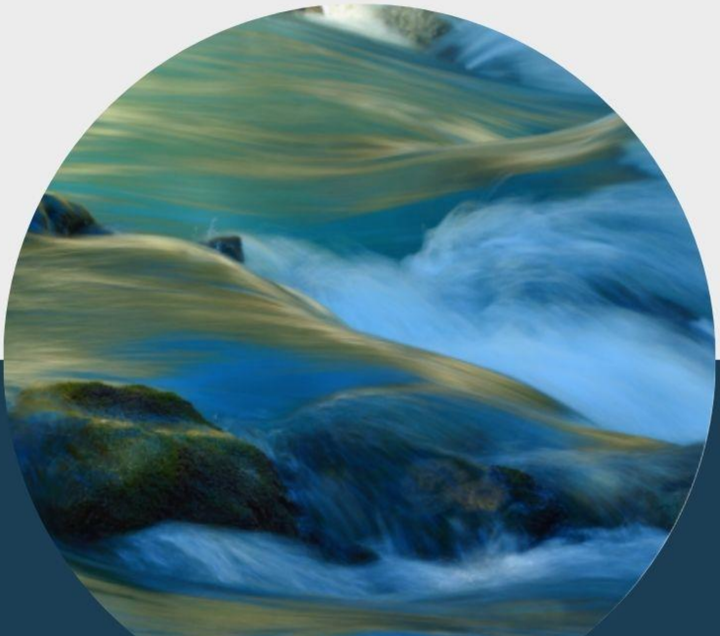
SUBMISSION ON

NDIS RULES:

PUBLIC CONSULTATION ON NEW FRAMEWORK PLANNING



OTSi

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Executive Summary

The Occupational Therapy Society for Invisible Disabilities (OTSi) welcomes the opportunity to respond to the proposed New Framework Planning (NFP) Rules under the National Disability Insurance Scheme (NDIS)**.** We support reform that strengthens sustainability, equity and consistency.

Funding allocations under the NDIS directly shape safety, housing stability, safeguarding protections, community participation & human dignity. For this reason, reforms of this magnitude must be transparent, evidence-based, independently validated, trauma-informed and grounded in procedural fairness.

At present, critical elements of the framework remain opaque. The Support Needs Assessment (SNA) methodology translating I-CAN and PECQ outputs into funding amounts has not been published. Weightings, formulas, thresholds, and budgeting assumptions are not available for scrutiny. There are no published worked examples across low, medium and high-complexity scenarios, including 24/7 supports. Independent psychometric validation of the adapted I-CAN and revised PECQ, has not been released.

Without these safeguards, there is a material risk that complex, fluctuating and intersecting disabilities will be compressed into predetermined funding bands. Such compression may disproportionately affect participants with psychosocial disability, autism, acquired brain injury, intellectual disability, cognitive impairments, progressive conditions, and trauma histories. Small miscalculations in high-risk cohorts can result in hospitalisation, safeguarding incidents, carer breakdown or institutionalisation.

OTSi recommends NDIS reform and NFP Rule implementation should be delayed until:

- Full Exposure Draft Planning, Budget and Impairment Notice Rules are released;
- Independent validation and psychometric review of I-CAN and PECQ are published;
- Budget translation methodology is made transparent and independently audited;
- Participant-provided allied health and medical evidence is formally embedded in decision-making;
- Trauma-informed, culturally safe assessment pathways are legislatively protected;
- Clear, enforceable and accessible review and replacement assessment rights are guaranteed;
- National pilot testing with public evaluation completed prior to rollout.

NDIS NFP Rules must ensure that assessment mechanisms enhance safety, dignity and choice, rather than limit them. The current austerity-driven reform[1] is typified by reported policy upheaval[2], extreme and potentially harmful levels of fear and uncertainty for participants[3], and good-faith providers trying to hold up a system in chaos. Decision-makers must prioritise stability, safe access to reasonable and necessary disability support, and the prevention of harm.

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[1] Bill Shorten defends NDIS reforms that will save government $14 billion - ABC News

[2] New NDIS algorithm designed to fix scheme at 'critical risk'

[3] 'Overwhelming sense of doom': NDIS support cuts leave families in fear – and there are more to come | National disability insurance scheme | The Guardian

CONTENTS

ABOUT THE OCCUPATIONAL THERAPY SOCIETY FOR HIDDEN AND INVISIBLE DISABILITIES

OTSi is a national society whose purpose is to enable occupational therapists who work alongside people with invisible and hidden disabilities, to reduce barriers to full participation as active citizens of Australia. OTSi has a strong voice in systemic advocacy and policy direction, as well as enabling individuals to build better lives. Currently, over 70% of OTSi members identify as having a disability and/or as carers. OTSi is a formalised organisation arising from the NDIS Occupational Therapy Community of Practice, a community comprised of over 11,000 occupational therapists. Occupational therapists play a fundamental role within the NDIS through disability evidentiary report provision, and are on the front-line delivering building capacity, therapeutic support, and working with participants towards their goals.

SUMMARY OF RECOMMENDATIONS

Domain	Recommendation	Key Actions
Impairment Notice Governance	Protect ICF alignment and prevent reductionism	**1.** Publish decision-making framework for impairment categorisation. **2.** Provide clear correction and variation rights. **3.** Embed safeguards in Rules (not operational guidance). **4.** Reconsider classification as Category D Rules given participant impact.
SNA Independent Validation & National Piloting	Ensure evidence base prior to rollout	**5.** Require independent psychometric review of I-CAN and PECQ (reliability, validity, inter-rater consistency). **6.** Conduct national pilot with public evaluation prior to implementation. **7.** Review comparable international models and literature for SNA **8.** Cost and compare OTSi NEAT model with the proposed SNA model
PECQ Governance & Safeguards	Ensure scoring transparency and validity	**9.** Clearly articulate PECQ's role within overall assessment framework. **10.** Publish how conversational responses may convert into budget impacts. **11.** Allow participants to review and amend recorded information. **12.** Safeguard branching methodology to prevent exclusion of key domains. **13.** Clarify use of PECQ data in automated or semi-automated systems. **14.** Clarify approach for participants under 18
Allied Health & Participant-Provided Evidence Integration	Ensure multidisciplinary evidentiary inclusion within SNA decision making	**15.** Mandate documented review of participant-provided allied health and medical reports as a core SNA feature **16.** Require NDIA to record all evidence used in SNA decision making. **17.** Align planning processes with safeguarding expectations of the NDIS Quality and Safeguards Commission (See appendix 1).
Assessor Qualifications	Protect quality in high-stakes funding determinations	**18.** Mandate allied health-led or supervised Support Needs Assessments. **19.** Publish minimum training and competency standards. **20.** Implement independent oversight and audit frameworks.

Domain	Recommendation	Key Actions
Targeted & Trauma-Informed Specialist Pathways	Expand pathways for complex and high-risk cohorts	**21.** Expand targeted assessment pathways beyond a narrow cohort. **22.** Establish formal trauma-informed specialist pathway for complex psychosocial disability, progressive conditions, intersecting impairments, communication differences and safeguarding risk (enabling participant choice of assessor). **23.** Include option to utilise an allied health-led model such as the OTSi NEAT. **24.** Permit multi-session and longitudinal evidence integration for highly complex participant support needs
Participant Rights & Review Mechanisms	Guarantee enforceable and accessible review rights	**25.** Guarantee right to request Replacement Support Needs Assessment. **26.** Provide transparency of algorithmic inputs and outputs **27.** Publish clear, participant-friendly review pathways. **28.** Introduce periodic audits confirming review rights are operational. **29.** Ensure access to independent advocacy.
Complex & Fluctuating Needs Safeguards	Prevent compression of needs into rigid funding bands	**30.** Enable timely funding adjustments where complexity or risk warrants. **31.** Introduce independent audits to monitor cohort-specific impacts.
Therapy Supports Framework (ICAN & Therapy Access)	Ensure ICAN is not used to restrict therapy access and replace rigid therapy categories with flexible allied health budgets	**32.** Acknowledge that ICAN has not been validated to determine therapy access, therapy categories, or capacity-building eligibility. **33.** Suspend any use of ICAN outputs to restrict or segment therapy supports. **34.** Ensure policy alignment with NDIS Act and the ICF. **35.** Remove functional domain-linked ICAN scoring to define therapy access. **36.** Withdraw proposed "general", "social", and "physical and health-related" therapy categories as not fit for purpose. **37.** Provide flexible, participant-centred allied health budgets unrestricted by artificial domain categories. **38.** Align therapy funding with participant goals and the ICF. **39.** Ensure therapy remains goal-directed and transferable across domains. **40.** Avoid structural segmentation that constrains interdisciplinary practice or participant choice.
Transparency & Budget Translation	Publish full methodology before implementation	**41.** Release Exposure Draft Planning, Budget including s.10 Rules. **42.** Publish full I-CAN and PECQ translation methodology (formulas, weightings, thresholds, ceilings). **43.** Provide worked examples across low, medium and high-complexity scenarios, including 24/7 supports. **44.** Confirm assessors retain discretion to depart from tool-generated budgets where evidence and risk warrant. **45.** Commission independent validation demonstrating real-world cost alignment. **46.** Publish de-identified cohort outcome data to monitor equity impacts.

1. Context and Comparisons

1.1 The Original Vision for the NDIS

The NDIS was founded on a vision for a social model of disability and aimed to align with the World Health Organization International Classification of Functioning, Disability and Health (ICF). The Scheme centred goals, participation and choice. The language of "impairment categories" and "impairment notices" marks a profound cultural shift. These terms are administrative constructs and reduce complex human lives to classificatory labels.

In an era of fiscal constraint, we must ask: how did we move from aspirations of social and economic participation to bureaucratic categorisation of impairment? Sustainability cannot require abandonment of dignity and the original vision for the NDIS; the principles of the NDIS Act 2013 must remain central to reform.

1.2 Concerns arising from NDIS co-design

It is important to recognise that significant concerns raised by DRCOs involved in NDIS co-design between September and December 2025 remain unresolved[4]. These organisations are still seeking basic clarity about how the Support Needs Assessment will operate. There are also unresolved concerns about transparency, fairness and rights. Participants want to understand how assessment outcomes will translate into budgets, what role automated systems may play, and what safeguards and oversight mechanisms will apply. They are seeking clear appeal pathways, timely reassessments where plans are inadequate, and trauma-informed, accessible communication throughout transition. Many have expressed reduced confidence in consultation processes to date, highlighting the need for genuine co-design and clear, accountable implementation before the new framework proceeds. Allied health and occupational therapy peaks and representative organisations were not included in departmental co-design committees for the NFP Rules.

In the absence of operational clarity, the consultation process itself risks being characterised as tokenistic. Reform of this magnitude must withstand scrutiny, not only politically but clinically, administratively and legally.

1.3 Departure from the 2023 NDIS Review

The NDIS Review 2023 recommended that needs assessments include disability evidence provided by health professionals, embedded within a co-design framework, and supported by robust safeguards[5]. The current proposal, however, departs from these recommendations in several key respects. Workforce qualifications remain undefined, the inclusion of participant and clinical evidence is uncertain, the

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[4] NDIS new framework planning: what we heard summary report | Australian Government Department of Health, Disability and Ageing

[5] Working together to deliver the NDIS | NDIS Review

methodology for translating assessment outcomes into budgets is opaque, review rights appear constrained, and implementation plans are not yet finalized moves to establish legislative instruments.

1.4. International Scoping Review and Best Practice Recommendations

The international scoping review conducted by the Health Information and Quality Authority (HIQA, Ireland) was published in August 2024, the same month the Australian Labor government changed legislation to bring mandatory Disability Support needs Assessments to the NDIS. It examined disability support needs assessment approaches across ten jurisdictions: England, Scotland, Wales, Northern Ireland, Ireland, New Zealand, Iceland, Romania, Hong Kong, and Singapore[6]. Using desktop research and expert consultation, the review identified core principles underpinning best practice disability support needs assessments. These included: co-designed, person-centred and trauma-informed processes; use of qualified and regulated professionals (particularly allied health or multidisciplinary teams) for decision-making and formulation; incorporation of multiple evidence sources rather than reliance on single point-in-time interviews; culturally safe and inclusive practice; and strong governance mechanisms for regulation, monitoring, and quality assurance.

The Scoping Review cautioned against oversimplifying complex needs into categorical scores or algorithm-driven outputs without rigorous trialling, noting risks of under-identifying support needs and misallocating resources. It emphasised that assessment findings must be reliably translated into tailored support packages, and that assessment systems should be tested and refined prior to full implementation to safeguard participant wellbeing and uphold human rights obligations.

1.5 The OTSi NEAT Model

OTSi designed the NEAT (National Endorsed assessor Team) model[7] to propose a trauma-informed disability Support Needs Assessment for the NDIS that enables participant choice of assessor, aligned with the findings of the 2022 Independent Assessment Parliamentary Inquiry and incorporating elements previously costed by the Parliamentary Budget Office; and aligned with the international scoping review (HIQA, Ireland, 2024), and other contemporary approaches to Disability Support Needs Assessments.

OTSi submitted the NEAT proposal to the NDIS Joint Standing Committee in January 2025, and it was subsequently published on the Committee's website submission page in August 2025[8].

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[6] Health Information and Quality Authority (2024) Scoping review to inform standards for assessment of need. Dublin, Ireland. Scoping review to inform standards for assessment of need Retrieved 26/01/2026

[7] Best-Practices-Support-Needs-Assessment-for-the-NDIS-OTSi-31012025-FINAL.pdf

[8] Submission no 1, Attachment B. *NDIS Joint Standing Committee* Submissions – Parliament of Australia

Fig 1: Comparative Table: OTSi NEAT model and Australia's Proposed NDIS SNA

Assessment Feature	Proposed OTSi NEAT Model (Scenario A)	Proposed NDIS SNA (Scenario B)
Assessor background	AHPRA-registered allied health professionals endorsed under a regulated National Endorsed Assessor Team (NEAT) program; bound by professional codes of conduct and under defined conflict of interest management standards.	Workforce will include assessors without professional qualifications. No minimum training or registration published.
Use of external evidence	Required; assessors synthesise existing medical, allied health, participant, family, and multidisciplinary reports alongside assessment findings to produce an individualised support needs report.	External evidence is broadly excluded, with the exception of a small cohort who may undergo 'targeted' assessments.
Assessment method	Trauma-informed, flexible, multi-session assessment (1–8 sessions as needed), combining structured and semi-structured approaches, observation, validated instruments aligned to ICF, and clinical formulation grounded in theory of change.	Semi-structured interview using the ICAN and PECQ tools; 1-2 sessions; exclusion of clinical and health professional evidence.
Quality safeguards	National endorsement program; regulation through AHPRA registration; adherence to professional standards; co-designed guidelines; possible integration with Medicare infrastructure; capacity for audit and oversight through existing regulatory frameworks.	No published expectations or standards for audits, workforce supervision, or quality control.
Review pathway	Standard NDIS review and appeal mechanisms apply; evidentiary assessment report provided to inform decisions; transparent documentation supports participant access to review processes.	No SNA-specific review rights.
Implementation readiness	Builds on existing allied health workforce and Medicare infrastructure; recommended for co-design and rigorous trial prior to full roll-out to ensure safe translation of assessment findings into budgets.	Unpiloted; rapid introduction planned for mid-2026.
Rights protections	Emphasises evidentiary transparency, participant choice of assessor, trauma-informed safeguards, and regulated decision-making; assessment report explicitly links findings to recommended supports.	Rights protections, such as review and appeals avenues, as proposed, are limited. Replacement Assessment only possible at CEO discretion.

1.6 Comparison to the Uk Personal Independence Model

The United Kingdom's Personal Independence Payment (PIP) is a non-means-tested disability benefit designed to help cover the extra costs of long-term health conditions or disability, determined through a structured assessment that scores daily living and mobility impacts[9]. Australia should closely examine the UK experience, including extensive litigation, high appeal rates, and criticism regarding assessment accuracy and fairness[10] [11], before embedding a similarly score-driven Support Needs Assessment model, to ensure transparency, professional oversight, and strong review and quality safeguards are built in from the outset.

Fig 2: Comparative Table: UK PIP and Australia's Proposed NDIS SNA

Assessment Feature	UK PIP (Scenario A)	Proposed NDIS SNA (Scenario B)
Assessor background	Regulated health professionals with mandated training and ongoing monitoring.	Workforce will include assessors without professional qualifications. No minimum training standards published.
Use of external evidence	Required; all medical and allied-health reports must be considered.	External evidence is broadly excluded, with the exception of a small cohort who may undergo 'targeted' assessments
Assessment method	Structured functional assessment combined with clinical evidence.	Semi-structured interview; exclusion of clinical and health professional evidence
Quality safeguards	National standards, audits, supervision, and remediation processes.	No published expectations or standards for audits, workforce supervision, or quality control
Review pathway	Clear multi-stage review and appeal rights.	No SNA-specific review rights
Implementation readiness	Mature system refined over years.	Unpiloted; rapid introduction planned for mid 2026.
Rights protections	Evidentiary transparency, regulated decisions, and appeal rights.	Rights protections, such as review and appeals avenues, as proposed, are limited. Replacement Assessment only possible at CEO discretion.

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[9] Timms Review of Personal Independence Payment: Terms of Reference - GOV.UK

[10] Full review of Personal Independence Payment (PIP) application process - Petitions

[11] PIP and ESA assessments: claimant experiences - Work and Pensions Committee - House of Commons

1.7 NDIS Parallels with Aged Care Assessments

The rollout of the Integrated Assessment Tool (IAT) in the Support at Home aged care program, offers a cautionary tale for the proposed NDIS Support Needs Assessment (SNA) model. In aged care, older Australians remain human-assessed, yet their support allocations are now determined by a classification algorithm that assessors cannot override[12]. Responses are scored, weighted, and converted into a support classification, leaving professional judgement secondary to a mechanistic output. Early evidence shows the human cost: nuanced needs are routinely overlooked, carer strain goes unaddressed, and individuals may be reassessed at lower levels than their actual requirements[13]. Transparency is minimal, changes to assessor discretion occurred without meaningful notice, and appeal mechanisms are limited[14]. The parallels for the NDIS are striking: the proposed SNA would similarly tie individual budgets to structured assessment scores rather than holistic support planning, risking “black box” outcomes where complex, fluctuating needs may be under-recognised, professional expertise is constrained, and participants face practical barriers to review.

2. A Safe and Trauma Informed Approach

Safety and trauma awareness must be prioritised in the co-design of NDIS SNA, and in translating assessment findings to support budgets. There are known risks associated with disability assessments that determine access to support and resources. International studies evidence the potential for harmful outcomes when disability assessment is conducted via a point-in-time standardized assessment by a mandated assessor[15]. These harmful outcomes include increased rates of suicide, increased mental health impacts and increased reliance on prescribed medication. An Australian study published May 2023 documents an increase in anti-depressant use and need for medical intervention when disability entitlements were re-assessed, regardless of the outcome of the assessment[16].Understanding these risks will help shape a safer, evidence-based approach for future SNA delivery. The NDIS Review report and the Disability Royal Commission report emphasised participant-centered and trauma aware approaches to government-mandated assessment, due to the significant proportion of people with disabilities with trauma histories[17].

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[12] Algorithms overriding clinicians: why aged care’s new IAT system is eroding trust and burning out assessors | Hello Leaders AUS

[13] Advocates fear My Aged Care funding algorithm could become Australia's next robodebt - ABC News

[14] Invox | A Letter to the Minister

[15] Barr, B; Taylor-Robinson, D; Stuckler, D; Loopstra, R; Reeves, A. (2015). ‘First, do no harm’: are disability assessments associated with adverse trends in mental health? A longitudinal ecological study. Journal of Epidemiology and Community Health Vol 70 (4). BMJ Publishing Group Ltd.

[16] The impact of Disability Insurance reassessment on healthcare use - Badji - 2023 - Health Economics - Wiley Online Library Retrieved 05032026

[17] Final Report | Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

The NDIS Joint Standing Committee Inquiry to Independent Assessments highlights the importance of trauma-informed approaches in NDIS assessments, emphasising the need for sensitivity to participants' emotional and psychological safety to prevent re-traumatisation. It stresses the value of culturally safe and inclusive practices, particularly for Aboriginal and Torres Strait Islander participants and those from diverse backgrounds, to foster trust and improve assessment accuracy. The report cautions that rigid, impersonal procedures and power imbalances can exacerbate trauma, especially for those with past negative experiences in institutional systems[18]. Many participants describe how interactions and assessments by NDIA assessors and contractors can bring afear of losing supports, fear of not being believed, fear of experiencing discrimination, fear of abuse and neglect, and fear of systemic co-opting of concepts such as recovery[19].The pressure to meet certain criteria, alongside the fear of having support needs minimised or rejected, can further intensify anxiety and trauma.

Strategies that restore a sense of control and choice can minimise the risk of trauma and harm and foster a sense of safety. The JSC report highlights that a community-based choice of provider approach to assessment is safer and more trauma-informed because it empowers participants to self-select qualified professionals with expertise in their particular disability, reducing the risks of stress and anxiety associated with mandated, assigned assessors (Chapter 9, recommendation 5). The OTSI NEAT model is a trauma-informed approach that respects the participant's autonomy and ensures that assessments are conducted in a way that aligns with their preferences and specific needs. This is particularly important for individuals from marginalised or culturally diverse backgrounds, as well as those who have experienced trauma or institutional harm.

While a small group of 30 participants have engaged in sample Support Needs Assessments to assist assessor training, and to test useability, accessibility, comprehension and participant experience[20], this group self-selected and are not representative of the broader group of NDIS participants, particularly those with complex needs. Trauma-informed assessments must be trialled in real-world contexts and harm screening embedded as a quality control initiative.

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[18] NDIS Joint Standing Committee Inquiry to Independent Assessments Final Report (2021) Independent Assessments – Parliament of Australia

[19] Improving the NDIS for people with psychosocial disability: NDIS Participant & Mental Health OT Co-design 2023 - Allied

[20] Participants are shaping a new way of planning for the NDIS | Health, Disability and Ageing Ministers | Australian Government Department of Health, Disability and Ageing

3. Response to the Draft National Disability Insurance Scheme (Getting the NDIS Back on Track No. 1) (Notice of Impairments) Rules – Explanatory Document

This Explanatory Paper represents a significant structural change to how support access and funding boundaries will operate within the NDIS. Yet the Explanatory Document provides limited insight into the determination, methodology, governance, safeguards and review mechanisms that will underpin Impairment category prescription. OTSi has significant concerns regarding the lack of transparency surrounding the operationalisation of impairment categories and notices, and the potential implications this may have for participant access to supports.

Given the central role that impairment categories will play in shaping support access, the current lack of transparency is deeply concerning. Without greater clarity, stakeholders cannot properly assess consistency with the NDIS Act, alignment with the ICF, or the practical implications for participants.

We respectfully submit that further detail, including decision-making frameworks, should be released for consultation, and included in the drafting of a publicly available Exposure draft of the Rules. The integrity of participant support access, and the long-term sustainability of the Scheme, depend on a transparent and coherent approach to Impairment Categories and Notices.

3.1 Lack of Transparency in Determining Impairment Categories

The Explanatory Document does not describe how impairment categories will be determined in practice. There is no explanation of:

- How existing evidence already held by the Agency (including evidence provided at access) will be used to determine impairment categories;
- The methodology or criteria that will guide decision-making;
- Whether clinical judgement, administrative guidance, or algorithmic processes will be used;
- How consistency and accuracy will be ensured across delegates and regions.

The method for prescribing impairment categories has not been shared. Without a clear articulation of the decision-making framework, stakeholders cannot scrutinise whether the approach is consistent with the NDIS Act or aligned with the International Classification of Functioning, Disability and Health (ICF).

Given the central role that impairment categories will play in determining the scope of funded supports under amended section 34, the absence of procedural detail represents a significant gap in this consultation process.

3.2 Conditions That Do Not Fit Neatly Within Categories

The Explanatory Document does not address how conditions that may “sit” across multiple impairment categories will be treated. Many disabilities do not align neatly with a single diagnostic or functional label. The functional impact of a condition may span cognitive, psychosocial, neurological, sensory and physical domains simultaneously.

Participants with multiple, acquired, progressive or fluctuating impairments may find that their lived functional reality is not captured adequately within a single impairment category. There is no description of how overlapping or interacting impairments will be recognised, nor how their combined functional effect will be reflected in the impairment notice. These issued are compounded by an apparent intention to use the ICAN assessment tool to split access to supports, not just by impairment category, but also by functional domain. Disability and legal advocates have caution against an NDIS that does not recognise and fund ‘whole of person’ support needs.

3.3 Risk of Re-Embedding Primary vs Secondary Condition Issues

There is a substantial risk that the proposed approach may inadvertently reintroduce the reductionist “primary versus secondary condition” issues that have emerged under the current NDIS and PACE systems. The recent NDIS Review cautioned against narrowing access based on overly rigid diagnostic distinctions.

If funding under section 34 is restricted only to supports that relate to recognised impairments, then how impairments are categorised becomes determinative of access. This creates a risk that secondary impacts, comorbidities, or cascading functional consequences may not be fully recognised.

Such an approach would be inconsistent with the ICF framework, which recognises that disability arises from the interaction between impairments, environmental factors and personal factors, rather than from a single linear causal pathway.

3.4. Variation of Impairment Notices

It is not clear when a participant can apply to vary a notice of impairment, or what criteria the NDIA CEO may apply in considering such a request. There is no detail regarding the evidentiary threshold for variation; timeframes for review; whether reassessment is required; the interaction between impairment notices and internal review or AAT processes.

Given that impairment categorisation may directly influence funding scope, procedural clarity is essential. Without clear mechanisms for correction, there is a risk of entrenched errors affecting participants for extended periods.

Advocates have reported ongoing administrative issues where impairments appear to be removed or inaccurately recorded within NDIA systems[21]. Under a model where funding is explicitly tied to impairment attribution, the accuracy and transparency of impairment notices becomes critical.

3.5 Tension Between Holistic Assessment and Impairment "Slicing"

The note to section 34 appropriately recognises that support needs arising from an impairment may be affected by environmental factors or by the impact of another impairment in relation to which the participant does not meet disability or early intervention requirements. This reflects an understanding consistent with the ICF: support needs cannot be inferred in a simple or linear way from diagnosis alone.

However, there appears to be a tension between this holistic recognition and the administrative requirement to "slice" or attribute supports to specific impairment categories or functional domains, for funding purposes.

If a tool such as ICAN is used to capture support needs in a broad, 'holistic' informed manner, but funding must ultimately be allocated only to recognised impairment categories of functional domains, the integrity of the holistic assessment risks being compromised. The interactive effects of multiple impairments may be underestimated, and support needs that cannot be neatly attributed to a recognised impairment may be excluded.

From a clinical and ethical perspective, this raises serious questions:

- How can a holistic, ICF-informed assessment be reconciled with a reductionist impairment or domain-specific allocation model?
- Are there safeguards or guidance mechanisms that will preserve the integrity of comprehensive assessment while satisfying the administrative requirements of section 34(1)(aa)?
- How should urgent or significant support needs be addressed where they arise from interacting impairments not fully captured in the impairment notice?

3.6 Categorisation of the Rules related to impairment categories

Given the substantial implications of section 32BA and amended section 34 for access to NDIS supports, these Notice of Impairment Rules warrant a high degree of scrutiny and intergovernmental oversight. The decision to classify them as Category D Rules is concerning. Their impact on participant rights, funding scope and procedural fairness suggests that stronger agreement mechanisms with States and Territories would be appropriate. This Rule must be comprehensive to avoid relegation of critical detail to Operational Guidelines.

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[21] NDIS Joint Standing Committee, Submission no. 5, (Villamanta), p.11 Submissions – Parliament of Australia

4. NDIS Support Needs Assessments

4.1. Assessment Process

4.1.1 Absence of Published Validation and Trial Evidence

The proposed Support Needs Assessment (SNA), incorporating the adapted NDIS ICAN and the PECQ, currently lacks publicly available independent validation data. There is no evidence demonstrating reliability, inter-rater consistency, construct validity, or predictive validity for funding adequacy across different disability cohorts. Integrating these two tools to inform NDIS decision-making represents a novel approach, and the adaptations made to the ICAN for this context have not undergone formal research evaluation. No published pilot studies, external evaluations, or peer-reviewed validation exist to support the use of this framework in determining disability support budgets. Introducing a national assessment model without transparent validation contravenes established policy and governance best practice and poses substantial risks to participants, potentially undermining public confidence in the Scheme.

4.1.2. Consideration of Allied Health, Medical, and Occupational Therapy Evidence

A significant concern is the unclear role of participant-provided evidence from allied health, medical, and occupational therapy sources. International best practice highlights the importance of multidisciplinary triangulation to ensure comprehensive functional assessment, particularly for individuals with invisible, fluctuating, or complex disabilities. The Minister’s response to Parliamentary Petition EN7545 indicated that participant-provided reports would only be considered in limited circumstances. Excluding or downgrading this evidence risks overreliance on single-point assessments, reducing the accuracy and safety of funding determinations. Without formal integration of allied health and medical documentation, the SNA may fail to capture nuanced functional needs, increasing the likelihood of underfunding and participant disadvantage.

Health professionals, doctors and providers routinely identify foreseeable risks for participants. These risks directly align with the safeguarding focus areas of the NDIS Quality and Safeguards Commission and underpin providers’ reportable incident obligations.

Excluding health professional reports from planning processes creates a structural inconsistency between safeguarding obligations and funding determinations. The Commission requires providers to manage and report foreseeable risks, yet the principal documents identifying those risks may not inform funding decisions. In the absence of a clearly defined alternative mechanism, this gap creates foreseeable and preventable risk to participant safety and system integrity. Please refer to Appendix 1 for further info on foreseeable risks. Participants living with these complex needs, require access to an alternative, trauma informed skilled assessor pathway, including capacity to utilize known health professionals with expertise in the disability type.

4.1.3. High-Risk Cohorts and Safeguards

The semi-structured nature of the ICAN and PECQ, combined with the lack of clear guidelines on multi-impairment assessment, creates heightened risk for participants with complex, intersecting disabilities. Groups particularly vulnerable include individuals with cognitive impairments, psychosocial disability, fluctuating conditions, or those skilled at masking limitations. Single-point assessments may capture peak functioning rather than baseline needs, leading to underestimation of support requirements. Fear of funding reduction, prior negative experiences, and concerns about restrictive interventions may result in under-reporting of needs. Best-practice safeguards, including multi-source data gathering, specialist allied health review, and scenario modelling to capture peak and crisis needs, are not clearly embedded in the proposed process, leaving participants exposed to systemic risk.

Targetted assessment pathways should be expanded to enable at-risk groups, including complex psychosocial disability, to access a trauma informed assessment approach such as that proposed under the OTSi NEAT model.

4.1.4 Targeted Assessments and Home and Living Decisions

The SNA framework provides insufficient detail regarding the conduct of targeted assessments, including triggers, timeframes, interim supports, or mechanisms for securing specialist input. Participants may face delays in accessing essential services, particularly those with complex communication needs or unstable housing. Additionally, the methodology for assessing home and living supports—the most complex and high-cost elements of the Scheme—is inadequately explained. Without clarity on how ICAN and PECQ data will inform these decisions, there is a real risk of destabilising access to critical supports and increasing dispute rates.

4.2. Assessment Tools

4.2.1 ICAN: Structure, Scope, and Limitations

The NDIS-adapted ICAN is a semi-structured support needs profiling tool that generates a support intensity profile. It was not originally designed to determine eligibility, allocate funding, assess functional capacity for access, categorise therapy into administrative domains, or determine early intervention eligibility pathways. While it measures frequency of support, ICAN is insufficiently sensitive to several critical factors, including duration of support episodes, nuanced frequency, environmental barriers, capacity-building needs, assistive technology requirements, and fluctuating or episodic support requirements. The tool relies heavily on professional judgement, interview skill, and participant self-report, introducing significant variability and risk of assessor bias, particularly when assessors are not allied health-trained.

Several additional issues were raised by OTSi members. Therapists with experience in the current, validated ICAN tool noted that the instrument was designed to explicitly incorporate allied health and medical reports as part of its evidence base. Removal of this feature for NDIS purposes would fundamentally alter the tool and risk compromising its psychometric validity. Members cautioned that removing supplementary clinical evidence pathways may disproportionately disadvantage participants who cannot independently articulate their support needs, particularly those with communication, cognitive or psychosocial barriers. Concerns were also raised about implementation readiness, including workforce capability, the quality and consistency of assessor training, and the potential for inconsistent application across the assessment workforce.

OTSi members also emphasised that attributing discrete support needs to individual impairments is frequently clinically impractical. Functional impacts commonly arise from the interaction of multiple co-occurring conditions, and impairment categories such as intellectual, cognitive and neurological disability often overlap in practice. Participants are reportedly already experiencing difficulties where secondary diagnoses are not recognised, alongside increasing requests for functional assessments that attempt to artificially separate the impacts of co-occurring conditions. Members considered that legislative requirements to attribute support needs to specific impairments do not reflect clinical reality and may lead to inaccurate or ethically problematic reporting.

OTSi members further highlighted heightened risks for participants experiencing intersecting disadvantage, including those with psychosocial disability, trauma histories, homelessness, cognitive impairment or long-term socioeconomic disadvantage. The clinical work required to evidence permanency and functional impact within legislative thresholds is substantial, and rigid impairment categorisation may make this work more difficult.

4.2.2 Validation, Cohort Limitations, and High-Risk Groups

ICAN's validation evidence is limited and predominantly covers physical, intellectual, acquired, and autism with intellectual disability cohorts. Evidence for psychosocial disability is moderate and emerging. Validation for neurodivergent individuals without intellectual disability, those who mask, or individuals with fluctuating or episodic conditions remains inadequate. Using ICAN as the primary determinant of budget allocations across the full NDIS population represents a substantial, unvalidated expansion of its original purpose. Vulnerable populations—including those with cognitive impairments, trauma histories, First Nations participants, and individuals with fluctuating conditions—face elevated risk of under-recognition and misclassification. The semi-structured format amplifies variability in outcomes, particularly where assessors lack formal allied health or clinical experience.

Using I-CAN as the primary budget-determining mechanism across the entire NDIS population represents a novel and unvalidated expansion of its purpose. The psychometric properties need to meet a robust standard:

"For psychometric assessments, even minor changes to the wording of an item or the number of items involved brings into question whether all psychometrics need to be recalculated and any allocation algorithm redeveloped or at least recalibrated." (Centre for Disability Studies, 2011)[22]

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[22] Centre for Disability Studies. (2011). Public submission to the Productivity Commission inquiry into a lifelong disability care and support scheme: Response to the draft report. Sydney Medical School, The University of Sydney, Ryde, NSW.

"Further, to properly test or develop an assessment tool generally requires several hundred participants, as opposed to computer software, which only requires a handful of good beta testers." (Centre for Disability Studies, 2011)

Concerns have been raised by allied health peaks[23] [24] and representative bodies regarding the current, proven validity and reliability of the ICAN, given the magnitude of the role it has been assigned within NDIS decision making.

4.2.3 PECQ: Function, Limitations, and System-Level Implications

The Personal and Environmental Circumstances Questionnaire (PECQ) forms part of the proposed Support Needs Assessment within the New Framework Planning process of the National Disability Insurance Scheme. The PECQ has been identified as requiring revision prior to the New Framework Planning Process, but this has not been made publicly available. In this submission we refer to the version of the PECQ currently available through Freedom of Information.

The current PECQ design relies substantially on conversational elicitation, delegate interpretation and translation of responses into categorical ratings within the PACE system. While conversational approaches may support rapport, they do not in themselves ensure reliable identification of foreseeable harm. Where responses are converted into fixed levels that influence budget allocations, the process must ensure that the information is not diluted by subjective interpretation.

The PECQ guidance in several domains instructs delegates not to read response options aloud and to select the most appropriate category based on conversational responses. This approach risks reducing nuanced and context-dependent information into simplified ratings without the participant's explicit awareness of how their answers will be scored. For participants with neurodivergence, trauma histories, communication differences or fluctuating capacity, this may lead to under-identification of needs.

The PECQ contains some references to medical or allied health reports but we are unsure if this remains in the final version. Other domains within the PECQ also require integration of existing clinical evidence to reduce reliance on participant recall at a single point in time and to ensure that structured ratings reflect documented functional realities.

The proposed branching methodology within a revised PECQ is concerning. Where subsequent questions depend on earlier responses, any initial misinterpretation or under-reporting may prevent critical areas of need from being explored. An alternative to this process is to explicitly check in with the participant. Eg You have stated that you do not have continence needs, do you need any more questions regarding continence? It is also unclear if the proposed branching methodology will include branching based on impairment categories. This rigid categorisation is not suitable for a person with complex disability needs.

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[23] NDIS tool to determine support not tested on variety of disability types – including diverse autism, experts warn | Australia news | The Guardian

[24] Australian Association of Social Work 20260216 https://www.linkedin.com/posts/australian-association-of-social-workers-aasw-_aasw-socialwork-ndis-activity-7428969398708707328-yGVT?utm_

The structured nature of PECQ data entry, including numerical ratings and categorical levels linked to capacity building and support coordination tiers, suggests that responses may inform system-level decision-support processes. It is important to clarify whether such data are aggregated or utilised within automated or semi-automated functions. Where structured scoring influences budgeting, transparency regarding how qualitative information and professional judgement are incorporated is essential.

There is currently limited information available regarding how the Personal and Environmental Circumstances Questionnaire (PECQ) will operate in conjunction with the proposed Support Needs Assessment process for participants under 18 years of age within the NDIS. While the consultation materials refer to the PECQ as one component of the broader assessment framework, the specific assessment tools or processes intended for children have not been clearly identified. It therefore remains unclear whether the PECQ will function as a preliminary information-gathering tool, a complementary component to a separate developmental needs assessment, or effectively constitute the primary assessment process for this cohort. Greater clarity is required to understand how children's developmental needs will be comprehensively assessed and how or if information from different sources will be integrated within planning decisions.

There is currently no publicly available evidence indicating that the PECQ has undergone formal testing for reliability or validity. The terminology used to describe the instrument suggests a focus on gathering personal and environmental background information. However, the versions of the PECQ that have been publicly released indicate that the questionnaire may play a much more substantive role in determining support needs, informing structured ratings, and contributing to the development of participant budgets. This apparent discrepancy between how the tool is described and the functions it appears to perform highlights the need for greater transparency regarding its methodological foundations, intended use within decision-making processes, and the evidence supporting its application in high-stakes funding determinations.

The PECQ requires explicit integration of allied health and medical evidence, transparent administration processes, qualified interpretation of responses, and clear safeguards where branching or structured scoring is used. Without these protections, there is a al risk that foreseeable harms may not be identified within the planning process, with downstream consequences for participant safety, provider compliance obligations, and system integrity.

4.2.4 The ICAN and broader SNA cannot determine NDIS eligibility or trigger eligibility re-assessment

OTSI seeks assurances that the ICAN and broader SNA will not be used for NDIS eligibility purposes and/or to trigger eligibility re-assessment. The ICAN does not measure functional capacity, the construct required to be understood to determine NDIS eligibility. Support need assessment or support need level, cannot be used as a proxy or used to infer the functional capacity of a disabled person.

The ICAN tool, by its nature and structure, requires a positive framing of functional abilities and focused on the person describing "what I can do", which cannot be then construed to indicate the person's functional capacity by functional domain under the NDIS Act 2013. Further, the implementation of the SNA by an unqualified assessor who chooses both assessment questions and domains to be assessed for that person, further demonstrate the absence of reliability of the SNA as an indicator of functional capacity.

4.3. Workforce

4.3.1. Qualifications and Assessor Competence

The proposed SNA lacks clarity regarding assessor qualifications, independence, professional standards, and governance arrangements. High-stakes determinations, such as total funding allocations, 24/7 support access, safeguarding, and assistive technology pathways, require advanced clinical reasoning. Allied health professionals possess the necessary competencies to conduct functional assessments, observe and interpret performance in context, evaluate interaction effects between impairments, assess fluctuating or episodic conditions, and apply trauma-informed approaches. Without these qualifications, NDIA-employed assessors risk misclassifying support needs, overlooking high-risk indicators, and underestimating complexity, potentially leading to harm and inequitable outcomes. Published minimum competency standards for assessors must precede implementation.

4.3.2 Professional Accountability and Ethical Frameworks

Registered allied health professionals operate under codes of ethics, registration standards, continuing professional development requirements, and regulatory oversight. It is unclear what professional or ethical frameworks would govern NDIA-employed assessors lacking registration. Without independent complaint mechanisms, competency standards, and ethical accountability, participants cannot have confidence that assessments are objective, needs-driven, and ethically grounded. Embedding workforce safeguards, including mandatory allied health qualifications and disability-specific expertise, is essential to ensure consistency, reliability, and protection of participant interests.

5. Use of the SNA to '*Define Therapy Supports*'

OTSi welcomes the opportunity to respond to the Department's Discussion Paper on Defining Therapy Supports. As a professional body representing occupational therapists working across the lifespan and across disability cohorts, OTSi is committed to ensuring that NDIS policy settings align with the objects and principles of the *National Disability Insurance Scheme Act 2013* (NDIS Act); the *International Classification of Functioning, Disability and Health* (ICF); and contemporary evidence-based allied health practice.

This submission raises significant concerns regarding the proposed categorisation of therapy supports into "general", "social", and "physical and health related" categories, particularly as these categories are proposed to be linked directly to domains identified through the ICAN Support Needs Assessment.

Our central concern is that the proposed framework may not be compatible with the NDIS Act, conceptually inconsistent with the ICF, and relies on an assessment tool (ICAN) that has not been validated for the purpose of determining therapy categories or therapy access.

5.1 Compatibility with the NDIS Act

5.1.1 Statutory Purpose and Participant Goals

The NDIS Act establishes that the Scheme is intended to support people with disability to pursue their goals and aspirations; facilitate choice and control; and, provide reasonable and necessary budgets based on individual needs.

The current NDIS approach positions therapy as a means of enabling participants to work toward their self-defined goals. By contrast, the proposed categorisation model appears to anchor therapy eligibility to pre-defined “core assessment tool domains” derived from the ICAN. This risks subordinating participant goals to administrative domain structures.

Therapy in practice is goal-directed, dynamic, and often cross-domain. A participant’s goal to parent safely, to return to work, or to participate in community life cannot be meaningfully reduced to discrete subdomains such as “mobility”, “interpersonal relationships”, or “learning and applying knowledge”. The Act does not confine participant aspirations to domain boxes.

5.1.2 Artificial Segmentation of Supports

The proposal to divide therapy into “social” and “physical and health related” categories reflects a reductionist separation that does not reflect contemporary disability practice. Therapeutic interventions routinely target transferable skills across multiple domains. It is unclear if this form of categorisation will extend to other supports also.

Importantly, if therapy is categorised in this way, the precedent may extend to other support types. If therapy can be confined to domain-linked categories based on assessment outputs, the same logic could be applied to assistive technology, behaviour supports, employment supports, or capacity building more broadly. It is unclear how these categories may interact with participant Impairment categories to limit access to therapy supports, or other supports also. This would represent a structural shift in how “NDIS supports” are conceptualised under section 10 of the Act.

The proposed approach therefore has implications well beyond therapy. The rationale for the proposed three therapy support categories has not been clearly articulated. We also note apparent duplication across these categories, which suggests that specific criteria are being applied but have not been made transparent to readers.

5.2 Compatibility with the ICF

The proposed separation of therapy into “social” versus “physical” categories reintroduces a dualistic model that the ICF explicitly rejects. Therapeutic interventions frequently address body functions in order to enable participation outcomes. Similarly, participation-based therapy often influences physical function.

Under the ICF, functioning is dynamic and interdependent. The proposal’s domain-linked therapy categories risk fragmenting that integrated model and incentivising siloed intervention rather than whole-of-person practice.

5.3. The ICAN Assessment: A Novel and Unvalidated Use

OTSi is deeply concerned about the proposed reliance on the ICAN Support Needs Assessment (SNA) to determine therapy categories. This is an entirely novel way to use the ICAN assessment. It has never been used, piloted, or trialled in any context to determine therapy categories or therapy eligibility.

The ICAN contains no set or standardised questions; has no structured focus on capacity measurement (the binary of “can” versus “can’t” is conceptually vastly removed from the concept of ‘capacity’); does not embed a theory of change regarding “improving, maintaining or reducing decline”; relies heavily on the ability of the assessor (who may not be clinically qualified) to ask the “right” questions; relies equally on the participant’s ability to verbally articulate needs.

There is no published evidence demonstrating that the ICAN can reliably identify therapy support needs or determine which therapy category applies. Our community needs to know that this assessment has reliability and validity before it is rolled out in this way.

Without published psychometric validation demonstrating reliability, inter-rater consistency, construct validity, and predictive validity for therapy allocation, the proposed use of ICAN risks arbitrary or inconsistent outcomes.

5.4 Legal Precedent: Relevance of Recent Case Law

5.4.1 NDIS v Sutherland

In *Sutherland*[25], the Federal Court emphasised that support needs cannot be artificially constrained by administrative interpretations inconsistent with the statutory framework. The Court reinforced that eligibility and support determinations must align with the text and purpose of the NDIS Act.

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[25] Access to NDIS safeguarded by Federal Court win | Victoria Legal Aid

The reasoning in *Sutherland* is relevant here: therapy supports cannot be artificially confined to rigid domain boxes if that structure is inconsistent with the Act's purpose or with how functional needs manifest in practice.

5.4.2 Eastham and CEO of the NDIA

In *Eastham*[26], the Tribunal considered whether a mobility scooter met the criteria for funding under the Act and Transitional Rules. The decision reinforced that supports must be assessed holistically, in light of real-world functional need and environmental context, rather than by narrow administrative categorisation.

This reasoning is directly applicable to therapy. If therapy access is determined primarily by alignment with assessment domains rather than by holistic functional analysis and goal-directed need, similar legal challenges may arise.

6. Transparency in Budget Determination

We are concerned that the proposed model lacks sufficient transparency regarding how assessment inputs translate into plan budgets. Without clarity, the risk of arbitrary or misaligned funding allocations is high, particularly for participants with complex support needs.

Of particular concern is the reliance on the I-CAN tool as a core component of determining funding allocations. I-CAN was developed as a structured instrument to classify and describe support needs; it was **not designed as a budget-setting mechanism**. Converting classification outputs into funding ceilings or automated allocations represents a fundamental repurposing of the tool.

Without clear methodological transparency, this creates significant risk:

- It remains unclear how I-CAN domain scores and PECQ responses will be weighted, combined, and converted into a total budget allocation.
- There is no published explanation of the algorithm, assumptions, thresholds, or ceilings embedded in the budgeting methodology.
- Draft rules, operational guidelines, and worked examples demonstrating how assessment results produce funding outcomes have not been released.
- Participants, planners, and providers may be unable to interrogate or understand how final budget figures are calculated.
- There is concern that planners/delegates may be required to accept automated outputs without meaningful discretion.

Algorithmic tools may improve consistency in Support Needs Assessments; however, opaque systems create systemic risk. If weighting tables, formulas and thresholds are not published, participants cannot

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[26] Eastham and Chief Executive Officer of the National Disability Insurance Agency (NDIS) - [2025] ARTA 198 - Case | CaseNote AU

understand how scores translate into budgets. Transparency should include publication of methodology, worked examples (including high-complexity and 24/7 scenarios), and the ability for participants and advocates to interrogate assumptions. Algorithms trained on historical data may also entrench existing inequities, with high-need participants at risk of systematic underfunding. This is a high risk in the NDIS context where past Typical Support Packages may have been derived from inaccurate translation of planner-delivered WHODAS 2 scores to participant budget[27]. This submission recommends independent algorithm audits, public reporting of cohort outcomes, and mechanisms to identify and correct bias or gaps in predictive validity.

For participants with complex disability, psychosocial conditions, degenerative diseases, or 24/7 support needs, even small miscalculations can have **catastrophic consequences**: hospitalisation, safeguarding incidents, carer breakdown, or institutionalisation. A budgeting model that lacks transparency prevents independent scrutiny of whether it accurately captures real-world costs and safeguarding requirements.

7. Appeals and Replacement Assessments

The Support Needs Assessment (SNA) does not appear to constitute a reviewable decision under section 99 of the NDIS Act. Participants may only challenge the plan as a whole. Where funding is largely determined by assessment outputs, and the assessment itself cannot be directly appealed or replaced, errors risk becoming entrenched within budgets and support arrangements.

OTSi appeared at the Senate Inquiry into the NDIS (Integrity and Safeguarding) Bill and formally requested an amendment to section 32L to enable a Replacement Support Needs Assessment at the participant's request[28]. This request was declined on the basis that it was out of scope of the Bill.

OTSi remains extremely concerned that participants cannot request a replacement assessment, cannot have the full suite of disability evidence recognised, and that Administrative Review Tribunal (ART) avenues of appeal will not have the capacity to amend support and budget funding where these are driven by assessment outputs.

A central principle of rights-based disability support is that participants must be able to challenge and review decisions affecting their funding and supports. The proposed model provides insufficient clarity regarding review pathways, appeal mechanisms, and the capacity to correct errors or contest assumptions embedded in algorithmic outputs. Participants must be able to access clear instructions for requesting reassessment, receive timely acknowledgment and updates, challenge both factual inaccuracies and methodological assumptions, and engage independent advocates or support coordinators in the review process. Without formal and accessible review rights, errors may cascade, leaving participants underfunded or exposed to harm.

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[27] Effectiveness of the National Disability Insurance Agency's Management of Assistance with Daily Life Supports | Australian National Audit Office (ANAO)

[28] Senate Inquiry into the NDIS (Integrity and Safeguarding) Bill Public Hearing 20260224 OTSi Opening Statement and transcript Public Hearings – Parliament of Australia

8. Conclusion

OTSi recognises the complexity of administering a national disability insurance scheme and the genuine policy challenge of balancing sustainability with fairness. We acknowledge the Agency's commitment to reform and its stated intention to improve consistency and transparency.

However, reforms of this scale must be built on published evidence, procedural clarity, independent validation and enforceable safeguards. Funding decisions determine safety, stability and dignity. They must never rest on opaque methodologies or constrained review rights.

OTSi stands ready to assist constructively in co-design, piloting, independent review processes and development of trauma-informed, evidence-based safeguards that protect both participant wellbeing and the long-term integrity of the Scheme.

APPENDIX 1:

NDIS Quality and Safeguard Commission and Risk assessment process

Health professionals, doctors and providers routinely identify foreseeable risks for participants. These risks directly align with the safeguarding focus areas of the NDIS Quality and Safeguards Commission and underpin providers' reportable incident obligations.

If NDIS planners do not review health professional and medical reports, critical risk information may not inform funding decisions regarding support needs. It is currently unclear how this risk identification function would otherwise be replicated within the planning process.

Dysphagia and Mealtime Risk

Clinical reports frequently identify swallowing impairment, aspiration risk, modified diet or fluid requirements, positioning needs and levels of supervision required at mealtimes. The NDIS Commission has issued repeated provider alerts regarding choking deaths and inadequate dysphagia management. Providers are required to ensure staff are trained, risks are mitigated and serious incidents are reported. If planners do not review dysphagia assessments, funding decisions may fail to reflect the supervision ratios and competency requirements necessary to prevent foreseeable harm. No alternative mechanism has been identified to ensure aspiration risk is systematically detected at planning stage.

Pressure Injury and Skin Integrity

Health professionals assess pressure injury risk, prescribe repositioning schedules, recommend specialist mattresses or seating and monitor wound care requirements. The Commission has identified preventable pressure injuries as a safeguarding concern and may treat serious wounds as reportable incidents. If such clinical information is not considered in planning, participants may not receive adequate equipment or staffing supports, increasing the likelihood of preventable injury and potential findings of neglect.

Seizure and Neurological Risk

Medical documentation outlines seizure frequency, triggers, rescue medication protocols and post-ictal supervision needs. The Commission has highlighted seizure-related deaths and the importance of seizure management plans and High Intensity Support capability. Without review of this information, planners may not recognise the need for appropriately trained staff or higher levels of supervision. There is no clear explanation of how seizure-related mortality risk would otherwise be identified within funding decisions.

Medication Risk and Chemical Restraint

Clinical reports identify polypharmacy, high-risk medications, monitoring requirements and psychotropic prescribing patterns. The Commission closely regulates medication management and chemical restraint, requiring appropriate authorisation, monitoring and incident reporting. If planners do not review medical documentation, funding may not account for medication complexity or behavioural support requirements, creating systemic tension between safeguarding obligations and allocated supports.

Falls and Mobility Risk

Allied health assessments identify high falls risk, unsafe transfers, fracture risk, spasticity, fatigue and mobility aid requirements. The Commission treats preventable injury and unsafe environments as safeguarding issues. If this information is not considered in planning, funding may not support adequate supervision, manual handling training or assistive technology, thereby increasing foreseeable injury risk.

Continence and Complex Health Supports

Clinical documentation may outline catheterisation, complex bowel care, enteral feeding, autonomic dysreflexia risk or other high intensity daily personal activities. The Commission requires providers delivering high intensity supports to ensure staff competency and compliance with skill descriptors. If planners do not review this information, participants may not receive funding aligned with the complexity of their health supports, despite providers remaining legally obligated to manage and report associated risks.

Mental Health, Suicide and Behavioural Risk

Reports frequently document suicide risk, trauma triggers, psychosis, emotional dysregulation and behavioural escalation patterns. The Commission has issued alerts regarding suicide, self-harm and the use of restrictive practices. Failure to consider clinical risk assessments at planning stage may result in insufficient psychosocial supports or behavioural expertise being funded, increasing the likelihood of crisis events and reportable incidents.

Decision-Making Capacity and Safeguarding

Health professionals assess impaired decision-making capacity, vulnerability to exploitation, guardianship arrangements and communication barriers. The Commission places strong emphasis on abuse prevention, informed consent and safeguarding of vulnerable participants. If such information is not reviewed during planning, risks relating to financial exploitation, coercion or neglect may not be adequately mitigated through funded supports.

Progressive and Degenerative Conditions

Medical reports often outline anticipated functional decline and escalating equipment or support needs in progressive conditions. The Commission's safeguarding focus includes prevention of foreseeable harm and appropriate clinical governance. Without consideration of documented trajectories, plans may fail to anticipate deterioration, leading to crisis-driven responses and avoidable hospitalisation.

Central Policy Concern

The NDIS Commission consistently requires providers to proactively identify foreseeable risks, implement participant-specific safeguards, ensure staff competency and report serious incidents. Health and allied health reports are the primary mechanism through which these risks are formally identified and synthesised.

If NDIS planners do not review these reports, risk identification becomes disconnected from funding decisions. Providers remain legally obligated to identify and report risks, yet participants may not receive funding aligned with those same risks. There is currently no clearly articulated framework explaining how clinical risk synthesis, functional risk forecasting, anticipatory equipment planning or capacity assessment interpretation would otherwise occur within the planning process.