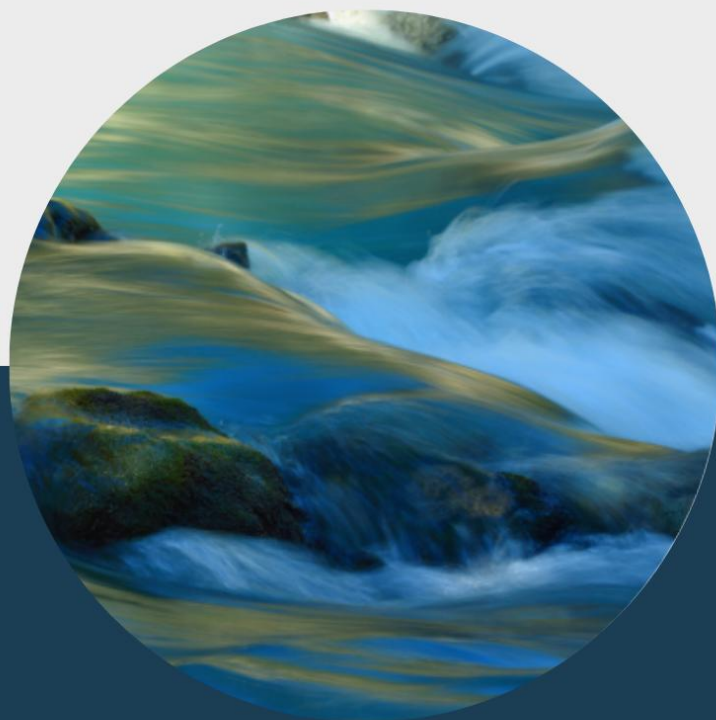


SUBMISSION TO THE CONSULTATION ON THE NDIS NEW FRAMEWORK PLANNING RULES AND NDIS SUPPORTS.



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OTSi Submission Consultation on NDIS New Framework Planning and Section 10 Rules Oct 2026

Occupational Therapy Society for Hidden and Invisible Disability (OTSi)

Submission to the Consultation on the NDIS New Framework Planning Rules and NDIS supports.

October 2026

About OTSi

The Occupational Therapy Society for Hidden and Invisible Disability (OTSi) is a national professional society representing occupational therapists working alongside people with hidden and invisible disabilities.

OTSi's purpose is to enable occupational therapists who work with people with invisible and hidden disabilities to reduce barriers to full participation as active citizens of Australia. OTSi has a strong voice in systemic advocacy and policy direction, as well as enabling individuals to build better lives.

OTSi arose from the NDIS Occupational Therapy Community of Practice, a professional community comprising more than 11,000 occupational therapists. More than 70 per cent of OTSi members identify as having disability and/or lived experience as a carer. Occupational therapists are on the frontline of the NDIS, providing functional assessment and disability evidence, delivering therapeutic supports, prescribing and assessing assistive technology, and working with participants towards their goals.

OTSi welcomes the opportunity to provide feedback on the proposed New Framework Planning Rules and NDIS supports. This submission is divided into 3 sections:

Section 1: New Framework Planning

Section 2: NDIS Supports

Section 3 Appendix: Analysis of the I-CAN v6 as a measure of cognitive, executive functioning, and decision-making support needs under the NDIS

Section 1: New Framework Planning

Executive Summary

OTSi supports the objective of developing a more consistent, equitable and transparent approach to NDIS planning. A national approach to determining participant budgets has the potential to improve consistency and reduce inequity, provided that consistency does not come at the expense of individualised assessment, professional judgement and participant choice and control.

OTSi has contributed significantly to NDIS reform consultation over the past two years. We invite government bodies, and decision makers, to engage with our two recent submissions to the NDIS Joint Standing Committee, on NDIS New Framework planning.¹

The New Framework Planning model represents a fundamental change to how participant support needs will be assessed, translated into funding, used through a participant's plan and subsequently changed where circumstances change.

The consultation paper identifies four core areas for the new Rules:

1. how a participant's disability support needs will be assessed;
2. how reasonable and necessary budgets will be developed;
3. how a participant can use their plan; and
4. how a new framework plan can be changed.

OTSi has structured this submission around these four areas.

Our central concern is that a structured national framework must not become a mechanism through which complex human lives are compressed into predetermined funding bands. The framework must instead provide a consistent and transparent process while retaining sufficient flexibility to recognise the reality that disability support needs are individual, contextual and often non-linear.

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

The proposed framework brings together the Support Needs Assessment (SNA), the Personal and Environmental Circumstances Questionnaire (PECQ), targeted assessments, assessed categories of NDIS supports and a new budget methodology. The consultation paper indicates that these components remain under development and testing.

This provides an important opportunity to establish the safeguards that must underpin the new framework before it is implemented at scale.

¹ Submission no. 10 and Supplementary, NDIS Joint Standing Committee, Annual Report No. 2 of the 48th Parliament Submissions – Parliament of Australia

OTSi's central recommendation is that the Government evaluate the **whole assessment-to-budget system**, rather than validating individual components in isolation.

Every link in this chain must be valid, transparent and capable of responding to individual circumstances.

This is particularly important for people with complex, fluctuating, episodic or progressive disabilities; psychosocial disability; autism and neurodevelopmental disability; acquired brain injury; intellectual and cognitive disability; communication differences; multiple interacting impairments; and people with significant safeguarding risks.

Summary of Recommendations

No.	Recommendation	Proposed rule / action
1	Independent validation before implementation	Require independent psychometric and methodological review of the SNA, I-CAN v6, PECQ, targeted assessments and the overall assessment-to-budget methodology.
2	National pilot and public evaluation	Undertake national pilot testing across diverse disability cohorts and publicly report reliability, validity, inter-rater consistency, participant experience, errors and budget adequacy.
3	Whole-person, ICF-aligned assessment	Ensure assessment considers disability-related support needs in the context of the person's actual life and does not reduce needs to isolated functional domains.
4	Participant-provided evidence must be embedded	Require participant-provided allied health, medical and other relevant professional evidence to form part of the core evidence base, not merely trigger a targeted assessment.
5	Transparent evidence consideration	Require the SNA report to identify evidence considered, evidence not considered, significant areas of disagreement and the reasons for material decisions.
6	Complex and fluctuating disability safeguards	Establish specialist pathways, multi-session assessment, longitudinal evidence and scenario-based assessment where needs are complex, fluctuating, episodic or progressive.
7	Qualified and competent assessors	Establish minimum qualification, training, competency, supervision, disability expertise and ethical standards for SNA assessors.
8	Trauma-informed and culturally safe pathways	Embed accessible, trauma-informed and culturally safe assessment requirements, including reasonable adjustments and participant choice regarding communication and support.
9	Replacement assessment as a participant right	Establish a clear and enforceable right to request a replacement assessment where there is material error, evidence has not been considered or needs have been inadequately captured.
10	Transparent budget methodology	Publish formulas, weightings, assumptions, thresholds, ceilings, unit costs, adjustments and other policy settings used to translate assessment outcomes into budgets.

11 Professional judgement	Ensure professional and delegate judgement can depart from a tool-generated budget where evidence, risk, complexity or individual circumstances demonstrate that it is inadequate.
12 Independent budget adequacy audit	Establish independent review of whether budgets generated by the methodology are sufficient to meet assessed support needs, with specific monitoring of high-risk cohorts.
13 No use of SNA as an eligibility proxy	Explicitly prohibit the use of I-CAN, PECQ or SNA outcomes as a proxy for statutory functional capacity or as a mechanism for triggering eligibility reassessment.
14 Therapy must not be segmented by I-CAN domains	Do not use I-CAN outputs to determine therapy eligibility or artificially divide therapy into general, social, physical or health-related categories.
15 Genuinely flexible plan use	Ensure flexible and stated support arrangements do not create artificial silos or prevent participants responding to interconnected or changing disability-related needs.
16 Clear rules for plan changes	Enable timely plan variations for deterioration, progression, fluctuating needs, safeguarding risks, breakdown of informal supports, changes in living circumstances and urgent support needs.
18 Functional replacement pathway	Where replacement supports are removed, ensure participants retain timely access to functionally equivalent supports where these are required to maintain established disability-related functions.
19 Public monitoring and accountability	Publish de-identified cohort-level information on assessment outcomes, budgets, replacement assessments, plan variations, reviews and participant experience.
20 Staged implementation	Do not proceed to full implementation until the methodology, support rules, budget settings, safeguards and review mechanisms have been independently validated and publicly scrutinised.

1. How a participant's disability support needs will be assessed

1.1 A whole-person and evidence-based assessment framework

OTSi supports the principle of a nationally consistent approach to assessing disability support needs. However, consistency must mean consistency of process and standards, rather than an assumption that every person's disability support needs can be assessed or funded in the same way.

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The proposed Support Needs Assessment (SNA) consists of a core needs assessment, the Personal and Environmental Circumstances Questionnaire (PECQ), targeted assessments and assessed categories of NDIS supports. The core assessment is proposed to use a modified version of I-CAN v6 across 12 life domains.

OTSi supports the use of structured assessment approaches where they improve consistency. However, the use of a structured instrument in a high-stakes funding system requires a robust evidence base.

The critical question is not whether I-CAN can provide useful information about support needs. It is whether the modified I-CAN, as administered within the proposed SNA, can reliably and validly identify the level and type of support required by the full diversity of NDIS participants.

The assessment framework should therefore be independently validated before it is used to determine participant budgets at scale. Validation should include reliability, validity, inter-rater consistency, construct validity and performance across diverse disability cohorts, cultural groups and gender.

Testing must also examine the complete pathway from assessment through to budget allocation. It is not sufficient to demonstrate that an assessment tool produces reasonably consistent scores if those scores are subsequently translated into inadequate budgets. The framework should be independently evaluated as a complete system.

1.2 The SNA must remain aligned with the ICF

OTSi strongly supports maintaining an ICF-informed approach to understanding functioning and disability. The ICF recognises functioning as dynamic and contextual. Functioning arises through the interaction between a person's health condition, body functions and structures, activities, participation, environmental factors and personal factors. This is particularly important for people with hidden and invisible disabilities.

A person's support needs may change substantially according to the environment in which they are functioning, sensory or cognitive load, communication demands, fatigue, pain, psychosocial stressors, available informal support, changes in health or the cumulative impact of multiple impairments.

The purpose of the SNA should therefore be to understand the person's support needs **across their life and circumstances**, rather than to allocate a person to a predetermined support band.

The PECQ has an important potential role in this respect because it is intended to capture information about personal and environmental circumstances that may affect a participant's budget.

However, these factors must have a meaningful and transparent influence on planning decisions. They cannot simply be collected as background information and then effectively disregarded by the budget methodology.

1.3 Participant-provided allied health and medical evidence

Participant-provided allied health, medical and other professional evidence must be part of the core evidence base.

OTSi is concerned that a model in which professional reports are primarily used to determine whether a targeted assessment is required could unintentionally create a hierarchy of evidence.

Occupational therapists, physiotherapists, speech pathologists, psychologists, social workers, nurses, medical practitioners and other professionals may hold longitudinal knowledge of a participant's functioning that cannot reasonably be reproduced during a single structured assessment.

This is particularly important where disability is fluctuating or episodic, progressive, highly context-dependent, associated with communication or cognitive differences, difficult to observe during a single assessment, or associated with significant safeguarding risks.

Professional evidence should not automatically determine funding. However, it should be considered alongside the participant's own account, family or informal support information, environmental circumstances and assessment findings.

Where material professional evidence is not accepted or is inconsistent with the assessment outcome, the SNA report should explain why. This is essential to procedural fairness.

1.4 Complex, fluctuating, episodic and progressive disability

A single-point assessment will not adequately capture every participant's support needs. This is particularly true for participants whose presentation varies substantially over time or according to environmental demands.

A person may be able to perform an activity independently in a quiet, familiar and supported environment but require substantial assistance to perform the same activity safely in an unfamiliar or demanding environment.

Similarly, people with progressive conditions may have support needs that are increasing but are not yet fully represented by their current presentation.

The assessment framework must therefore accommodate **baseline needs, higher-support periods, foreseeable deterioration and risk**.

OTSi recommends a specialist pathway for participants with complex, fluctuating, episodic or progressive needs, significant communication differences, multiple interacting impairments or identified safeguarding risks. This pathway should allow for multi-session assessment and integration of longitudinal evidence where necessary.

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For high-risk participants, the assessment should also consider foreseeable consequences of under-support. These may include falls, aspiration, pressure injury, seizures, medication management problems, continence issues, self-harm or suicide risk, behavioural risk, decision-making vulnerability, carer breakdown or loss of housing.

The objective is to ensure that foreseeable and material disability-related risks are not excluded simply because they are not captured during a particular assessment conversation.

1.5 Targeted assessments

OTSi supports targeted assessments where a participant requires more detailed consideration of a particular area of need. However, targeted assessments should supplement, not replace, the broader evidence base.

The Rules should establish clear criteria for when a targeted assessment is required, who can request one, how a participant can challenge a decision not to undertake one, and how information from the targeted assessment will interact with the core SNA and PECQ.

Participants should not be disadvantaged simply because their support need does not fit neatly within one of the predefined targeted assessment pathways. There should also be an urgent pathway where failure to undertake an appropriate targeted assessment creates a foreseeable safety or safeguarding risk.

1.6 Assessor qualifications, competence and professional accountability

The proposed framework places substantial responsibility on assessors. They will conduct assessments, determine relevant areas of enquiry, interpret participant responses, integrate evidence and contribute to decisions that ultimately influence funding. These are high-stakes decisions.

The Rules should establish published competency standards for SNA assessors, including disability-specific knowledge, functional assessment, communication, trauma-informed practice, cultural safety, safeguarding and recognition of complex and fluctuating disability. Appropriately qualified allied health professionals should be required to lead SNA and targeted assessment. Professional accountability is extremely important. Registered allied health professionals operate within professional standards, codes of ethics, continuing professional development requirements and regulatory oversight.

1.7 The SNA must not be used as an eligibility proxy

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OTSi seeks an explicit assurance that I-CAN and the broader SNA will not be used to determine NDIS eligibility or trigger eligibility reassessment. The constructs of **functional capacity** and **support need** are related but distinct.

I-CAN is a support needs assessment tool. It does not measure functional capacity in the statutory sense required for determining NDIS eligibility. Support need must not be used as a proxy for functional capacity. Nor should a change in a person's SNA score automatically trigger an eligibility review. This distinction should be explicit in the Rules and associated operational guidance.

1.8 Replacement Support Needs Assessments

The replacement assessment mechanism must be an enforceable participant right rather than a discretionary administrative process.

A participant should be able to seek a replacement assessment where there has been material error or where the assessment has failed to adequately capture their circumstances.

This should include circumstances where:

- relevant evidence was not considered;
- factual information was recorded incorrectly;
- needs were materially misunderstood;
- fluctuation, progression or environmental context was not adequately considered;
- the assessor did not have the necessary expertise;
- communication or accessibility barriers affected the assessment;
- trauma or distress materially affected participation;
- material safeguarding risks were missed; or
- the assessment methodology was incorrectly applied.

The replacement assessment should operate as a mechanism of **error correction and procedural fairness**, rather than an adversarial appeal.

Participants should receive clear information about the process, expected timeframes and reasons for decisions. Access to independent advocacy should be protected, and essential supports should not be placed at risk while a material assessment error is being considered.

1.9 The SNA report

The SNA report will become a critical document in the planning process. It should enable a participant to understand what was assessed, what evidence was considered, what support needs were identified, how risks and fluctuation were considered, what professional evidence informed the assessment, what support categories were derived and how those findings were translated

into the participant's budget. Where material evidence is not accepted, the report should explain why.

Participants should also have an opportunity to identify factual errors before the report is relied upon to establish their budget.

2. How reasonable and necessary budgets will be developed

2.1 The assessment-to-budget methodology

The budget methodology is arguably the most consequential component of the new framework. The consultation paper proposes 18 categories of NDIS supports, with different approaches to calculating funding depending on the support category. These may include quotes, set funding levels and estimated hours of support. OTSi supports differentiated approaches where there is a sound policy rationale for doing so.

However, participants and their representatives must be able to understand how assessment results become a dollar amount. Transparency should include publication of the formulas, weightings, thresholds, ceilings, unit costs, frequency and duration assumptions, treatment of informal supports, complexity and risk adjustments, assumptions regarding fluctuation and progression, and rules governing professional judgement.

Worked examples should be provided across a range of circumstances, including low, moderate and high support needs, complex disability, psychosocial disability, fluctuating and progressive disability, intersecting impairments, substantial informal support and high safeguarding needs.

A participant should be able to see a credible pathway between **their assessed needs and the funding provided**.

2.2 Professional judgement must remain part of budget development

A central risk of any formula-driven system is that a tool-generated result becomes treated as the answer rather than as one component of decision-making. OTSi does not oppose standardisation. We oppose standardisation that removes professional judgement where the available evidence demonstrates that the standard output is inadequate.

The Rules should expressly permit departure from a tool-generated or formula-generated budget where individual evidence, complexity, risk or other relevant circumstances demonstrate that the calculated amount is insufficient. Such departures should be documented and auditable.

This provides a better balance between consistency and individualisation than a system in which a formula is effectively determinative.

2.3 Independent validation of budget adequacy

The Government should establish an independent mechanism to test whether the budgets generated by the methodology actually meet participants' assessed needs. This should not simply examine whether the methodology produces internally consistent results. It should examine whether those results are **adequate in the real world**.

Independent evaluation should monitor outcomes across disability cohorts, including participants with complex, fluctuating and progressive disability, psychosocial disability, autism, acquired brain injury, intellectual disability, cognitive impairment and high safeguarding needs.

Historical expenditure should not automatically be treated as an appropriate benchmark. If historical funding was itself inadequate, reproducing historical spending patterns through an algorithm risks entrenching existing inequities. Where systemic underestimation is identified, the methodology must be capable of being corrected.

2.4 Therapy and allied health supports

OTSi has significant concerns about using I-CAN domains to define therapy supports. Therapy is goal-directed, dynamic and often cross-domain.

A participant's goal to parent safely, return to work, manage their home, participate in community life or maintain independence cannot meaningfully be reduced to a single functional domain.

Under the ICF, functioning is interdependent. Therapeutic interventions may address body functions in order to enable participation, while participation-based interventions may improve physical, cognitive, emotional or sensory functioning.

The proposed separation of therapy into categories such as "general", "social" and "physical and health-related" risks reintroducing precisely the dualism that the ICF was designed to overcome.

Most importantly, I-CAN has not been validated for the purpose of determining therapy eligibility or allocating therapy into categories.

OTSi therefore recommends that therapy remain within a flexible, participant-centred allied health funding framework, linked to participant goals and the ICF rather than artificially segmented according to assessment domains.

Therapy funding should be capable of responding to changing goals and transferable outcomes across domains.

3. How a participant can use their plan

3.1 Flexibility and participant choice and control

OTSi supports the principle that participants should have greater flexibility and choice and control within their plans. However, the distinction between flexible and stated supports must not create artificial barriers to responding to disability-related needs.

The consultation paper proposes flexible and stated support categories. The rationale for placing each category into one of these groups should be transparent. A support should not be made stated merely because it is administratively easier to control.

Where a support is stated, participants should understand why it has been stated, what evidence was used to determine the amount, and what mechanism exists to respond when circumstances change. This is particularly important for people whose support needs fluctuate.

3.2 Support categories must reflect real-world disability

The support categories must not operate as artificial silos. A person may require several forms of support to achieve one outcome, and one support may address multiple areas of functioning.

This is especially important for occupational therapy and other allied health supports, where interventions frequently cross domains.

The final framework should therefore allow funding to follow the participant's goals and assessed disability-related needs rather than requiring supports to be artificially separated according to administrative categories.

4. How a new framework plan can be changed

4.1 Plan variations must respond to real-world change

OTSi supports the principle that most changes should be managed through plan variations rather than requiring a complete reassessment.

However, the Rules should recognise that significant change is not always linear or permanent.

Plan variations should be available where there is a material change in support need arising from deterioration or progression, an increase in the frequency or severity of an episodic condition, a

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significant safeguarding risk, breakdown or reduction of informal supports, changes in living arrangements, hospital discharge, failure or loss of essential assistive technology, changes in environmental circumstances, or a material error or inadequacy in the existing plan.

For people with fluctuating or progressive disability, requiring a complete SNA every time there is a foreseeable increase in support need would be inefficient and potentially harmful. The framework should allow anticipatory and responsive funding mechanisms where the pattern of support need is known.

4.2 Fluctuating and progressive disability

A change in presentation should not automatically be interpreted as a reduction in disability-related support need.

Changes in masking, environmental demands, informal support, accommodation, medication or other contextual factors can alter observed functioning without representing a genuine reduction in disability-related need.

Similarly, a person with a progressive condition may require additional support before their level of impairment has changed sufficiently to produce a major change on a standardised assessment.

The Rules should therefore allow professional and longitudinal evidence to establish the nature and trajectory of a participant's support needs.

Where foreseeable deterioration is associated with an established disability and known pattern of support need, the planning framework should be capable of responding without requiring repeated full reassessment.

4.3 When a full reassessment is appropriate

A full reassessment should be reserved for circumstances where there has been a substantial and sustained change in the participant's circumstances or where there is a material reason to reconsider the underlying assessment.

A participant should not be required to undergo a full SNA simply because they have experienced a temporary increase in support needs, a change in living circumstances or a foreseeable fluctuation associated with their disability.

The Rules should provide clear criteria for the distinction between a plan variation and a reassessment.

This will be particularly important in preventing unnecessary administrative burden for participants with episodic or fluctuating disability.

4.4 Procedural fairness and correction of errors

The plan-change framework must also provide a mechanism for correcting errors.

A participant should be able to seek a change where their existing plan is based on materially incorrect information, relevant evidence was not considered, their support needs were misunderstood or a material risk has emerged.

The existence of a replacement assessment mechanism should not prevent urgent plan changes where the participant's immediate safety or essential supports are at risk.

The framework must also clearly distinguish between three situations:

- correcting an error;
- responding to a change in circumstances; and
- conducting a new assessment.

Each situation should have its own proportionate process.

Cross-cutting safeguards for the New Framework

Although these safeguards apply across all four areas, OTSi considers they should be embedded throughout the Rules rather than treated as optional operational guidance.

Trauma-informed and culturally safe practice

A high-stakes assessment and planning system must account for the fact that assessment itself can be difficult for some people.

This is particularly relevant to people with trauma histories, psychosocial disability, communication differences, cognitive impairment, autism and other conditions in which the ability to describe needs in a structured interview may not correspond to actual support requirements.

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Participants should have appropriate choice and control over communication methods, reasonable pacing, support people and accessible information. They should be able to pause or reschedule where required.

Cultural safety must also be embedded into the assessment process rather than treated as an optional communication consideration.

Cultural safety includes people who have experienced discrimination, or who may have good reason to distrust government systems. This includes LGBTIQ+ people, First Nations people, and people from culturally and linguistically diverse (CALD) backgrounds. For these groups, a person's sense of safety can affect what they feel able to disclose, and therefore how accurately their needs are recorded.

Participants should have appropriate choice and control over:

- communication methods, including interpreters, Auslan, and augmentative and alternative communication;
- reasonable pacing of the assessment;
- the support people present, including family, advocates, peer supporters, community members and chosen family; and
- accessible information, provided in advance and in a format and language that suits them.

Participants should also be able to pause or reschedule an assessment where required, without penalty or adverse inference.

Cultural safety must be embedded in the assessment process rather than treated as an optional communication consideration. This should include the following.

First Nations participants

- Assessments should be culturally safe and trauma-informed, and should allow for yarning-style conversations in a setting of the participant's choosing.
- Participants should be able to involve Aboriginal and Torres Strait Islander community-controlled organisations, Aboriginal liaison officers or other trusted community members.
- Assessors should understand that disability, wellbeing, family and kinship may be understood collectively, and that connection to Country, community and culture can be integral to a person's support needs.

CALD participants

- Qualified, independent interpreters should be provided where needed, and family members (particularly children) should not be relied upon to interpret.
- Information should be available in the participant's preferred language and format.
- Assessors should be aware that understandings of disability, stigma and help-seeking vary across cultures, and should accommodate cultural and religious preferences, such as the gender of the assessor.

LGBTIQ+ participants

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- Assessors should be trained to work respectfully with diverse sexualities, gender identities and variations in sex characteristics, and should use a participant's chosen name and pronouns.
- Chosen family and community supports should be recognised on an equal footing with biological family.

Many participants will belong to more than one of these groups, and the cumulative effect of these experiences should be recognised. Participants should be able to request a different assessor where they do not feel safe, and should have access to a simple way of giving feedback or raising concerns about the cultural safety of their assessment.

Equity and bias in support needs assessment

The principle of equity must be applied across the support needs assessment itself, the assessor workforce, and the overall process for determining the level and type of support a participant receives.

Support needs assessments and the standardised tools that inform them need careful scrutiny for bias. There has been insufficient analysis of whether the tools and processes used in the NDIS produce different outcomes for people of different genders, cultures and identities, or for people who express their needs differently. This matters because evidence from the eligibility stage already shows significant disparities. Disney, Yang et al. (2025)² found that, among applicants with physical disability, women and girls had 145 fewer approvals per 1000 applicants than men and boys, and among applicants with psychosocial disability, 83 fewer approvals per 1000. Although these findings relate to NDIS access decisions, they raise important questions about equity at the support needs assessment stage. If similar patterns occur at this stage, they could affect the level of funding allocated and the supports participants can access, not only whether they enter the scheme. Any evaluation of equity should also examine the intersections between gender, culture, sexuality and disability type.

Bias in how distress and need are expressed

Support needs are often inferred from how a person presents during an assessment. This risks treating a particular style of presentation as a proxy for need. People express distress, risk and difficulty in very different ways, and the same level of need may be visible in one person and hidden in another.

- **Visible or disruptive presentations may be weighted more heavily.** A person who expresses distress outwardly, through agitation, anger or behaviours that are challenging for others, may be more readily recognised as having high support needs.

² 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). <https://doi.org/10.5694/mja2.52594>

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- **Internalised or concealed presentations may be under-recorded.** Some people mask or suppress distress, withdraw, comply, or appear calm and articulate during an assessment while struggling significantly in daily life. This is particularly relevant for autistic people, who may mask in unfamiliar settings, and for people with trauma histories, who may dissociate or present as flat or composed. Because masking and internalising are more common among women and girls, this may contribute to gender inequities.
- **Vulnerability may be overlooked.** As with eligibility, assessments may fail to capture vulnerability to coercion, exploitation, abuse or aggression, even though this can create significant support needs.
- **Distress may be misread.** Distress may be attributed to personality, motivation or “behaviour” rather than to disability, or dismissed as a reasonable response to circumstances.
- **A single assessment is a snapshot.** How a person presents in a structured interview may differ markedly from their needs at home, in the community or in a crisis. It is also possible that some people will use sedating medication or substances to manage the support needs interview process.

Transparency and public accountability

The new framework will only command confidence if participants, providers, Parliament and the broader community can understand how decisions are made.

OTSi recommends public reporting of de-identified information about assessment outcomes, inter-rater reliability, replacement assessment requests and outcomes, plan variations, appeals and review outcomes, budget adequacy, cohort-level differences, gender differences, participant experience and identified systemic errors.

Particular attention should be given to outcomes for cohorts whose needs are most vulnerable to under-recognition.

Independent oversight should include psychometric review, budget methodology review, algorithmic audit and cohort impact monitoring.

Where systemic errors are identified, there must be a mechanism for correcting them rather than requiring individual participants to repeatedly challenge the same systemic problem.

Implementation and transition

The consultation paper states that the framework remains under development and that the NDIA is continuing to test processes, systems, rules and participant experience before rollout.

OTSi supports continued testing.

However, the consequences of introducing a flawed methodology are potentially significant and difficult to reverse.

Implementation should therefore be staged and conditional upon publication of the complete relevant Rules and policy settings, independent validation of the assessment methodology, national pilot testing across diverse disability cohorts, independent validation of the assessment-to-budget methodology, publication of the methodology and worked examples, establishment of enforceable replacement assessment and review rights, clear workforce competency requirements, and consultation on the detailed support categories and section 10 rules.

The framework should not be treated as complete simply because its legislative instruments have commenced. A system of this scale must be capable of demonstrating that it works in practice.

Matters requiring further consultation

OTSi considers that several important components of the New Framework Planning Rules cannot yet be assessed fully because sufficient detail was not available in the consultation material.

In particular, further work is required on the **18 support categories**, including whether they reflect real-world disability support needs, whether they create artificial silos, how intersecting needs will be managed, and whether the flexible/stated distinction is justified.

The **Support Lists and section 10 rules** require dedicated scrutiny to ensure that they do not become de facto diagnostic, impairment or functional exclusion lists.

The **detailed budget methodology** also requires further consultation. OTSi requires the actual formulas, assumptions, thresholds, ceilings, adjustments and worked examples before it can assess whether the proposed methodology is likely to generate adequate budgets.

The **participant plan template** should be assessed to ensure that the relationship between assessment findings, support categories, funding amounts, flexibility and participant goals is readily understandable.

Finally, the proposed arrangements for **replacement supports** require further examination against real-world examples, particularly essential communication and participation technology.

These matters should be subject to further consultation before the framework is finalised.

Conclusion



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OTSi recognises the complexity of administering a national disability insurance scheme and the genuine policy challenge of balancing sustainability with fairness, consistency and individualised support.

We support a planning framework that improves transparency and reduces inequity.

However, **consistency must not become standardisation, transparency must not be replaced by an opaque algorithm, and person-centred planning cannot become person-centred assessment followed by an impersonal budget calculation.**

The strength of the New Framework Planning model will depend not simply on whether it produces consistent decisions, but on whether those decisions are accurate, fair and safe.

A participant's support needs cannot always be understood through a single conversation, a single assessment tool or a predetermined category. Disability is often complex, fluctuating, contextual and interconnected. The planning system must be capable of recognising this.

OTSi therefore recommends that the Government prioritise independent validation, transparent budget methodology, meaningful integration of participant-provided professional evidence, qualified assessment, specialist pathways for complex disability, trauma-informed and culturally safe practice, enforceable replacement assessment rights and independent monitoring of budget adequacy.

The objective should be a system in which participants can understand how decisions about their support are made, can provide and challenge the evidence on which those decisions are based, and can have confidence that the resulting budget is sufficient to meet their disability-related needs.

OTSi remains committed to constructive engagement with Government, the NDIA, Parliament and the disability community in the development, testing and independent evaluation of the New Framework Planning system.

Section 2: NDIS Supports

Executive Summary

OTSi supports the Agency's aim of simplifying the NDIS Rules, using plain language and reducing the number of support categories. Clearer Rules can make the Scheme easier to navigate for participants, families, providers and planners, provided that simplification does not narrow access, participant choice or the supports people with invisible and hidden disabilities rely on.

OTSi has contributed to NDIS reform consultation over the past two years, including our submission on Defining Therapy Supports and our submissions to the NDIS Joint Standing Committee on New Framework planning.[1] We encourage decision makers to read this submission alongside those.

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The consultation paper proposes 18 broader support categories, a revised list of assistive technology and excluded items, the removal of the replacement supports process, and greater use of flexible supports. This submission responds to each of these areas, and to the practical impacts on providers and workers.

Our central concern is that simplified categories must not become a way of restricting access to therapy and assistive technology. The Rules must be available to all participant groups, recognise the full scope of allied health practice, and stay flexible enough to respond to needs that are individual, contextual and often non-linear.

These supports directly affect safety, independence, mental health and community participation. Changes to them must therefore be transparent, evidence-based, inclusive of lived experience evidence and procedurally fair. It is not yet clear how the need for therapy supports, home modifications and assistive technology will be determined under new framework planning, or how professional assessment will inform those decisions. This should be resolved before the Rules are finalised.

OTSi's six recommendations are set out above. In summary, we ask the Agency to keep Therapy supports inclusive and open to choice of professional, to recognise mental health occupational therapy, to broaden assistive technology, to retain a review pathway for unlisted supports, to reconsider the exclusion of noise-cancelling headphones, and to support providers through any transition.

These matters are especially important for people with psychosocial disability; autism and neurodevelopmental disability; functional neurological disorder; acquired brain injury; intellectual and cognitive disability; fluctuating or episodic conditions; and people in regional areas and thin markets, where choice is already limited.

Summary of Recommendations

No.	Recommendation	Proposed rule / action
1	Inclusive Therapy supports	Retain a clear and inclusive description of Therapy supports. Ensure that Therapy Supports are available to all participants, regardless of impairment group, and allows participants to choose the allied health professional best suited to their goals.
2	Full scope of occupational therapy	Revise the description of occupational therapy so that it recognises mental health occupational therapy and the full scope of the profession, not only physical and functional aspects.
3	Support rules must not become exclusion lists	Ensure new support categories and section 10 rules are person-centred, transparent and do not create diagnosis- or impairment-based exclusion.

- | | | |
|---|---|--|
| 4 | Broader assistive technology list | Broaden the list of assistive technology supports described in the Rules, so that it reflects the needs of people with invisible and hidden disabilities |
| 5 | Replacement supports pathway retained. | Retain a replacement supports mechanism (or an equivalent review pathway) rather than removing it. |
| 6 | Noise-cancelling headphones & Sensory AT | Reconsider the proposed exclusion of electronic noise-cancelling headphones and other sensory AT so that disability-related sensory and safety needs are not excluded. |
| 7 | Retain flexibility in access to supports in the support lists. | Ensure that the categories of supports do not exclude and prevent needs being met. |

1.1 NDIS support rules and section 10

OTSi supports clearer NDIS support rules where this improves certainty for participants and providers. However, greater clarity must not be achieved by creating rigid categories that fail to reflect the complexity of disability.

The support rules must remain compatible with the objects and principles of the NDIS Act and with an ICF-informed approach to functioning. In particular, OTSi cautions against support categories becoming de facto exclusion lists.

A support should not be excluded simply because it does not fit neatly within a predefined category where it is otherwise disability-related and necessary to address an identified support need.

The relationship between the new support categories, the Support Lists and section 10 will therefore require particularly careful scrutiny.

Are the proposed support categories clear?

OTSi supports the Agency's aim of simplifying the Rules and using plain language and reducing the number of categories. However, the move to 18 broader categories raises several issues that need to be addressed before the Rules are finalised.

2.1 Access for all participant groups is not clear

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It is not clear whether the proposed categories, and Therapy supports in particular, will be available to all participant impairment groups or whether access will be restricted by impairment type, by assessment domain or by other criteria. OTSi's earlier submission on *Defining Therapy Supports* raised concern that therapy categories linked to domains of the ICAN Support Needs Assessment may subordinate participant goals to administrative structures, and that the rationale for the categories had not been made transparent.

OTSi is also concerned that it is not yet clear how the need for supports will be determined under new framework planning, particularly for therapy supports, home modifications and assistive technology. We understand that separate modules are being developed for these supports, but the consultation paper does not explain how they will work or how they will draw on professional assessment. Without a clearly described role for allied health input, there is a risk that decisions about these supports will not be based on the recommendations of the allied health professionals who know the participant best. OTSi recommends that the Agency set out, before the Rules are finalised, how allied health assessments and recommendations will be used to determine budgets for these supports, and how participants and their therapists can contribute evidence and have it taken into account.

OTSi advocates for therapy supports to be available to all participants, and for participants to be able to choose the allied health professional they wish to work with. We also ask that the Agency confirm that the categories will not be used to restrict access to other supports based on a participant's impairment category.

OTSi is concerned that narrow or rigid definitions of NDIS supports may create de facto exclusion lists for participants whose needs do not fit the assumed profile of an impairment group. Disability-related support needs arise from the interaction between a person's impairments and their environment, not from diagnostic category alone. The ICF recognises this, and the Rules should reflect it.

For example, a participant with a cognitive impairment may be unable to plan routes, manage public transport, recognise hazards or cope with unpredictable environments, and so may need transport assistance to attend work, study, therapy or community activities. If transport supports are interpreted as available only to people with a physical or mobility impairment, this participant could be denied a support that is directly related to their disability and necessary for their participation. The same risk applies to other categories.

OTSi recommends that the Rules and guidance:

- state clearly that eligibility for a support depends on whether it is reasonable and necessary to address the participant's disability-related need, not on the participant's primary impairment or the assessment category through which their funding was determined;
- avoid language or examples that imply a support is intended only for a particular impairment group; and
- include examples across a range of impairment types, including cognitive, psychosocial, neurological and sensory disability, so that participants, planners and providers understand the breadth of what may be funded.

2.2 Risk of a narrow definition of occupational therapy

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The current Therapy Supports Operational Guideline description of occupational therapy focuses on practical skills, home safety, planning and organisation, and equipment to cook, dress or shower. These are important areas of practice, but they describe only part of the profession. Occupational therapists also work in mental health, in sensory and emotional regulation, in cognitive and executive function, in trauma-informed practice, in return to work and in social inclusion.

A narrow definition risks signalling to participants, planners and providers that mental health occupational therapy is not a Therapy support. For people with psychosocial disability and other invisible disabilities, this could mean losing access to the professional best placed to support their capacity building and participation.

OTSi recommends that the description of occupational therapy be strengthened, and a suggested description is:

Occupational therapy is a therapy support to help you build skills, confidence, independence and quality of life so you can take part in the everyday activities that matter to you. Occupational therapists have expertise in physical, mental health, sensory, social, learning, cognitive and developmental needs, and can work with people across all life stages. They can work with you to create a personalised plan to explore and implement practical solutions at home, in your community, at school or at work. For example, they may support you to increase capacity in self care tasks, manage change and make informed decisions, develop planning and organisation strategies, build emotional and sensory regulation strategies, increase capacity to access the community and increase friendships. Navigate life stage transitions such as leaving school or starting a job, stay safe in your home and community, or use equipment and adapt environments so everyday tasks such as cooking, dressing and showering work for you. They can also train your family, carers and support workers to help you put these strategies into practice. Occupational therapists must have a current Australian Health Practitioner Regulation Agency (AHPRA) registration as an occupational therapist.

2.3 Artificial segmentation of therapy

OTSi is concerned that the NDIS may be considering an approach that divides therapy into separate 'social' and 'physical and health related' streams. This division was reflected in a therapy supports closed consultation and feedback on this consultation was not provided. The division of therapy supports into categories reflects a dualistic model that the ICF explicitly rejects. Under the ICF, functioning is an interaction between body functions and structures, activities, participation, environmental factors and personal factors. Therapeutic interventions often address body functions in order to enable participation, and participation-based therapy often improves physical function. Rigid categories risk constraining interventions, restricting interdisciplinary practice, limiting flexibility in thin markets and reducing participant choice.

2.4 Consolidation of categories

The mapping at Attachment 1 shows that categories such as therapeutic supports, exercise physiology and personal wellbeing activities will be consolidated into Therapy supports. OTSi asks the Agency to confirm that this consolidation will not narrow what is funded, and to provide

examples for each type of professional so participants and planners understand the breadth of what is included.

Are there areas where further explanation, examples or guidance would be helpful?

3.1 The list of supports is too narrow

The proposed descriptions and examples are too narrow to capture the range of supports that people with invisible and hidden disabilities use to build capacity. OTSi also requests that participants be provided with the choice to use more than one allied health professional on the same goal, and that therapists may coordinate with each other where this will improve outcomes.

OTSi supports a definition of evidence-based practice that recognises lived experience evidence alongside research evidence and clinical expertise. We note that very few research trials include people with complex disabilities, and even fewer focus on capacity building rather than on diagnoses. This area has not attracted significant research funding internationally, so the number of high-level research papers is limited. This reflects a gap in funding and research priorities, not a lack of effectiveness. OTSi asks that the limited availability of high-level trial evidence not be used to restrict access to therapy supports, but instead utilised lived experience, outcomes and supports emerging and innovative practices which are grounded in other research.

3.2 Occupational therapy approaches to social participation and social inclusion

The Rules and guidance should explicitly recognise occupational therapy models that support social participation in a contemporary, trauma-informed and participation-based way. These approaches enable participation in real-world contexts, address environmental and personal barriers, and support people to engage in ways that are meaningful and sustainable, rather than addressing social behaviours in isolation. They include the following.

Occupation-based groups. Occupational therapists have long used activity-based groups to improve social participation. In occupational therapy, 'occupation' is not limited to paid work. It covers the full range of activities that people do to fulfil their roles in life, such as cooking, playing, socialising and caring for themselves. There is a fundamental difference between a person simply engaging in an activity, such as gaming, Lego or loose parts play, and a qualified occupational therapist using that activity as part of a planned strategy to increase functional capacity in social participation. Activities used by occupational therapists include Lego, gaming, Dungeons and Dragons, art, craft, cooking, creative writing, loose parts play and nature-based activities such as gardening and bushwalking. Animal-assisted therapy is a further example, where the environment or animal is the means to achieving skill development rather than the focus in itself. OTSi welcomes the proposed clarification that animal-assisted therapy may be funded where it forms

part of a therapeutic intervention delivered by an appropriately qualified allied health professional. We ask that the Rules and guidance also recognise that occupation-based and activity-based groups are best practice, engaging and non-threatening strategies for achieving participant goals when delivered or directed by qualified professionals.

The CORE Approach. The Capabilities, Opportunities, Resources and Environments (CORE) Approach³ is an evidence-based framework used in occupational therapy to understand and address the factors that influence a person's ability to engage in meaningful activities and to experience social inclusion (Pereira & Brown, 2023). It considers a person's capabilities, the opportunities available to them, the resources they can draw on and the environments in which they live and participate. It supports assessment and intervention that is personalised, values-based and focused on authentic outcomes. Because it makes use of existing resources, it also supports the sustainability and economic efficiency of government programs.

Social inclusion and social prescribing. Occupational therapists understand that meaningful social occupations are crucial for physical, social and mental wellbeing. They tailor interventions to the person's goals and identity, identify and address barriers to participation (including environmental barriers such as noise, bright lights or movement) and advocate for accessible, inclusive communities. Social prescribing complements this by connecting people with community resources such as social groups, volunteering and recreational activities that align with their interests and needs. This empowers participants, strengthens collaboration between health, community and social services, and supports more sustainable outcomes.

3.3 Capacity building and maintenance therapy

OTSi does not support the distinction between capacity building and maintenance therapy supports in the current form as it is unclear as to whether these definitions will restrict access to people who are making slower progress or who do not meet rigid criteria.

Assistive technology and the proposed excluded items

4.1 The range of assistive technology remains limited

OTSi remains concerned that the range of assistive technology available through the NDIS is limited and that many mainstream items that would be useful for people with invisible disabilities

³ Pereira, R. B., & Brown, T. (2023). The CORE Approach (Capabilities, Opportunities, Resources, and Environments) to social inclusion and occupational therapy practice.

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are excluded. Many low-cost options would help build capacity, increase independence and reduce reliance on more expensive supports.

The proposed Rules clarify that assistive technology and consumables may be purchased from mainstream retailers. OTSi supports this because it improves choice, speed of access and cost-effectiveness. However, the Rules and guidance do not make clear which assistive technology will and will not be available, or whether it will be capped. Participants, providers and suppliers need further information.

OTSi considers that there is a risk that assistive technology will be limited to people with a physical or communication impairment and not available to other participants. We request that the NDIS maintain flexibility with access to assistive technology to not disadvantage participants with other impairments.

OTSi has previously made submissions on the need for the NDIS to recognise sensory, cognitive and executive functioning assistive technology as a disability-related support. These items assist participants to build functional capacity through regulating sensory input, manage attention, memory, planning and time. Many are low cost, widely available and effective in building independence and reducing reliance on more expensive supports.

Despite this, most of this technology is not currently accessible under the NDIS Rules. The Rules tend to describe assistive technology in terms of physical and communication needs, and many sensory, cognitive and executive functioning supports are treated as everyday or mainstream items. This overlooks the fact that, for a person with an invisible or hidden disability, these items address a disability-related need that other people do not have to the same degree. The consequence is that people with psychosocial disability, autism, acquired brain injury, intellectual and cognitive disability and functional neurological disorder are more likely to go without supports that are reasonable and necessary.

4.2 Specific needs that must be recognised and not excluded:

- **Functional neurological disorder (FND).** People with FND need access to assistive technology, including mobility equipment, and the Rules should not inadvertently exclude them by categorising it as a psychological impairment.
- **Overload and meltdowns.** People who experience meltdowns or sensory and emotional overload may need access to a wheelchair or rollator so they can be moved safely and supported to remain in the community. Mobility equipment should not be limited to people with a physical impairment.
- **Sensory assistive technology and learning supports.** Many low-cost items support sensory regulation, attention, memory, planning and communication, and enable participation at home, school, work and in the community.
- **Self care needs.** People with psychosocial impairments benefit from access to bath in bed wipes and other low cost assistive technology to assist with self care needs.
- **Falls risk alerts.** People with psychological and neurological impairments have a high risk of falls and require access to fall monitoring and alert systems.

4.3 Proposed additional exclusions

The consultation paper proposes adding electronic noise-cancelling headphones, fencing and gates, hair styling tools, hydrogen fuel and electric vehicle charging costs, and scuba therapy to Schedule 2. OTSi provides the following comments.

- **Electronic noise-cancelling headphones.** For many autistic people, people with psychosocial disability, neurological disability, intellectual disability and other people with sensory processing differences, noise-cancelling headphones are not a convenience item. They are a disability-related support that reduces sensory overload, prevents distress and allows participation in education, work and community settings. OTSi recommends against excluding these items, or at a minimum that the Rules provide an exception where a qualified allied health professional has recommended them to address a disability-related need.
- **Fencing and gates.** We recognise the Agency's intent to avoid funding general property improvements. However, in some cases fencing and gates are used as a safety measure for people at risk of absconding or harm. The Rules should clarify how a safety-related need would be assessed and whether it may be addressed through home modifications or another category.
- **Hair styling tools.** Hair brushes and similar items may be used in personal care routines and sensory-informed strategies. The Rules should make clear that ordinary hair styling is excluded but items used as part of a therapist-recommended personal care or sensory plan are not.
- **Scuba therapy.** OTSi has no particular concern with this clarification.

Removal of replacement supports

OTSi does not support the removal of the replacement supports process without an alternative mechanism. There needs to be a way for some supports to be reviewed and considered where they fall outside the stated list but meet a participant's disability-related need. OTSi requests that the need to replace the item with another support be removed.

The Agency's own data suggests a high level of demand and a genuine need. As at 17 July 2026, 11,051 replacement support requests had been received. Of these, 5,545 had been approved, which is about half of all requests. The most requested items were tablets, apps for accessibility and communication, smart watches and smart phones. This shows that participants are using mainstream technology to meet disability-related needs, and that the process has been working for many of them.

OTSi supports including tablets, smart phones, smart watches and accessibility and communication apps as supports where they meet the requirements. However, this addresses only the most common requests. There will be other items, particularly for people with invisible and hidden disabilities, that do not appear on any list but are reasonable and necessary. Removing the process entirely, including for old framework plans, risks the following unintended impacts:

- participants with existing approved items or pending requests losing access or certainty;

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- the 2,072 pending requests and the participants waiting on them being left without a clear pathway;
- people with less common or emerging needs having no way to have a support considered;
- increased reliance on internal reviews and external appeals, which are costly and stressful; and
- reduced innovation in the use of mainstream and low-cost technology.

OTSi recommends that, if the process is simplified, a clear and accessible review pathway remains available for items not listed, supported by evidence from a qualified allied health professional.

Flexible and stated supports

OTSi supports the proposal that most supports be flexible, so that participants can use funding across supports within a category. . We ask that:

- the circumstances in which a support must be stated in a plan be clearly defined and published;
- stated supports be used only where there is a clear reason for specific oversight or funding set aside, and not as a way to restrict access to therapy or capacity building; and
- participants and therapists be given the option to use their choice of therapy professions within the Therapy supports category.

Practical issues and unintended impacts

7.1 Impact on providers and workers where demand is expected to fall

If the Agency foresees a decreased need for a group of supports, whether as a result of consolidation of categories, new exclusions, the removal of replacement supports or the move to new framework planning, it must provide clear information to the providers who deliver these supports, and support them to transition to other areas.

Many providers are small and medium businesses and sole traders. They have often invested in staff, premises, equipment and training in reliance on current NDIS settings. A sudden or poorly communicated change could result in business failures, loss of experienced workers and loss of local knowledge. This would reduce choice and access for participants, particularly in regional areas and thin markets and for people with invisible and hidden disabilities whose needs are not well met by generic services.

OTSi recommends that the Agency:

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- publish clear and early information for providers on the expected impact of changes on demand such as communicating upper limits to occupational therapy capacity building changes, communicating the ongoing need for Functional Capacity assessments outside of eligibility;
- sequence changes with realistic timeframes so providers can adapt;
- fund a temporary, targeted transition strategy, modelled on the approach taken in the 2019 *Growing the NDIS Market and Workforce Strategy*, which includes financial transition-out support, support to move into new roles or business models, and compliance and administrative assistance; and
- ensure that providers are supported financially during transition so that they are not left bankrupt as a result of policy changes beyond their control.

7.2 Reporting requirements

The agency currently has Operational Guidelines and website pages that are contradictory and difficult to achieve. Reports are required to be less than 4 months but participants are often given very little notice of a plan reassessment. Functional Capacity Assessments are listed on the NDIS website but there is not clarity as to whether these will continue to be funded in the future. The difference between a plan reassessment report and a therapy progress report are not clear. The Agency has indicated that it may ask therapists for evidence of progress before plan reassessment. For people with invisible and hidden disabilities, progress is often non-linear. Evidence requirements should recognise that maintaining function, preventing deterioration and re-engaging after a setback are valid and valuable outcomes.

7.3 Training for planners and assessors

Planners and assessors should be given training on invisible and hidden disability, mental health occupational therapy and the contribution of occupation-based approaches, so that decisions about the Rules are applied consistently and fairly.

Conclusion

OTSi supports the Agency's goal of making the Rules simpler and easier to use. However, simplification must not come at the cost of narrowing access to the supports that people with invisible and hidden disabilities rely on. OTSi urges the Agency to ensure that Therapy supports are available to all participants with genuine choice of professional, to recognise the full scope of occupational therapy including mental health, to broaden the list of supports and assistive technology, to retain a review pathway in place of replacement supports, to reconsider exclusions that affect sensory and safety needs, and to support providers and workers through any transition.

OTSi would welcome the opportunity to discuss this submission further and to contribute to the ongoing development of the Rules.

APPENDIX 1:

Analysis of the I-CAN v6 as a measure of cognitive, executive functioning, and decision-making support needs under the NDIS

Executive summary

The I-CAN v6 has strengths as a semi-structured, person-centred assessment tool for exploring support needs across areas of everyday life. It is explicitly based on the International Classification of Functioning, Disability and Health (ICF), encapsulated with a 12-domain structure. The NDIA has described the I-CAN as applicable across disability types. [NDIA, 2025–26]. OTSi acknowledges the established strengths of the ICAN as a clinical practice tool, and the current efforts by the NDIA to pilot and trial an adapted version of the ICAN v6 for a brand new purpose - as a tool to assist NDIS plan development and budget-setting tool.

However, there are significant concerns about the extent to which the I-CAN subdomains, as presently structured, adequately capture the full scope of support needs, particularly when we map the 12-domain structure across the six NDIS functional domains of mobility, communication, social interaction, learning, self-care and self-management.

The principal concern is not that I-CAN fails to mention cognitive or executive tasks. It does mention several of them, including initiating and completing tasks, decision-making, daily routines, punctuality, medication management and safety. The concern is that these functions are distributed across multiple practical activities rather than being systematically assessed as underlying cognitive functions.

The following cognitive and executive functioning elements are essential to consider :

- executive functioning;
- planning, organisation and sequencing;
- initiation and task activation;
- sustained attention and working memory;
- cognitive flexibility and task switching;
- problem-solving;
- self-monitoring and error detection;
- processing speed;
- cognitive fatigue;
- the impact of stress, sensory load or psychological demands on cognition;
- fluctuating or episodic functional capacity;
- supported decision-making;
- communication supports required to enable decision-making;
- the person's need for assistance to understand information, consider options, weigh consequences and implement decisions;
- the role of environmental and interpersonal barriers in producing functional limitation.

These gaps are particularly significant for people with **psychosocial disability, autism, ADHD, intellectual disability, acquired brain injury, cognitive disability and some neurological conditions**, where disability-related functional limitations may be predominantly cognitive, executive, behavioural, sensory, communicative or fluctuating rather than observable through conventional task performance.

There is therefore a risk that the I-CAN will systematically produce a more complete picture of support needs for people with **observable physical or personal-care limitations** than for people whose disability primarily affects cognition, executive functioning, communication, emotional regulation, initiation, decision-making or the ability to navigate complex environments.

This is not merely a clinical issue. If the I-CAN is used to determine access to, quantity of, or intensity of NDIS supports, these structural features have potential consequences for **equity between disability groups**.

1. I-CAN and the ICF: an important distinction

I-CAN states that it is conceptually based on the ICF and maps support needs across 12 life domains. The ICF, however, is substantially broader than the I-CAN's practical activity structure. It distinguishes between:

1. **Body functions and structures;**
2. **Activities and participation;** and
3. **Environmental factors**, with personal factors recognised as relevant contextual factors.

The Activities and Participation component of the ICF includes not only observable activities such as dressing, walking and cooking, but also cognitive activities such as:

- focusing and directing attention (d160–d161);
- thinking (d163);
- reading (d166);
- writing (d170);
- calculating (d172);
- solving problems (d175);
- making decisions (d177);
- undertaking single tasks (d210);
- undertaking multiple tasks (d220);
- carrying out daily routines (d230); and
- handling stress and other psychological demands (d240).

The I-CAN subdomains supplied for consideration map reasonably well onto many *activities* within the ICF. However, the mapping is considerably less complete when the objective is to understand **why a person cannot reliably perform an activity, what cognitive functions underpin that difficulty, and what environmental or interpersonal supports enable performance**.

This distinction is critical. Consider the following examples:

- A person may be physically capable of cooking but unable to reliably initiate cooking, sequence the steps, maintain attention, manage competing demands, identify that food has spoiled, respond appropriately to an unexpected event, or complete the task without prompting.
- A person may be capable of reading a form but unable to understand its implications, compare options, identify risks, formulate a decision or implement that decision.
- A person may be capable of speaking but unable to communicate effectively when anxious, overloaded, fatigued or required to process complex information rapidly.

These are **functional limitations**, even where the underlying physical task can technically be performed.

2. Mapping the I-CAN subdomains against the ICF and NDIS functional domains

I-CAN subdomain	Primary ICF correspondence	NDIS functional domain(s)	Assessment gap / concern
Transferring and positioning	d410–d420	Mobility, self-care	Strong coverage of physical mobility; comparatively task-based and observable

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Carrying, moving and handling objects	d430–d440	Mobility, self-care	Strong physical coverage; less explicit assessment of fatigue, motor planning or cognitive demands
Walking and moving	d450–d455	Mobility	Strong coverage of physical mobility; potential under-emphasis on endurance, fluctuating capacity and environmental barriers
Transport	d470–d489	Mobility, self-management, social participation	Does not necessarily capture planning, navigation, problem-solving, sensory load or executive demands of transport
Shopping	d620	Self-management, learning, mobility, social interaction	Highly cognitively complex activity; risk of being treated primarily as a practical task rather than an executive task
Cooking	d630	Self-care, self-management, learning	Requires planning, sequencing, initiation, attention, safety and working memory; these underlying functions are not separately identified
Cleaning and domestic tasks	d640	Self-management	Similar executive-function gap; performance may depend heavily on initiation, organisation and fatigue
Household maintenance	d650	Self-management, mobility	Captures task completion but not necessarily problem-solving or recognising when maintenance is required
Eating and drinking	d550–d560	Self-care	Strong basic activity coverage; may need more explicit consideration of prompting, interoception, sensory factors and meal planning
Personal care	d510–d520	Self-care	Strong observable-task coverage
Toileting	d530	Self-care	Strong coverage of physical/personal-care needs
Dressing	d540	Self-care, mobility	Strong observable-task coverage
Money and economic life	d860–d865	Self-management, learning	Important area, but requires more explicit assessment of financial decision-making, vulnerability, scams, judgement and supported decision-making
Community life	d910	Social interaction, self-management, mobility	Broad and useful but potentially insufficiently granular for complex community participation
Leisure and recreation	d920	Social interaction, self-management	Captures participation but not necessarily initiation, motivation, sensory regulation or planning
Advocacy	d940	Communication, social interaction, self-management	Important inclusion; however, advocacy is not equivalent to supported decision-making or self-advocacy capacity
Receiving basic communication	d310–d329	Communication, learning	Needs differentiation between hearing/seeing language, processing information, comprehension and cognitive processing
Expressing basic communication	d330–d349	Communication	Potentially strong basic communication coverage; may under capture AAC,

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			processing and communication under stress
Feelings and emotions	d710, d720; also d240	Social interaction, self-management	Important but broad; does not necessarily capture emotional regulation as a functional support need
Conversations and complex communication	d350	Communication, social interaction	Good participation construct; requires consideration of processing speed, pragmatic communication and communication supports
Learning new tasks	d155	Learning	Captures learning outcome but not necessarily attention, working memory, processing speed or executive dysfunction
Decision making	d177	Self-management, learning	Significant inclusion, but insufficient by itself to capture supported decision-making
Literacy and numeracy	d140–d150, d166, d172	Learning, self-management	Useful but may conflate academic skills with broader cognitive functioning
Understanding time	d230, d163	Learning, self-management	Relevant but narrow compared with executive functioning
Daily routines	d230	Self-management	Important; should include planning, initiation, sequencing, flexibility and self-monitoring
Initiating and completing tasks	d210, d230	Self-management, learning	One of the strongest executive-function proxies in I-CAN, but remains a proxy rather than a comprehensive executive assessment
Managing medication	d570	Self-care, self-management	Useful functional outcome; underlying cognition, memory, judgement and executive functioning are not necessarily differentiated
Safety and risk abuse	d240, d250; environmental factors	Self-management, social interaction	Important but requires explicit assessment of vulnerability, judgement, risk recognition and exploitation
Finding, choosing and applying	d155, d160–d177	Learning, self-management	Potentially captures higher-order cognition but is ambiguous and insufficiently granular
Punctuality and preparation	d230, d210	Self-management, learning	Useful executive-function proxy; does not capture why preparation fails
Doing the job or participating in learning	d825–d859	Learning, self-management, social interaction	Important participation domain; may not distinguish cognitive, psychosocial, environmental and physical barriers
After hours	d850/d859 and participation	Self-management, social participation	Potentially useful for work/study participation but lacks clarity regarding the underlying functional mechanisms
Social skills	d710–d729	Social interaction	Important but broad; may disadvantage people whose social functioning is context-dependent
Seeking assistance and cooperating	d710–d729; d660	Social interaction, self-management	Important support-related activity; risks conflating ability to recognise a need for assistance with willingness to seek it

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Managing relationships	d750–d770	Social interaction	Reasonable coverage but limited explicit assessment of vulnerability, boundaries and relationship-related support
Intimate and dependent relationships	d770	Social interaction, self-management	Valuable inclusion; needs safeguards around vulnerability, consent, dependency and supported decision-making

The mapping above should be understood as an **analytical ICF examination rather than an official I-CAN-to-ICF coding schedule**. The I-CAN is described as ICF-informed, but the practical constructs do not provide a one-to-one equivalent for every ICF activity or participation category.

4. The most significant gap: executive functioning

The strongest concern is the treatment of **executive functioning**.

I-CAN contains several subdomains that indirectly assess executive functioning:

- finding, choosing and applying;
- decision-making;
- daily routines;
- initiating and completing tasks;
- punctuality and preparation;
- managing medication;
- safety and risk;
- doing the job or participating in learning;
- shopping;
- cooking;
- money and economic life.

These are predominantly **functional activities in which executive dysfunction may manifest**, rather than a systematic assessment of executive functioning itself.

The ICF expressly distinguishes a number of cognitive processes that underpin functional performance, including attention, thinking, problem-solving and decision-making. It also identifies undertaking a task, undertaking multiple tasks and carrying out daily routines as distinct activities.

This distinction matters because broad statements of need can conceal very different functional profiles. For example:

- "Requires support with cooking" does not adequately distinguish between a person who requires physical assistance with cooking and a person who can physically cook but requires prompting, sequencing, supervision, planning assistance, redirection or support to initiate and complete the activity.
- "Requires support with money" does not distinguish between physical assistance with accessing money and cognitive assistance with understanding financial information, evaluating risk, resisting exploitation, budgeting, prioritising expenditure or making and implementing financial decisions.

A robust functional-capacity assessment should therefore examine, across relevant activities:

- initiation;
- planning;
- organisation;
- sequencing;
- prioritisation;
- sustained attention;

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- working memory;
- cognitive flexibility;
- switching between tasks;
- inhibition;
- problem-solving;
- judgement;
- error recognition;
- self-monitoring;
- time estimation;
- prospective memory;
- processing speed;
- task persistence;
- fatigue;
- response to unexpected change; and
- the level and type of prompting or scaffolding required.

These functions are particularly important because a person can demonstrate apparently adequate performance during a structured assessment while being unable to reproduce that performance reliably in everyday life.

5. Supported decision-making is not adequately captured by "decision making"

The I-CAN's inclusion of **decision making** is welcome, but this should not be treated as equivalent to comprehensively assessing **supported decision-making needs**. The ICF's d177 category defines decision-making as making a choice among options, implementing the choice and evaluating its effects.

For NDIS purposes, however, a meaningful assessment also needs to establish whether a person requires support to:

- receive information;
- access information in an appropriate communication format;
- understand information;
- retain information long enough to use it;
- identify and understand available options;
- compare options;
- understand risks and benefits;
- communicate a preference;
- formulate a decision;
- communicate the decision;
- implement the decision;
- review the consequences of the decision;
- seek advice or assistance;
- recognise when assistance is required; and
- protect themselves from undue influence, coercion, exploitation or abuse.

This is particularly important because the NDIA itself has recognised that supported decision-making needs to be embedded in the Support Needs Assessment process. The Supported Decision Making Advisory Group has specifically identified the need for accessible information, sufficient time, communication methods that work for the participant, and support to understand options and consider their pros and cons.

A person's requirement for supported decision-making should therefore be treated as a **support need in its own right**, rather than simply as a score under "decision making". This is especially important for people with intellectual disability, acquired brain injury, psychosocial disability, autism, cognitive impairment and communication disability.

6. The distinction between capacity, performance and supported performance

A further structural concern is the potential for an interview-based tool to overestimate functional capacity where performance is substantially better in a structured, supported assessment environment than in ordinary life. The ICF provides a useful framework for distinguishing functioning in context. Environmental factors can act as barriers or facilitators, and the same individual may demonstrate substantially different functioning depending upon the environment and supports available.

This is particularly important for:

- psychosocial disability;
- autism;
- ADHD;
- acquired brain injury;
- intellectual disability;
- dementia and cognitive impairment;
- neurological conditions;
- fluctuating conditions;
- chronic fatigue and energy-limiting disability;
- sensory disability; and
- people who use augmentative and alternative communication.

The relevant question should be:

Can the person reliably, safely, repeatedly and sustainably perform the activity in the environments in which it is ordinarily required, and what disability-specific assistance is required to achieve that outcome?

The NDIS's own functional-capacity guidance recognises that assessment should consider what a person can do, the supports required, and whether activities were observed, assessed or reported. It also expressly identifies cognitive function, including thinking and decision-making, as relevant to functional capacity.

7. Potential disability-type bias

The structure of the I-CAN raises concerns about differential sensitivity across disability groups.

7.1 Physical disability

The I-CAN is relatively strong in relation to many physical disabilities. Transferring, positioning, walking, moving, carrying objects, personal care, dressing and toileting are concrete and readily observable activities.

7.2 Psychosocial disability

There is a significant risk of under-capture. Psychosocial disability may affect:

- initiation;
- motivation;
- energy;
- concentration;
- planning;
- organisation;
- emotional regulation;
- stress tolerance;

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- cognitive processing;
- social interaction;
- sensory processing;
- communication;
- confidence;
- judgement;
- community access;
- ability to respond to unexpected events;
- ability to maintain routines;
- ability to seek assistance;
- safety and vulnerability; and
- capacity to sustain participation over time.

Some of these are represented in I-CAN, but they are distributed across multiple domains. This fragmentation may make the cumulative impact of psychosocial disability less visible than a discrete physical limitation. The ICF specifically recognises handling stress and psychological demands as a functional activity (d240), including handling responsibilities, stress and crisis.

A comprehensive assessment should therefore examine not only whether a person can complete a task, but whether they can **initiate, sustain and complete it under ordinary psychological and environmental demands**.

7.3 Autism and neurodivergence

Autistic people and people with ADHD face particular risks in this type of assessment.

Many of their functional limitations arise from interactions between:

- executive functioning;
- sensory processing;
- cognitive flexibility;
- social communication;
- predictability and routine;
- processing speed;
- emotional regulation;
- interoception;
- fatigue;
- environmental demands; and
- the complexity of competing stimuli.

A person may perform a task adequately in a quiet, predictable assessment setting but require substantial support in a busy community environment. Likewise, a person may have the underlying skill but need external prompting, visual supports, environmental modification or another person to initiate and sequence tasks.

The I-CAN contains relevant activities, but from its listed structure it does not appear to differentiate explicitly between these underlying mechanisms. There is therefore a risk that support needs **will be underestimated where disability is highly context-dependent, or where a person has developed compensatory strategies or masking behaviours**.

7.4 Intellectual disability and cognitive disability

The inclusion of learning, literacy/numeracy, decision-making and task completion is positive.

However, there is a particular risk of conflating:

- knowledge;
- learned skill;
- decision-making;
- comprehension;
- adaptive functioning; and
- executive functioning.

A person may know *how* to do something but require ongoing assistance to initiate it, sequence it, generalise it to a new situation or make an appropriate decision in a novel circumstance.

Assessment should therefore distinguish **knowledge from independent functional performance**.

7.5 Acquired brain injury and neurological disability

People with acquired brain injury and some neurological conditions may have highly variable profiles involving:

- memory;
- attention;
- executive functioning;
- processing speed;
- sensory processing
- fatigue;
- initiation;
- impulse control;
- problem-solving;
- emotional regulation; and
- cognitive-communication.

These may be inadequately represented if assessment is primarily organised around whether the person can perform a practical task.

The absence of an explicit executive-function construct is therefore particularly significant for this population.

7.6 Sensory disability and communication disability

Communication is reasonably represented through receiving, expressing and complex communication. However, functional communication is not simply the ability to receive or produce communication.

Assessment should also establish:

- whether information must be modified;
- whether additional processing time is required;
- whether AAC is required;
- whether communication breaks down under stress;
- whether the person can communicate with unfamiliar people;
- whether they can communicate complex preferences and decisions;
- whether they can understand consequential information; and
- what communication support is required for supported decision-making.

The NDIA's own Supported Decision Making Advisory Group has specifically highlighted the importance of assessors enabling participants to communicate in ways that work for them and warned that a participant who is not understood may not receive the level of support required.

8. "Safety and risk of abuse" requires greater prominence

The inclusion of **safety and the risk of abuse** is important, but this area deserves substantially greater conceptual weight.

Functional capacity includes the capacity to:

- recognise danger;
- anticipate consequences;
- assess risk;
- respond to emergencies;
- seek assistance;
- identify exploitation;
- establish boundaries;
- protect oneself from abuse;
- recognise unsafe relationships;
- understand financial or interpersonal risks; and
- act on concerns.

These capacities are closely connected with executive functioning, judgement, communication, social cognition and supported decision-making.

A person may be technically capable of managing money, travelling independently or communicating with others, yet remain highly vulnerable to exploitation. This vulnerability should not be treated as a peripheral social issue. It can be a direct consequence of disability-related functional limitations.

9. Work and education require more than task participation

The following subdomains provide useful participation measures:

- finding, choosing and applying;
- punctuality and preparation;
- doing the job or participating in learning; and
- after hours

However, they may not adequately distinguish between the person's **skills and the supports required to sustain participation**.

For example, someone may be able to perform work when:

- tasks are highly structured;
- a supervisor provides regular prompting;
- environmental distractions are minimised;
- schedules are externally managed;
- social expectations are clearly explained;
- breaks are built in; or
- another person helps with planning.

The relevant functional question is therefore not simply whether the person can "do the job".

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It is whether they can **reliably sustain employment or education without disability-specific assistance**, and **what type, frequency and intensity of assistance is required**.

10. The I-CAN appears stronger at measuring activities than underlying support needs that may persist across a range of ICAN domains/activities.

The central structural issue can be summarised as follows:

Area	I-CAN coverage
Observable physical tasks	Strong
Personal care	Strong
Basic mobility	Strong
Domestic activities	Moderate–strong
Basic communication	Moderate–strong
Social participation	Moderate
Learning	Moderate
Self-management	Moderate
Executive functioning	Fragmented / indirect
Cognitive processing	Limited explicit coverage
Problem-solving	Insufficiently explicit
Attention	Insufficiently explicit
Working memory	Insufficiently explicit
Cognitive flexibility	Insufficiently explicit
Planning/organisation	Present indirectly
Initiation	Present
Task persistence	Present indirectly
Cognitive fatigue	Insufficiently explicit
Fluctuating capacity	Insufficiently explicit
Environmental barriers/facilitators	Requires complementary assessment
Supported decision-making	Insufficiently explicit
Communication support for decision-making	Insufficiently explicit
Vulnerability/exploitation	Present but requires greater depth
Context-dependent functioning	Potentially under-captured

11. The problem is compounded if I-CAN is treated as a functional-capacity assessment

The NDIA has been clear that I-CAN is intended to assess support needs, rather than serve as a conventional functional or diagnostic assessment.

There is no inherent problem with this approach. The difficulty arises if the output of that support-needs conversation is subsequently treated as an adequate proxy for a person's underlying functional capacity.

The NDIS currently defines six functional domains: communication, learning, mobility, self-care, self-management and social interaction. Its guidance expressly describes self-management as including organising one's life, planning, making decisions, problem-solving and managing finances.

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Accordingly, a national assessment system cannot assume that functional capacity has been adequately established simply because a person has been asked whether they need support with the practical activities listed in I-CAN. Support needs arise from functional limitations, but those limitations cannot always be inferred from practical task performance alone.

This is particularly important where the disability affects the cognitive, psychological, sensory or executive processes required to perform the task.

12. Recommended amendments and safeguards

For I-CAN to be used as a central component of NDIS Support Needs Assessments, the Government should require the assessment framework to include, either within I-CAN or through mandatory complementary modules:

A. An explicit executive-function assessment

This should cover:

- initiation;
- planning;
- organisation;
- sequencing;
- prioritisation;
- attention;
- working memory;
- cognitive flexibility;
- task switching;
- problem-solving;
- judgement;
- self-monitoring;
- error correction;
- time management;
- prospective memory;
- processing speed;
- task persistence; and
- cognitive fatigue.

B. A supported decision-making assessment

This should assess the supports required to:

- receive information;
- understand information;
- communicate preferences;
- consider options;
- compare risks and benefits;
- make decisions;
- communicate decisions;
- implement decisions; and
- review decisions.

It should explicitly distinguish **supported decision-making** from **substituted decision-making**.

C. Assessment of performance under ordinary conditions

The framework should consider:

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- performance across different environments;
- variability over time;
- fatigue;
- stress;
- sensory load;
- unfamiliar situations;
- competing demands;
- changes to routine; and
- the amount of prompting or scaffolding required.

D. A clear distinction between capacity and performance

Assessment should distinguish:

1. what a person can theoretically do;
2. what they actually do;
3. what they can do reliably;
4. what they can do safely;
5. what they can do repeatedly;
6. what they can do without disability-specific support; and
7. what they can achieve with appropriate support.

E. Mandatory consideration of environmental factors

The ICF framework makes clear that functioning occurs in context and that environmental factors can either facilitate or restrict functioning.

The assessment should therefore explicitly identify:

- communication environments;
- sensory environments;
- social environments;
- physical accessibility;
- availability of informal supports;
- availability of prompts and supervision;
- assistive technology;
- environmental modifications;
- reasonable adjustments; and
- the consequences of removing or reducing those supports.

F. Disability-specific validation

The Government should publish evidence demonstrating the sensitivity and validity of the assessment for different disability populations, including at minimum:

- physical disability;
- intellectual disability;
- autism;
- psychosocial disability;
- acquired brain injury;
- neurological disability;
- sensory disability;
- communication disability; and
- people with multiple disabilities.

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A tool cannot be considered equitable merely because it is nominally applicable to "all disability types". It must demonstrate that it identifies equivalent levels of functional limitation and support need across substantially different disability presentations.

G Equity-specific validation

The Government should publish evidence demonstrating the sensitivity and validity of the assessment at the support needs assessment stage for gender, CALD, First Nations and LGBTIQ+ groups. Any evaluation of equity should also examine the intersections between gender, culture, sexuality and disability type.

H Self report and collateral

The ICAN is relying on self report and accurate collateral. The Government should publish evidence demonstrating that this is a valid method of determining support needs in comparison to other methods of gathering data.

13. Conclusion

I-CAN v6 provides a useful structure for discussing everyday support needs and has the advantage of moving away from a narrow diagnosis-based approach. Its ICF-informed, person-centred structure is potentially valuable within a reformed NDIS assessment system.

The central issue is that **the tool is stronger at identifying the activities with which a person requires assistance than at identifying the cognitive, psychological, communicative, sensory and executive support needs that may persist across activities/domains.**

This distinction is particularly consequential for people with invisible, cognitive and psychosocial disabilities. The apparent inclusion of "decision making", "initiating and completing tasks", "daily routines", "punctuality and preparation" and related activities should not be taken as evidence that executive functioning is comprehensively assessed. These are functional manifestations of executive functioning rather than a systematic assessment of the underlying functions.

Similarly, the presence of a "decision making" subdomain does not adequately address **supported decision-making**, which requires assessment of the supports a person needs to understand information, consider options, communicate preferences, make and implement decisions, and exercise autonomy.

This is particularly concerning given that the NDIA itself has identified accessible communication, sufficient time, support to understand options and support to weigh the pros and cons of decisions as important components of supported decision-making.

There is therefore a substantial policy risk that a tool designed around observable activities will be more sensitive to physical and personal-care disability than to disability expressed through **executive dysfunction, cognitive impairment, psychosocial disability, neurodivergence, communication disability or fluctuating capacity.**

This does not mean that I-CAN should necessarily be abandoned. Rather, it should not be treated as a complete measure of functional capacity unless it is supplemented by demonstrated assessment of executive functioning, cognition, supported decision-making, environmental factors, and fluctuating or context-dependent performance.

Because assessment outcomes in this system may determine whether a person receives disability supports, the Government should demonstrate, through transparent and independent validation, that the assessment produces equitable estimates of support need across disability types.

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Until that evidence is available, there is a material risk that apparently neutral assessment architecture could produce systematically different outcomes for people whose disability is primarily physical and observable compared with people whose disability is primarily cognitive, executive, psychosocial, sensory, communicative or context-dependent. That is not simply a measurement issue. It is an **equity, validity and disability-rights issue**.