Submission
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INQUIRY INTO FOUNDATIONAL AND DISABILITY SUPPORTS AVAILABLE FOR CHILDREN AND YOUNG PEOPLE IN NEW SOUTH WALES

Organisation: Parents of Deaf Children

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Submission to the NSW Inquiry into Foundational Supports for Children and Young People with Disability, Developmental Concerns or Delay
Barriers to Access for Deaf and Hard of Hearing Children and Their Families

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Parents of Deaf Children (PODC) is a long-standing, family-led organisation based in New South Wales, with more than 60 years of experience supporting families raising deaf and hard of hearing (DHH) children. Our work is grounded in the lived experience of families, and this submission draws on decades of frontline engagement, research, community consultation, and direct service delivery.

Families of DHH children in NSW continue to face significant barriers across all systems—health, education, disability, and mainstream services. These challenges are not new, but they are persistent, and too often, they are invisible in the design of foundational supports. The barriers outlined in this submission affect families across the full spectrum of hearing loss—from mild to profound—and are felt acutely in regional, rural, and culturally diverse communities.

We have heard from families who are denied early intervention because their child's audiogram does not meet rigid eligibility thresholds. Others are offered speech-focused services with no access to Auslan, Deaf mentors, or culturally safe programs. Parents—especially Deaf parents—are regularly excluded from parenting and health services because of inaccessible communication. In schools, children are frequently misunderstood or unsupported, while families navigate complex systems with little guidance or recognition. These systemic gaps result in children being left behind—not because of their hearing loss, but because the systems around them do not respond to their needs. Families are exhausted. Many have been forced to fund private therapy, battle for inclusion in education, or give up on accessing services altogether due to the emotional and financial toll. Foundational supports should reduce barriers, not reinforce them. But the current model leaves many children and families excluded, isolated, and at risk of long-term developmental, social, and emotional impacts.

This submission highlights the real-world barriers families face and the urgent need for change. It presents detailed evidence of the failures in service design and delivery and offers clear recommendations to build a more inclusive, equitable, and responsive support system.

We urge decision-makers to engage in genuine co-design with Deaf and family-led organisations, and to ensure that lived experience drives reform. Organisations like PODC must be funded to continue our critical work, and families must be supported—not sidelined—in the systems intended to serve them.

Every child deserves the opportunity to thrive. That starts with ensuring that the supports around them are accessible, inclusive, and built with the voices of those who know them best: their families.

Summary of Systemic Barriers

Families of deaf and hard of hearing (DHH) children in New South Wales face persistent barriers across all stages of life and systems of support. These barriers affect access to early intervention, health services, disability support, education, and participation in community life. They disproportionately impact families in regional and remote areas, culturally and linguistically diverse (CALD) communities, First Nations families, and Deaf parents.

These barriers are systemic in nature and tend to fall into the following areas:

Health and Hearing Services

Children with mild, unilateral, or fluctuating hearing loss are consistently excluded from early intervention pathways due to restrictive eligibility criteria that focus on the severity of audiograms rather than the child's functional needs. This approach overlooks the well-established impacts of listening fatigue, inconsistent access to spoken language, social withdrawal, and delayed language development, all of which may occur regardless of how the hearing loss appears on paper.

The SWISH (Statewide Infant Screening – Hearing) program is designed to detect bilateral permanent hearing loss, but it often misses children with fluctuating, unilateral, or auditory neuropathy spectrum disorders. These children are left without follow-up, monitoring, or pathways to support. Even when a diagnosis is made, families often struggle to navigate a fragmented system where audiologists, general practitioners, paediatricians, and early intervention providers are not communicating or working together.

The Hearing Services Program (HSP), which funds hearing aids for children, only covers base-level technology. These devices may provide amplification, but often lack features like directional microphones, Bluetooth connectivity, and Roger/FM compatibility that are critical for children's participation in noisy environments like classrooms and playgrounds. Families who want these essential features must pay for expensive upgrades out of pocket. A single upgraded hearing aid can cost between $3,000 and $5,000, with Roger/FM systems ranging from $2,000 to $6,000 depending on the setup. Additional accessories such as remote microphones, battery packs, and streaming devices can further increase the cost.

An additional concern is the limitation within the HSP to supply only one receiver for Roger/FM systems, even for children who wear two hearing aids. This creates unequal access for children with bilateral hearing loss, as effective sound transmission to both ears is crucial for classroom comprehension, localisation of sound, and listening in noisy spaces. The cost of a second receiver—often exceeding $1,000—is unaffordable for many families, further widening the gap in learning and participation between children who can and cannot access dual-ear technology.

While hearing aids may amplify sound, this does not guarantee meaningful access to spoken language. Children may still struggle to understand speech in noisy settings or group environments. Yet, functional assessments such as Cortical Auditory Evoked Potentials (CAEPs), speech-in-noise testing, and aided audiograms are not routinely provided. These assessments are necessary to determine whether the child is truly accessing sound in real-world contexts and should form part of standard care.

Some families are directed toward cochlear implantation not because it is the most appropriate clinical solution, but because cochlear implants are fully funded, while high-quality hearing aids and support equipment are not. This financial bias risks pushing families towards medical interventions over more suitable, less invasive options.

Audiology reports are another weak point in the current system. Many focus narrowly on the technical results of hearing tests, without addressing the child's communication needs or daily functioning. These reports are not written in a way that supports families to apply for educational adjustments or NDIS funding, and there is a lack of shared planning between audiology and developmental or educational services.

Health

Health services play a crucial role in supporting children's development and wellbeing, but current mainstream healthcare systems are not meeting the needs of deaf and hard of hearing children or their families. There remains a widespread lack of awareness and understanding of the social, linguistic, and developmental impacts of hearing loss—especially in relation to early language access and the risks of language deprivation.

Families frequently report that health professionals—including general practitioners, paediatricians, maternal and child health nurses, and early childhood health workers—have limited knowledge of the communication needs of deaf children. Advice often centres around hearing devices, with minimal discussion of visual language access, Auslan, or the importance of early, fluent language exposure. As a result, families are left without critical information needed to make informed decisions about their child's communication and development.

Deaf parents also face significant barriers in accessing healthcare. Hospitals, clinics, and allied health providers routinely fail to provide Auslan interpreters for appointments, birthing services, or mental health care. Booking systems are inaccessible, consent processes are rushed or unclear, and communication support is often treated as optional. This compromises care, undermines autonomy, and leads to poor health outcomes.

There is also limited understanding within health settings of the lived experience of being deaf or raising a deaf child. Deaf cultural perspectives are not embedded in training, and most health professionals are unfamiliar with the long-term cognitive, social, and emotional consequences of language deprivation. This gap in professional knowledge contributes to harmful assumptions, misdiagnosis, and inconsistent referrals.

Health services are rarely integrated with early intervention, education, or disability systems, resulting in families having to coordinate supports across disconnected programs. There is no clear referral pathway from diagnosis to culturally safe and language-accessible supports, and little accountability for ensuring that families receive timely, coordinated care.

Mental health is another critical area where deaf and hard of hearing children, young people, and their families face systemic exclusion. There is a chronic shortage of Auslan-accessible and Deaf-aware mental health services across all age groups. Mainstream counselling and psychological services are rarely equipped to work with clients who are Deaf or who communicate using Auslan, and interpreters are often not provided. This lack of access means that early signs of distress, trauma, or mental ill health are frequently missed or misinterpreted.

Children who have experienced language deprivation or exclusion often present with behaviours or difficulties that are misunderstood by professionals unfamiliar with Deaf development. This can lead to incorrect diagnoses, inappropriate treatment plans, or no mental health support at all. For Deaf children and adolescents navigating mainstream environments without adequate communication access, the cumulative impact of social isolation, academic challenges, and identity struggles can place them at high risk of mental ill health.

Deaf parents also report feeling excluded from mental health support networks, including perinatal mental health programs, postnatal counselling, and parenting supports. The absence of culturally safe, language-accessible services undermines wellbeing and leaves many families to cope without professional guidance.

These gaps point to a Health and Hearing Services system that is not designed with the realities of deaf and hard of hearing children in mind. The current model is reactive, diagnosis-driven, and poorly integrated with broader developmental supports. A more inclusive approach would prioritise functional access to language, subsidise appropriate technology, incorporate routine functional testing, and build collaborative pathways between audiology, health, education, and early intervention providers.

Early Intervention and Disability Services

A key gap in the early intervention system is the lack of a structured and nationally recognised framework for the delivery of Auslan as part of a child's language development. While speech and auditory-based pathways are well-resourced, coordinated, and tracked through formalised models of care, Auslan is often treated as an optional add-on rather than a legitimate language pathway. There is no consistent guidance, funding structure, or developmental framework for Auslan acquisition in early intervention, despite it being a full and natural language that can serve as a child's primary or simultaneous language.

This creates inequality between communication pathways. Children who are placed on a spoken language-only path are supported with speech therapy, auditory-verbal programs, device mapping, and progress tracking. In contrast, children learning Auslan—either due to personal choice or limited benefit from hearing technology—are rarely given the same intensity or structure of support. Families are expected to find their own Auslan teachers, fund tuition privately, and navigate fragmented and underfunded programs. This limits the effectiveness of a bilingual or bimodal approach and increases the risk of language deprivation.

A bimodal bilingual approach—where children learn both Auslan and English, through sign and speech—is widely supported in research as the most flexible and protective model for many deaf children. It allows for full access to language through both visual and auditory means, supports literacy in both languages, and builds communication resilience across diverse environments. Yet, in practice, families are discouraged from using Auslan if their child has any access to sound. This undermines the right to choose a bilingual path and denies children access to the cognitive, social, and academic benefits of full language exposure from the start.

Early intervention is a critical window of opportunity for deaf and hard of hearing (DHH) children, yet many families face delays or exclusion due to systemic misunderstandings and rigid eligibility processes. Access is often denied or limited not because the child lacks need, but because the systems are structured around outdated assumptions about severity of hearing loss rather than the actual functional impact on language development, communication, and participation.

Children who do not meet strict audiological thresholds—such as those with mild, moderate, unilateral, or fluctuating hearing loss—are frequently excluded from early intervention programs altogether. This creates a dangerous 'wait and see' approach during a time when consistent and early language access is critical. By the time a language delay becomes apparent, crucial neural pathways may already be underdeveloped, requiring significantly more intervention to catch up.

In addition, early intervention services are often skewed toward an auditory-verbal model, with limited support for bilingual (Auslan and English) language development or visual communication. Families are rarely presented with a full range of communication options, and many report being discouraged from exploring sign language pathways even when their child receives limited benefit from hearing devices. This restricts informed choice and prevents families from selecting the most appropriate path for their child's needs.

Support coordinators, early childhood partners, and Local Area Coordinators (LACs) often have limited training in hearing loss, language deprivation, or the role of visual language. As a result, assessments and planning meetings can feel dismissive or adversarial, with families left to advocate for essential supports without professional backing. Parents are routinely told their child is 'not deaf enough' for services like Auslan tuition, Deaf mentors, or social connection programs, despite evidence of language deprivation or communication breakdown.

Many early intervention services are also not accessible or inclusive for Deaf parents. Deaf adults parenting DHH children are often left without interpreters or visual communication resources in parent education sessions, case meetings, or therapy environments. This undermines their ability to participate in their child's development and can lead to missed opportunities for culturally aligned role modelling and peer support.

Workforce limitations also contribute to inconsistent quality and access. There are very few practitioners trained to support bilingual language development, auditory neuropathy, or fluctuating hearing loss. Regional and rural areas are particularly impacted, with long waitlists, limited provider choice, and families travelling long distances to access basic services.

Additionally, early intervention planning rarely includes functional assessments or developmental milestone tracking tailored to the DHH population. Families need access to specialists who understand the intersection of hearing loss, early language acquisition, sensory development, and behaviour. Without this expertise, children may be misdiagnosed with cognitive delay or behavioural disorders when the real issue is language deprivation or environmental inaccessibility.

Finally, access to early intervention through the NDIS is limited by diagnostic criteria that do not account for fluctuating or less severe hearing loss. Even when children are accepted into the scheme, the supports provided often do not include what families truly need—Auslan instruction, interpreter access, family education, or identity-building programs. Plan reviews regularly reduce or remove key supports without consultation, leaving families scrambling to rebuild their team or fund services privately.

An effective early intervention system must be timely, flexible, and led by the needs of families. It must include Deaf cultural perspectives, provide accessible information about all communication options, and invest in a workforce with the skills to support the diverse experiences of deaf and hard of hearing children.

Communication Access and Auslan

Access to language is a fundamental right, yet for many deaf and hard of hearing children and their families, communication supports are inconsistent, poorly funded, and often inaccessible. Despite Auslan being the native and preferred language of the Australian Deaf community, families are rarely provided with timely or adequate access to Auslan instruction, Deaf mentors, or communication supports that match their needs.

Many families are unaware that Auslan is a valid and accessible first language for their child. There is limited public awareness, and early intervention providers frequently fail to include visual language options in service planning. In practice, families are often discouraged from pursuing Auslan unless their child is classified as profoundly deaf—even though research clearly shows that early exposure to visual language reduces the risk of language deprivation and improves cognitive, social, and educational outcomes.

The lack of embedded communication access planning results in children missing critical opportunities to develop language in the early years. Families who choose to pursue Auslan are left to fund tuition privately, source materials themselves, or wait on long waiting lists for scarce services. Many report significant out-of-pocket costs, limited availability of qualified instructors, and a lack of continuity in support. There is also little recognition of the need for ongoing access to Auslan across the life span, including in schools, community settings, and healthcare.

Access to qualified Auslan interpreters remains a challenge across all domains. In many early learning settings, Deaf parents report being excluded from meetings, events, and information sessions due to the unavailability of interpreters. Similarly, children and young people who require Auslan in classrooms or community programs are often denied interpreting support unless they meet rigid eligibility criteria.

The system does not yet treat Auslan as equal to spoken language. While speech and auditory-verbal approaches are supported through formal programs, funded therapy, and national clinical pathways, Auslan remains marginalised. This results in missed opportunities for bilingual development, reduced family participation, and a failure to uphold the child's right to full language access.

What is needed is a systemic shift that recognises Auslan as a legitimate, accessible, and valuable pathway for language acquisition. Communication access must be embedded across foundational supports, and Auslan should be available to any family who chooses it—not only those who meet arbitrary thresholds. Deaf cultural knowledge and community-led language programs should be resourced and recognised as essential components of inclusive early childhood and education systems.

Education and Inclusion

Deaf and hard of hearing (DHH) students continue to face systemic barriers in mainstream education settings, where inclusive practice often exists more in policy than in lived reality. While access to education is a legal right, equitable participation remains out of reach for many, due in large part to a widespread lack of understanding of deaf learners' needs, inconsistent support practices, and a fragmented system that relies on outdated assumptions.

A significant barrier is the Department of Education's access request process. This process is supposed to determine whether a student is eligible for additional supports, but in practice, it relies heavily on audiological data—such as hearing thresholds—rather than the actual functional impact of hearing loss on learning, language access, and wellbeing. The process does not differentiate between students who are prelingually deaf and those who are post-lingually deaf, even though these students have vastly different developmental and linguistic needs.

Prelingually deaf children, particularly those who have experienced delayed identification or inconsistent early access to language, may present with language deprivation. These students often require daily support to access and develop language—whether spoken or signed—yet the access request system does not acknowledge this. Children with strong expressive language may still struggle with comprehension, vocabulary, and processing, but if their speech is clear, they are often perceived as coping. This results in many being denied vital supports such as one-on-one assistance, Auslan access, or visual communication tools.

Itinerant teachers of the deaf are intended to provide specialist support and help schools implement appropriate adjustments. However, these teachers are often managing excessive caseloads and are only able to provide brief, infrequent check-ins with students. This is far from sufficient, especially for students who require structured language support, scaffolding of academic content, or guidance for classroom teachers on communication access. In many schools, itinerant support is treated as a compliance measure rather than an active educational strategy.

Compounding this is the widespread absence of fluent Auslan language models in educational settings. For students who use Auslan as their primary or supplementary language, access to adult signers and Deaf mentors is crucial for linguistic and cultural development. Yet most schools have no Auslan-fluent staff, no funding to employ Deaf support workers, and no consistent exposure to visual language. This deprives students of natural language acquisition, peer interaction, and participation in classroom discourse.

Teachers and school staff often lack foundational knowledge about deafness, leading to assumptions that hearing aids or cochlear implants restore full access. There is also a lack of awareness and implementation of essential assistive technologies, including classroom captioning tools, personal FM and Roger systems, and soundfield amplification systems. These supports, which can drastically improve access to learning for DHH students, are inconsistently applied and often misunderstood. Captioning, in particular, is rarely embedded as a standard adjustment—even though many students benefit from the visual reinforcement of spoken content. Instead, schools tend to rely on verbal instruction alone, placing the onus on students to constantly adapt to inaccessible environments. There is limited professional development in inclusive practices for deaf students, and many schools are unaware of how to support captioning, soundfield amplification, or other basic adjustments. As a result, DHH students are frequently left to navigate complex communication environments without meaningful support.

Access requests are inconsistently submitted, poorly completed, or rejected based on inadequate evidence. Parents are often expected to advocate repeatedly, provide multiple professional reports, and challenge decisions in order to secure even minimal support. Many families describe being worn down by the process or pressured into accepting insufficient adjustments. This experience is even more challenging for families from culturally and linguistically diverse backgrounds, or those living in rural and regional areas.

True inclusion requires a shift in how deaf education is understood and delivered. Hearing loss is not just a medical issue—it is a language and communication issue that affects access to every aspect of learning. Inclusion must start with understanding, be driven by lived experience, and be supported by consistent, coordinated action. The recent redundancy of the Department's Complex Sensory Support Advisor role further compounds these issues. This role provided expert guidance on the intersection of hearing, vision, and communication needs—particularly for students with multiple disabilities or those requiring highly individualised supports. With this position now removed, schools have lost a key source of specialised advice at a time when students with complex sensory profiles are already struggling to receive equitable access. The absence of a dedicated advisor limits the

Department's capacity to implement evidence-informed strategies and results in further fragmentation between health, education, and disability systems. Unlike other states such as Queensland—which offers comprehensive educational supports including qualified educational interpreters, language models, and Auslan translations of the full K–12 curriculum—New South Wales remains significantly behind. Queensland also provides a dedicated Auslan resource portal, the Auslan Project, and has system-wide access to Deaf education specialists who actively support schools in implementing inclusive practices. In NSW, these structures are lacking. There is no equivalent investment in visual language access or Deaf cultural inclusion within the curriculum. This inequity across state lines has real consequences, resulting in lower levels of access, identity development, and educational outcomes for deaf and hard of hearing students in NSW. Other states, such as Victoria and South Australia, have also embedded bimodal bilingual classrooms into their public school systems. These classrooms support the use of both Auslan and English, recognising the importance of developing fluency in both a visual and spoken language. This model supports cognitive flexibility, promotes stronger educational outcomes, and affirms Deaf identity. In contrast, New South Wales has no formal provision for bimodal bilingual education within the public school system, limiting the choices available to families and reducing the accessibility of bilingual learning environments for children who would benefit from them. Unlike many hearing support units that prioritise speech and device use, these bilingual classrooms focus explicitly on language development—supporting both Auslan and English as part of a cohesive educational model. This commitment to language over modality gives families greater flexibility and supports stronger language acquisition outcomes. As a result, some families have felt forced to relocate interstate in order to access these inclusive and language-rich programs—highlighting the lack of equitable options available within the NSW public education system., yet for many deaf and hard of hearing children and their families, communication supports are inconsistent, poorly funded, and often inaccessible. Despite Auslan being the native and preferred language of the Australian Deaf community, families are rarely provided with timely or adequate access to Auslan instruction, Deaf mentors, or communication supports that match their needs.

Systemic Fragmentation

Families of deaf and hard of hearing children are often forced to navigate a fragmented web of services, each with its own criteria, language, and process. There is no single, coordinated system to guide families through early diagnosis, early intervention, technology provision, education support, and community inclusion. Instead, families must act as the coordinator, advocate, and educator in systems that frequently contradict or ignore each other.

Health, disability, and education systems operate in silos, with little communication between professionals. Audiologists may not refer to early intervention services; early childhood educators may not understand the implications of auditory access; and NDIS planners often have no training in deafness or communication needs. As a result, children fall through the gaps—not because of a lack of need, but because the systems are not designed to work together.

Parents report having to repeat their child’s story multiple times to different agencies, fill out overlapping assessments, and chase reports across departments. Critical decisions about access to supports, including early intervention and classroom accommodations, are made in isolation by professionals who may not understand the broader context of the child’s development or family needs.

This fragmentation is especially harmful for children with complex needs or those from marginalised communities. For First Nations families, CALD communities, Deaf parents, and those in regional or remote areas, navigating disconnected systems without culturally safe, accessible, or language-appropriate guidance can result in complete disengagement.

Despite repeated recommendations from inquiries, commissions, and research, there remains no central, multidisciplinary pathway that brings together health, disability, and education professionals to collaborate with families. Early intervention providers are not automatically linked with audiology clinics. Schools are not trained to build on early language foundations. Families are left without continuity or consistency in care.

To address this, foundational supports must be underpinned by cross-sector coordination and service integration. Deaf and hard of hearing children cannot afford to lose time in fragmented systems—language development, social inclusion, and academic achievement depend on timely, informed, and collaborative action

NDIS Access and Support

Accessing the National Disability Insurance Scheme (NDIS) remains one of the most significant and persistent barriers for families of deaf and hard of hearing children. While the NDIS is designed to provide individualised support based on functional needs, in practice, many children are excluded from accessing supports due to restrictive interpretations of eligibility criteria that prioritise diagnosis over impact.

Families frequently report being told that their child is 'not deaf enough' to qualify for access or meaningful support, even when clear evidence exists of communication challenges, listening fatigue, social exclusion, and developmental delay. This disproportionately affects children with mild, moderate, unilateral, or fluctuating hearing loss—many of whom experience real-world barriers to learning, participation, and language acquisition.

Even when children do meet access criteria, the planning process often fails to recognise the role of language deprivation, bilingual language needs, and communication access. Auslan tuition, Deaf mentoring, captioning tools, and interpreting support are routinely denied unless the child meets rigid audiological thresholds. Requests for visual language access are frequently challenged, with some planners suggesting that hearing devices alone are sufficient—despite evidence to the contrary.

There is also a lack of consistent access to assistive technology. Tools such as personal FM systems, captioning apps, visual alerting devices, and real-time transcription tools are often considered “not reasonable and necessary” if they fall outside what is offered by the Hearing Services Program. This leaves families to self-fund essential tools or go without. In contrast, families of hearing children with comparable functional challenges often receive timely access to appropriate supports.

Compounding these barriers is the lack of deaf-specific knowledge among planners, Local Area Coordinators (LACs), and Early Childhood partners. Many families report being forced to educate their planner about deafness, explain why Auslan is necessary, or prove repeatedly that their child’s support needs are ongoing. This results in inconsistent plans, cuts to vital supports at review, or an exhausting cycle of advocacy with no clear pathway for resolution.

NDIS planning rarely takes into account whether a child has experienced language deprivation, or whether their communication environment is fully accessible. Children who have missed early language milestones due to inaccessible services are treated the same as those with early, consistent access to language—despite having vastly different needs. Supports for communication access in mainstream settings are particularly difficult to secure, and families are often left without any mechanism for inclusion in their communities.

Additionally, psychosocial and mental health supports for deaf and hard of hearing children are almost impossible to access unless there is a formal co-occurring diagnosis. Children experiencing social withdrawal, anxiety, or frustration due to language barriers are unlikely to receive funding for psychology or counselling—particularly if services are not Deaf-aware or Auslan-accessible.

The lack of funded Deaf mentors, identity-building programs, and peer connection also has long-term consequences for wellbeing. These supports are essential for building self-esteem, resilience, and a positive sense of Deaf identity. Yet they are rarely included in plans, and often not understood as necessary supports by planners unfamiliar with the lived experience of deafness.

Ultimately, the current system places the burden on families to fight for every support. This disadvantages families with less time, less knowledge of the system, or fewer financial resources to pay for private reports. For deaf and hard of hearing children to access equitable and meaningful support through the NDIS, systemic reforms are needed to embed lived experience, improve planner training, recognise language deprivation, and ensure visual language access is treated as a right—not an exception.

Inaccessible Mainstream Parenting, Pregnancy, Health, and Advocacy Supports

Mainstream supports funded through state and Commonwealth programs—such as parenting education, pregnancy health services, Centrelink, playgroups, DCJ child and family services, and community workshops—are rarely inclusive of deaf and hard of hearing families. Despite being designed as universal services, they often fail to provide accessible communication formats or culturally safe engagement for Deaf parents and carers, or for families raising deaf children.

These programs typically rely on spoken and written English, with no Auslan translation, captioning, or visual supports. Parenting support services are rarely equipped with staff trained in communicating with Deaf parents or understanding the language access needs of deaf children. This leaves families isolated from programs that could otherwise offer early guidance, connection, and practical support.

Playgroups, swimming lessons, family days, council-run events, and library programs are frequently inaccessible. Even when inclusion is promised, interpreters are often not booked, communication support workers are unavailable, and staff are unaware of how to accommodate Deaf or hard of hearing attendees. For many families, this results in complete exclusion from everyday community life.

Pregnancy and maternal health services—including hospital antenatal classes, child and family health clinics, and perinatal mental health programs—often fail to provide interpreters or appropriate communication strategies for Deaf parents. This compromises informed consent, safety, and access to critical early support.

Deaf families also face significant barriers navigating government agencies. Centrelink, the Department of Communities and Justice (DCJ), the Office of the Children’s Guardian, and family advocacy organisations rarely offer pathways for Deaf-friendly engagement. Information is not available in Auslan or Easy Read, online systems are inaccessible, and phone-based services present significant communication barriers.

While many of these services are designed to provide advocacy or support to vulnerable families, they often lack the expertise to understand the unique risks associated with language deprivation, limited access to communication, and systemic exclusion. As a result, Deaf parents and carers are frequently misjudged, under-supported, or denied access to services meant to protect and empower them.

Deaf-led and peer-informed organisations like PODC (Parents of Deaf Children) play a vital role in bridging these gaps. However, they remain chronically underfunded and are often excluded from broader service delivery frameworks. Ensuring that these families can access foundational parenting, health, and community services requires investment in access, communication equity, and community-led service design.

Mainstream Community Supports and Public Spaces

Mainstream community services and public programs are rarely designed with deaf children or Deaf parents in mind. While many councils and organisations promote inclusion, their interpretation of accessibility often overlooks communication access entirely. As a result, many families find themselves excluded from everyday community experiences that most others take for granted.

Local playgroups, parenting sessions, libraries, recreation programs, and community events frequently do not provide Auslan interpreters, captioning, or visual alternatives. Staff are often untrained in engaging with Deaf or hard of hearing families, leading to awkward or exclusionary interactions. Families describe turning up to “inclusive” events only to find no communication supports in place, forcing them to leave or sit silently on the sidelines.

Public venues—including cinemas, leisure centres, and museums—rarely prioritise communication access. Captioned screenings are limited or held at inconvenient times, live events are not interpreted, and exhibition spaces rely heavily on audio guides or spoken presentations without visual alternatives. Even basic infrastructure like visual emergency warnings or signage is often lacking, creating risks in public environments.

Deaf parents also experience systemic exclusion. Participation in school P&C committees, parenting workshops, family support groups, or council consultations is often impossible without Auslan access or culturally competent facilitation. As a result, many Deaf parents are cut off from the broader parenting community and miss key opportunities to engage in decisions that affect their child’s learning and wellbeing.

The impact of these barriers is especially acute for complex families—those navigating multiple vulnerabilities such as socioeconomic disadvantage, regional isolation, language barriers, or additional disabilities. These families often rely more heavily on public and community services, yet they face the highest degree of exclusion. Without access to interpreters, visual information, or culturally safe support, their ability to engage with community life is severely limited.

Parents of Deaf children who are also Deaf themselves face double exclusion. Not only are their children's needs misunderstood or overlooked, but they themselves are excluded from key parenting spaces and decision-making forums due to inaccessible services. CALD families raising deaf children encounter additional language and cultural challenges, with little to no support tailored to their circumstances. Families of children with DeafPlus needs—deaf children with additional disabilities—are particularly disadvantaged, often falling through the cracks between siloed services.

PODC works with many such families and hears repeatedly that they are not looking for special treatment—just equal access. These systemic barriers, when layered upon complex family contexts, lead to compounding disadvantage. Children miss out on formative experiences, parents are unable to advocate or participate fully in community life, and opportunities for inclusion and belonging are lost.

Families living in regional and remote areas face even greater exclusion due to the absence of local Auslan-fluent staff, interpreters, and culturally appropriate programs. Accessible community events or inclusive family workshops are almost non-existent outside major cities, forcing families to travel long distances—if they can afford to—or miss out altogether. The lack of local resources leaves many feeling disconnected and unsupported within their own communities.

Carers and parents with disability also face unique challenges. Services rarely provide accessible formats or physical adjustments to ensure inclusive participation. Deaf parents, in particular, encounter compounded barriers when navigating programs designed without consideration of both their child's and their own access needs. Assumptions about capacity and poor communication access create a culture of exclusion, even in spaces that claim to support diversity and inclusion.

For these families, foundational supports are not just about specialist services—they are about equitable access to everyday life. Without intentional inclusion in community design, Deaf families and those supporting children with hearing loss are left behind in systems that were never built for them. Recognising intersectionality—and resourcing for it—is essential if we are to shift from tokenism to true equity.

What Needs to Be Done: Moving Toward Equity Through Action and Collaboration

The barriers outlined in this submission are not new. Many have been raised repeatedly by families, professionals, advocates, and Deaf community members over decades. What has been missing is not awareness—but action. The time has come to move beyond consultation and towards genuine, funded implementation of solutions that are community-informed, culturally safe, and built for equity.

At the heart of this is the recognition that deaf and hard of hearing children are not a homogenous group. Their needs vary depending on hearing level, language access, geographic location, additional disabilities, cultural background, and family circumstances.

The systems that serve them must be flexible, responsive, and individualised—not constrained by rigid eligibility criteria or siloed funding models.

To achieve meaningful change, the following must occur:

- **Bimodal bilingual pathways from birth must be standardised.** Every family should be given access to both spoken language and Auslan from the point of diagnosis, regardless of hearing level. This means establishing national standards and structured pathways that support bilingual language acquisition, ensuring that all children can develop robust communication and cognitive foundations from the earliest months of life.
- **Language access must be non-negotiable.** Auslan is not an optional support—it is a language. All public services and programs, including health, education, community, and parenting initiatives, must embed visual language access as a core requirement. Captioning, Auslan interpretation, and visual communication tools must be routinely funded and available.
- **Foundational supports must be accessible to all children with hearing loss, regardless of their audiogram.** Early intervention, NDIS, and educational supports should be based on the functional impact of hearing loss, not arbitrary severity categories. The cost of exclusion is too high, both developmentally and socially.
- **State and federal systems must work together.** True inclusion requires cross-sector planning. Education cannot succeed without health; disability supports cannot function without language access; early intervention cannot be effective if it’s isolated from family support. Coordination across these systems must be funded and mandated.
- **Specialist organisations must be resourced.** PODC and similar Deaf and family-led organisations provide culturally safe, trusted support that generalist services cannot replicate. Without secure, long-term funding, these organisations are at risk—along with the families who depend on them.
- **Equity must extend to regional, CALD, and complex families.** Outreach, targeted funding, and flexible service models are needed to ensure all families—regardless of postcode, language background, or complexity—can access the same standard of support.
- **Lived experience must lead.** Government must prioritise the voices of people with lived experience—including Deaf adults, Deaf parents, and families of deaf children—over the perspectives of service providers or institutions. Solutions must reflect what communities know works, not what systems find easiest to deliver.
- **Undertake a full audit of foundational supports.** An independent audit is needed to map existing foundational supports, identify service gaps, assess geographic and cultural coverage, and evaluate whether current services are equipped to meet the needs of deaf and hard of hearing children and their families.

- **Invest in research.** Ongoing research must be funded into the effects of auditory and language deprivation, the efficacy of bimodal bilingual pathways, long-term educational and social outcomes for deaf children, and system-level enablers for inclusive service delivery. Current data is outdated or absent in many critical areas.
- **Improve cross-sector communication and collaboration.** Health, disability, education, child protection, and family services must be supported to work together through joint planning, shared training, and coordinated case management. Families should not bear the burden of navigating disconnected services.
- **Acknowledge and address the risks of language deprivation.** Service systems must formally recognise language deprivation as a preventable developmental risk. Ensuring consistent and accessible language exposure—whether through Auslan, spoken language, or both—should be a core objective across early intervention, education, and healthcare.
- **Invest in early intervention centres that embed bimodal bilingual development.** Support the creation and sustainability of centres that provide rich, accessible language environments from birth. These should be family-centred, culturally safe, and led by teams of Deaf and hearing professionals working together to support children's spoken and signed language development. Families of deaf children have carried the burden of navigating broken systems for too long. If we want an inclusive future, we must commit to building it—together.

Deaf and hard of hearing children and their families continue to face systemic barriers across foundational supports, including health, education, early intervention, and community services. These barriers—ranging from narrow eligibility criteria and language deprivation to inaccessible programs and underfunded support structures—impact development, learning, and inclusion, particularly for families in regional areas, CALD communities, and those with complex needs. Despite these challenges, practical and proven solutions exist. By prioritising co-designed, culturally safe services led by lived experience, embedding bimodal bilingual pathways from birth, and funding peer-led organisations like PODC, the NSW Government has an opportunity to create a truly inclusive system. We welcome the opportunity to work together in partnership to improve access, equity, and outcomes for all deaf and hard of hearing children

Suzanne Robertson
President

Glossary of Terms

Auslan – Australian Sign Language, the visual language of the Australian Deaf community.

Bimodal Bilingualism – An approach where a child learns two languages through different modalities (e.g. Auslan and spoken English), supporting full language access and cognitive development.

CALD – Culturally and Linguistically Diverse; refers to individuals and communities with cultural backgrounds and languages other than English.

Culturally Safe – Services or practices that are respectful of and responsive to a person's cultural identity, especially regarding language and community values.

Deaf – With a capital "D", refers to individuals who identify as part of the Deaf community and use Auslan as their primary language.

DeafPlus – Refers to deaf children who also have one or more additional disabilities or diagnoses.

Early Intervention – Services and supports provided to children in the early years (typically 0–6) to address developmental delays or disabilities and promote optimal development.

Foundational Supports – A category of supports available to all children and families outside the NDIS, including early childhood education, community-based supports, and health services.

Functional Impact – The effect a condition (such as hearing loss) has on a person's ability to participate and function in everyday activities, rather than the severity of the diagnosis alone.

Language Deprivation – A lack of access to natural language (spoken or signed) during the critical early years of development, which can lead to long-term cognitive, academic, and social delays.

Lived Experience – Knowledge gained through direct, personal experience of disability or raising a child with disability.

PODC – Parents of Deaf Children, a family-led organisation supporting families of deaf and hard of hearing children across NSW and ACT.

Visual Language Access – Communication supports that are not reliant on hearing, including Auslan, captioning, transcripts, visual cues, and text-based resources.

READING LIST

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