

Australian Psychosocial Alliance

Consultation on NDIS Access Change – Psychosocial Disability.

October 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, Richmond Fellowship Queensland, Ruah Community Support, Stride Mental Health, Open Minds and Wellways Australia. We are eight of the largest and longest service specialist providers of community managed mental health and wellbeing services in Australia. We provide support to over 120,000 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: psychosocialalliance.org.au

Introduction

The APA welcomes the renewed commitment to fair and equitable access to the NDIS. Access rates for people with psychosocial disability remain low: participation is below Productivity Commission projections, applications continue to decline[1], and applicants report that the process is difficult and costly.

The Scheme and its processes should be inclusive and responsive to everyone, regardless of disability type. Its failure to achieve this for people with psychosocial disability has prompted previous calls for a specialist psychosocial pathway. An inclusive approach must recognise that:

- Psychosocial disability is not always visible.
- Although it can be enduring, support needs may fluctuate.
- The relationship between diagnosis, impairment and level of disability varies because of each person's circumstances, available supports and experience of mental health condition.
- Functional incapacity can be cumulative and variable. It may be independent of clinical treatment or treatment response.
- A person's ability to perform a task in a controlled setting does not necessarily mean they can do so safely, reliably and sustainably in everyday life.

The NDIS must also have a clear place within the broader ecosystem of care and support for people experiencing mental health issues and psychosocial disability. It should form part of a coordinated commitment to deliver the right support at the right time and in the right place. Our response to Question 4 outlines appropriate referral pathways.

Recent changes to the NDIS Act risk disproportionately affecting people with psychosocial disability[2]. It is concerning that access guidelines have already changed before a valid, reliable and inclusive approach has been developed, particularly given the high unmet demand for psychosocial support outside the NDIS.

To address these risks, the NDIA needs to:

- Recognise that consideration of environmental and personal circumstances is fundamental to determining both the existence, and permanence, of psychosocial disability. Assessment must consider how a person functions in everyday life, rather than measuring performance at a single point in time in a standardised setting. Our response to Question 3 provides further detail.
- Develop a new approach to assessing permanency for people with psychosocial disability, supported by clear evidence requirements. Our response to Question 6 provides further detail.

As the NDIS moves towards nationally consistent assessment tools, embedding the 2001 WHO International Classification of Functioning, Disability and Health Framework (ICF) should improve coherence across disabilities, reduce variability and promote fairness[3]. However, it needs to be embedded as a totality. It is also not an assessment tool, and as yet there is no tool which covers all aspects of the ICF from a psychosocial disability perspective. The I-CAN (being tested for planning but possibly to inform eligibility) is yet to be peer reviewed and validated for psychosocial disability. Our response to question 2 provides more information.

We would be happy to discuss our submission in more detail, and to work with the NDIA to implement our recommendations.

[1] NDIS quarterly report. Q4 2025-2026.
[2] [2] APA Submission to the Senate Committee Affairs Legislation Committee – Inquiry into the NDIS Amendment (Securing the NDIS for Future Generations) Bill 2026.
[3] [3] See NDIS Assessment Toolkit | OTSI - Resources for Disability Assessment

Recommendations

1. The Government should not introduce a national eligibility threshold until the assessment framework and tools have been independently demonstrated to be valid, reliable, equitable and clinically fit for purpose for people with psychosocial disability.

2. The NDIA should adopt, and apply as intended, the International Classification of Functioning, Disability and Health (ICF) to underpin functional capacity assessments for eligibility and needs assessments for planning. This means assessing how a person functions in everyday life and considering how environmental and personal circumstances affect psychosocial disability. New Becoming a Participant Rules may be needed to clarify that these factors cannot be excluded when assessing functional capacity for people with a psychosocial disability.

3. Assessment tools should be used only where they have been validated for the relevant disability cohort and cultural group. No single tool should substitute for a comprehensive assessment that integrates self-report, observed functioning and evidence from carers, supporters and service providers.

4. The NDIA needs a distinct psychosocial access stream that is relationship-based, trauma-informed, recovery-focused and inclusive of families, carers, kin and service providers, with assessors who have specialist psychosocial disability expertise. The access process should provide assertive outreach, practical and candid information, personalised engagement support, multiple meetings where needed, in-person assessment in the applicant's environment where appropriate, and an opportunity to review proposed decisions and supporting evidence before a final decision is made.

5. The NDIA should create clear, evidence-based referral pathways for people with sustained involvement in public mental health services, long-term psychosocial support programs, multiple service systems or supported living arrangements, while preserving an accessible pathway for people outside these systems.

6. The Government should develop new Becoming a Participant Rules and a dedicated framework for assessing permanency in psychosocial disability. This new framework should identify relevant and publicly available evidence-based treatments, recognise long treatment histories and patterns of service use as evidence, account for fluctuating and episodic disability, and ensure evidence is interpreted by people with advanced psychosocial disability expertise.

7. The guiding principles should prioritise equity over procedural uniformity. Remove "consistent" from Principle 3, or clarify that consistency means consistent and equitable outcomes rather than identical assessment processes.

Responses to the consultation questions

Guiding Principles

1. ***Do the draft guiding principles provide the right foundation for a future NDIS access process?***
2. ***Should any principles be added, removed or changed?***

In principle, the guiding principles are sound. However, they are expressed at such a high level that their practical effect is unclear. There is a risk that the NDIA will implement a standardised and consistent assessment system that produces inequitable outcomes.

Principle 3, "evidence-based and consistent", is problematic. The word "consistent" should be removed because:

- Consistency can conflict with the overarching principle of equity, which recognises that different approaches may be needed to achieve consistent outcomes.
- Principle 5 appropriately states that access decision-making should be "equitable, inclusive and safe". Principle 3 therefore risks undermining Principle 5.

Many people with psychosocial disability have had to navigate a Scheme designed primarily for other disability groups. Access, assessment, planning and supports have not been designed or delivered in ways that enable their participation.

The desire for consistency continually undermines access and equity for this cohort. We see this reflected in the data which shows that access rates for this cohort are at 34% (compared to 78% for all disabilities)[4] and representation within the Scheme is less than initially predicted by Productivity Commission modelling[5]. Similarly, the recent legislation changes to the NDIS Act, designed to allow for the removal of the "diagnostic" lists (which did not include mental health conditions) occurred without consideration of the impact on people with psychosocial disability, and the decision to cut Social Civic and Community Participation budgets that will disproportionately affect people with psychosocial disability, are further evidence of how the desire for Scheme consistency over equity is and will lead to much poorer outcomes for some.

Access decision-making process design

3. ***What do we need to consider when designing an access decision-making process that is fair, consistent, transparent, disability-informed and evidence-based?***

a) **Ensure that assessments of functional capacity recognise that a person's ability to perform everyday activities is shaped by the interaction between personal factors and their environment.**

The new definition of functional capacity (Part 1: 9B definition of functional capacity), aims to exclude, as far as possible, the impact of a person's environmental 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; and this promotes a more objective and consistent assessment of the functional impact of the person's impairment (page 16). The Department and NDIA's submission regarding the Bill, further explains that it will confine assessment to a person's intrinsic ability to undertake an activity. It references

[4] NDIS quarterly report. Q4 2025-2026.
[5] Threfall D et al (2026) *Access Denied: Psychosocial Disability in the NDIS.* Australian Psychosocial Alliance

the 2001 WHO International Classification of Functioning, Disability and Health Framework (ICF) and how it distinguishes between "capacity" and "performance".

Although "as far as possible" acknowledges that environmental and personal circumstances cannot always be excluded, the phrase is open to broad interpretation. It has the potential to create a new and unfair barriers to access for people with psychosocial disability because it is **impossible** to make such exclusions without compromising understanding of the person's psychosocial disability and undertake a fair assessment of functional limitations.

Firstly, it is not possible to understand functional incapacity for a person with a psychosocial disability if only "capacity" rather than "performance" is considered. Performing a task under controlled conditions does not show whether a person can function safely, reliably and sustainably in everyday life. For example, someone may communicate fluently in a structured interview yet be unable to manage the communication, planning and cognitive demands of daily life. In fact, this gap between capacity and ability to undertake (or perform) a task is often evidence of a psychosocial disability. A capacity-only model therefore risks systematically under or over estimating people whose disability is context-dependent, fluctuating or hidden. It is also not how the ICF was intended to be used.

Secondly, the proposed new definition, while "excluding" consideration of the supports that might be assisting a person to function, without qualification, could also wrongly exclude consideration of environmental and personal factors that impact on, but are also evidence of, functional incapacity. For example, a person could be excluded because functional (in)capacity associated with living or self-care skills, is defined as an impact of being homeless, rather than the homelessness an outcome of poor living or self-care skills; or because the cumulative impact of the experience of social disadvantage such as long-term homelessness, physical health problems, unemployment on mental health and functional capacity is dismissed.

We are not confident that any assessment tool can reliably separate the extent to which functional limitation causes social disadvantage from the extent to which disadvantage causes functional limitation. In any event, that distinction is not relevant to whether a person has lifelong support needs or requires support to live a better life.

This proposed approach also conflicts with the NDIA's definition of psychosocial disability, which includes an understanding that it is the outcome for a person with mental health conditions attempting to interact with a social environment that presents barriers to their equality with others.[6]

b) A valid, reliable and clinically fit for purpose assessment tool/s

The APA supports embedding the ICF to improve coherence across assessments, reduce variability and promote fairness. The ICF's biopsychosocial framework understands disability as an interaction between health conditions, personal factors and environmental influences, and we understand that it was central to the original design of the NDIS. It shifts attention from diagnosis to function and from deficit to participation and inclusion—an approach that is especially important for psychosocial disability, where impairments are often non-apparent, episodic or context-dependent. However, the ICF must be applied as intended and in full.

However, the ICF is also not an assessment tool and we are not aware of any tool that has been identified which has reliability for different disability cohorts. The assessment and strengths-based tools such as WHODAS v2, I-CAN v6 and LSP 16 which have been used in NDIS assessment for a number of years, also do

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

not by themselves, cover all aspects of the ICF and each have their own strengths and weaknesses and variations for reliability for different disability cohorts.

We are concerned that the I-CAN, which is being adapted by the NDIA for planning, and which may also inform eligibility, will not be suitable, valid or reliable for people with psychosocial disability. The tool is grounded in a framework developed for intellectual disability and does not adequately reflect the distinctive features of psychosocial disability. Concerns include that it may not consistently identify fluctuating needs. and implementation may rely on self-report without safeguards for people who may have difficulty describing their functioning. As far as we know, the I-CAN is yet to be peer-reviewed or validated in a psychosocial disability population. It is also unclear how the NDIA (using the I-CAN or other tool) will be able to accurately distinguish the one or more impairments to which a psychosocial disability are attributable (as per the Act definition) from other causes, creating a risk of subjective and inconsistent results.

The Government should not implement a national eligibility threshold until it can demonstrate that the assessment system and tools used to determine that threshold is valid, reliable and clinically fit for purpose for assessing eligibility for people with psychosocial disability – including that they reflect a broader conceptual framework and do not reduce functional capacity to severity ratings or isolated task completion.

c) A relationship-based, family, carer and kin inclusive, trauma-informed and recovery-focused process for people with psychosocial disability.

The access decision-making process must be fair, transparent, disability-informed and evidence-based. This does not require an identical process for everyone; it requires processes that deliver equitable access for people with long-term, permanent disability.

The NDIS was intended as a safety net that enables people with disability and their families, carers and kin to live well and participate in community life, education and employment. The access process must include people who need and are entitled to this support, and to proactively facilitate them to obtain the right support at the right time.

There is already substantial guidance on designing a fair and equitable process for people with psychosocial disability, including Mental Health Australia's 2019 consultation report for the NDIA on developing a pathway for people with psychosocial disability, and the 2023 NDIS Review. These reports call for a relationship-based, trauma-informed and recovery-focused approach designed, supported and delivered by people with psychosocial expertise and understanding.

Some important factors include:

- **Outreach, personalised NDIS engagement support and community resources.** These measures should reach people who are not connected to services or who may be reluctant to test their eligibility for reasons related to their psychosocial disability.
- **Practical and candid information to help people decide whether the Scheme is suitable.** Information should be available in plain-language and detailed formats for individuals, communities and service providers, supported by real-life examples. Current public NDIS information is often so simplified that it lacks precision and clarity.
- **A proactive and supportive approach to assessment.** The assessment process should gather all necessary information and actively help the applicant provide it. To achieve this:
    - Assessors should build trust, allowing multiple meetings where needed.

    - Assessors should meet applicants in person and, where appropriate, in their home environment. This provides context and may reveal differences between stated capability and everyday functioning.
    - Family, carers and service providers should be actively supported to participate, as they may provide information about needs that the applicant cannot articulate.
- **Assessors having the skills, expertise and understanding needed to assess psychosocial disability.** They should provide a trauma-informed, recovery-focused experience, ask appropriate questions, recognise when information needs clarification or corroboration, and build trusting relationships.
- **People with psychosocial disability and their supporters should routinely be able to review proposed decisions and the supporting evidence before a final decision is made.**

4. ***How could the access decision-making process, including referral pathways, reduce administrative burden and make it easier and more equitable for people with disability, their families and carers to understand what information is required and how decisions are made? How could a proportionate approach minimise the assessment burden for people who are clearly eligible and have very significant impairments?***

This means creating clear referral pathways to the NDIS for people who have permanent, long term and significant psychosocial disability and articulating how the NDIS links and coordinates with other mental health and psychosocial supports. This recognition will deliver better life outcomes for participants and deliver significant benefits to the whole service system and community, including to reduce administrative burden.

However, it is equally important that the access process remains inclusive and accessible to all people with psychosocial disability, regardless of referral pathways.

Answering this consultation question requires thinking about how the NDIS operates as part of an eco-system of care and its role alongside other psychosocial supports, the mental health service system and families, carers and kin who are relied upon for both informal and formal support.

The experience of a person within the broader (non-NDIS) service system is also a good predictor of long-term psychosocial disability. Building in appropriate referral pathways and acknowledging how this experience provides this evidence is integral to providing a more efficient, effective and fair access system.

People already accessing publicly funded programs where access and utilisation of those programs is indicative of long-term disability, should have a clear pathway into the NDIS. This would be similar to the provisions put in place in the early days of the NDIS, when people transferred from existing programs into the NDIS. Available NDIS participation data suggests that this approach successfully identified those who needed to be in the scheme, as people with primary psychosocial disability, at full roll out and now, have amongst the highest support needs in the Scheme[7].

Two referral pathways are already supported by evidence and practice; a third is less established. Together, they could provide efficient, responsive and coordinated access for people with the highest support needs.

Pathway 1: People accessing some public mental health services; frequent users of acute care.

[7] For example, the earliest reported level of function data in Q1 2023-2024 shows only 6% with the lowest support needs; and 31% with the highest. In Q1 2020/2021 at full roll out, only 5% of payments were self (partly or fully) managed; now 3%.

In *Access Denied*, we reported that public mental health services spent 100 hours preparing an NDIS access application, up from 20 hours in 2019. Applicants included people living in subacute residential programs, such as Community Care Units or Secure Extended Care, and people known to services through repeated acute admissions or frequent or long-term community treatment. This group were likely to have been or were severely unwell, have had issues with medication and treatment, unable to live independently, or reliant on family or other services, and may have or be experiencing physical health issues and/or homelessness. Frequent acute admissions, subacute residential care and extended contact with public mental health services are strong indicators of long-term, permanent disability.

Public mental health services are well placed to identify this group. A direct pathway would reduce the administrative burden on applicants, services and the NDIA. Timely access to NDIS support would also improve individual and community outcomes and ease pressure on the mental health system.

Pathway 2: People who need frequent and ongoing psychosocial support for longer than 2 years.

Most psychosocial support programs are funded to provide a 12 month episode of care; and 90% of people exit these programs within 12 months. Programs with longer (or more flexible) episodes of care, identify that by two years 97% people will have exited[8]. The remaining 3% will have long term psychosocial disability and most likely would benefit from the NDIS.

Because testing NDIS access requires substantial financial, emotional and time investment, providers may encourage a person who is likely to need the NDIS and meet access criteria to apply within months of entering a program. This can occur before it is fully clear that this level of support is needed, and at the same time redirects effort away from recovery support to access support. It is not an effective use of resources, and it is not optimal for recovery – not just because the person has less access to direct support than they would have had otherwise but because of difficulties of reconciling a recovery approach with the deficit focussed NDIS process.

A national approach to the commissioning of psychosocial support (which should be a goal of the National Mental Health Suicide Prevention Framework) would continue to expect that most people accessing individual psychosocial recovery programs (or similar) exit before 12 months and that a small percentage (around 3%) should test eligibility for the NDIS if they have been unable to exit and/or it is immediately clear that a higher level of support is required than can be provided[9].

The insights of the support provider, and how the support service has (or has not) been able to meet someone's needs, should be considered paramount as evidence of long-term psychosocial disability in the access process.

Pathway 3: People with sustained multi-system involvement and/or living in long term supported environment.

Although less established than the first two pathways, this pathway would identify people whose psychosocial disability has caused them to fall through service gaps or whose families provide the support needed to maintain daily functioning.

This includes people with sustained contact across health, mental health, homelessness and criminal justice systems—for example, repeated emergency department presentations, contact with the criminal justice system, use of homelessness services, victimisation, or difficulty maintaining housing.

[8] Internal data from APA organisations.
[9] Australian Psychosocial Alliance, Building a National Psychosocial Pathway Outside the NDIS, August 2026; https://psychosocialalliance.org.au/position-statements

It also includes people who have lived for an extended period in a supported setting, such as a Supported Residential Service, or with family, carers or kin who provide substantial day-to-day assistance.

5. ***What should be considered to ensure the access decision-making process, as well as referral pathways, works well for all disability cohorts including people with communication, cultural, cognitive, degenerative, fluctuating, episodic or complex support needs?***

The architecture of the access process should as much as possible be inclusive and responsive to all people with disability. However, while everyone should be assessed to either meet or not meet the same benchmark, different assessment processes will be required to ensure that this can be achieved.

Many people with psychosocial disability can find it difficult to recognise or articulate a need for support or that they are not managing. For example, it is well recognised that there is limited concordance between self-reported and objectively assessed cognition and functioning across the schizophrenia-spectrum literature. A 2024 systematic review of 26 studies found minimal to modest associations, with a general tendency to overestimate[10]. Comprehensive assessment is typically needed to integrate often discrepant sources.

This occurs for many reasons, including because in the past identifying a need may have resulted in hospitalisation or compulsory treatment, of wanting to please or fear of stigma and discrimination, cognitive impairment or because they do not want to talk about deficits and/or prefer to focus on what they can do, not what they can't.

The access decision making process therefore needs to be able to respond appropriately, and the approach outlined in answer to question 2 provides a basis for this. We emphasise:

- Use only assessment tools that have been shown to be valid and reliable for their intended disability cohort and cultural group[11]. As noted in the Introduction, the I-CAN has not been peer-reviewed or validated in a psychosocial disability population.
- Ensure assessors can adapt their approach to each person's needs, disability and circumstances. For psychosocial disability, assessors should understand trauma-informed and recovery-focused practice, mental health and the service system, including how stigma, discrimination, past experiences (trauma), and cognitive impairment or avolition may affect presentation and self-report.
- Focus on building trust with the applicant, including through meeting with them in person, allowing for multiple meetings if required, and meeting them in their own environment. There should be capability for proactive engagement.
- Engage proactively with carers, supporters and service providers to confirm and expand on needs that the applicant may not articulate and to gather supporting evidence. Where an applicant has no nominee, family member or knowledgeable carer, the Agency should fund allied health assistance through the access process.

Evidence requirements

6. ***What factors and evidence should be considered when determining whether an impairment is permanent or likely permanent, including whether appropriate treatment is likely to improve the functional impact of an impairment?***

[10] Harris et al., "The Discrepancy between Subjective and Objective Evaluations of Cognitive and Functional Ability among People with Schizophrenia."
[11] Particular attention needs to be paid to cultural appropriateness for First Nations people, who are under-represented in the NDIS and 28% less likely than other people with disability to access support through the Scheme. Deloitte. (2023). Research report – Options to improve service availability and accessibility for First Nations people with disability.

Our report *Access Denied: Psychosocial Disability and the NDIS* found that people were often initially rejected because the NDIA imposed unreasonable or inappropriate treatment-evidence requirements. Our continuing discussions with applicants and their supporters indicate that the current expectation to exhaust all treatments is often impossible to meet. It may also require evidence of treatments that do not address, or may worsen, the impairment and can create pressure to pursue inappropriate or irrelevant options.

People most affected include those without a clear diagnosis, with co-occurring conditions, or with diagnoses that have changed over time. Their treatment response may be unclear or variable, and records may be unavailable because they were lost, clinicians retired, or treatment was disrupted by homelessness, trauma or family violence—circumstances that may themselves indicate psychosocial disability. The current process can force people to privilege one diagnosis over the cumulative effects of several conditions. It can also undermine hope by requiring people who continue to seek treatment after many years to declare that they have "tried everything" and expend further financial and emotional resources proving it.

Many people will continue to seek treatment and other ways to address their mental health conditions and distress. Cost and limited availability, particularly of psychosocial support, may restrict their options. Nevertheless, the longer a person is experiencing mental ill health which is impacting their capacity to participate economically, to form and maintain social connection and relationships or care for themselves, the more likely that this will continue and that a psychosocial disability is present.

There is a high risk that the recent changes to the Act which have strengthened the permanency rules to "exhaust all appropriate treatment", even with the qualifiers that treatment should not be restrictive, and be available publicly, will reinforce this poor practice rather than address it.

The factors and evidence of whether an impairment is permanent or likely permanent, including whether appropriate treatment is likely to improve the functional impact of an impairment needs to be tailored for different types of disabilities and experiences. The Act changed in 2021 to specify that the NDIS is for people with a disability that is "attributable to one or more impairments to which a psychosocial disability is attributable". The NDIA must address its current failure to develop guidance to reorientate assessment in line with this less diagnostic and psychiatric focussed understanding of psychosocial disability[12] and ensure that any new guidance is fit for purpose.

The factors to be considered when determining permanency for psychosocial disability include that:

a) A psychosocial disability has unique characteristics which make a test of permanency difficult.

These characteristics include that:

- While all people with a psychosocial disability have an impairment and have a mental health condition, not all people with a mental health condition will have an impairment and not everyone with an impairment will have a psychosocial disability.
- The relationship between condition, impairment and disability varies considerably. Two people with the same mental health condition may experience very different levels of impairment and disability because of their individual experiences of their mental health condition, personal circumstances (including trauma) and environment.

[12] In 2019, a review of the legislation undertaken by Mr David Tune identified that *eligibility decisions were too diagnosis-driven and inconsistent with a functional, recovery-oriented understanding of psychosocial disability.* Changes to the wording of the Act were made with the intention to address this but they were subtle, and there is no evidence that the underlying issues were properly understood, or changes made to the way eligibility was assessed. In fact, neither the NDIS (Becoming a Participant) Rules (2016/18) nor the NDIA's psychosocial evidence form were updated following these amendments.

- Support needs may fluctuate with episodic illness and changing circumstances. The impairment can remain permanent even when its effect on capacity for core activities varies or is not visible.

b) Assessments of whether appropriate treatment has been sought should consider only treatments relevant to the psychosocial impairment. The key questions are: which treatments could address the impairment, and which of those has the person tried?

It is generally the "negative symptoms" of psychotic illnesses[13], along with poor cognition[14], that undermine quality of life and functioning. It is not the condition per se. Negative and positive symptoms are well recognised features of severe mental health conditions and, along with cognitive impairments, are significant contributors to psychosocial disability.

Negative symptoms include avolition and amotivation, and it is likely that there is a synergistic relationship between negative symptoms and cognitive impairment; with negative symptoms arising from cognitive impairment but also impacting detrimentally on cognition (or working memory functioning).

Examples of positive symptoms are hallucinations or delusions. A person's functional capacity can be affected by the positive symptoms, including because they can contribute to disordered thinking and other difficulties, and can make the experience of the negative (disabling) symptoms worse.

Psychiatric treatments (medication) that focus on treating positive symptoms, can have minimal effect on the treatment of negative symptoms. The medication can also make the negative symptoms worse. For example, the sedating effects of antipsychotic medication, may mean a person lacks the drive and energy to attend an appointment and the side effects of medication can impact on cognition.

Altman (2023) reports that there is concerning level of poor mental health literacy regarding the cognitive difficulties experienced by individuals with mental health conditions, including among patients and clinicians[15].

Evidence on treatments for negative symptoms remains limited. A meta-analysis and systematic review found that psychological and psychosocial interventions can reduce symptoms of psychosis but that more effective treatments are needed[16]. Recent Australian research has also identified cognitive remediation as a therapeutic approach showing some benefit,[17] and there is increasing evidence of the importance on a focus on addressing social functioning deficits as a primary outcome[18] However, these interventions do not fit neatly within treatment as commonly understood or applied by the NDIS, and they are not routinely available in clinical (public) mental health services. Access to psychosocial interventions is also limited because many programs ceased when their funding was transferred to the NDIS.

There is no single quantifiable test for determining the permanence of psychosocial disability, and it is unlikely that it can be developed. A literature review undertaken in 2014 for the Independent Advisory

[13] Lutgens, D., Gariepy, G., & Malla, A. (2017). Psychological and psychosocial interventions for negative symptoms in psychosis: systematic review and meta-analysis. *The British Journal of Psychiatry*, *210*(5), 324-332

[14] Greenwood, K. E., S. Landau and T. Wykes (2005). "Negative symptoms and specific cognitive impairments as combined targets for improved functional outcome within cognitive remediation therapy." SCHIZOPHRENIA BULLETIN **31**(4): 910-921.

[15] Rosalie Ariane Eva Altman, Eric Josiah Tan, Susan Lee Rossell (2023). Access to cognitive remediation in Australia for people with schizophrenia, Schizophrenia Research,Volume 256, Pages 44-46,

[16] Lutgens et al (2017)

[17] Rossell SL, Allott K, Bryce S, et al. Where next for cognitive remediation in Australasian mental health care? *Australian & New Zealand Journal of Psychiatry*. 2025;59(7):573-575. doi:10.1177/00048674251333567

[18] Carrión, R. E., B. S. Ku and C. U. Correll (2026). "Deconstructing Social Functioning in Psychosis Risk—From Prediction to Recovery." JAMA Psychiatry.

Council to the NDIA[19] identifies the difficulties in determining permanency, and notes that insurance agencies generally consider whether the disability is likely to be present between one and three years and whether it prevents them from participating in social and economic activity. However, this review also points to indicators of functioning or disability that appear early in the illness course, elapsed length of illness and identifies certain illness characteristics that repeat across studies as significant predictors of poor course and outcomes. For example, a 15-year study of social disability in people with schizophrenia found that the best predictor of disability at the 15-year mark was the level of disability at two years.

A new framework for assessing permanence

The APA proposes that the Government commits to the development of a new framework for assessing permanence for psychosocial disability. At a minimum, it should be:

- evidence based
- be built around building evidence for a permanent psychosocial impairment to which a psychosocial disability is attributable (as defined in the Act) and not a mental health condition per se.
- include concepts of disability and treatment.

While we acknowledge that further work is required to develop such a framework, we believe the following provides a good starting point. It would:

- Define treatment and identify which evidence based "treatments" are relevant, and appropriate, to addressing the impairments to which a psychosocial disability is attributable (not just a mental health condition). These "treatments" should also be readily available through publicly funded mental health/ health services. Treatments provided by psychiatrists and psychologists funded by medicare should be excluded if they are not also available in public mental health services.
- Consider the length of time a person has received treatment. The assumption would be that if a person has been actively seeking treatment for multiple years, and their level of disability (functional capacity) has been low for some time and/or has declined then they are more likely to have permanent disability.
- Recognise that people will continue to seek treatment and other ways to address their psychosocial impairments, mental health conditions and distress over their whole lifetime.
    - The NDIA should not create a barrier to access when the trajectory of psychosocial disability is evident in that person's history, or for the Scheme (or anyone else) to determine when the person has tried enough treatments if that person has been in treatment for many years.
- Consider experience, trajectory and outcomes of service use. Our referral pathways provided earlier, show that the experience within funded mental health services are good indicators of level of disability. This includes the type of program/service that has been accessed (such as sub acute residential programs), the patterns of use (such as frequent inpatient admissions) and length of time where no or minimal changes to (high) support needs occur despite receiving psychosocial support.

The implications for the NDIS access process, which should be referred to the Technical Advisory Group, is to:

- Identify which evidence-based treatments are relevant, and appropriate, to addressing the impairments that are attributable to a psychosocial disability (rather than a specific mental health condition).
- Articulate the characteristics of, and experiences of people (including length of time) in accessing mental health support (including psychological and psychosocial support) which indicate permanency.

[19] Nicholas and Riefels (2014). An examination of the current state of evidence relating to the impact of psychosocial disability on the context of the implementation of the National Disability Insurance Scheme Act 2013. Commissioned by Mind Australia for the Independent Advisory Council to the NDIA.