Supplementary Submission to Senate Community Affairs Legislation Committee Inquiry Re: National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026

Introduction

OTSi is writing to raise significant human rights concerns regarding the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026.

The proposed Bill contains a number of provisions that may engage and potentially limit the rights of people with disability under the Convention on the Rights of Persons with Disabilities (CRPD), including rights relating to equality and non-discrimination, bodily autonomy, informed consent, independent living, participation in the community, privacy, procedural fairness and equal recognition before the law.

OTSi is particularly concerned about the breadth of discretionary powers created by the Bill, the extent to which substantive matters are deferred to future Rules, and the risk that some provisions may disproportionately disadvantage particular groups of people with disabilities, including people with psychosocial disability, women, First Nations people, people in rural and remote areas, and people experiencing poverty or barriers to accessing treatment and services.

OTSi respectfully request that the Committee closely scrutinise the following provisions of the Bill for compatibility with Australia's human rights obligations.

Schedule 1 – Items 88–94 (Permanence and treatment)

The proposed permanence test risks coercive treatment expectations, undermines bodily autonomy and disadvantages participants unable to access specialists or historical records.

Disability support eligibility should be based on functional impairment and support needs, not compliance with particular medical or therapeutic pathways.

People should not be coerced into needing treatments before being able to access NDIS support or maintain eligibility if not currently on the NDIS. They need to be able to not engage in treatments due to:

Geography:

Disregarding geographical location as a barrier to accessing treatment fails to recognise structural inequities in service availability, and may indirectly discriminate against people in rural and remote areas by treating unequal access as equivalent to choice, undermining the right to equality and the right to health.

Cost:

Excluding inability to afford treatment as a valid reason for not accessing it risks penalising people for socioeconomic disadvantage, effectively conditioning access to disability supports on financial capacity and undermining the principles of equality, non-discrimination, and the right to an adequate standard of living.

Religious reasons

Adults with capacity can refuse any medical treatment, including disability-related treatment, for religious reasons

Cultural reasons

Some Aboriginal people may decline, delay, or modify certain biomedical interventions when care is not culturally safe, when there is mistrust due to historical harm, or when cultural authority and community decision-making processes are not respected.

Some Deaf people may choose to decline a cochlear implant due to recognising Auslan as their primary language and valuing Deaf culture and identity.

Psychological safety

Autistic people may refuse Applied Behaviour Analysis due to evidence based concerns re increased rates of PTSD afterwards.

Side effects and bodily integrity (including fertility and sexual function)

Individuals should have the right to refuse treatment based on concerns about significant side effects, including impacts on fertility, sexual function, weight, metabolic health, or organ function. This includes psychiatric medications and other long-term treatments where risks may affect reproductive autonomy, bodily integrity, and quality of life. Conditioning access to supports on acceptance of such treatments may undermine informed consent and the right to control decisions about one's own body.

Invasive procedure

Adults with capacity have the right to not be subjected to an invasive procedure without consent or other lawful justification.

Autonomy and informed consent

Adults with capacity should have the right to refuse any treatment on the basis of personal autonomy and informed consent, even where the treatment is clinically recommended. This includes situations where individuals do not accept the risk–benefit balance, prefer non-medical supports, or choose alternative pathways to wellbeing. Respect for autonomy is central to the rights to liberty, security of the person, and bodily integrity.

Spiritual, philosophical, or identity-based reasons

Individuals may refuse treatment based on broader spiritual, philosophical, or identity-based beliefs that are not strictly religious. This includes worldviews relating to the mind, body, and healing, including neurodiversity-affirming perspectives, holistic health beliefs, or concerns about altering

one's sense of self. These beliefs are protected under principles of freedom of thought, conscience, and belief.

Risk tolerance and personal values

Individuals should have the right to refuse treatment where they assess the risks, benefits, and impacts differently from clinical opinion. This includes valuing quality of life, daily functioning, or personal identity over symptom reduction, and may include refusal of treatments such as ECT or long-term psychotropic medication. Respect for differing risk tolerance is part of recognising person-centred care and equality in decision-making.

EMDR / trauma processing concerns

Individuals should have the right to refuse trauma-focused therapies such as EMDR where they are concerned about emotional destabilisation, loss of control, or reactivation of traumatic memories. This includes situations where people prefer stabilisation-based approaches or non-trauma-focused supports. Engagement in trauma therapy should always be based on informed consent, therapeutic readiness, and respect for the person's sense of safety and agency.

Service system mistrust and historical harm

Refusal of treatment may be grounded in legitimate mistrust of health systems arising from past experiences of coercion, discrimination, or harm, particularly in mental health and disability contexts. This is especially relevant for groups who have experienced systemic inequities, including Aboriginal and Torres Strait Islander peoples and people with psychosocial disability. A human rights approach requires recognition that refusal may reflect rational responses to structural harm rather than non-compliance.

Disability-related barriers

Individuals may be unable to access treatment because disability supports are required in order to participate in that treatment, yet those supports may not be available. For example, a person may require assistance with dressing, transportation, communication, emotional regulation, or leaving their home to attend a treatment program or group. If the necessary disability supports are unavailable, the person's inability to access treatment may be a consequence of their disability and support needs rather than a refusal or failure to engage in treatment.

Social determinants and access to evidence

Individuals may be unable to access the required extensive historical documentation to establish disability or demonstrate treatment history. Such requirements may disproportionately disadvantage participants who have been unable to access specialists, obtain assessments, or retain historical records.

These barriers may arise for disability-related reasons, but may also result from broader social determinants, including family and domestic violence, childhood adversity, poverty, homelessness, geographic isolation, cultural barriers, or limited access to health and disability services. As a result, individuals with similar levels of impairment and support needs may experience significantly different outcomes in establishing eligibility based on factors beyond their control.

Table of examples

The table below provides examples of potential treatments that may be considered relevant to different disabilities and highlights some of the invasive treatments that people may need to have prove that they have undertaken in order to access the NDIS for disability supports. OTSi submits that people should have the right to refuse these treatments without losing their rights to access the NDIS.

While some of the treatments listed below may not currently be widely used or accepted, the breadth of the proposed definition requires consideration of how future evidence-based treatments may be treated under the legislation. The legislative framework should therefore be assessed not only against current practice but also against foreseeable developments in healthcare and disability support.

Disability	**Treatment that may be required prior to NDIS** *some may not be common or evidence-based currently but could be in the future so are included.
Deaf	**Cochlear Implant**
Epilepsy	**Vagus Nerve Stimulation (VNS)** → implanted electrical device (insertion under skin, chest + lead to nerve) **Deep Brain Stimulation (rare for epilepsy)** → electrodes implanted in brain (surgical insertion) **Intracranial EEG monitoring (in some surgical evaluations)** → electrodes placed in brain tissue (incision + insertion) **Epilepsy surgery (e.g. resection, lesioning)** → skull opening + brain tissue removal (incision)
Huntington's disease Motor neurone disease (ALS) Acquired brain injury / stroke	**Feeding tube (PEG tube in advanced stages)** → insertion through abdominal wall
Huntington's disease	**Deep brain stimulation** (experimental for chorea) → surgical implantation
Multiple Sclerosis (MS)	**IV infusions (e.g. ocrelizumab, natalizumab)** → venous cannulation (needle insertion) **Central venous access ports (rare long-term treatment)** → implanted device (insertion under skin) **Deep brain or spinal stimulation (very rare experimental use)** → surgical implantation
Spinal Cord Injury Multiple Sclerosis	Catheters (urinary or suprapubic)
Psychosocial Disability	**Electroconvulsive therapy (ECT)**

• severe major depression (especially treatment-resistant) • catatonia • severe mania • sometimes schizophrenia (particularly catatonia or treatment resistance)	ECT is a legitimate, regulated treatment in Australia, but it is also one of the most ethically contested psychiatric interventions. In Australia, ECT normally requires consent unless it is administered under involuntary treatment orders of mental health legislation. Can result in memory loss
Schizophrenia Bipolar Psychosis	**Medications** such as • risperidone • olanzapine • quetiapine • aripiprazole • clozapine • haloperidol Can result in sexual dysfunction. This is very common, especially with dopamine-blocking antipsychotics: • reduced libido • difficulty achieving orgasm • erectile dysfunction • vaginal dryness • delayed ejaculation
Psychosocial Disability	**Medications** Some medications may result in Severe side effects Obesity and metabolic sybndrome Inpatient treatment May result in • restraint and seclusion • Loss of autonomy
Autism	**Applied Behavioural Analysis**. • PTSD is a recognised side effect yet it is often defined as Best Practice • Focus is not neuroaffirming • Can incolve restraint , hand over hand and coorcian
Post-Traumatic Stress Disorder (PTSD) Complex PTSD (CPTSD) • Trauma-related: • anxiety disorders • Panic symptoms • Depressive disorders • Phobias	**EMDR** whether access to and engagement in recognised psychological treatment could unintentionally disadvantage survivors in legal processes if misunderstood as affecting the reliability of their testimony
Haemophilia	**blood or plasma-derived products**

	religious reasons can influence refusal of hemophilia treatment, especially where beliefs restrict use of human blood components (notably Jehovah's Witnesses)
Dystonia	**Botulinum toxin injections ("Botox")** — most common treatment **Deep Brain Stimulation (DBS) — major surgical treatment** **Procedure** Electrodes are surgically implanted into parts of the brain (usually globus pallidus internus). The electrodes connect to a pulse generator implanted under the skin in the chest. Because it is invasive surgery, concerns may include: • brain surgery risks • infection • bleeding/stroke • hardware complications • cognitive or mood effects • battery replacement procedures **Intrathecal baclofen pumps** A surgically implanted pump delivers Baclofen directly into spinal fluid. • surgery complications • pump malfunction • withdrawal emergencies if interrupted

Schedule 1 – Items 25a5 Different classes of participants

(5) Without limiting subsection 33(3A) of the Acts Interpretation Act 15 1901, or subsection 209(1A) of this Act, National Disability 16 Insurance Scheme rules made for the purposes of subsection (4) of 17 this section may make different provision in relation to: 18 (a) different classes of participants; and 19 (b) different impairments or classes of impairments.

The Bill permits NDIS Rules to make different provisions for "different classes of participants" and "different impairments or classes of impairments." The Committee may wish to consider whether differential treatment between groups remains compatible with human rights principles in circumstances where the distinction is:

- not objective;
- not evidence-based;

- not proportionate to a legitimate aim;
- not individually assessable;
- not transparent and subject to meaningful review; and
- results in direct or indirect discrimination in effect.

The Convention on the Rights of Persons with Disabilities (CRPD) requires equal recognition before the law and protection from discrimination. The Committee may wish to examine whether a regulatory approach that differentiates between classes of disability or participant groups could, in practice, risk disproportionate impacts on certain groups, including people with psychosocial disability, neurodivergent people, women, First Nations peoples, and people experiencing socio-economic disadvantage, even where the rules are framed in neutral terms.

Schedule 1 – Proposed section 34A (Ministerial funding reductions)

The introduction of financial sustainability as a legal threshold for individual supports raises questions as to whether an individual's assessed support needs are able to be overridden by system-wide budget considerations. The Committee may wish to consider whether this shifts the determination of reasonable and necessary supports away from an individualised assessment of need, towards broader fiscal constraints determined at a system level.

In this context, it may be relevant to consider the United Nations Convention on the Rights of Persons with Disabilities, particularly Article 19 (living independently and being included in the community) and Article 26 (habilitation and rehabilitation), and the extent to which resource considerations can appropriately inform, but not displace, the progressive realisation of disability rights. The Committee may also wish to consider relevant jurisprudence and commentary from the CRPD Committee indicating that fiscal constraints alone should not determine the non-fulfilment of core disability rights obligations.

It is notable that these decisions will not be reviewable on an individual level based purely on not meeting an individuals needs.

Schedule 1 – Proposed section 9B (Functional capacity)

The CRPD, particularly Article 1, recognises disability as arising from the interaction between impairments and environmental and attitudinal barriers. In a similar way, the World Health Organization's International Classification of Functioning, Disability and Health (ICF) framework conceptualises functioning and disability as dynamic and context-dependent, shaped by environmental, personal, and social factors rather than impairment alone.

Article 26 of the CRPD also emphasises the importance of individualised habilitation and rehabilitation supports that respond to a person's goals and circumstances. The Committee may wish to consider whether the proposed functional capacity framework sufficiently reflects these principles of contextualised and individualised assessment, particularly where personal circumstances and environmental barriers and fluctuating or episodic conditions may significantly influence functional presentation at a given point in time.

Schedule 1 – Impact on living arrangements / informal supports / carer expectations]

The Committee may also wish to consider the compatibility of the proposed approach with United Nations Convention on the Rights of Persons with Disabilities Article 19 (living independently and being included in the community), which includes the principle that access to supports should not be conditional upon a person's living arrangements, including expectations that they reside with or rely upon family members as a prerequisite for support.

Article 23 (respect for home and family) may also be relevant, particularly in relation to whether the design of supports sufficiently safeguards against unintended pressure on family members to provide informal care in circumstances where formal supports are reduced or constrained. The Committee may wish to examine whether the practical effect of the provisions could be to shift responsibility for disability-related support away from the state and onto families, rather than ensuring supports are structured to enable choice and independence in family and living arrangements.

In this context, the Convention on the Elimination of All Forms of Discrimination Against Women may also be relevant, particularly given that unpaid carers in Australia are disproportionately women. The Committee may wish to consider whether any increase in reliance on informal care may have gendered impacts, including potential reinforcement of unequal distribution of unpaid care work and associated impacts on workforce participation, income security, and long-term economic equality.

The Carer Recognition Act 2010 (Cth) (s.7) recognises that carers should not be expected to provide care to the extent that it negatively affects their health or economic participation. The Committee may wish to consider whether the overall policy settings in this Bill adequately align with this principle, particularly where changes to formal supports may have the practical effect of increasing reliance on unpaid care without corresponding safeguards or recognition mechanisms.

Other Concerns

OTSI is referring the committee to its main submission which also includes recommendations which can be viewed from a human rights concerns perspective. The recommendations are available in Appendix one.

Appendix 1

TABLE 1: OTSi Recommendations

Schedule / Provision	Key Concern	Recommendation
Schedule 1 – Item 66 (Repeal of section 31)	The repeal of section 31 removes the central legislative protection for participant-directed and individualised planning and fundamentally alters the philosophical foundation of the NDIS.	Delete Item 66 of Schedule 1 in full and retain section 31 as a core interpretive provision of the NDIS Act. Reinstate explicit legislative obligations requiring participant plans to remain individualised, participant-directed, outcomes-focused and grounded in participant goals, aspirations and lived circumstances.
Schedule 1 – Proposed section 34A (Ministerial funding reductions)	Proposed section 34A permits broad percentage-based funding reductions for reasons of "financial sustainability" without individual reassessment, impact modelling or meaningful parliamentary scrutiny.	Delete proposed section 34A in full. Alternatively, require any determination under section 34A to be subject to public consultation, parliamentary disallowance, independent review, publication of human rights and safeguarding impact assessments, and Category A Rule status requiring agreement of states and territories.
Schedule 1 – Proposed section 25B (Alternative supports)	Participants may be excluded from NDIS supports based on hypothetical, inaccessible or inadequate mainstream supports that do not actually exist in practice.	Amend section 25B so exclusion is only permitted where alternative supports are demonstrably available, accessible, timely, culturally safe, geographically obtainable and substantially equivalent to the NDIS support that would otherwise be provided.
Schedule 1 – Proposed section 9B (Functional capacity)	The proposed definition artificially separates disability from environmental realities, assistive technology and support systems, creating an inaccurate and reductionist model of functioning.	Amend section 9B to require functional capacity to be assessed in real-world conditions, taking into account assistive technology, environmental barriers, reasonable adjustments, fluctuating disability, executive functioning impairments and cumulative impacts of multiple impairments.
Schedule 1 – Items 88–94 (Permanence and treatment)	The proposed permanence test risks coercive treatment expectations, undermines bodily autonomy and disadvantages participants unable to access specialists or historical records.	Amend items 88–94 so participants are only expected to undertake treatments that are evidence-based, clinically appropriate, reasonably available, financially accessible and undertaken with free and informed consent. Explicitly protect the right to decline treatment without losing Scheme access.
Schedule 1 – Proposed section 17B (Sustainability principles)	Financial sustainability risks becoming a dominant interpretive principle capable of overriding reasonable and necessary support entitlements.	Amend section 17B to expressly state that sustainability is a relevant administrative consideration but cannot override statutory entitlements to reasonable and necessary supports under section 34.
Schedule 1 – Proposed subsections	The amendments risk shifting unsustainable caring burdens onto families	Amend the provisions to require consideration of family sustainability, child wellbeing, cumulative caring burden, parental disability and the

34(1G)–(1J) (Parenting and family responsibility)	and increasing child protection involvement.	comparative social and economic costs of withdrawing supports.
Schedule 1 – Reassessment and suspension powers	Expanded reassessment delays and suspension powers create serious safeguarding risks for participants with communication barriers, fluctuating conditions or psychosocial disability; or autism.	Restore appeal rights removed by Items 21–25, narrow suspension powers, require accessible communication attempts, mandate safeguarding review before suspension, and ensure deterioration or aggravated circumstances are captured within reassessment provisions.
Schedule 2– Fraud and Integrity	Expanded compliance, investigative and nominee liability powers risk creating fear, surveillance and disproportionate enforcement impacts for disabled people, particularly participants with communication barriers, psychosocial disability, executive functioning impairments and fluctuating capacity	Amend all fraud and integrity provisions to require that compliance, investigation and enforcement measures are implemented proportionately, transparently and with embedded and responsive safeguarding mechanisms. Require accessible compliance pathways, independent oversight, trauma-informed administration, funded advocacy access and explicit recognition that the impacts of disability may directly affect a participant's capacity to comply with Agency expectations, communication processes and procedural requirements.
Schedule 3 – Automation and algorithmic decision-making	The Bill creates broad powers for automated decision-making without sufficient transparency, oversight or review rights.	Prohibit fully automated eligibility and funding decisions. Require publication of algorithms, calculation methodologies and assumptions. Mandate human review rights, independent audits, algorithmic transparency obligations and parliamentary scrutiny before expansion of automation powers.
Schedule 4 – New Framework Planning	The proposed planning model risks replacing individualised supports with standardised budgeting and partial funding approaches.	Retain person-centred planning principles, prohibit standardised rationing replacing reasonable and necessary assessment, preserve lived experience evidence and require transparency regarding assessment tools and budgeting methodologies.
Schedule 5 – Transitional powers	Broad transitional rule-making powers permit significant changes with limited scrutiny.	Require parliamentary oversight, public consultation, publication of implementation impact assessments and independent review of transitional arrangements.