNICEF (2025). Feeding Profit. How food environments are failing children. 2025 child nutrition report. Report brief. English version. https://www.unicef.org/media/174026/file/CNR%202025%20-%20Feeding%20Profit%20-%20Brief%20-%20English%20-%20Final.pdf, 3 October 2025.

[4] https://openknowledge.worldbank.org/entities/publication/2c0b8b5e-0f67-47fe-9eae-d4707d9ed195

- **Dietitians don't just "treat" the child during appointments**, they coach the whole family to integrate strategies into daily life, which can create more sustainable change compared to other more therapist-driven, appointment-heavy models.
- **Cost-effective care:** early investment in dietetic services for autistic children who need support helps avoid downstream costs from complications, hospitalisations, or health and functional decline.
- **Strengthening holistic, coordinated care:** ensuring consistent access to dietetic services for children with complex developmental needs prevents gaps in care, supports team-based frameworks, and enhances chances for integrated, wraparound nutrition support**.**
- A meta-analysis has shown across studies (many with autism/developmental comorbidities), that multidisciplinary teams that include dietitians were associated **with significant improvements in oral intake and reductions in tube dependence**.[5]
- **Adverse effects of lack of dietetic supports:** a 2025 case example of nutrition neglect is provided below (Box 3)
- **Complexity of care**: APD services include specialised assessment, clinical judgment, and tailored interventions to manage complex medical conditions, swallowing difficulties, enteral feeding, medication-nutrient interactions, prevention and treatment of malnutrition.

"I just got one of my clients "back" today after not seeing him for his last plan (more than a year), they got me back because he has gained so much weight and is in kidney failure, heart failure and lymphedema. I fear I am going to see more and more of this or even worse a call from the coroner's court to submit my notes" APD- October 2025

Box 3 Unintended consequences of cutting dietetic supports.

Children with global developmental delay and autism and their relationship with food

Some of our members see the funding of eating disorder services under Medicare as a positive step, and it provides a useful basis to broaden recognition of conditions such as Avoidant/Restrictive Food Intake Disorder (ARFID), food selectivity, gastrointestinal issues, and other nutrition-related needs, where APDs play an essential role. Eating disorders are highly prevalent in this cohort.

Children with **autism** often experience barriers to access to food and nutrition. Heightened sensory perceptions and certain restrictive or repetitive behaviours may influence dietary preferences and habits. Such patterns can result in health complications, such as problematic mealtime behaviours, mealtime anxiety and malnutrition.

Additionally, evidence suggests that people with autism are more likely to experience other comorbidities including (ARFID), eating disorders, and gastrointestinal issues such as constipation, diarrhoea, and bloating. Appropriate adjustments to the eating environment and nutrition and dietetic support are

[5] Sharp WG, Volkert VM, Scahill L, et al. (2017). A Systematic Review and Meta-analysis of Intensive Multidisciplinary Intervention for Pediatric Feeding Disorders. Journal of Pediatrics.

essential to effectively support children with GDD and autism to eat in a way that best meets their individual needs.

The price we pay if APDs are not core to the Thriving Kids program

Our members have reported **the damaging clinical impacts** of disability reforms and pricing cuts during a member survey in June 2025:

- **91%** surveyed APDs expect greater carer burden and risk of nutrition neglect
- **84%** expect exacerbation of feeding difficulties and mealtime aversions (e.g., in autism and intellectual disability)
- **79%** expect increased emergency department and hospital visits
- **63%** increased enteral feed complications due to over/underfeeding, dehydration, or formula intolerance
- **51%** faecal impaction & necrotic bowel due to mismanaged bowel management plans.

Given the above reasons, we urge the Australian Government to ensure nutrition care be explicitly included as a core component of Thriving Kids across all care settings, with APDs recognised and utilised as essential support providers. Nutrition is not ancillary to quality care, it is fundamental. Without adequate nutrition support, the safety and wellbeing of children in the Thriving Kids program in all care settings will be compromised. The Government has strengthened food and nutrition regulation and compliance requirements in aged care, increasing provider capability and accountability to ensure older people consistently receive safe, enjoyable, and nutritious meals.[6] This should be extended to our children through Thriving Kids programs and cross-sector reporting frameworks.

In summary, Dietitians Australia urges that Thriving Kids explicitly elevate food and nutrition to a priority area across all care settings. Key actions under this pillar should include:

- **Embed APDs in key regulation and oversight:** require care settings to have access to APDs and to meet evidence-based nutrition standards (e.g., menu quality, nutrition screening, etc)[7] , with nutrition indicators (e.g., malnutrition) standards monitored and publicly reported as part of quality audits.
- **Strengthen nutrition safeguards across all care sectors**: guarantee that regulatory frameworks and funding mechanisms support access to APDs, with explicit requirements to manage nutrition risk and prevent malnutrition, choking, and related harms.
- **Enforce credentialing for quality:** align regulations so that only accredited APDs for dietetic care are entrusted with leading nutrition-related interventions and supports in health, disability,

[6] https://www.health.gov.au/our-work/improving-food-nutrition-aged-care/regulation-compliance

[7] https://www.agedcarequality.gov.au/providers/food-nutrition-dining/why-meals-matter

education and other child-related services. This ensures high-quality, safe practice and accountability.

- **Integrate food and nutrition into clinical governance:** encourage all key stakeholder organisations to incorporate nutrition care plans into safety and quality improvement initiatives. For instance, primary care clinics should have protocols for timely APD referral for conditions like malnutrition, diabetes, gastrointestinal diseases, etc., consistent with best-practice guidelines.

By strengthening nutrition care requirements and leveraging APDs as the recognized nutrition experts, regulators and policy makers will support a more cohesive child-centred approach, one in which quality and safety truly extend to nutritional well-being. High standards in nutrition will translate to fewer adverse health events, better consumer satisfaction, improved wellbeing, more efficient care delivery system-wide and ultimately better outcomes for individuals, families and the broader society and economy.

Answers to Terms of Reference

1) 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.

Our members highlighted measures to strengthen early recognition and referral, and to ensure explicit inclusion of APDs, to improve the functional capacity of children participating in Thriving Kids programs.

The following resources or information can help parents recognise early signs of mild to moderate developmental delay:

- https://raisingchildren.net.au/guides/a-z-health-reference/developmental-delay
- https://www.schn.health.nsw.gov.au/developmental-delay-factsheetisted

More useful resources are listed under the next section (ToR-2).

Focus Area	Key Actions	Rationale
National parent-facing resources	• Develop a plain-language **"Worried About Development?" microsite** integrated with Pregnancy Birth & Baby and State child health pages. • Include red-flag checklists, videos, and practical strategies (feeding, sleep, routines, responsive mealtime practices). • Ensure translated resources and First Nations-led content. • Provide **evidence-based resources for parents (0–8 years)**: neuro-affirming guidance on typical vs. concerning development, practical steps, and service prioritisation.	APDs bring specialist expertise in nutrition and feeding, ensuring parents understand when growth, restrictive diets, or mealtime distress require professional input. Clear visibility of APDs in parent resources ensures timely referral and prevents nutrition being overlooked.

Focus Area	Key Actions	Rationale
	• Offer capacity-building modules (e.g., parent coaching).	
Self-referral mechanisms when parents are worried about nutrition and feeding practices	• Provide clear self-referral pathways to child & family health, dietetics, and allied health playgroups.	These strategies have been proven effective in other areas: Older people living in the community can self-refer for medication reviews. Carers of people with a disability or chronic conditions can self-refer to Carer Gateway Services.
Mandatory nutrition screening & referral pathways	• Embed validated paediatric malnutrition screening into milestone checks (e.g., 6–18 months, preschool entry, school transitions). • Incorporate into "blue books"/child health records with both mandatory and on-demand assessments. • Screenings to be delivered by **trained** GPs, maternal/child health nurses, or educators, with positive results triggering referral to APDs. • Use existing paediatric malnutrition screening tools; consider ARFID tools where relevant.	APDs are the professionals best equipped to interpret screening results and provide tailored nutrition interventions. Formal referral pathways safeguard against missed growth or feeding concerns and ensure families access dietetic expertise early.
Barriers to address	• GPs and educators are often too busy and may lack scope/skills for nutrition screening. • Nutrition is deprioritised compared to other developmental issues.	Without embedding APDs, nutrition concerns risk being dismissed. APDs reduce this gap by offering dedicated expertise in identifying and managing feeding and growth problems.

Strengthening recognition of dietitians in early intervention	• Ensure dietitians are included in early intervention frameworks and parent resources alongside occupational therapists (OTs) and speech pathologists.
	• APDs should be involved in managing:
	  ○ Mealtime distress, food refusal, selective eating.
	  ○ Growth concerns, nutrient deficiencies, and restrictive diets.
		APDs are essential for holistic early intervention. Their expertise is unique and complements OTs and speech pathologists, directly addressing the nutritional dimension of neurodiverse children's health and preventing longer-term health and developmental impacts.

2) Examine the effectiveness of current (and previous) programs and initiatives that identify children with developmental 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.

Attachment 1 shows a summary of 4 models of care for children with mild to moderate autism that include a dietitian based on evidence from the literature. Further recommendations and insights are provided below.

Medicare

Our members highlighted that new allied health Medicare items should:

- recognise the role of APDs, to reflect the real cost and duration of dietetic services for children with developmental delay and mild/moderate autism
- not be constrained by arbitrary annual or lifetime limits
- have referral processes that align with practical access pathways
- support collaborative, team-based and family-centred models of care.

Members already working with Medicare items expressed clear structural and funding preferences, but we urge further consultation is required:

- **Medicare payment flow is preferable** to NDIS: clients pay or are bulk billed because the existing rebate system is straightforward and less administratively burdensome.
- Ideally: **single item number covering all dietetic work** (assessment, review, resource development, diet analysis) with flexibility in use and time.
- **Multiple tiers** could be useful: e.g.," requires support", "requires substantial support or "requires very substantial support" consistent with the Diagnostic and Statistical Manual of Mental Disorders-5 support needs levels.
- Preference for **direct funding access for dietitians**, rather than via intermediaries (e.g., PHNs, large providers), which dilute funds and complicate processes.

Our members suggested the following Medicare related improvements for dietetic supports:

Recommendations and key features	Key actions & rationale
1. No-gap access & appropriate consult length	• Adequately fund dietetic care so eligible families incur **no gap fees**. • Establish MBS-style items (or equivalent) that support evidence-based durations, initials ≥ 45–60 min; reviews ≥ 30 min, including time for care coordination and resource preparation. • Higher Medicare rebates to cover true cost of care.

Recommendations and key features	Key actions & rationale
2. Adequate annual hours	• Provide at least **20–25 clinical hours per child per year**, tiered by need ("requires support", "requires substantial support or "requires very substantial support**"**). • Separately fund travel time for outreach, home, or school visits (i.e., travel not deducted from clinical hours).
3. Single flexible item / funding block	• Use a single flexible funding block per child to cover assessment, review, care planning, case conferencing, resource development, report writing, carer education. • Reduces administrative burden from multiple discrete items.
4. Travel & rural access	• Quarantine travel funding so it's not drawn from clinical hours. • Offer hybrid delivery models (telehealth + outreach). • Enable regional loadings, commission roving clinics in underserved areas.
5. Equity guardrails	• Ring-fence priority access for First Nations, CALD, and low-income families via targeted outreach, interpreters, cultural brokerage. • Automatic fee-free status for Health Care Card, eligible households.
6. Light-touch reporting & fast payment	• Replace lengthy narrative reports with **brief outcome templates**. • Accept professional reports. • Ensure provider payment within **2 days** (bulk-bill style processing).
7. Direct commissioning to dietitians	• Allow direct access to funding for APD providers (with proportionate governance / credential requirements). • Avoid delays and inefficiencies from intermediaries.
8. Data, outcomes & continuous improvement	• Collect a **minimum national dataset** (e.g. wait time, contact type, hours used, agreed goals, functional outcomes, parent-reported experience). • Publish public dashboards. • Employ rapid cycle evaluation to refine the program over time.

Community Programs

Our members also provided feedback on what works and what does not. Overall, there were no widely known dietitian-specific tools currently available. However, some were aware of programs that would be useful for Thriving Kids and should be expanded to include APDs. As many existing allied health programs for autism and developmental delay include OTs and speech pathologists, but not APDs. Across all programs, APDs should be explicitly included e.g., delivering the nutrition / feeding components in group programs, contributing to screening, education, adaptation, and ongoing support. The tables below provide recommendations for further improvement of community programs.

Recommendation	Key actions & rationale
Leverage Existing Strengths in Frontline Services	Child & Family Health can intervene early; schools and ECECs observe children's daily functioning; telehealth has widened reach, particularly for rural families. These strengths should be deliberately built into program design.
Address Service Gaps that Limit Access	Reduce barriers by extending consult times, minimising out-of-pocket costs, and ensuring dietitians are recognised in screening and planning. Standardise referral pathways nationally and expand outreach options to supplement telehealth in rural areas.
Embed Standard Referral Prompts in GP/ECEC Templates	Introduce referral triggers for nutrition-related risks (e.g. growth faltering, restrictive diets, micronutrient deficiencies, ARFID). This would normalise nutrition referrals and ensure dietitians are engaged consistently.
Fund School/ECEC Case Conferencing for Dietitians	Allocate funding to include dietitians in multidisciplinary case conferences, ensuring children's nutrition needs are addressed alongside speech, OT, and behavioural supports.
Commission Accessible, Community-Based Group Programs led by APDs	Invest in dietitian-led group programs (e.g., parent coaching, label reading, sensory-friendly food exposure) delivered with allied health partners. These provide scalable, equitable, and cost-effective support for families.
Update eligibility for allied health treatment programs to include dietitians	This ensures children with feeding, growth, and nutrition concerns receive timely, expert support. APDs address issues that speech and OT alone cannot resolve, such as micronutrient deficiencies, growth faltering, restrictive diets, and ARFID. Inclusion would align programs with evidence-based, multidisciplinary models of care and reduce inequities in access to essential nutrition services.
Fund food-centric, family/child-led community programs (home-based routines, food play, kitchen-based education).	Support family- and child-led initiatives (e.g., home routines, food play, kitchen-based education) shown to improve feeding practices and nutrition outcomes. Embedding dietitians strengthens program impact.
Scale up programs like the Stephanie Alexander Kitchen Garden	Ensure these are both privately and government funded.
Program funding must ensure low or no out-of-pocket cost to families to avoid inequities	Program funding should guarantee low or no out-of-pocket costs, removing financial barriers for families and reducing inequities in access to nutrition support.

The table below highlights programs for children, noting gaps and where dietitian involvement could improve outcomes. These suggestions are based on member feedback.

Category	Program / Resource	Strengths and limitations
Needs Dietitian Integration / Potentially Useful	FOODs Toolkit (UK)	Some awareness among professionals; focuses on identifying eating / drinking / nutrition problems and guiding parents toward supports
	Kitchen Garden (Stephanie Alexander)	Existing food / garden education programmes; could be strengthened by embedding dietitian input
	Waratah for Kids	Targets developmental delay, behaviour, screening tools; currently only includes speech therapy and OT, expand to include dietetic component
	PlayConnect+ and Envisage (0–8 yrs)	Government-funded programmes for early developmental concerns; expand to include dietitians
	FEEDS Framework	Program researched and run out of Newcastle University (UK) that may be useful for consideration. It may step on from the early recognition of differences such as through Inklings.[8]
	WA Child development service	Child Development centres have been running in WA for many years. Originally they were part of Community Health, which unfortunately has been severely trimmed. [9]
	DIR®/Floortime (Home of DIRFloortime®).	Members identified this program as neuro-affirming and evidence-based. While dietitians are not currently included in this model, it provides a strong foundation for requesting the formal inclusion of dietetic expertise.[10]
Not Recommended	Fun Not Fuss with Food	Nurse-led, deemed ineffective for children with developmental delay (does not suitably target needs)
	Go For Fun	Focuses on obesity / movement; not appropriate for children with developmental delay / disability
	SOS Feeding Program	Declining in use; preference shifting toward **Responsive Feeding Therapy** approaches
	Inkling	Lacks dietitian involvement, not neuro-affirming, emphasizes reducing autistic traits rather than supporting children; targets 6–18 months, while many nutrition challenges begin after 18 months

[8] https://research.ncl.ac.uk/neurodisability/ourstudies/feedstraining/

[9] https://cahs.health.wa.gov.au/our-services/community-health/child-development-service

[10] https://www.icdl.com/institute/intensives

Funding and access via PHNs

Member observations on PHN-Delivered Nutrition Programs are varied and summarised in the table below. We also refer to Attachment 2 'Embedding Collaborative Commissioning' for more information.

Recommendation	Strengths / What works	Limitations / Issues
Give dietitians direct access to funding	Nutrition programs were most effective when delivered directly by APDs.	PHN administrative inefficiencies and withholding of funds undermine outcomes. Subcontracting often excludes APDs, particularly in autism and early intervention.
Standardise and expand inclusion of APDs in allied health programs	PHNs have existing block funding structures that can integrate dietitians.	Current subcontracting favours OT and speech; dietitians are frequently excluded.
Ensure equity and consistency across regions	Some Aboriginal health models include child nutrition support, showing local value.	Access depends on relationships and awareness; nutrition support is inconsistent and difficult to track across regions.
Safeguard against monopolisation in collaborative commissioning	PHNs are positioned to coordinate multidisciplinary programs.	Large providers risk dominating contracts, leaving dietitians constrained, underutilised, and underpaid.

3) Identify equity and intersectional issues, in particular, children who identify as First Nations and culturally and linguistically diverse.

Children from First Nations, culturally and linguistically diverse, low-income, and rural or remote families face greater barriers to nutrition care, requiring targeted equity-focused actions.

Recommendation	Strengths / What works	Limitations / Issues
Engage PHNs and Aboriginal health organisations to ensure equitable dietetic services across regions	Some Aboriginal health funding streams already purchase children's services, including outside mainstream PHN pathways.	Regional variation: some children access services while others miss out. Access often depends on local relationships rather than consistent provision.
Make Thriving Kids flexible to support existing Aboriginal health funding models and local priorities	Aboriginal health models demonstrate culturally appropriate ways of delivering care; flexibility can build on these.	Current PHN pathways are rigid and not always responsive to local priorities or community-led solutions.
Provide no-gap access, interpreters, and regional loadings	Reduces financial barriers for low socioeconomic families and improves accessibility for CALD families.	Gap payments and short consult times disproportionately affect low-income families; interpreters are not consistently funded; rural access is limited.

Recommendation	Strengths / What works	Limitations / Issues
Support rural and First Nations-led services and outreach via Aboriginal Medical Services, playgroups, schools, and outreach services	Trusted community hubs strengthen engagement and cultural safety.	Families in remote and underserved areas rely heavily on telehealth, which may compromise quality and continuity of care.
Identify and fill training gaps for dietitians, GPs, child health nurses, and educators	Builds workforce capacity to recognise nutrition and developmental issues early.	Limited training and tools in nutrition screening and referral reduce timely identification and support for children at risk.
Provide tools, CPD, and resources for first-contact roles	Equips frontline providers to screen, refer, and monitor appropriately for nutrition-related risks	Without adequate tools and ongoing CPD, nutrition and developmental concerns are often missed in early contact settings.

4) Workforce support and training gaps

Attachment 3 provides an overview of current workforce retention and recruitment issues in allied health and APDs. It is crucial to address these issues to ensure a successful Thriving Kids programs. APDs report leaving children's services due to the uncertainty created by Thriving Kids (see Box 4) and other disability reforms, leading to increased workforce shortages and loss of experienced clinicians.

"I have been moving away from children in the past few months as I cannot absorb the uncertainty of Thriving Kids" APD- September 2025

Box 4 '*Accredited Practising Dietitian*

Members have expressed concerns that proposed funding models under Thriving Kids could unintentionally reduce access to specialist paediatric dietitians (Box 5)

"Some concerns I have with the Thriving Kids program is that if it is block funded it will likely go to large providers who may not have skilled senior paediatric dietitians to oversee junior dietitians or no dietitians in this space. As paediatric dietitians we have a highly specialist skill set and a lot of us work privately as sole traders so this may mean that these children who currently have access to an experienced practitioner may lose access to specialists. Or the workforce may lose its most experience practitioners" APD- October 2025

Box 5 '*Accredited Practising Dietitian*

To ensure children receive safe, timely, and specialised nutrition care, key recommendations to strengthen and sustain the APD workforce within Thriving Kids are outlined below.

Recommendation	Strengths / What works	Limitations / Issues
Embed workforce planning for APDs in Thriving Kids	Existing NDIS dietitians are adaptable and accustomed to navigating new compliance requirements.	Workforce sustainability requires explicit recognition of APDs in NDIS and disability strategies; independent pricing reform is lacking.
Explicitly name APDs in Thriving Kids service guidelines and tenders	Recognition in guidelines would formalise their role alongside OTs, speech pathologists, and physios.	Currently, APDs are not consistently named, leading to exclusion from programs.
Build multidisciplinary models with dietitians as core members	Models including APDs ensure holistic child support.	Without mandated inclusion, dietitians are often overlooked in team composition.
Provide national billing/claims guidance and helpline	Existing NDIS dietitians could transition into Thriving Kids if supported with billing resources.	Many disability-focused dietitians are unfamiliar with Medicare-style claiming, causing confusion and inefficiencies.
Train assessors/planners on dietetic scope, risk, and standard hour needs	Better informed assessors would improve recognition of dietitians' expertise and nutrition needs in eligibility and planning.	Assessors currently have limited understanding of dietetic scope and typical hour requirements, leading to underfunding or exclusion.
Fund supervision and mentoring networks, including rural outreach rotations	Networks would strengthen rural providers and improve service reach.	Rural providers often lack supervision and structured professional support.
Simplify billing, reporting, and compliance systems	Simplification would reduce workforce strain and enable APDs to focus on care.	Complex, inconsistent systems increase administrative burden and risk of workforce burnout.

5) Draw on domestic and international policy experience and best practice.

The table outlines best-practice models and recommendations for embedding nutrition into Thriving Kids, highlighting what works and where gaps remain. We also refer to attachment 1.

Recommendation	Strengths / What works	Limitations / Issues
Fund and scale food-centric, play-based approaches	Kitchen-based and tailored food play approaches are engaging and family-friendly.	Current programs (e.g., Stephanie Alexander Kitchen Garden) are highly regarded but funding-dependent and unaffordable for many parents.

Recommendation	Strengths / What works	Limitations / Issues
Adopt/adapt proven food education initiatives in public systems	Models like Jamie Oliver–style food education raise awareness and promote healthy eating.	Currently delivered as private-sector initiatives; lack sustained public funding and reach.
Embed nutrition support in schools and early learning centres	School-based models historically funded OT and speech therapy; dietitians could integrate seamlessly in similar frameworks.	Dietitians were not previously included; cent Australian initiatives such as the Healthy Kids Bus Stop and Busy Bee Screening demonstrate that integration of dietitians into early learning settings is both feasible and effective, identifying nutrition risks that would otherwise be missed (See attachment 1 for further details)
Develop multidisciplinary feeding clinics (APD + OT + speech pathologist + physiotherapist)	Intensive, team-based clinics deliver strong outcomes, especially for children exiting NDIS.	These clinics are not widely available or sustainably funded. Evaluation work is in progress by one of our members in NT.
Ensure continuity of dietitian involvement across pathways	Families value consistent relationships and trusted providers as children transition across services.	Current systems fragment care; continuity of nutrition support is often lost between early childhood, school, and neurodevelopmental services.
Adopt principles from best-practice early childhood systems	Early, family-centred intervention, team-based care, and outcomes-focused funding reflect international evidence and align with Australia's strengths.	Fee-free access, reduced reporting burden, and outreach/telehealth hybrids are not consistently implemented, leaving gaps for priority and rural populations.

6) Identify mechanisms that would allow a seamless transition through mainstream systems for all children with mild to moderate support needs.

Attachment 2 provides our views and recommendations related to Collaborative Commissioning, if this an area the government will pursue for rolling out certain elements of Thriving Kids.

Funding for sole traders and smaller providers to allow for choice and control

APDs must be valued appropriately in the Thriving Kids design. There is a clear link between autism and the nutrition supports required, and it is vital that children and families can continue to access dietitians. We are concerned that government changes may further cannibalise the sector, leaving only large providers and shifting services into direct commissioning and panel arrangements. Many members are concerned 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. Cuts to NDIA hourly rates and travel also make it harder to deliver quality services, yet the government has not created a better model since shelving the Independent Health and Aged Care Pricing Authority findings. Dietitians Australia strongly

supports the NDIS principle of participant choice and control and we believe this principle should also be extended to programs that will sit outside the NDIS, like Thriving Kids.

To ensure equitable access and uphold this principle all APDs must be recognised and able to apply for relevant funding.

Long-term economic benefits of nutrition interventions must be recognised in budget processes.

Crucially, **the long-term economic benefits of nutrition interventions for children must be recognised in budget processes**. We echo the calls from the Public Health Association of Australia and others to reform Federal Budget rules so that future savings (beyond the four-year forward estimates) are counted when justifying prevention spending[11]. For children, preventive nutrition measures, such as addressing feeding difficulties, reducing malnutrition, and improving healthy growth, deliver returns over 5–10+ years through reduced hospitalisations, better educational outcomes, and lower chronic disease risk. Our fiscal planning should accommodate these longer timeframes. The Productivity Commission's recommended National Prevention Investment Framework is an ideal vehicle to mandate this change.[12] By doing so, policymakers can confidently invest in nutrition measures that will pay off in the long run, in both health expenditure avoided and healthier children, stronger families, and future productivity gains. We urge the government to be bold and commit to those investments now.

The table below identifies mechanisms that would allow a seamless transition through mainstream systems for all children with mild to moderate support needs. Further consultation and co-design with Dietitians Australia and its members is however required.

Recommendation	Strengths / What works	Limitations / Issues
Single point of entry with shared child record	Simplifies navigation and ensures all providers (Child Family Health Nurses, GPs, ECECs, schools, allied health, etc) have access to the same information.	Current systems are fragmented; families repeat their story; access to services depends on PHN connections.
Care coordinator and warm handovers at key transition points	Builds trusted relationships, maintains continuity of care, and improves family experience across services.	Loss of continuity as children transition (e.g., NDIS to mainstream, or early years to school); no standardised mechanism to maintain support.
Stage-based reassessments linked to developmental transitions	Reviews at milestones (e.g., preschool entry, school start) identify emerging needs early and support timely interventions.	Annual-only reviews miss key developmental changes and risk delayed support.

[11] https://www.phaa.net.au/Web/Web/News/Media-releases-2025/Productivity-Commission-report-reveals--nuts--Budget-barrier.aspx

[12] https://www.pc.gov.au/inquiries-and-research/quality-care/interim/

Recommendation	Strengths / What works	Limitations / Issues
Embed dietitians in collaborative models and transition points	Multidisciplinary care models (with dietitians, OT, speech pathologists, physio, educators) support whole-child outcomes and address nutrition, a core driver of health and learning.	Dietitians are often excluded from commissioning and transitions, leaving nutrition gaps unaddressed.
Recognise nutrition in all future national and state policy frameworks related to children with developmental delay and autism .	Embedding nutrition as a cornerstone in Thriving Kids aligns with evidence that diet underpins health, learning, and participation	Key national Autism policy documents have not yet recognised nutrition as a cornerstone of care, including: • The National Autism Strategy • The National Roadmap to Improve the Health and Mental Health of Autistic People 2025–2035

Conclusion and **Call to Action**

Nutrition is a proven driver of healthy child development, learning, and wellbeing, and should play a key role in Thriving Kids policy and funding structures. APDs are uniquely positioned to deliver measurable gains, supporting growth, reducing feeding difficulties and malnutrition, preventing chronic disease, and improving long-term outcomes for children and families.

We urge the government to:

- act immediately upon our recommendations
- engage with Dietitians Australia to implement these recommendations.

We are available to discuss these matters further and support the development of policy and programs to align with evidence-based practice.

Attachment 1 Models of care for children with mild-to-moderate autism that include a dietitian: evidence from the literature

The Thriving Kids initiative seeks to identify programs that support children with mild-to-moderate developmental delay and autism. Evidence indicates that models of care which include **dietitians as part of a multidisciplinary team** can address feeding challenges and nutritional deficiencies common in autism. We provide 4 examples below. Successful models include, but are not limited to:

1. **Structured parent-training programs** like the MEAL Plan where a dietitian co-facilitates sessions and provides individualised nutrition guidance
2. **Primary care-based clinics** that integrate dietetic consultation within the medical home (CAST clinic)
3. **Mobile and community-based screening models** (Healthy Kids Bus Stop and Busy Bee Screening) that include dietetics in comprehensive developmental screening.

These models align with the Thriving Kids terms of reference, which emphasise child and maternal health, primary care, allied health and early childhood education. **Integrating dietitians into multidisciplinary teams ensures that nutritional issues, often overlooked in autism, are addresse**d alongside behavioural and developmental needs, supporting better long-term outcomes for children with mild to moderate autism.

Example 1 - Multidisciplinary parent training – Autism MEAL Plan	
Description	The Managing Eating Aversions and Limited variety (**MEAL**) Plan is a structured 16-week parent-training program designed for children with Autism Spectrum Disorder and **moderate food selectivity**. It blends behavioural interventions with nutrition education. Sessions are led by a psychologist. Session 2 and 7 were co-led by a **dietitian** who assesses each child's growth and nutritional needs, helps select foods to expand dietary diversity and provides child-specific guidance on how to achieve a balanced diet (e.g., by adding a variety of fruits and vegetables to a child's meals each day.) Parents are taught to structure mealtimes and use praise to reinforce target behaviours. MEAL Plan combines behaviour strategies with nutrition education to encourage balanced eating. With APDs leading the nutritional component delivery, it acts as a valuable health promotion program.
Role of the dietitian	The dietitian evaluates growth measures and nutritional needs, selects foods to expand diversity, and provides information to reduce nutritional deficiencies. This multidisciplinary model demonstrates how nutrition and behaviour specialists can jointly address feeding difficulties in children with mild-to-moderate autism.
Evidence	A randomized trial comparing the MEAL Plan with a parent-education control showed that the MEAL Plan improved mealtime behaviours and dietary variety in children with ASD. The authors discuss the scaling up potential.
Source	Sharp WG, Burrell TL, Berry RC, Stubbs KH, McCracken CE, Gillespie SE, Scahill L. The Autism Managing Eating Aversions and Limited Variety Plan vs Parent Education: A Randomized Clinical Trial. J Pediatr. 2019 Aug;211:185-192.e1. doi: 10.1016/j.jpeds.2019.03.046. Epub 2019 May 3. PMID: 31056202; PMCID: PMC6661002.

Example 2 - Primary care–based medical home with dietetic support (CAST clinic)	
Description.	The **Center for Autism Services and Transition (CAST)** provides primary care for adolescents and young adults on the autism spectrum, incorporating patient-centred medical-home principles. *Although the clinic is not focussed on children below 8 years of age, it is an example* **how continuity of care** *could be built into the system.* The clinic offers extended appointment times, nursing and social work support, and integrates specialists such as psychiatry, pharmacy and **dietetics**. The **dietitian** is shared by multiple primary care clinics within the same healthcare system as CAST and are available by referral for consultation for all primary care patients. The program provides a continuum of care where families can access medical and behavioural services in one setting and includes telehealth visits.
Role of the dietitian	Dietitians provide consultation for nutritional concerns, weight management and healthy eating. Their integration into the primary-care team ensures that **nutritional issues** are addressed alongside medical and behavioural needs
Evidence	The CAST clinic has served over 858 patients since 2014 and continues to be used regularly. The inclusion of dietetic services demonstrates a scalable model for integrated autism care.
Source	Hart LC, Saha H, Lawrence S, Friedman S, Irwin P, Hanks C. Implementation and Evolution of a Primary Care-Based Program for Adolescents and Young Adults on the Autism Spectrum. J Autism Dev Disord. 2022 Jul;52(7):2924-2933. doi: 10.1007/s10803-021-05171-w. Epub 2021 Jul 2. PMID: 34215949; PMCID: PMC8252984.

Example 3 - Healthy Kids Bus Stop – mobile multidisciplinary screening	
Description	The **Healthy Kids Bus Stop (HKBS)** in New South Wales is a mobile service that conducts comprehensive health screenings for children aged 3-5 years. The HKBS provides a thorough health screening aligned with the NSW Health Child Personal Health Record **("Blue Book")**. Children are screened for **child health, oral health**, hearing**, dietetics**, speech and language and motor development. The service is delivered by a multidisciplinary team of nursing and allied-health staff from Royal Far West working with staff from other agencies such as the Local Health District (LHD), the Primary Health Network (PHN), Aboriginal Health Services, and other local health service Providers. At the end of the day, the team holds a multidisciplinary case conference to review each child's results and create a coordinated referral pathway that includes the local GP, child-and-family health nurse and allied-health services. Six percent of children require referral to a dietitian.
Role of the dietitian	**Nutritional screening should be embedded into an existing system such as the NSW Blue Book used in this study**. Dietetics screening identifies nutritional issues early (e.g., growth or dietary deficiencies). The dietitian contributes to the case conference, ensuring that children with mild-to-moderate developmental delays and autism receive appropriate nutrition referrals.
Evidence	The program provides access to preventive care in rural areas and links families to services; while not specific to autism, the inclusion of dietetics in the screening highlights the importance of nutrition within early-intervention models as well the ability to use existing child health systems to embed nutritional screening and referral to an APD.
Source	Gosse G, Kumar S, Banwell H, Moran A. Exploring Allied Health Models of Care for Children with Developmental Health Concerns, Delays, and Disabilities in Rural and Remote Areas: A

Example 3 - Healthy Kids Bus Stop – mobile multidisciplinary screening	
	Systematic Scoping Review. Int J Environ Res Public Health. 2024 Apr 19;21(4):507. doi: 10.3390/ijerph21040507. PMID: 38673418; PMCID: PMC11050593. Royal Far West. Early Learning, Intervention and Screening in Rural and Remote Areas; Royal Far West: Sydney, Australia, 2022 https://www.royalfarwest.org.au/wp-content/uploads/2022/11/HKBS-report-web.pdf

Example 4 - Busy Bee Screening – community-based multidisciplinary screening	
Description	The **Busy Bee Screening** program in Australia conducts development screening for children aged 6 months to 5 years. A multidisciplinary team, including **dietitians**, physiotherapists, occupational therapists, speech-language pathologists, social workers, provides 15-minute appointments twice a year. Parents rotate through appointments with each professional, and a report with recommendations from each specialist is provided. The dietitian was available for parents who had any queries about their children's diet and eating habits.
Role of the dietitian	The dietitian assesses growth, dietary intake and feeding concerns, offering advice on nutrition and referrals for further support. This ensures that nutritional issues are addressed alongside other developmental concerns. Dietitians have developed their own component for the Busy Bee screenings in relation to food and nutrition. It is aimed as a method for determining if a more comprehensive developmental assessment is required for nutrition. **Outcomes / Benefits** • Ensures nutrition is integrated alongside other developmental concerns. • Early identification of feeding or growth issues. • Facilitates timely referral to dietetic and other specialist services.
Evidence	A model implemented in practice in rural Australia
Source	Gosse G, Kumar S, Banwell H, Moran A. Exploring Allied Health Models of Care for Children with Developmental Health Concerns, Delays, and Disabilities in Rural and Remote Areas: A Systematic Scoping Review. Int J Environ Res Public Health. 2024 Apr 19;21(4):507. doi: 10.3390/ijerph21040507. PMID: 38673418; PMCID: PMC11050593. https://www.ruralhealth.org.au/9thNRHC/9thnrhc.ruralhealth.org.au/program/docs/papers/williams_E7.p

Attachment 2 Embedding Collaborative Commissioning for Thriving Kids

Context

Collaborative Commissioning offers an opportunity to strengthen care for children with developmental delays and mild/moderate autism and health needs by ensuring food and nutrition are integrated across primary, community, and specialist services. APDs play a critical role in supporting growth, feeding, and nutrition for children with mild-to-moderate developmental concerns, yet are often underrepresented in commissioning, governance, and funded service models.

Recommendations

1. **Collaborate with Dietitians Australia to shape governance**
   Governments should formally collaborate with Dietitians Australia and our members to ensure the unique role of APDs is reflected in new governance and operational frameworks for Collaborative Commissioning under the *Thriving Kids* initiative. This would support consistency, align with legislative requirements, and strengthen the integration of nutrition into early support systems.
2. **Recognise nutrition and dietetics as core to child development**
   Nutrition should be explicitly embedded as a core element of Collaborative Commissioning for children. This will reduce fragmentation, ensure growth and feeding concerns are addressed early, and improve outcomes across health, education, and community care settings.
3. **Embed APDs in governance structures**
   Require PHNs, LHNs, and ACCHOs to include APDs in Collaborative Commissioning governance committees for child health. This ensures nutrition is considered alongside speech, OT, and behavioural supports where it directly impacts growth, development, independence, and participation.
4. **Integrate nutrition-sensitive performance indicators**
   Include child-focused nutrition indicators—such as rates of growth faltering, feeding difficulties, micronutrient deficiencies, and access to dietetic services—in joint needs assessments and outcome evaluations. Without these measures, quality outcomes for children cannot be assessed holistically.
5. **Provide dedicated funding for dietetic services in Thriving Kids commissioning**
   Allocate flexible funding within PHN and LHN budgets for collaborative projects that integrate dietetic services, including culturally appropriate programs led by ACCHOs. Dedicated streams prevent dietitians being sidelined and enable sustainable child- and family-focused services.
6. **Commission place-based, community nutrition programs for children and families**
   PHNs and LHNs should co-design and fund group-based and community-led initiatives—such as parent coaching for mealtimes, sensory-friendly food exposure, or antenatal and early years nutrition education—delivered by APDs in partnership with allied health teams. Pooled funding (e.g., Medicare items, state prevention budgets) can sustain these programs beyond short-term pilots.
7. **Leverage Dietitians Australia's local networks**
   Dietitians Australia's state branches and local members provide on-the-ground expertise for co-designing child and family nutrition initiatives. Engaging this network ensures programs are evidence-based, culturally safe, and responsive to community needs.

Rationale
Embedding APDs in Collaborative Commissioning for *Thriving Kids* strengthens equity and quality of care by recognising nutrition as a foundation of healthy child development. APDs bring specialist skills in addressing growth faltering, restrictive diets, ARFID, and chronic disease prevention, complementing speech pathology and OT. Without dietitian inclusion, early intervention risks remain fragmented, and children with nutrition-related challenges may miss timely support.

Nutrition-sensitive indicators are essential for accountability, ensuring gaps in access and outcomes—particularly for Aboriginal and Torres Strait Islander children, children with disability, and those in rural areas—are visible and addressed. Sustainable funding models enable innovation and continuity, from food-first approaches to dietitian-led multidisciplinary clinics.

In practice, this could include:

- PHNs commissioning APD-led feeding and nutrition programs in partnership with schools, early learning, and child health services.
- LHNs integrating APDs into discharge planning so children with feeding concerns or growth faltering receive community follow-up.
- Community-based group programs delivered by dietitians and allied health teams to support parents with mealtime coaching, sensory food exposure, and label reading.
- Culturally tailored nutrition initiatives co-designed with ACCHOs to improve child health, food security, and family wellbeing.

By embedding APDs "at the table," Collaborative Commissioning for *Thriving Kids* can move beyond siloed models, integrate nutrition as a core element of child development, and deliver consistent, family-centred care across Australia.

Attachment 3 Allied health workforce exodus, burnout and retention

Context

According to the 2025 Workforce Census, of the 60,278 employees reported, **2,705 were allied health professionals** and **254 were allied health assistants**, making up a relatively small proportion compared to disability support workers. Allied health professionals are mainly in permanent roles 46% permanent full-time, 44% permanent part-time, and 5% casual and fixed term. This is far more stable compared to disability support workers (41% casual). However, there was a **net loss of 134 permanent allied health professionals** in 2024. Overall, **turnover for permanent staff sits at 16%, among the highest across industries in Australia. Losses in permanent positions show vulnerability in workforce planning.** Fatigue, high caseloads, and NDIS system pressures contribute to attrition, despite providers report investing about $61,000 annually per organisation in wellbeing and burnout-prevention initiatives. Dietitians face emotional toll, complex client caseloads, and system frustrations (NDIS processes, limited career pathways), contributing to attrition. Funding models that cut or freeze allied health pricing put dietitians further at risk of underutilisation, despite their critical role in nutrition, swallowing, and complex care supports.

Pricing fallout:

- **June 2024 - 25%** APDs in disability considering stopping some or all services to NDIS participants due to the ongoing pricing restrictions since 2019.
- **June 2025 - 64%** of APDs in disability considering ceasing or reducing NDIS services.
- **Significant risk of losing expertise in nutrition support**s for people with disability.

Continued lack of consultation, transparency and information makes it very hard to plan and have confidence in providing dietetic and nutrition services in the disability sector.

Recommendation

1. **Workforce planning for Accredited Practising Dietitians (APDs) should be embedded in the design and delivery of Thriving Kids.**
   To ensure sustainability, this must be supported by independent pricing reform and explicit recognition of APDs within NDIS and disability workforce strategies.