

SUBMISSION ON NDIS ACCESS CHANGES CONSULTATION



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Consultation on NDIS Access Changes

A Submission by OTSi

Executive Summary

The consultation on NDIS access changes is one of the most consequential policy consultations currently underway for the disability community and for the future of the NDIS.

The definition of functional capacity in the NDIS legislation has been changed, alongside the meaning of substantially reduced functional capacity¹. The changes arise from the amended NDIS legislation and were embedded in NDIS operational guidelines, effective **27 August 2026**^{2 3 4}. It is unclear how they are operationalised by the NDIA currently, in the absence of legislative Rules agreed by State and Territory Governments. The new definitions are in force at the Administrative Review Tribunal and will be applied "to all matters not finalised before the NDIA or the Tribunal prior to that date"⁵.

The Government proposes that, from 1 January 2028, people will be required to demonstrate eligibility through a standardised, assessment of functional capacity that is yet to be developed. All existing NDIS participants are proposed to be reassessed over a three-year transition period. The scale is therefore unprecedented: more than 700,000 people currently receiving NDIS support will ultimately be subject to a new access test, with estimates associated with the reforms indicating that around 240,000 people may leave the Scheme. This is a fundamental redefinition of the gateway to Australia's principal disability support system.

The consultation is therefore of profound importance. It may help determine what constitutes sufficient evidence of disability, what functional capacity means in law and practice, how impairment is understood, whose professional evidence is relied upon, how people with complex or fluctuating disabilities are assessed, and ultimately who is recognised as requiring the level of disability-specific support that the NDIS is intended to provide.

OTSi supports the policy objective of improving consistency, transparency and fairness in access. However, the plans to raise the threshold for NDIS access, based on functional assessment, remains contentious, due to the absence of meaningful disability supports tailored to need, outside the NDIS. Alternative, needs-based supports must be in place before large cohorts of disabled people lose access to the NDIS.

A functional approach is only as fair as the construct of function being measured and the methodology used to measure it. This distinction is critical. This submission summarises key recommendations for consideration by the Technical Advisory Group, government bodies, and decision makers.

¹ [New NDIS Definitions of Functional Capacity; and the consultation on the future of NDIS access is open for community input - Every Australian Counts](#)

² [Our guidelines | NDIS](#) Applying to the NDIS.

³ [OG-Applying-to-the-NDIS \(3\).pdf](#)

⁴ Deputy NDIA CEO, Amity Durham, confirms the new definition of functional capacity took effect Aug 27th 2026, at the Joint Standing Committee Public Hearing on Sept 11th, 2026 [Public Hearings – Parliament of Australia](#) [10.11- [ParlView | Video 4906980](#)]

⁵ Riordan [2026] ARTA 2164, (25 September 2026), (no.24, p.10) [Riordan and CEO, National Disability Insurance Agency \(NDIS\) \[2026\] ARTA 2164 \(25 September 2026\)](#)

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About the OTSi contribution

The Occupational Therapy Society for Hidden and Invisible Disability (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 in our world as active citizens of Australia.

Our focus is ensuring access to resources, opportunities, and supports for people with invisible disabilities of all ages, including access to occupational therapy. 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.

To inform this submission, OTSi engaged deeply with our members through release of a discussion paper, engagement sessions, and individual members feedback. We also engaged with participants, advocates including lived experience advocates, peak bodies, disability lawyers, and others.

OTSi has already contributed substantially to public and professional discourse on the topic of functional capacity assessment. OTSi has built a best-practice guideline, toolkit and template to assist occupational therapists currently charged with the responsibility of providing functional capacity and support needs assessment for the NDIS, both at the point of access, and throughout the NDIS journey. Our assessment guideline and template are evidence informed, trauma-informed, and align the NDIS functional domains with the International Classification of Functioning, Health and Disability (ICF) ^{6 7}.

OTSi contributed three submissions to the inquiry on the NDIS (Securing the Future) Bill 2026⁸; and responses to Questions on Notice to the Bill Inquiry, focused on functional capacity assessment and raised the concern that the amendment to s24 (1) (c) risked creating a dangerously high threshold for NDIS access, leaving gaps in access to disability support⁹. Further, in early 2026, OTSi made a submission to the Joint Committee of Public Accounts and Audit *Inquiry into the Administration of the National Disability Insurance Scheme*, detailing the history, challenges, and learnings, from the provision of allied health evidence, including occupational therapy evidence provided as functional capacity assessment reports, to the NDIS to assist decision making, since the Scheme began¹⁰. We invite the Technical Advisory Group, government bodies, and decision makers, to engage with these documents.

The submission raises 14 recommendations for the future of NDIS functional capacity assessment, NDIS eligibility processes and safeguards.

As NDIS referral pathways do not appear to be within the Technical Advisory Group Terms of Reference, we have not provided feedback on this aspect and would welcome future opportunities to do so. However, we emphasise that access pathways should be universal, adopt a 'no wrong door' approach, and should not be gatekept by programs or organisations outside the NDIS, or medicalised entry pathways. Unnecessary delays or barriers to accessing the NDIS for those who need it, must not creep into the program design. Priority access pathways must sustain, for life-limiting and rapidly progressing conditions, and where there is evidence of urgent need.

⁶ [NDIS Assessment Toolkit | OTSi - Resources for Disability Assessment](#)

⁷ [International Classification of Functioning, Disability and Health \(ICF\)](#)

⁸ Submission no. 32 plus supplementary submissions [Submissions – Parliament of Australia](#)

⁹ NDIS Bill (Securing the Future) 2026, Response to Questions On Notice, no. 10 [Additional Documents – Parliament of Australia](#)

¹⁰ Submission number 23, JCPAA *Inquiry into the Administration of the NDIS* [Submissions – Parliament of Australia](#)

As a Priority, Minimise and Manage the Risk of Harm

For many disabled people, repeated assessment is itself part of a history of institutional, medical and administrative trauma¹¹. Participants may have repeatedly been required to demonstrate that their disability is real, severe enough, permanent enough or costly enough to warrant support.

A new access system should not compound that experience. All three elements of the new assessment must be trauma informed- the assessment, the eligibility determination process, and the workforce.

Participant choice of assessor is therefore not merely a consumer preference. It was recommended by the Independent Assessment Inquiry final report, and it can be a clinical safeguard. Trust, communication, familiarity and longitudinal knowledge can materially affect the quality of information obtained. This is particularly important for people who mask, have difficulty communicating under stress, experience psychosocial distress, use alternative communication, or have disability-related barriers to participating in formal administrative processes.

Trauma-informed assessment should therefore be embedded in the design of the system through choice of assessor, accessibility, reasonable adjustments, minimisation of repeated disclosure, and explicit assessment of the potential harms created by the process itself¹².

Harm and negative impacts arising from disability assessment to determine disability support, is noted by research internationally and in Australia^{13 14}. 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.

Already, OTSi members describe the mental health impacts, including loss of hope, suicidality, and clinical-degree anxiety, arising from overwhelming uncertainty of access to disability support due to NDIS reform, funding cuts, and eligibility tightening. As NDIS moves to reassess all existing participants for eligibility, harm must be both minimised, and measured.

¹¹ [Final Report | Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability](#) Retrieved 26/09/2026

¹² NDIS Joint Standing Committee Inquiry to Independent Assessments Final Report (2021) [Independent Assessments – Parliament of Australia](#) Retrieved 26/09/2026

¹³ The impact of Disability Insurance reassessment on healthcare use-Badji-Health Economics-Wiley Online Library Retrieved 26/09/2026

¹⁴ 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

OTSi Recommendations

OTSi recommends that the Australian Government, departmental decision-makers, and the Technical Advisory Group:

1. **Retain a genuinely functional, participation-focused approach to NDIS access**, anchored in the ICF and clearly distinguishing functional capacity from diagnosis and impairment severity.
2. **Defer implementation of the new access assessment framework** until the construct, methodology and thresholds have been independently validated and demonstrated to be valid, reliable, equitable and feasible across the diversity of NDIS disability cohorts.
3. **Ensure assessment captures both capacity and real-world performance**, including the impacts of executive functioning, cognition, fatigue, communication and multiple or interacting disabilities. Medicalised and impairment focused evaluation are not a proxy for functional assessment.
4. **Provide legislative and operational clarity about the new functional capacity definitions and eligibility implications**, including how they are to be applied between 27 August 2026 and 1 January 2028, while the new Rules and assessment framework are being developed.
5. **Require transparent, purpose-specific validation of any assessment instrument**, including any adapted use of existing instruments. Modified instruments must be validated for their proposed NDIS purpose and assessment scores should not enable automated eligibility decisions.
6. **Use standardisation to support, rather than replace, professional judgement**. Decision-makers should consider assessment findings alongside longitudinal clinical evidence, lived experience, collateral information, environmental factors and other relevant evidence, with explicit mechanisms for complex, borderline and outlier cases.
7. **Embed occupational therapy and lived-experience expertise throughout the reform**, including the design, validation, piloting, implementation, workforce development, governance and ongoing evaluation of the assessment framework.
8. **Adopt a two-step process – firstly**, an external functional capacity assessment completed by an endorsed assessor team, sustaining choice of assessor, and **secondly**, a skilled NDIA team making the decision on NDIS eligibility based on the sum of the evidence provided. Consider the OTSi NEAT model.
9. **Embed trauma-informed, equitable and accessible assessment**, including participant choice of assessor wherever practicable, reasonable adjustments, minimisation of repeated disclosure, consideration of gender and cohort-specific impacts, and recognition of cumulative and interacting disability. Explicitly minimise and measure participant harm impact arising from the broad eligibility reassessment policy.
10. **Ensure permanence and treatment requirement expectations are transparently listed**, considering only evidence-based, clinically appropriate and realistically accessible interventions, while respecting bodily autonomy, informed consent and the right to decline treatment.
11. **Do not withdraw NDIS access without demonstrating that foreseeable risks have been assessed and appropriate alternatives are actually available, including through Medicare reform**. Require a Participant Impact Assessment, Statement of Alternative Supports and safe, graded transition arrangements where supports are reduced or withdrawn.
12. **Protect procedural fairness and review rights**, including meaningful human decision-making, transparent reasons, independent functional assessment through merits review, and prohibition of automated eligibility determinations.
13. **Maintain ongoing parliamentary and independent oversight**, with public reporting of validation evidence, reliability, equity impacts, cohort performance, error rates and implementation outcomes.
14. **The Agency should publish a clear statement of how Impairment Categories are determined**. It should specify the evidence required, who makes the determination, how the determination interacts with both the access and planning processes, and how impairments spanning more than one category are treated in both access and support needs decision making.

Responding to the Consultation Questions

1. Guiding principles

OTSi broadly supports the proposed principles underpinning the future NDIS access and assessment framework. However, in OTSi's view, these principles are currently expressed at too high a level to provide sufficiently clear and measurable standards for the development and implementation of a substantially changed approach to NDIS eligibility.

Transparency should extend to the evidence underpinning the assessment methodology itself. The Government should make public the validation evidence, population testing, reliability data, threshold methodology, calibration processes and evaluation findings on which the system is based. Where an instrument has been modified for NDIS purposes, the evidence must relate to the modified instrument and proposed use, rather than relying on validation studies undertaken for a different purpose.

Given the significant consequences of eligibility decisions for people with disability, principles need to do more than articulate broad aspirations; they must provide practical safeguards against inconsistency, inappropriate exclusion and inequitable outcomes.

OTSi therefore recommends that the principles be developed as **three separate and distinct sets**, addressing: **(1) the design and application of the functional assessment itself; (2) the qualifications, competencies, independence and support of the workforce undertaking assessment and decision-making; and (3) the process by which eligibility is determined, including evidence requirements, procedural fairness, transparency, review and rights of appeal.** OTSi has previously developed such a triad of principles in its work on an alternative model for NDIS support needs assessment¹⁵, informed by an international scoping review of support needs assessment approaches¹⁶. This framework provides a practical foundation for developing principles that can be translated into clear standards, accountability mechanisms and safeguards across the assessment and eligibility process.

Recommendation: That the Australian Government develop and publish **three separate, comprehensive and operational sets of principles** to govern the new NDIS eligibility and functional assessment framework:

1. **Principles for functional assessment** — establishing minimum standards for the validity, reliability, comprehensiveness, person-centredness and contextual sensitivity of functional assessment, including how functional capacity is assessed across environments, with and without appropriate supports, and in the context of fluctuating, episodic and invisible disabilities.
2. **Principles for the assessment and eligibility workforce** — establishing minimum requirements for qualifications, competencies, training, supervision, independence, conflicts of interest, disability expertise and ongoing quality assurance for professionals undertaking functional assessments and/or making eligibility determinations.
3. **Principles for the eligibility determination process** — establishing minimum standards for evidence, test of permanence, transparency, procedural fairness, consistency, communication of reasons, participant involvement, supported decision-making, access to advocacy, review and appeal, and mechanisms to identify and rectify errors.

¹⁵ Appendix 1 [Best-Practices-Support-Needs-Assessment-for-the-NDIS-OTSi-31012025-FINAL.pdf](#)

¹⁶ 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 27/09/2026

These three sets of principles should be **co-designed with people with disability, representative organisations, relevant professional bodies and broader community**, and should be incorporated into the Rules, operational guidance, assessment methodology, workforce requirements and quality-assurance arrangements before the new eligibility framework commences.

The principles should be sufficiently granular to operate as enforceable safeguards, rather than remaining high-level statements of intent.

Example- the principle of gender equity must be applied across the assessment itself, the workforce, and the overall process for determining NDIS eligibility:

Assessments and eligibility processes also need to carefully consider gender. There has been insufficient analysis of the extent to which the assessment processes and standardised assessment tools used in the NDIS may contribute to gender inequities in access. This is particularly important given evidence of substantial differences in eligibility rates. An analysis of NDIS administrative data by Disney, Yang et (2025)¹⁷, found that, among applicants with physical disability, women and girls had 145 fewer approvals per 1000 applicants than men and boys, while women and girls with psychosocial disability had 83 fewer approvals per 1000 applicants than men and boys. The authors concluded that women and girls with certain disability types were less likely to be deemed eligible for NDIS support and that changes to eligibility processes could reduce these inequalities.

The selection and validation of assessment tools should therefore explicitly consider whether they adequately identify disability and support needs across genders and whether the constructs being measured privilege particular presentations of disability over others. For example, an assessment may place greater weight on observable behaviours that present as challenging, disruptive or risky to others, while failing to adequately capture disability-related vulnerability, including vulnerability to coercion, exploitation, abuse or being the recipient of aggression. A person whose disability substantially increases their vulnerability to harm may therefore have significant support needs that are not adequately reflected if the assessment primarily captures behaviours that are more visible or disruptive to others. We support the consideration of Gender equity as a principle but recommend that there is explicit analysis in:

- the selection, validation and ongoing evaluation of standardised assessments used to inform NDIS access decisions, including examination of whether particular assessment constructs or scoring systems produce systematic false negatives for girls and women;
- the development of the workforce
- the overall NDIS eligibility process and access decision making.

¹⁷ Disney, G., Yang, Y., Summers, P., Devine, A., Dickinson, H., & Kavanagh, A. M. (2025). Social inequalities in eligibility rates and use of the Australian National Disability Insurance Scheme, 2016–22: An administrative data analysis. *Medical Journal of Australia*, 222(3), 135–143. <https://doi.org/10.5694/mja2.52594>

2. What is required for a fair, consistent, transparent, disability-informed and evidence-based process?

2.1 A clear and contemporary definition of functional capacity

Functional capacity is a core construct of the NDIS. Its importance reflects the Scheme's deliberate alignment with contemporary disability policy and, particularly, the World Health Organization's International Classification of Functioning, Disability and Health (ICF). The NDIS was conceived as a functional and participation-focused scheme rather than a medical or diagnosis-based welfare system. Occupational therapists have consequently been undertaking functional capacity assessment for the NDIA since the Scheme's inception, including for access and reassessment, because understanding how disability affects everyday functioning and translating that evidence into support requirements is a core area of occupational therapy expertise.

The proposed reforms create an opportunity to establish a more coherent and consistent approach to functional capacity assessment. They also create a significant risk if functional capacity is reduced to a score, threshold or administrative proxy that does not adequately capture the diversity of disability and the way disability is experienced in everyday life. In Appendix 1, we share a case study, highlighting the risks created for an NDIS participant, following a planner-delivered WHODAS 2 utilised as evidence of support need, over-riding evidence provided through occupational therapy functional capacity assessment, for a person with a psychosocial disability -demonstrating the perils of decision making based on assessment scores in the absence of consideration of clinical context, and personal and environmental factors.

The first requirement for a fair process must therefore be **conceptual clarity about what is being assessed**. Functional capacity must not be conflated with diagnosis, impairment severity, support need or performance on a discrete task. These constructs may be related, but they are not interchangeable. A set of assessments for each functional 'domain' or 'activity' may be an appropriate approach, however each set of assessments must be validated for this purpose and bring equity across disability cohorts. Without transparency about the method, participants, assessors and decision-makers cannot understand, test or challenge how a score has been derived.

The Rules must urgently expand on, and clarify, this narrow definition, alongside the narrow definition of substantially reduced functional capacity contained in s24 (1) (c). A person's ability to complete a task under controlled conditions, is not necessarily equivalent to their ability to function safely, reliably, repeatedly and sustainably in everyday life. For many people with invisible, psychosocial, cognitive, sensory, fluctuating or multiple disabilities, the difference between capacity and performance is itself important evidence of disability.

The ICF provides an established conceptual framework for understanding this distinction. It recognises functioning as an interaction between health conditions, body functions and structures, activities, participation and environmental factors, and distinguishes between capacity and performance. The future NDIS assessment framework should remain faithful to this multidimensional understanding rather than reverting to impairment severity, isolated task completion or a single numerical score as a proxy for functional capacity.

2.2 Functional capacity must be assessed as it operates in real life

A disability-informed assessment cannot assume that function is static, context-free or observable during a short clinical interaction. Functional assessment therefore considers not only whether a person can perform an activity, but whether they can initiate, plan, sequence, complete and sustain it; whether they can do so safely and reliably; what prompting, supervision or assistance is required; and how cognitive, sensory, psychosocial, physical and environmental factors affect performance.

A person may be physically capable of holding a spoon but unable to consistently prepare and consume an adequate meal. They may be able to remove their clothing but be unable to shower safely without assistance. They may be able to walk a defined distance in a clinical environment but be unable to reliably leave their home and navigate the community. They may communicate fluently during a structured assessment but be unable to manage the planning, executive functioning and communication demands associated with coordinating multiple services in everyday life.

These are not exceptions to functional assessment. They are precisely the circumstances that functional assessment is intended to identify.

This is particularly important for people whose disability is context-dependent, fluctuating or not readily observable, including, for example, psychosocial disability. Functional effects may persist between periods of acute illness or exacerbation and may not be adequately captured by medical records that focus on episodes of treatment or crisis. Similarly, fatigue, post-exertional deterioration, pain, autonomic dysfunction, sensory overload, executive dysfunction and cognitive fatigue may not be apparent during a brief assessment but may substantially affect a person's ability to function over time.

The assessment framework must therefore be capable of capturing **reliability of function, consistency of function, and sustainability of functioning recognising environmental demands, to translate capacity into actual performance**. It must also recognise executive functioning as a substantive component of functional capacity, including planning, organisation, initiation, sequencing, emotional regulation, maintaining routines and navigating complex systems.

A fair process must further ensure that the assessment methodology does not disadvantage a person because of the nature of their disability. Assessment must be accessible and responsive to cognitive, communication, psychosocial, neurological and executive functioning differences, rather than treating those differences as limitations in the person's ability to participate in the assessment itself.

2.3 The assessment methodology must be demonstrated to be valid and reliable before it determines eligibility

The second fundamental requirement is an evidence base capable of demonstrating that the proposed methodology actually measures what the legislation requires it to measure. The Consultation Paper appropriately identifies reliability, validity, equity and consistent application as important characteristics of the future assessment process. These cannot, however, simply be design aspirations. They must be demonstrated empirically before an assessment methodology is relied upon to determine access to the NDIS at scale.

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There is currently no single validated instrument capable of comprehensively assessing functional capacity across the breadth of NDIS domains and disability presentations. Developing such a system requires more than selecting an existing instrument and establishing a threshold. It requires clear construct definition, psychometric validation, testing across diverse disability populations, assessment of inter-rater reliability, calibration of thresholds, assessor training, examination of differential impacts between cohorts, and independent evaluation of outcomes.

The assessment methodology must therefore be tested against the construct it is intended to establish, rather than against administrative convenience or the apparent consistency of its scores.

2.4 Any proposed use of I-CAN must be separately validated for functional capacity

OTSi understands that the I-CAN may be considered as part of the future assessment architecture. The potential use of I-CAN for this purpose requires particular caution because it would represent a significant departure from the purpose for which the instrument was developed.

I-CAN was designed as an instrument for identifying and classifying disability support needs in real-world environments. Its value lies in eliciting information about what a person can and cannot do, what assistance is required, and how functioning is affected in context. It is not, in its original form, an instrument designed to establish the statutory threshold of substantially reduced functional capacity; or if a person needs a support that is an NDIS support, to inform an access decision.

Utilising ICAN scores, in a NDIS access decision context, to determine “if you usually need disability related supports to participate in or complete [the above] tasks (NDIS (Becoming a Participant) Rules r 5.8), would raise issues, including the capacity of the tool for this purpose; the reliability and validity of the tool to inform access decisions; and the capacity of this assessor workforce to undertake such high-stakes assessment.

Further, limiting assessment of support need via the iCAN to functional domains or activities for which the person met access criteria only, could lead to a restricted, inappropriate or rigid NDIS plan and/or funding outcomes.

There is a further validation issue. I-CAN was developed and researched on the basis of triangulating multiple sources of evidence, including the perspectives of carers and support people. If those sources are excluded or the instrument is otherwise adapted for NDIS purposes, the adapted methodology cannot simply inherit the validation evidence of the original instrument. It must be validated for its new purpose and in its new form, for NDIS support need determination, and also if it were to have a role in access decisions.

OTSi recommends that validation occur in distinct stages: first, validation of any adapted I-CAN methodology for its proposed needs-assessment purpose; and second, separate validation if it is proposed to be used to inform access decisions. It should not be assumed that evidence supporting one purpose establishes validity for the other.

Most importantly, neither I-CAN nor any other instrument should be used to generate a score that automatically determines eligibility without consideration of the broader evidence and the exercise of skilled, professional judgement and oversight.

2.5 Standardisation must support, not replace, professional judgement

Consistency is an essential characteristic of a fair access system. However, consistency should not be achieved by eliminating professional judgement. It should be achieved by **making professional judgement more consistent, transparent, accountable and evidence-informed.**

Historically, occupational therapists have provided functional capacity evidence to the Agency, while the ultimate determination of whether the statutory access criteria are satisfied has rested with the Agency. In the absence of sufficiently detailed Agency guidance, occupational therapists have had to interpret the legislation, draw on disability and legal expertise, select appropriate assessment methods and integrate multiple sources of evidence to describe the person's functional capacity.

The future system should build on, rather than discard, this body of professional expertise and experience.

OTSi proposes a two-step process – firstly, an external functional capacity assessment completed by an endorsed allied health assessor team, sustaining choice of assessor, and secondly, a skilled NDIA team making the decision on NDIS eligibility based on the sum of the evidence provided.

A standardised tool can provide a common language and improve consistency in the collection of evidence. It cannot, however, determine the meaning of that evidence in every individual case. Skilled assessors are required to understand whether a result is representative of the person's usual functioning, whether contextual factors have influenced performance, whether the assessment has adequately captured fluctuating or hidden disability, and how the assessment findings relate to other available evidence.

A fair system should require NDIS decision-makers to consider the assessment result alongside the person's history, lived experience, longitudinal evidence, medical and allied health evidence, collateral information and evidence of functioning across relevant environments. Where evidence is inconsistent, borderline or falls outside the population on which an instrument was validated, that discrepancy should trigger further consideration rather than automatic exclusion. A solid assessment tool and sound professional judgement should generally converge. Where they do not, however, the appropriate response is not necessarily to privilege the score. The discrepancy itself may be evidence that requires investigation.

This principle is particularly important at the boundary of eligibility. Any system that seeks to translate complex human functioning into a threshold will inevitably encounter people whose presentation does not fit neatly within the parameters of the assessment instrument. A fair system therefore requires an explicit mechanism for reviewing borderline and outlier cases through appropriately skilled decision-makers. Escalated automated decision-making powers contained in the amended legislation, carry human-rights risks¹⁸, and these powers **must not be used as part of an NDIS eligibility determination process.**

¹⁸ [Human Rights Commission urges Australian Government to 'hit pause' on NDIS reform Bill](#)

2.6 Occupational therapy expertise must be embedded in the design, assessment and governance of the system

Occupational therapists should not be positioned merely as professionals who administer a tool after the Government has determined the assessment model. Occupational therapy expertise is directly relevant to the **design of the construct, selection and development of assessment methodology, interpretation of functional evidence, assessor competency standards and ongoing evaluation of the system.**

Occupational therapy is a profession specifically concerned with the relationship between the person, occupation and environment and with how disability affects participation in everyday life. Functional assessment is therefore not an incidental component of occupational therapy practice; it is a core area of professional expertise.

Occupational therapists routinely integrate multiple forms of evidence, including self-report, observation, standardised measures, collateral information, longitudinal history and environmental assessment. They understand that the same diagnosis can produce profoundly different functional outcomes, and that apparently similar functional presentations can arise from very different combinations of impairment, environment and personal circumstances.

This expertise is particularly important in the development of a national assessment methodology intended to operate across diverse disability populations. It is also critical to recognising areas of function that are frequently underestimated by assessment systems, including executive functioning, functional cognition, sensory processing, emotional regulation, initiation, planning, fatigue, cognitive endurance and the interaction between a person's functioning and their environment.

Decision-makers should therefore ensure that occupational therapy expertise is embedded throughout the assessment reform process, including in methodology development, pilot design, validation, assessor competency frameworks, quality assurance, review of borderline cases and ongoing evaluation. Occupational therapists should be participants in determining whether the proposed methodology is clinically defensible, not simply trained in its administration once it has been selected.

2.7 A competent assessor workforce providing the evidence for skilled NDIA eligibility decision-making.

A national assessment framework cannot achieve consistent outcomes simply by standardising an instrument. OTSi proposes a two-step process – firstly, an external functional capacity assessment completed by an endorsed assessor team, sustaining choice of assessor, and secondly, a skilled NDIA team making the decision on NDIS eligibility based on the sum of the evidence provided

OTSi has previously proposed the establishment of a National Endorsed Assessor Team (NEAT)¹⁹, for the NDIS, in line with the findings of the Independent Assessment Inquiry final report (2021)²⁰ and international best-practice evidence²¹. The NEAT principles could be adapted for the purpose of NDIS functional assessments, ensuring a defined, competency-based assessor workforce, supported by strong clinical and conceptual leadership, structured professional development, and ongoing evaluation. An adapted NEAT

¹⁹ [Best-Practices-Support-Needs-Assessment-for-the-NDIS-OTSi-31012025-FINAL.pdf](#)

²⁰ NDIS Joint Standing Committee Inquiry to Independent Assessments Final Report (2021) [Independent Assessments – Parliament of Australia](#) Retrieved 26/09/2026

²¹ 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 27/09/2026

model could supply the functional capacity evidence for consideration by the NDIA to determine eligibility for NDIS. Enabling functional capacity assessment through a Medicare item, was recommended by the Parliamentary Inquiry to Independent Assessment, and costed by the Parliamentary Budget Office²². This type of approach is trauma-informed and is particularly important for disabilities where functional impact is less readily observable or where the relationship between impairment, functioning and participation is complex.

An endorsed, competency-based workforce would allow the Agency to establish explicit expectations about the knowledge and skills required to undertake functional capacity assessment. This should include competence in functional assessment for the NDIS, ICF concepts, functional cognition, executive functioning, fluctuating disability, psychosocial disability, communication accessibility, environmental assessment, interpretation of standardised measures and integration of multiple sources of evidence.

Consistency of NDIA decision making on eligibility should then be developed through a quality-managed approach, involving calibration of decisions, review of complex cases, feedback, supervision and evaluation. This is more likely to produce durable consistency within NDIA decision making on both the permanence and disability requirements, than attempting to engineer consistency through a desktop assessment implementing a single instrument or automated decision-making algorithms.

2.8 The reform must proceed through staged implementation, independent evaluation and genuine co-design

The scale and consequences of this reform require a staged approach. The assessment methodology should be developed, tested, independently evaluated and refined before it is used to determine access at national scale.

This is not an argument against reform. It is an argument for evidence-based reform.

The Government should first establish the construct to be measured, develop the assessment methodology, test it across diverse disability populations, establish assessor competencies, evaluate inter-rater reliability, examine differential impacts, and undertake independent review before relying on the methodology as a national eligibility gateway.

People with disability and their representative organisations must be involved throughout this process, not simply consulted after the fundamental architecture has been determined. Genuine co-design requires meaningful participation in the construction, testing, interpretation and evaluation of the system.

Professional expertise must be treated similarly. Occupational therapists and other relevant allied health professionals should contribute to the development and validation of the assessment methodology itself, drawing on established expertise in functional assessment and clinical reasoning.

The overarching principle should be that the eligibility system is tested against the lived reality of disability, rather than people with disability being required to conform to the limitations of an untested assessment system.

²² NDIS Joint Standing Committee Inquiry to Independent Assessments Final Report (2021) [Independent Assessments – Parliament of Australia](#) Retrieved 26/09/2026

2.9 The standard OTSi proposes

Taken together, these requirements point to a model in which standardisation and professional judgement are complementary rather than competing principles.

A fair and evidence-based NDIS access system should be founded on the ICF and a clearly defined conception of functional capacity; use assessment methodology that has been specifically validated for the statutory purpose for which it is proposed; capture both capacity and real-world performance; recognise environmental and contextual factors; distinguish functional capacity from support need without severing the relationship between them; and incorporate multiple sources of evidence.

It should use standardised tools to support consistency, but should not convert complex functional evidence into an automatic eligibility score. It should rely on a competency-based assessor workforce with strong occupational therapy and allied health expertise, supported by clinical leadership, calibration, supervision and ongoing evaluation. It should provide deliberative review of borderline and complex cases and require decision-makers to explain how the available evidence has been weighed.

Most importantly, the system should demonstrate empirically that it is equitable across disability populations before it is relied upon to determine access at scale.

Occupational therapists have been assessing function for the NDIS since its inception. The profession brings a distinctive body of knowledge to this reform: the ability to understand functioning not simply as what a person can demonstrate in a controlled assessment, but as what a person can initiate, perform, sustain and participate in across the environments and circumstances of their actual life.

That expertise should be central to the design and governance of the new system.

The question for Government is therefore not whether Australia can develop a more consistent approach to functional capacity assessment. It can. The question is whether consistency will be achieved through a valid, transparent and disability-informed assessment system supported by skilled professional judgement, or through the administrative convenience of reducing complex functional evidence to scores and thresholds. OTSi considers that only the former can provide the level of fairness, transparency, equity and evidentiary integrity required of a national disability access system.

2.10 Fairness issues arising from premature operationalisation of new definitions of functional capacity

The definition of functional capacity in the NDIS legislation has been amended, alongside the provisions concerning substantially reduced functional capacity. These amendments commenced on **27 August 2026** and have been reflected in the NDIA's operational guidance for applying to the NDIS²³.

²³ [New NDIS Definitions of Functional Capacity; and the consultation on the future of NDIS access is open for community input - Every Australian Counts](#)

²³ [Our guidelines | NDIS](#) Applying to the NDIS.

²³ [OG-Applying-to-the-NDIS \(3\).pdf](#)

²³ Deputy NDIA CEO, Amity Durham, confirms the new definition of functional capacity took effect Aug 27th 2026, at the Joint Standing Committee Public Hearing on Sept 11th, 2026 [Public Hearings – Parliament of Australia](#) [10.11- [ParlView | Video 4906980](#)]

However, there is currently a significant gap between the **statutory provisions now in force**, the **operational guidance being applied by the NDIA**, and the Government's stated intention that a new assessment framework for NDIS access will commence from **1 January 2028**. The legislative Rules that will give effect to the future access and assessment framework have not yet been developed.

This creates considerable uncertainty for people seeking access to the NDIS or undergoing eligibility reassessment, their families and representatives, and the professionals who provide functional evidence to support applications. It is particularly concerning where applicants are currently being assessed against amended statutory concepts, while the detailed Rules and assessment framework intended to operationalise the future access arrangements are not yet in place.

The issue is not simply one of future policy design. The amended definitions are already legally operative and are relevant to current decision-making and administrative review. Recent Administrative Review Tribunal proceedings have also highlighted the application of the amended provisions to matters that had not been finalised before the commencement date and state that NDIA can also apply them.

The Government should therefore urgently provide transparent public clarification of:

1. How the amended definitions of functional capacity and substantially reduced functional capacity are to be applied by the NDIA between 27 August 2026 and 1 January 2028;
2. Whether and how the amended definitions are to be applied to current NDIS access applications, internal reviews and matters before the Administrative Review Tribunal;
3. How the current operational guidance interacts with the existing legislative Rules while the new Rules are being developed and agreed with State and Territory Governments;
4. Whether the application of the amended definitions before 1 January 2028 is intended to alter the substantive threshold for NDIS access, given the Government's stated position that changes to how people access the NDIS will commence from 1 January 2028; and
5. What protections are in place to ensure that applicants are not disadvantaged by an interim period in which statutory definitions have changed but the new assessment methodology, Rules and associated evidence requirements have not yet commenced.

The Government should publish this clarification promptly and in a form that is accessible to **NDIS participants and applicants, families and carers, advocates, legal representatives, allied health professionals and other practitioners providing functional evidence**.

There should be particular transparency about the transition period. People should not be required to navigate a materially different interpretation of functional capacity without clear information about the legal basis for that interpretation, the evidence required, and how decisions made during the transition period will interact with the new assessment framework commencing on **1 January 2028**.

Recommendation:

That the Australian Government urgently and transparently clarify how the amended statutory definitions of **functional capacity** and **substantially reduced functional capacity** are to be applied in NDIS access decision-making between **27 August 2026 and 1 January 2028**, including by the NDIA and the Administrative Review Tribunal.

²³ Riordan [2026] ARTA 2164, (25 September 2026), (no.24, p.10) [Riordan and CEO, National Disability Insurance Agency \(NDIS\) \[2026\] ARTA 2164 \(25 September 2026\)](#)

3. How can the process reduce administrative burden while remaining proportionate?

OTSi strongly supports the objective of reducing the extraordinary administrative burden currently experienced by participants and families.

However, the answer cannot be to reduce the evidentiary quality required for a high-consequence decision. It should instead be to place greater responsibility upon government to obtain, integrate and interpret evidence.

The NDIS Review's Action 3.1 envisaged a transparent and robust functional capacity approach in which existing instruments would be tested against the populations for which they are intended, new instruments would be developed where necessary, assessment would span relevant domains, fluctuating disability and environmental circumstances would be recognised, and treating professionals would remain an important source of evidence. Action 3.1 was intended to establish a more consistent and robust approach to NDIS eligibility and an agreed definition of substantially reduced functional capacity²⁴.

A proportionate process should mean that people with clearly profound and permanent disability are not repeatedly required to prove what is already established. It should not mean that people with complex, fluctuating or less visible disabilities are given a superficial assessment because a superficial assessment is administratively easier.

4. How can the process work across all disability cohorts?

4.1 Equity must be demonstrated across disability populations

A fair national assessment process must demonstrate that it operates equitably across disability populations. Equity cannot be assumed simply because the same assessment tool is applied to everyone. The consultation recognises the diversity of communication, cultural, cognitive, degenerative, fluctuating, episodic and complex support needs. These characteristics must be embedded in the design of the assessment methodology, rather than treated as exceptions or special cases.

Standardisation should not be equated with uniformity. Fairness requires that the same statutory threshold is applied consistently, but through assessment methods that validly capture how disability affects functioning across different populations.

Functional capacity may present differently depending on the nature of disability and the interaction between the person and their environment. For example, capacity may fluctuate or deteriorate following exertion; significant functional limitations may be masked in an unfamiliar assessment environment; cognitive skills may not generalise or be independently initiated; and communication may require Auslan, AAC or other supports. Reduced functional capacity may also arise from the interaction of multiple impairments rather than a single diagnostic category. These are not reasons to exclude people from a standardised process; they demonstrate the need for an assessment methodology capable of accurately capturing diverse functional presentations.

²⁴ [Working together to deliver the NDIS. NDIS Review: Final Report](#)

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This is particularly important for people with, for example, psychosocial disability, acquired brain injury, intellectual or cognitive disability, autism, neurological or sensory disability, ME/CFS, dysautonomia, and multiple or fluctuating disabilities. A tool may be reliable in producing consistent scores while nevertheless systematically under-identifying functional impact in a particular population if its constructs, domains or thresholds do not adequately reflect that population's experience of disability.

The requirement to use a standardised environment for assessment will also need elaboration. A person living on a First Nations outstation in a remote area, or a person experiencing homelessness, will not have access to a standardised environment. It is unclear whether the government plans to fund travel to a standardised assessment environment, or how cultural sensitivity and standardised environments will be met. The lure of administratively convenient, medicalised and reductionist approaches to assessing functional capacity risks leading to the erasure of the lived and cultural reality of '*substantially reduced functional capacity*' arising from disability.

Equity must therefore be demonstrated empirically. Any proposed assessment methodology should be piloted across diverse disability populations and independently evaluated for differential outcomes before implementation at scale. Evaluation should examine whether the methodology produces false negatives, inconsistent outcomes, or significant discrepancies between assessment results and other credible evidence of functional impact. The Government should publish sufficient evidence to demonstrate how the methodology performs across disability cohorts.

The objective should not be to ensure that every person or disability produces the same assessment result. It should be to ensure that people with different disabilities are assessed against the same statutory construct, **substantially reduced functional capacity**, using a methodology that validly captures the different ways in which disability affects functioning.

The critical question is therefore not simply whether an assessment tool produces consistent results, but whether those results are a valid representation of the statutory construct across the diversity of people seeking access to the Scheme. Consistency without construct validity risks producing a system that is administratively uniform but substantively inequitable.

This leads to one of the most important unresolved questions in the entire reform.

4.2 Future Impairment categories, and existing flawed 'Severity Scales'

The consultation is focused on access, but the broader legislative framework gives impairment categories potential significance. The 2024 amendments introduced the notice of impairments under section 32BA of the *National Disability Insurance Scheme Act 2013* (Cth) (the Act). Following an access decision, the participant will receive a notice specifying the category or categories of impairment in respect of which they meet the disability requirements under section 24, the early intervention requirements under section 25, or both. The Act provides for six categories: intellectual, cognitive, neurological, sensory, physical, and impairments to which a psychosocial disability is attributable. The notice does not identify a person's specific impairments (Explanatory document, Notice of Impairments Transitional Rule).

At present it is unclear how impairment categories will be determined, what methodology will be used, whether categorisation will depend upon listed medical conditions, administrative rules or algorithmic processes, and how overlapping impairments will be handled. Impairment categories defined at the point of access, may determine what supports that person can access. Current processes for determining impairment categories, are simply via NDIA lists of medical conditions – embedding a medicalised approach at the heart of NDIS infrastructure. This strategy of determining impairment categories is not consistent with the ICF.

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Current participants must be issued Impairment Notices as a matter of critical urgency, and as an essential safe-guarding strategy. Participants need to have advance notice of assigned impairment categories so they can seek to have them amended where they are not correctly identified by the NDIA and through the PACE system, as they will have implications for access to support, and potentially, access to the NDIS.

Most importantly, **will impairment categories be determined following an access decision, or will applicants apply for access under an impairment category? This has major implications for the access process.**

Where the new functional assessment assess function broadly, how will the NDIA determine the Impairment Categories? If categories are determined after a whole-of-person functional assessment, will the process subsequently disaggregate the person's impairments in a way that undermines the assessment that established them?

And if a person's reduced functional capacity is attributed to an impairment that is not recognised as qualifying, could the person effectively fail the access test despite having substantial disability?

These questions cannot be left to future administrative guidance. Without transparency, there is a real risk that diagnosis lists will simply be replaced by an alternative form of categorical reduction. The current impairment categories are effectively diagnostic lists and not aligned with an ICF-based understanding of impairment.

Further, it is not clear if Impairment Categories will replace current 'Severity Ratings'. OTSi acknowledges the previous critique and flaws in the 'Severity Scale' ratings, including those arising from NDIS planner delivered WHODAS 2²⁵ 26 27. The ANAO has highlighted the role the WHODAS 2 assessment tool and the process surrounding it, was a key risk in NDIS budget blowout for the NDIS²⁸. OTSi contends that current 'Severity scores' should not be used to inform future NDIS decision making in any form, and critically, should not be embedded in NDIS algorithms determining access or support needs, or funding. Their role in past NDIS decision making should be fully and publicly investigated. They must not be used to prioritise cohorts for eligibility reassessment under the new access process.

Elsewhere, impairment is assessed utilising impairment ratings and tables. Australian workers' compensation schemes generally assess permanent impairment using guidelines based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (as cited in" the AMA Guides Newsletter.). A medical assessor rates the impairment once the condition has stabilised and expresses it as a percentage of whole person impairment. That percentage is then compared against statutory thresholds that determine access to entitlements.

²⁵ AIHW (Australian Institute of Health and Welfare) (2024) *People with disability in Australia 2024*, AIHW, Australian Government, doi:10.25816/5ec5be4ced179.

²⁶ [NDIS REFORM STRATEGIES THAT ENSURE SCHEME SUSTAINABILITY & UPHOLD NDIS CORE PRINCIPLES - Allied](#)

²⁷ Submission number 23, JCPAA *Inquiry into the Administration of the NDIS* [Submissions – Parliament of Australia](#)

²⁸ Final report [Effectiveness of the National Disability Insurance Agency's Management of Assistance with Daily Life Supports | Australian National Audit Office \(ANAO\)](#)

These schemes do not treat the impairment rating as a measure of functional capacity. Both the fifth and sixth editions of the Guides distinguish impairment from disability, and the sixth edition states that impairment percentages do not directly measure work participation restrictions (Andersson & Cocchiarella 2000, pp 8, 13; AMA 2008, pp 5–6). In Australian schemes, work capacity is assessed separately, as a distinct process concerned with current capacity to work, and impairment percentages operate as thresholds for particular entitlements (SIRA 2021; Safe Work Australia 2021). Questions have also been raised about the reliability, validity and evidence base of the Guides, and one comparison found that the sixth edition produced systematically lower ratings than the fifth for injured workers (PMID 19627958). These are weaknesses of a system built on impairment classification and numerical thresholds, and the NDIS should not import them²⁹.

The NDIS Section 24 requires a determination of whether impairment results in substantially reduced functional capacity in relation to specified activities, and the amended Act requires those activities to be considered as a whole. That question cannot be answered by rating impairment against a reductionist impairment rating. Body-system classes do not capture how impairments affect an activity as a whole.

5. Permanence, Treatment and the Evidence Required to Establish Disability

OTSi recognises that permanence is an important component of NDIS eligibility. However, permanence should be determined on the basis of clinical and functional evidence, rather than by requiring a person to exhaust every theoretically available intervention. The proposed approach to “appropriate treatment” risks treating treatment availability as a theoretical proposition rather than a lived reality. As the parliamentary inquiry heard, treatment may be inaccessible because of cost, geography, limited service availability or a limited evidence base for particular conditions. These barriers should not be interpreted as evidence that a disability is potentially remediable.

The framework must also recognise that people may be unable to produce a complete treatment history for reasons directly related to disability or disadvantage, including disrupted continuity of care, lost records, closure of services, practitioner retirement, homelessness, trauma, domestic and family violence, or cognitive or psychosocial impairment. Treatment should not be conflated with cure: for many lifelong, fluctuating or degenerative disabilities, intervention aims to maintain function, prevent deterioration, preserve participation or reduce hospitalisation and carer burden. Improvement in one aspect of functioning does not, in itself, demonstrate that a person's disability is no longer permanent or substantially impacts functional capacity.

²⁹ **American Medical Association. (2008).** *AMA Guides to the Evaluation of Permanent Impairment* (6th ed.). American Medical Association.

Cocchiarella, L., & Andersson, G. B. J. (Eds.). (2000). *Guides to the Evaluation of Permanent Impairment* (5th ed.). American Medical Association.

Rondinelli, R. D. (2009). Changes for the new AMA Guides to impairment ratings, 6th Edition: Implications and applications for physician disability evaluations. *PM&R*, 1(7), 643–656. <https://doi.org/10.1016/j.pmrj.2009.04.012>.

Safe Work Australia. *Permanent impairment*. Australian Government.

State Insurance Regulatory Authority. (2021). *Workers compensation guidelines for the evaluation of permanent impairment*. NSW Government.

State Insurance Regulatory Authority. *Workers compensation guidelines — Part 5: Work capacity assessment*. NSW Government.

Spieler, E. A., Barth, P. S., Burton, J. F., Himmelstein, J., & Rudolph, L. (2000). Recommendations to guide revision of the Guides to the Evaluation of Permanent Impairment. *JAMA*, 283(4), 519–523. <https://doi.org/10.1001/jama.283.4.519>

Any consideration of treatment must also respect bodily autonomy and free and informed consent. People must retain the right to refuse treatment without losing access to disability support, including where an intervention is inconsistent with personal, cultural or communication preferences, carries significant risks, or has previously caused functional harm. Capacity-building or function-focused therapeutic supports that maintain function should not be reclassified as “treatment” or “rehabilitation” that a person must exhaust before establishing eligibility, particularly as these interventions are not reasonably available or accessible within mainstream systems.

The appropriate test should therefore be whether an impairment is likely to be substantially remedied by evidence-based, clinically appropriate and **realistically accessible** intervention undertaken with free and informed consent. These treatment and intervention expectations **should be provided in advance**, to enable applicant clinical and treatment providers to respond to them.

The assessment framework should provide clear guidance on how longitudinal functional evidence can contribute to establishing permanence and substantially reduced functional capacity, without imposing arbitrary waiting periods or requiring people to exhaust services that cannot appropriately address their disability-related needs. **Engagement with non-NDIS services may provide relevant evidence in some circumstances but should not become a mandatory precondition where permanence and substantially reduced functional capacity are already established.**

6. The risks of an unacceptably high threshold for NDIS access.

As described in section 2.10 above, OTSi is also concerned by the proposal to consider activities “as a whole” (legislation s24 (1) (c)). The phrase requires legislative clarity because everyday occupations are not singular acts. They are complex sequences of interdependent activities.

Eating involves recognising hunger, planning, accessing food, preparing it, tolerating sensory demands, physically consuming it and monitoring nutritional needs. Showering involves initiation, preparation, sequencing, sensory tolerance, balance, physical access, safety and completion. Community participation involves leaving the home, navigating transport, communicating, regulating sensory and emotional demands and sustaining participation. A person may perform one component while remaining substantially unable to perform the occupation independently.

If “activity as a whole” is interpreted to mean that capacity to perform one component negates significant limitations elsewhere within the activity, the NDIS threshold will become substantially more restrictive, and effectively block access for hundreds of thousands of Australians who currently meet the eligibility threshold.

An NDIS with a substantially high threshold for access, creates unacceptable risks for disabled Australians, and the obliteration of the national disability safety net. There are no comparable systems available at State-level, or anywhere outside the NDIS. This creates the widening of service gaps and the foreseeable risk of unmet need, and elevates the risk of abuse, neglect, harm, entrenched disability, and death. The gaps hold well-recognised clinical consequences when essential disability supports are removed without alternative support, including but not limited to:

- preventable hospital presentations and admissions.
- functional deterioration resulting from loss of maintenance therapies;

- mental health deterioration associated with social isolation and withdrawal of community participation;
- falls and injury associated with reduced equipment and environmental supports;
- carer burnout and family breakdown;
- child protection involvement where disability-related parenting supports are withdrawn;
- homelessness and housing instability;
- avoidable entry into residential care or institutional settings;
- suicide risk for participants experiencing abrupt loss of essential supports; and
- the risk of increased death rates.

The commencement of Thriving Kids raises significant concerns about implementation readiness, particularly given that the Government's own fact sheet acknowledges that Australian, state and territory governments are **still working to define and describe what constitutes "low to moderate support needs"** for children with developmental delay and/or autism, on the eve of the rollout of the program³⁰ i.e. The threshold for NDIS access for these children, remains undefined. It is difficult to reconcile the commencement of a major reform that will determine children's access to supports with the absence of a settled definition of the cohort it is intended to serve, raising risks of critical service gaps. There must not be a repeat of this debacle across the broad range of disability cohorts.

7. Safeguarding, review rights, and the consequences of being found ineligible

A national eligibility system must be transparent about how evidence is interpreted and how decisions are reached. Applicants should be able to understand what evidence was considered, how their functional capacity was assessed, how conflicting evidence was resolved and why the decision-maker reached the conclusion they did.

There must also be independent assessment available through merits review where functional capacity findings and eligibility decisions, are disputed. The Administrative Review Tribunal must be able to interrogate the methodology underlying a decision rather than simply reviewing an administrative conclusion generated by an opaque assessment system. This is especially important if automated or algorithmic processes are introduced. No participant or applicant should be subject to a high-consequence eligibility decision that cannot be meaningfully explained, challenged and independently reviewed.

The Consultation Paper appropriately asks how the access process can determine whether the NDIS is the most appropriate system of support and connect people with other available services. OTSi supports this principle, but "available" must mean available in real terms, within the person's actual circumstances.

Recent parliamentary inquiries have already heard that the disability support ecosystem outside the NDIS is not yet reliably established and that states and territories have not agreed to provide equivalent services to people who leave the Scheme. This creates an obvious safeguarding obligation.

Once the new eligibility assessments and higher access threshold commence, robust safeguards should be in place for participants who may lose or reduce access to the NDIS. This should include a documented **Participant Impact Assessment** identifying foreseeable risks associated with withdrawal or reduction of supports, together with a **Statement of Alternative Supports** setting out the mainstream, foundational or community supports expected to replace NDIS-funded supports, their availability, accessibility, timeliness and appropriateness, arrangements for continuity of care, identified service gaps and any residual risks.

³⁰ Australian Government Factsheet on Thriving Kids, 30 September 2026.

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Participants should also have access to **graded step-down and transition plans**, including an appropriate transition period where required, to support safe and sustainable movement out of the Scheme. These measures reflect fundamental principles of safe clinical handover: essential supports should not be withdrawn without assessing the resulting risks, identifying how those risks will be managed, and ensuring that appropriate alternative supports are actually available. The TAG should include recommendations for these processes in their final report.

For the approximately 240,000 people expected to leave the Scheme under the broader reform agenda, this should include graded transition arrangements, including consideration of step-down plans, rather than a support and funding cliff drop. The purpose of transition should be to establish safe continuity of support. Medicare reform, and the inclusion of focused-functional strategies through Medicare, should be considered as part of the foundational support ecosystem outside the NDIS.

8. Parliamentary and independent oversight

The scale and consequences of the proposed reform warrant oversight beyond the administrative machinery responsible for implementing it. The Technical Advisory Group is an important mechanism. The Consultation Paper states that it will consider approaches, tools and thresholds and provide expert advice to governments.

However, the development of the access framework should not become a closed technical exercise. OTSi recommends ongoing oversight by the Joint Standing Committee on the NDIS, with publication of the evidence underpinning the eventual assessment methodology, validation results, cohort-specific performance, error rates, equity impacts and implementation outcomes.

Conclusion

OTSi supports the development of a more consistent, transparent and equitable approach to NDIS access, and the move towards a genuinely functional assessment of disability.

However, consistency must be underpinned by validity, equity and clinical integrity. A national assessment framework must accurately capture the complexity of disability in real life, including fluctuating, invisible, psychosocial, cognitive, sensory and multiple disabilities, and must recognise both capacity and performance.

Before the new framework is used to determine access at scale, it should be clearly defined, independently validated, tested across diverse disability populations, supported by a competent assessment workforce, and subject to meaningful lived-experience and professional oversight.

The transition must also be transparent and safe, with clear legislative guidance, procedural safeguards and appropriate alternative supports for people whose NDIS access changes.

OTSi urges the Government to ensure that the future NDIS access system is not simply more standardised, but demonstrably **valid, equitable, transparent, evidence-based and safe**.

APPENDIX 1 Case Study: “Jason” (name changed) -when foreseeable risk goes unmanaged

Jason’s story

Jason is a man in his mid-30s living in metropolitan Victoria. He lives with severe and enduring psychosocial disability alongside cognitive impairment that affects his memory, insight, judgment and ability to make safe decisions. Day to day, this means Jason struggles to organise his life, understand complex information, and recognise when situations or people are unsafe. Navigating systems, contracts, budgets and money is overwhelming for him.

Jason wants stability. He wants to live safely, feel supported, and avoid hospital. He requires support to make decisions. Without this, he is at risk of exploitation, misinformation and poor-quality services. These risks are well-documented, long-standing, and recognised by health professionals across mental health and disability systems.

Despite this, Jason was placed into an NDIS environment that assumed a level of autonomy and decision-making capacity he simply did not have.

What the evidence said, and why it mattered

Over several years, Jason’s treating occupational therapist provided multiple functional capacity assessments and written risk reports. They clearly explained how Jason’s cognitive impairment affected his ability to self-manage, understand provider roles, give informed consent, and protect himself from harm.

The OT repeatedly warned that without safeguards, Jason was at high risk of:

- misuse or rapid depletion of NDIS funds
- unsafe or inappropriate living arrangements
- provider-induced demand and coercion
- mental health deterioration and crisis
- escalation into hospital and statutory intervention

The recommendations were practical and preventative: Agency-managed funding, specialist support coordination, a structured housing solution, and clear separation of provider roles. Taken together, they formed a coherent plan to stabilise Jason’s life, protect him from harm, and reduce long-term system costs.

This was foreseeable risk, clearly articulated, and preventable.

What happened instead

Despite this consistent allied health evidence, NDIA planning decisions did not implement the recommended safeguards. Jason was issued a plan with significant flexible funding and complex arrangements that he did not understand and could not safely manage.

Rather than relying on the detailed evidence already available, the NDIA substituted this with a planner-administered WHODAS assessment, presumably using the scores to determine a funding level and package. This tool did not capture Jason’s cognitive disability, impaired decision-making, or safeguarding needs. As a result, his capacity was overestimated and risk was underestimated.

The outcome was predictable. Flexibility without protective structure became a liability rather than a support.

When risk becomes harm

Without safeguards in place, Jason's situation deteriorated. He was placed in unsuitable and unsafe living arrangements. He experienced confusion about who was supporting him and why. He was exposed to restrictive practices without appropriate authorisation. His mental health declined.

Eventually, Jason was involuntarily hospitalised and placed on a Community Treatment Order. He ultimately required very intensive NDIS supports to restore functional capacity and stabilise his living situation.

This was not an unexpected crisis. It was the realisation of risks that had been clearly identified years earlier.

Policy implications

Jason's experience highlights a critical policy failure: when allied health evidence identifying foreseeable risk is ignored or overridden, the NDIS shifts from prevention to crisis response. When 'naked' assessment scores are utilised in decision making, context is lost. This does not save money. It escalates NDIS costs, harms participants, and pushes pressure onto hospitals, mental health services and statutory systems. These are the failures to act early, when intervention is most effective and least costly.

Jason's case shows that individualised funding only works when it is risk-adjusted, evidence-led and safeguarded; and supported-decision-making supports are in place when needed. Ignoring allied health evidence did not preserve Jason's autonomy - it removed his safety net. And the harm that followed was both foreseeable and preventable.