
# Australian Psychosocial Alliance

## Submission to the Senate Committee Affairs Legislation Committee.

## Inquiry into the NDIS Amendment (Securing the NDIS for Future Generations) Bill 2026

**May 2026**

## About the Australian Psychosocial Alliance

The Australian Psychosocial Alliance (APA) is Flourish Australia, Mind Australia (incorporating One Door Mental Health and The Haven Foundation), Neami National, Ruah Community Support, Stride Mental Health, Open Minds and Wellways Australia. We are seven of the largest and longest service specialist providers of community managed mental health and wellbeing services in Australia. We provide support to over 110,000 people with mental health challenges and psychosocial disability every year. This includes expert support to around 5,800 NDIS participants with a psychosocial disability. We come together around a shared policy agenda to improve outcomes for people with mental ill-health and psychosocial disability, and a shared understanding of quality service delivery.

Our members deliver Medicare Mental Health Centres, headspace programs, carer connect centres, step-up step-down services (sub-acute, short-term residential care), residential rehabilitation, supported housing, employment, suicide prevention and postvention programs, individual mental health recovery support and NDIS supports. We respond across the spectrum of need and to people in priority populations, such as LGBTIQA+ individuals, culturally and linguistically diverse (CALD) communities, Aboriginal and Torres Strait Islander people, young people and people experiencing or at risk of homelessness.

We combine evidence-based practice with service delivery wisdom to provide recovery-oriented services that support people to build their capacity to participate in society and manage their lives. We focus on personal goals, participation and living a meaningful life. This can include support to sustain a tenancy, build the skills to live independently, find fulfilling work and build social connections.

Our organisations embed lived experience across our governance and service delivery. We employ a specialist cross disciplinary workforce with expertise in mental health and psychosocial disability, and with the technical skills to deliver recovery-focused, trauma-informed and person-centred support.

web: https://psychosocialalliance.org.au/

## 1. Key points

- **People with psychosocial disability are already underrepresented in the Scheme** (compared to original estimates) and are already meeting a high bar to entry. This legislation was designed to reduce the number of people in the Scheme and reduce costs. People with a psychosocial disability were not the target but this Amendment as it stands risks having a disproportionate negative impact on this group.
- Amendments to Sections 24 and 25 define permanency and treatment, including to require that "all" treatments must be exhausted, while 9 (B) introduces a definition of functional capacity. This trio of changes will **cement current, well documented and understood barriers to access for people with a psychosocial disability,** and particularly for those with the most complex, long term and permanent needs. An interpretation that treats diagnosis of mental illness as an impairment, means that the focus is on clinical treatment for that diagnosis (illness) and ignores the circumstances and experiences which impact on and defines the functional limitations. It may offer a suitable logic for physical and other impairments which have linear and clear treatment pathways but fails in responding appropriately to mental illness and psychosocial disability and ignores how community support and circumstance both contribute to and address functional capacity. While new rules, through the development of specific definitions applicable to psychosocial disability, could address the issues, there is no requirement for these to exist or to be developed in a timely manner.
- There are **few guardrails in this Amendment** to protect the integrity of the intent of the Scheme and original legislation.
- The **Bill has been put together hastily without sufficient time to fully consider and understand the implications**. This is particularly significant given the amendments give the Minister and the NDIA unprecedented power and discretion to make changes to the administration of the Act through the issuing rules and guidelines without sufficient oversight.
- **The NDIA does not have good history of developing rules, tools, processes and systems which respond to psychosocial disability**. For example, guidelines developed following amendments to the Act in 2019, with the intent to improve the experience of people with psychosocial disability accessing the Scheme, did the opposite.
- **A contraction in NDIS eligibility and/or restriction in access to supports cannot occur without first establishing alternative supports outside of the NDIS.** There is already documented unmet need for psychosocial support for 493,600 people with medium to severe mental health issues1. This unmet demand directly affects people's opportunities for recovery, and means higher levels of illness and disability, increasing demand for the NDIS, hospital and crisis services and shifting responsibility to unpaid carers.
- **The need for a specialist psychosocial response or stream within the NDIA is overdue**. The NDIA must commit to developing this expertise across all parts of the organisation, including across policy, pricing, partner agencies, assessment and planning. At a minimum, the proposed Technical Advisory Group must include psychosocial expertise and impact analysis on people with psychosocial disability

[1] Analysis of unmet need for psychosocial supports outside of the NDIS: Final Report. Health Policy Analysis, 2024

## 2. Summary of Recommendations

1. That the Bill be delayed until such a time that full and proper consideration can be given to the impact of the Bill. This includes further impact analysis to ensure that no aspect of the Bill will cause harm for whom the Scheme was intended to support; for consultation and codesign with people with lived experience of psychosocial disability and to provide both time and resources to rebuild supports outside of the NDIS where required.

2. The Technical Advisory Group that is to advise on eligibility and the definition of substantially reduced functional capacity must include expertise in assessing psychosocial disability, and that this group explicitly consider how definitions apply to psychosocial disability compared to other disabilities. The legislation should specify that the Technical Advisory Group must include psychosocial expertise.

3. With respect to Clause 9B:
    a. Delay implementation of 9B until the NDIA has developed an appropriate definition of functional capacity which is specific to psychosocial disability and an assessment tool which is able to measure this.
    b. Include a note to Clause 9B that in the case of a primary psychosocial disability that the person's environment and personal circumstances must be considered in determining functional capacity.

4. Remove the broad sweeping and unchecked power of the Minister to make support determinations (Section 34 A). At the very least this must:
    a. Require that modelling of such a determination for reducing funding for groups of support includes specific consideration of disproportionate disadvantage to particular groups of people (with consideration, but not limited, to disability type, age, gender, cultural background, indigeneity, sexuality and geography), and the impact on other parts of the service system. This modelling is to be made publicly available, and the process is to allow for a response and consideration of that response before implementation.
    b. Include provisions in the legislation to address at the individual level significant negative impact from any such determination.

5. That the legislation specifically include:
    a. That the definition of treatment in 25(A) does not apply to the assessment of the permanency of psychosocial disability.
    b. A new provision for the assessment of permanency of psychosocial disability which has a focus on the experience of mental illness and functional incapacity.

6. Delay the start date for new framework planning until such a time that there is confidence in the NDIA that it has in place:
    a. Tools that can appropriately assess psychosocial disability, noting that these need to be able to take into account the impact of fluctuating mental health conditions.
    b. An assessment process which is relationship based, trauma informed and recovery focussed.
    - A psychosocial capability framework which embeds psychosocial expertise across the NDIA and its practices.

## 3. Introduction

The APA understands that it is not the intention of these amendments to exclude access to people with permanent psychosocial disability. At his recent press club announcement, Minister Butler publicly stated that people with psychosocial disability belong in the Scheme and acknowledged that they already faced a high barrier to access. The latest data from the NDIA, identifies that there are now 64,964 people with a primary psychosocial disability in the Scheme. This is almost 5,000 people less than was estimated by the Productivity Commission in 2011 (as adjusted for population growth).

Access issues and negative experiences with the Scheme for people with a psychosocial disability are well understood. Most recently these were documented in our report *Access Denied: psychosocial disability and the NDIS*. Both the 2019 Review of the NDIS Act, and the 2023 NDIS review, also documented issues.

Psychosocial disability is different to other disabilities. It can't always be seen, and while the disability can be enduring, support needs can be episodic and variable, the relationship between medical diagnosis, impairments experienced and level of type of disability varies from person to person because of other supports around them and their individual experiences of having a mental health condition. Additionally, functional incapacity can be cumulative and variable, and may be quite independent of clinical treatment and treatment responses.

These amendments introduce a range of significant changes and new powers and discretion to the Minister and the NDIA to make rules and determinations. We note that some of these would allow for the tailoring of new definitions which impact eligibility and assessment.

However, the NDIA does not have a good history of developing rules, tools, processes and systems which respond to psychosocial disability. In fact, the 2019 Review of the Act was amended with the intent to improve experiences of people with psychosocial disability. The intention was to shift the weight toward "functional capacity assessments" and away from diagnosis in determining permanency. This resulted in a shift in terminology from psychiatric to psychosocial (thus removing the medicalised terminology), and to recognise that psychosocial disability may be broader than the classification of psychiatric condition. The eligibility reference (24(1a) was changed from one or more impairments attributed to a psychiatric condition to "one or more impairments to which a psychosocial disability is attributable". The intention of these Amendments were never realised, and as documented in *Access Denied*, the processes and rules used for assessment have over-emphasised diagnosis and treatment, and functional capacity is often ignored, such that those with the most complex and long-term needs struggle to prove eligibility. The proposed Amendments to sections 9, 24 and 25 will cement the approach that the 2019 Amendments were designed to prevent.

This submission focuses explicitly on the aspects of this Amendment Bill which will have the potential for significant negative and disproportionate impact for people with psychosocial disability, and in turn the community and the service system. We also support submissions made by the National Mental Health Consumer Alliance and Mental Health Australia.

The APA is however concerned, as documented by others, about the curtailing of re-assessments and loss of opportunity to appeal, including because of the lack of guarantee that plans will be reasonable and/or are meeting needs in the first place, the ability to introduce automation without adequate oversight, the move away from a "whole of person" approach and inadequate safeguards around plan suspensions. We also refer to the submission made by National Disability Services, and particularly in relation to Fraud and Integrity Measures and Governance Arrangements.

We urge the Senate to call on the Minister and the NDIA to invest in psychosocial capacity and expertise within the agency so that the implementation of this Bill occurs with people with permanent psychosocial disability at front of mind.

*Recommendations*

1. That the Bill be delayed until such a time that full and proper consideration can be given to the impact of the Bill. This includes further impact analysis to ensure that no aspect of the Bill will cause harm for whom the Scheme was intended to support; for consultation and codesign with people with lived experience of psychosocial disability and to provide both time and resources to rebuild supports outside of the NDIS where required.

2. The Technical Advisory Group that is to advise on eligibility and the definition of substantially reduced functional capacity include expertise in assessing psychosocial disability, and that this group explicitly consider how definitions apply to psychosocial disability compared to other disabilities. The legislation should specify that the Technical Advisory Group must include psychosocial expertise.

## 4. Specific comments and explanations

### 4.1 Part 1: 9B Definition of functional capacity

Section 9B defines functional capacity, in relation to an activity, is the person's ability to undertake the activity:

a) Without assistance from other people, assistive technology or modifications; and
b) In a context that excludes, as far as possible, the impact of the person's environment and personal circumstances.

The explanatory memorandum explains that this approach avoids reliance on personal and external factors that may vary between individuals and are not attributable to the impairment, such as financial means or living arrangements. This promotes a more objective and consistent assessment of the functional impact of the person's impairment. (page 16).

While "as far as possible" recognises that it may not always be possible to exclude the impact of the person's environment and personal circumstances, the potential interpretations of "as far as possible" are very broad.

It is **not** possible to exclude the impact of the person's environment and personal circumstances in determining whether a psychosocial disability is present, such that this new section is almost non-sensical in this context.

Psychosocial disability, by definition, encompasses both medical and social aspects. While definitions vary in how this is expressed they all seek to include the nexus between social conditions and experiences and psychological state. The NDIA's own definition articulates that psychosocial disability is used to describe the outcomes for a person with mental health conditions attempting to interact with a social environment that presents barriers to their equality with other others; and that it may also describe the experience of people with impairments and participation restrictions related to mental health issues such as the loss of/or reduced function, think clearly, experience the full physical health and manage the social and emotional aspects of their lives. [2]

The very nature of the disability means that people with psychosocial disability also often experience high levels of social disadvantage, high levels of social isolation, have poorer physical health, struggle to maintain stable housing, and are over-represented in homelessness statistics for example. Moreover, these experiences increase the likelihood of psychosocial disability, and the cumulative impact of these experiences contribute to life-long permanent functional limitations (and disability).

[2] National Disability Insurance Agency (2018) Glossary: terms for understanding the NDIS and psychosocial disability https://www.ndis.gov.au/media/119/download

The proposed new definition, without qualification, creates a risk that it will be used to deny for a person with a psychosocial disability that a functional limitation exists. For example, to a person who is homeless because their functional (in)capacity associated with living or self-care skills, will be defined as an impact of being homeless, rather than the homelessness being identified as a consequence of difficulties with living or self-care skills. It also risks dismissing the cumulative impact of the experience of social disadvantage such as long-term homelessness, physical health problems, unemployment on mental health and functional capacity.

We have no confidence that there is an assessment tool which can accurately identify the degree to which a functional limitation has contributed to a position of social disadvantage, versus that position of social disadvantage contributing to that functional limitation. And in any case it is irrelevant in the context of whether that person has lifelong support needs and/or has support needs that must be met to live a better life.

Proposed subsection 9B (2) provides for the NDIS rules to make provision for determining any matter for the purpose of this subsection; and subsection 9B (3) allows that the new NDIS rules may prescribe methods or criteria to apply classifications or thresholds relevant to the assessment of functional capacity. It also allows the prescription of matters that may, must or must not be taken into account when assessing functional capacity or circumstances in which a matter is taken to exist or to not exist in relation to assessing a person's functional capacity. However, as previously stated the NDIA does not have a good history of developing rules which respond to psychosocial disability.

### *Recommendation*

3. With respect to Clause 9B:
    a. Delay implementation of 9B until the NDIA has developed an appropriate definition of functional capacity which is specific to psychosocial disability and an assessment tool which is able to measure this.
    b. Include a note to Clause B that in the case of a primary psychosocial disability that the person's environment and personal circumstances should be taken into account in determining functional capacity.

## Part 4: Support determinations

Section 34A gives the Minister significant powers to make changes to expenditure within the NDIS. There are insufficient safeguards to ensure that use of such powers will not deliver detrimental effects to individuals or the broader service system.

For example, the regulatory impact statement notes that the current proposal to cut social and community participation will have a disproportionate impact on people with a psychosocial disability because functional incapacity in social and community participation is a core part of the disability, compared to other disabilities. A significant cut in such support, for some people with psychosocial disability, is likely to result in decrease in their mental health and wellbeing, with impacts felt in parts of the service system including hospitals and emergency care. In this case, the absence of alternative supports increases the impact which must be considered.

The Committee should also be aware that the proposed restrictions to plan reassessments (Schedule 1, parts 2 and 5) also mean that any person who experiences an unintended consequence of a reduction in expenditure from such a determination does not have any means to have this addressed. Of particular concern are those who may be using their budgets flexibly across categories, to respond to fluctuating needs.

***Recommendation***

7. Remove the broad sweeping and unchecked power of the Minister to make support determinations (Section 34 A). At the very least this must:

a. Require that modelling of such a determination for reducing funding for groups of support includes specific consideration of disproportionate disadvantage to particular groups of people (with consideration, but not limited, to disability type, age, gender, cultural background, indigeneity, sexuality and geography), and the impact on other parts of the service system. This modelling is to be publicly available and allow for a response and consideration of that response before implementation.
b. Include provisions in the legislation to address at the individual level significant negative impact from any such determination.

## Part 8: Tightening meaning of permanence to reduce access where an impairment can be treated.

The new definition of permanence (24(4)/ 25 (1A), including the meaning of treatment (25A), largely mimics the current rules and processes being used by the NDIA to assess psychosocial disability. As documented in *Access Denied* it does not work to assess permanent psychosocial disability and has had the effect of excluding people with complex mental health and psychosocial disability. It is a framework that only makes sense for impairments where the relationship to functional capacity and disability and treatment pathways are linear. For example, in the case of blindness or a loss of a limb.

The emphasis on diagnosis to identify impairment, and the failure of this, to determine psychosocial disability was noted in the 2019 Review and changes were made to the legislation in attempt to move away from diagnosis to functional (in)capacity. Unfortunately, this failed due to NDIA processes reverting to a medicalised understanding of psychosocial disability, which have focussed on diagnosis and the importance of trying clinical treatments, rather than functional (in)capacity and community- based support.

Reasons why the language and practice of diagnosis and treatment of an impairment do not work for psychosocial disability include because:

- The relationship between illness, impairment and treatment of and from mental illness is not uniform and is also highly individual. There is also a relationship between mental ill health and psychosocial disability where each impacts on and can cause the other[3].
- A mental health issue is diagnosed from symptoms and treatments address those symptoms, which may or may not address the impairment. Two people with the same symptoms and responding to the same treatment, can have different impairments. Additionally, some treatments might result in improvements in symptoms over many years, but the person may still have substantially reduced functional capacity.
- The evidence base for "treatments" is broad, and treatments highly individualised. What might be suitable for one person cannot be generalised to another, such that to show that every treatment has been exhausted is technically impossible. Additionally, some psychiatric treatments come with a range of other risk factors – including the risk of significant impairment – that people should not be expected to undertake them before accessing NDIS support. This includes for example, ECT or clozapine therapy. We have documented examples where assessors have indicated to potential participants that not trying these therapies is why they should not get access.
- Many people with complex needs may have multiple mental health diagnoses, and these may also have changed over time. Not only is treatment highly individualised, but the associated impairment is not the result of one diagnosis but the cumulative impact of many. Again, it would be impossible and inappropriate to expect to show that all treatments have been exhausted.

Ironically, if the Government is serious about ensuring that the NDIS is only available for people with long term permanent and significant psychosocial disability, it would invest in psychosocial support outside of the NDIS to

[3] Mind (2014), *Mental Health and the NDIS: A literature review*

give people the earliest opportunity to reduce a) the likelihood of a disability emerging and b) the best chance of improving functional capacity such that the NDIS was not necessary.

If these supports were more uniformly available, it could also look to the experience within these supports to determine whether the NDIS access was appropriate. For example, we know that 80% of people in psychosocial support programs will exit the program within two years because they have had their needs met[4]. Requiring support for longer than two years can be a significant (and relevant) indicator that the disability is likely to be long term.

However, we welcome the clarification that there are circumstances where some impairments require ongoing clinical care (treatment), such as impairments attributed to psychosocial disability.

We note that clauses 25A 4 and 5 allow for NDIS rules to determine circumstances for considering when a person is taken to have undertaken all appropriate treatment for an impairment or impairments. The APA contends that relying on NDIS rules to counter the inappropriate definition of permanency and treatment for people with psychosocial disability, based on past experience, is not satisfactory.

### *Recommendation*

5. That the legislation specifically include:

    a. That the definition of treatment in 25(A) does not apply to the assessment of the permanency of psychosocial disability.
    b. A new provision for the assessment of permanency of psychosocial disability which has a focus on the experience of mental illness and functional incapacity.

**Schedule 4: New Framework Planning**

We welcome the delay in the implementation of new framework planning but question whether the delay is long enough to ensure that the NDIA can both identify tools and build the capacity and capability within the organisation to implement so that people with psychosocial disability are not unduly disadvantaged.

The need for a psychosocial stream or approach within the NDIS has been identified as integral to getting assessment and planning right since the very earliest days of the Scheme, and reiterated in the 2023 NDIS review.

Given the significant removal of rights to plan reassessment, the new planning framework cannot be introduced until the tools, capacity and capability are in place.

### *Recommendation*

6. Delay the start date for new framework planning until such a time that there is confidence in the NDIA that it has in place:

    a. Tools that can appropriately assess psychosocial disability, noting that these need to be able to take into account the impact of fluctuating mental health conditions.
    b. An assessment process which is relationship based, trauma informed and recovery focussed.
    c. A psychosocial capability framework which embeds psychosocial expertise across the NDIA and its practices.

[4] For example: Papakotsias A and Tobias G (2015), 'Differentiating holistic mental health care from disability care', *newparadigm*, Spring; Purcal, C., O'Shea, P. Giuntoli, G., Zmudzki, F., Fisher, K.R. (2022). *Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative. CLS-HASI Evaluation Report*. Sydney: UNSW Social Policy Research Centre.