

Submission on the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026

Parliament of Australia, Community Affairs Legislation Committee

29 May 2026

Authors:

Dr Alyce Cannon – Psychosocial Disability Policy Manager

Ellie Christen – Policy Engagement Coordinator

Meredith Coote – Carer Network Facilitator



Mental Health Carers NSW

For general inquiries:

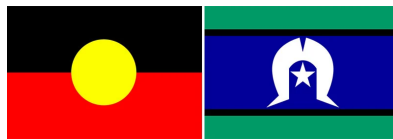
02 9332 0777

mhcnadmin@mentalhealthcarersnsw.org

Acknowledgement of Country

Mental Health Carers NSW acknowledges the Traditional Custodians of the lands and waters across Australia where we live, work, and advocate.

We pay our respects to Aboriginal and Torres Strait Islander peoples, and to their Elders past and present.



Acknowledgement of Lived Experience

Mental Health Carers NSW acknowledges the unique and critical contribution of people with lived and living experience of mental ill-health, family, carers, and supporters in championing change in Australia's mental health system. These contributions are essential to making meaningful decisions to improve the mental health of all Australians.

About Mental Health Carers NSW (MHCN)

Mental Health Carers NSW (MHCN) is the peak body for carers of people who experience mental health challenges in NSW. MHCN is a community managed organisation that provides systemic advocacy, capacity development and education for the carers, family, friends, and kin of those experiencing mental health challenges across NSW.

In Australia, there are approximately 354,000 mental health carers who, each year, provide 186 million hours of unpaid support.¹ Due to the demands of their caring role, carers are at a high risk of developing mental health issues, as well as experiencing loneliness and social isolation. MHCN supports mental health carers and advocates for services and systems that support them in their caring role. MHCN ensures the voices of mental health carers in NSW, and the people they care for, are represented in policy and service reform processes. We work to uphold the rights of carers and consumers to equitable, accessible, and adequately funded mental health services.

MHCN empowers mental health carers to become champions for mental health reform and advocacy. We engage regularly with carers so they can inform our policy priorities and advocacy; for example, every month we convene the *Carers of Forensic and Corrections Patients Network* meetings, and peer led *Mental Health Carer Connection* meetings. MHCN also consults with carers and lived experience representatives to develop and co-author select policy documents.

MHCN also provides the Disability Advocacy Futures Program. This program engages in systemic advocacy on behalf of those who experience psychosocial disability. In this role MHCN advocates to non-Health state government services under the Disability Advocacy Futures Program.

MHCN is funded by the NSW Ministry of Health and the NSW Department of Communities and Justice. We are a foundation member of Mental Health Carers Australia.

¹ Diminic, S., Lee, Y. Y., Hielscher, E., Harris, M. G., Kealton, J., & Whiteford, H. A. (2021). Quantifying the size of the informal care sector for Australian adults with mental illness: Caring hours and replacement cost. *Social Psychiatry and Psychiatric Epidemiology*, 56(3), 387–400.

Table of Contents

Acknowledgement of Country	2
Acknowledgement of Lived Experience	2
About Mental Health Carers NSW (MHCN).....	3
Table of Contents	4
Executive Summary	5
Response to Schedules and Proposals	10
Schedule 1, Part 1, Proposed section 9B (Definition of functional capacity)	10
Schedule 1, Part 2, 48A (Conditions for conducting reassessment of participant's plan on request)	12
Schedule 1, Part 6, 60-72 (Reasonable and necessary supports)	13
Schedule 1, Part 6, 73: Subsection 34(1) 1G-1K (Family etc. support)	14
Schedule 1, Part 7, (Plan suspension etc.)	15
Schedule 1, Part 8, Items 88-94 (Tightening meaning of permanence to reduce access where an impairment can be treated)	17
Schedule 1, Part 9, Proposed section 25B (Alternative support requirements)	20
Conclusion.....	22

Executive Summary

Mental Health Carers NSW (MHCN) welcomes the opportunity to contribute to the Senate Community Affairs Legislation Committee's inquiry into the *National Disability Insurance Scheme Amendment (Safeguarding the NDIS for Future Generations) Bill (2026)*.

MHCN acknowledges the Committee's tight timeframe; however, the combination of a lengthy Bill and Explanatory Memorandum, and a fifteen-day submission period limits the capacity to analyse the proposals, consult affected stakeholders, and provide informed feedback. As the most substantial restructuring of the NDIS since its inception, these reforms need broader consultation and a longer inquiry process. MHCN therefore encourages the Committee to reopen the consultation period to ensure Parliament receives the expertise and lived experience necessary to assess the proposed changes.

While MHCN recognises the importance of ensuring the long-term financial sustainability of the NDIS, we are concerned that the Bill prioritises cost containment over the Scheme's foundational principles of choice, control, and individualised support. When considered collectively, the proposed amendments represent more than technical legislative changes; they signal a significant shift towards a more restrictive and medicalised approach to disability that risks undermining the social model on which the NDIS was established.

The proposed reforms to functional capacity, reassessment processes, permanence requirements, and alternative support pathways are of particular concern for people with psychosocial disability. The Bill relies on standardised assessments and government-appointed assessors and reduces the weight afforded to lived experience and long-term clinical evidence. It creates barriers for people with episodic and fluctuating disabilities, forcing engagement with treatments that may be inaccessible, inappropriate, or harmful, and producing assessments that fail to reflect the realities of psychosocial disability.

In 2023, an estimated 230,500 people with severe mental illness aged 12–64 years required but did not receive psychosocial support through the NDIS or other government-funded programs.² The proposed constrained testing and unrealistic needs assessments acknowledge that they will fund less than what is needed or recommended. As such, the number of people needing psychosocial support will increase and the impact on hospitals will be dire.

The proposed assessment model will determine the outcomes for how and if people with psychosocial disability can access support, and this has the power to enhance or limit their

² Health Policy Analysis. (2024). *Analysis of unmet need for psychosocial supports outside of the NDIS*, 4.

inclusion both within the Scheme and in the community.³ The Bill gives undue weight to single assessments conducted by government-appointed assessors while also discounting historical clinical evidence and the lived experience of participants. The framework leaves little room for choice or control and risks forcing participants to engage with inappropriate or harmful treatment to prove they have attempted what individual assessors deem “all available treatment”. These changes distort the lived experience of psychosocial disability and create legal barriers to assessing the episodic characteristics that produce the disability itself. Legislating away the diversity of this disability via punitive assessment and permanence tests will only create a distorted picture of peoples’ needs, which undermine the evidence-based and participant-led principles of the NDIS.

MHCN is deeply concerned by provisions that expand expectations of unpaid family, carer, and informal support. Families and carers already provide substantial care that sustains both individuals and the broader disability support system. Previous estimations of the replacement cost of informal care and support by mental health carers in 2017 were \$13.2 billion, and this figure will only increase exponentially, causing significant financial strain on families and carers in an increasingly dire economic climate.⁴ The proposed amendments risk shifting further financial, emotional, and practical responsibility onto families whose caring roles are often already at capacity. This would disproportionately affect people with psychosocial disability and the families who support them, while increasing the risk of burnout, financial hardship, and reduced wellbeing.

MHCN urges the Committee to extend the deadlines for submissions before progressing any further. Legislative changes of this significance require more time to provide expert analysis. MHCN is ready to provide resources and access to our lived experience experts to support proper, meaningful legislative change.

³ Mental Health Carers NSW. (2026, April 28). *Media release on the Federal Government’s NDIS announcement* [Media release]. <https://www.mentalhealthcarersnsw.org/wp-content/uploads/2026/05/Mental-Health-Carers-NSW-Media-Release-to-Federal-Government-NDIS-Announcement-April-2026.pdf>

⁴ Diminic et al., (2017). The Economic Value of Informal Mental Health Caring in Australia. *Mind Australia*: p.107.



Scope of Submission

While the Inquiry does not include a Terms of Reference, MHCN's submission focuses on the following schedules and proposals addressed in the Bill and expanded on in the Explanatory Memorandum.

Amendment(s) Referenced	Risks	Recommendations
Schedule 1, Part 1 – Proposed section 9B (Definition of functional capacity)	- Definition excludes assistance, technology, and environmental context, creating an unrealistic and medicalised assessment of disability. - Misrepresenting psychosocial disability and reducing support eligibility. May lead to subjective interpretation of “directly” arising impairments and support cuts for current and future participants.	- Amend wording to align with the WHO and CRPD social model of disability. Assess disability within real-life contexts and recognise support needs as relational and environmental rather than based on unsupported independence. - Clarify the meaning of “directly” in support eligibility provisions.
Schedule 1, Part 2 – Section 48A (Conditions for reassessment of participant plans)	- Thresholds such as “significant”, “ongoing”, and “unanticipated” may disadvantage people with episodic psychosocial disability. - Increased evidentiary burden may discourage participation due to stigma, trauma, and administrative complexity. - Shifting financial and emotional burden onto carers and families.	- Ensure reassessment criteria account for fluctuating and episodic conditions. - Embed procedural fairness and trauma-informed assessment practices. - Clarify that foreseeable deterioration in psychosocial disability should still qualify for urgent reassessment.
Schedule 1, Part 6, Items 60–72 (Reasonable and necessary supports)	Narrowing access to “reasonable and necessary” supports by prioritising Scheme sustainability and cost restrictions over individual participant needs.	Clarify and narrow discretionary powers relating to Scheme sustainability to ensure participant needs remain the primary consideration in funding decisions.



Amendment(s) Referenced	Risks	Recommendations
	- Psychosocial disability will be disproportionately affected when planners redirect people to underfunded or non-existent community and foundational supports. - Shifts responsibilities onto unpaid families, carers, and mainstream systems, increasing burnout, financial strain, and inequitable outcomes, especially in rural and poorly resourced communities.	- Ensure “reasonable and necessary” supports reflect individual lived experience rather than standardised comparisons or cost benchmarks. - Prevent inappropriate reliance on unpaid carers and underfunded mainstream services. - Ensure community or foundational supports are available and adequate before redirecting participants.
Schedule 1, Part 6 – Subsection 34(1) 1G– 1K (Family etc. Support)	- Shifts responsibility for disability supports onto unpaid families, carers, and informal supports by broadly defining parental and informal care obligations. - Increase family burnout, financial hardship, and emotional distress, and disadvantage people with psychosocial disability whose fluctuating support needs may be mischaracterised as ordinary family responsibilities. - Sets a high threshold for recognising unsafe or unsustainable unpaid care.	- Amend or repeal provisions that presume unpaid family care should replace funded disability supports. - Clearly distinguish psychosocial disability supports from ordinary parenting responsibilities. - Recognise the diverse realities of families and carers. - Ensure assessor expertise in psychosocial disability. - Allow earlier intervention when unpaid care is unsustainable or unsafe.
Schedule 1, Part 7 – Plan suspension powers (Section 40A)	Suspension powers may penalise participants who are unreachable due to crisis, trauma, unstable housing, or disability-related communication barriers.	Introduce stronger safeguards before suspension, including welfare checks, outreach processes, and engagement



Amendment(s) Referenced	Risks	Recommendations
	Lengthy suspension periods risk leaving participants without supports, potentially resulting in effective exclusion from the Scheme.	with trusted supporters where appropriate. - Recognise communication barriers linked to disability. - Maintain appeal rights and ensure accessible communication procedures before suspension occurs.
Schedule 1, Part 8 – Items 88–94 (Meaning of permanence and treatment requirements)	- Requirement to undertake “all appropriate treatment” may force participants into inaccessible, unsafe, unaffordable, or unsuitable treatments. - Penalising informed decisions to decline treatment and undermines autonomy. - May disadvantage people with invisible, fluctuating, or treatment-resistant psychosocial disability.	- Amend provisions so treatment requirements are clinically appropriate, trauma-informed, and tailored to lived experience. - Ensure participants can refuse harmful or unsuitable treatment without losing eligibility. - Definitions of “appropriate treatment” should be developed with clinicians and lived-experience input.
Part 8 – Subsection 25A and 25B (Appropriate treatment and assessment barriers)	- Financial, geographic, safety, and evidentiary barriers may prevent equitable access to treatment and assessments. - Assessor opinions may override long-term treating clinicians. - Inaccurate assessments of psychosocial disability.	- Require assessments to consider affordability, accessibility, regional limitations, cultural safety, and prior treatment history. - Ensure assessors have expertise in psychosocial disability and recognise chronic and fluctuating conditions appropriately.
Schedule 1, Part 9 – Proposed section 25B (Alternative support requirements)	- Participants may be denied access based on hypothetical or inaccessible alternative supports. - Unsafe treatments or inappropriate medical interventions.	Limit exclusion only to cases where alternative supports are genuinely available, appropriate, culturally safe, geographically accessible, and equivalent to NDIS supports.

Amendment(s) Referenced	Risks	Recommendations
	- Excluding individuals whose compensation schemes provide inadequate long-term support. - Different state compensation systems may create inequitable outcomes for participants locked out of the Scheme.	Ensure compensation schemes do not replace access to necessary lifelong disability supports where gaps remain.

Response to Schedules and Proposals

Schedule 1, Part 1, Proposed section 9B (Definition of functional capacity)

The Bill proposes inserting a new statutory definition of functional capacity. **9B(1)** states this is to be assessed as their ability to act *“without assistance from other people, assistive technology, or modifications”* and outlines that this is *“in a context that excludes, as far as possible, the impact of the person’s environmental and personal circumstances”*.

The language issues are immediate and of significant concern for MHCN. **9B(1)** contradicts both the definitions of disability from the World Health Organization (WHO) and the Conventions on the Rights of Persons with Disabilities (CRPD). WHO’s International Classification of Functioning, Disability, and Health explain that disability emerges through the interaction between health conditions, impairment, and social and environmental barriers.⁵ Simply put, functioning cannot be separated from context. Disability cannot be assessed away from assistance, technology, modifications, or exclude environmental and personal circumstances. Article 1 of the CPRD states that people with disabilities include people with impairments which, when interacting with various barriers, impede full and equal participation in society.⁶

⁵ World Health Organization, (2001). *International classification of functioning, disability and health: ICF*. <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health>

⁶ United Nations, (2006). *Conventions on the rights of persons with disabilities*, Article 1, G.A. Res. 61/106, U.N. Doc. A/RES/61/106. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities>

Context is indivisibly linked to disability. For people with psychosocial disability, a core part of what makes their disability life-long and complex is that it is episodic and depends on the many contexts they interact with.⁷ Several complex mental health conditions are supported under the banner of “psychosocial disability” including schizophrenia, C-PTSD, bipolar disorder, clinical depression, dissociative disorders, and dual diagnoses. This means that people with one or more of the above diagnoses will function very differently according to the context. Removing these realities from assessment risks creating an artificial picture of independence that does not reflect lived experience.

The current wording of the provisions in **9B** imply a hyper-medicalised and neo-liberal model of disability that treats it as something outside of society. By measuring functioning *without* assistance, technology, or modifications as the *norm*, **9B** will subject disability to a deficit-based assessment model. Rather than prioritising assessments that inherently asks what a person can do without supports and out of context to instead ask what supports they need to participate in society equally.

MHCN recommends that:

- The definition be amended to explicitly include environmental, relational, and social factors.
- Assessment tools must be relational and person-focused rather than standardised tools.

9B, Item 11 – Application provision identifies that the new definition of functional capacity will apply to current and future participants. When read in conjunction with **9B(1a-b)**, this fundamentally changes how disability and support needs are understood under the legislation. For people in the psychosocial disability sector, this could result in reduced recognition of support needs despite the ongoing impact of their disability. The wording also signals to participants, families, and carers that cuts are inevitable.

9B impacts **Part 3, 22-33** because the latter proposed to insert that reasonable and necessary supports will be confined to the needs that arise “*directly from an impairment or impairments*”, indicating that only those that meet the disability requirements or early intervention requirements under **9B** will be approved. MHCN recommends that the Committee clarify why the terminology in **paragraph 34(1aa)** must insert “*directly*” when the previous wording was sufficient. Our concern around this change is that this will result in subjective applications of “*directly*” to assessments, especially when the “financial sustainability” of the Scheme is the Bill’s overall priority.

⁷ Devine, A., et. al. (2020). ‘I’m proud of how far I’ve come. I’m just ready to work’: Mental health recovery narratives within the context of Australia’s disability employment services. *BMC Public Health*, 20(1), 2.

Schedule 1, Part 2, 48A (Conditions for conducting reassessment of participant's plan on request)

As the peak body for families and carers of people experiencing mental health issues and psychosocial disability, MHCN is concerned that this proposal will shift unsustainable caring, financial, and emotional labour onto families, formal and informal carers, and trusted supporters. The replacement cost of informal care and support by mental health carers was last estimated in 2017 to be \$13.2 billion.⁸ What this means is that, when a participant has their plan reassessed and suspended, additional labour and expenditure shifts to families and carers who are already overloaded.

The thresholds for some amendments regarding reassessment are of concern. **48A(1a)** outlines the person must demonstrate “*significant change*”. It must be clear whether this relates to the material increase in support needed and anticipated duration. For participants with psychosocial disability, this threshold does not account for fluctuating and episodic symptoms. **48A(2a)** states that this threshold must be “*significant and ongoing*”, which risks excluding psychosocial disability participants who may experience acute symptoms for extended periods then experience neutral or positive periods. The term “ongoing” may be misinterpreted by assessors in psychosocial disability contexts whereby fluctuating symptoms are mistaken for temporary disability.

48A(3) requires that changes in an individual's circumstances meriting reassessment must be “*unanticipated*”. Psychosocial disability is often episodic, but individuals, families, and carers have a deep and historical understanding of what circumstances and events can lead to deterioration and know when additional supports are needed.⁹ While they may know the signs, this does not mean that reassessment is not urgent or that they can predict new signs or triggers. Requiring that circumstances be unanticipated may provide for unforeseeable circumstances such as accidents, living arrangements, education, and informal supports but it might create a barrier to urgent reassessment during periods of psychosis, severe depression, suicidal ideation, dissociation, and PTSD.

As the Bill uses terminology such as “significant”, “ongoing”, and “substantial reduction”, MHCN is concerned that people with psychosocial disability will face a more difficult and more evidence-heavy assessment process. This is because the proposed changes do not embed procedural fairness or mandated trauma-informed approaches, which disadvantage fluctuating conditions. While the Bill is focused on financial sustainability, our concern is that savings will result from applicants with psychosocial disability disengaging

⁸ Diminic et al. (2017). *The Economic Value of Informal Mental Health Caring in Australia*. Mind Australia, 107.

⁹ Doody et. al. (2017). Families' experiences of involvement in care planning in mental health services: an integrative literature review. *Journal of Psychiatric and Mental Health Nursing*, 24(6-7), 412-430.

from the process altogether due to stigma, fear, distress, and trauma from their experiences with the Scheme.

Schedule 1, Part 6, 60–72 (Reasonable and necessary supports)

Foremost, the definition of “*reasonable and necessary supports*” lacks specificity. This will result in inconsistent decision-making and a progressive broadening of supports funded under the NDIS due to Federal Court decisions, where the Minister can determine reductions in funding for groups of supports. Linking this proposal to the broader ministerial powers also proposed means that support is tied to scheme sustainability and cost restrictions rather than what the participant needs. This could establish precedents for the Administrative Review Tribunal that narrow the scope of funding at the cost of individual benefit.

The proposals in **66, 17B(2)(a)** emphasise a cost-restrictive approach that will narrow what counts as disability support and will make access more difficult for complex participants. **17B(2)(c)** essentially links decision-making around support provision to “*the financial sustainability of the Scheme*”. MHCN agrees that there is scope to identify lower cost supports when outcomes may be similar to reduce unnecessary spending. However, adding *sustainability* to the Bill will shift decision-making from what will genuinely help the person to what can the Scheme afford in the long-term. *Scheme sustainability* is broad and not defined clearly, and planners and assessors may interpret and invoke it differently. This will negatively impact participants with high support needs, complex behavioural support, and degenerative conditions. Benchmarked package limits and standardised funding levels will risk reduced therapy hours, denial of innovative supports, and prioritisation of lower-cost and lower-quality supports.

While **17B(3)** identifies that the NDIS was not intended to pay for ordinary living expenses, MHCN is concerned that this may affect participants who rely on support for meal preparation, cleaning, daily living supports, and assistive technology that has both personal and general uses. **17B(4)** acknowledges that funding should be “*equitable*” across participants with similar needs, however, when read with the proposals to change functional assessments and permanence, this could produce unrealistic comparisons between participants with similar diagnoses but very different lived experiences.

Of pressing concern for MHCN’s stakeholders is **Section 17B(2)(b)**, which outlines the CEO’s powers around “*supporting communities to respond to the goals and needs of participants*”. Given that the CEO can also exercise this in relation to Scheme sustainability in **17B(2)(c)**, this will only shift costs towards health, education, housing, community programs, and state-funded disability supports. The process for developing psychosocial disability ‘Foundational Supports’ has been a confusing and haphazard process, as the

information around when planning will start, available funding, and how it will be allocated is inconsistent or non-existent.

There is a real risk that NDIS participants will be redirected to supports that are chronically underfunded, at capacity, or, worse, do not yet exist because the need will be interpreted as a mainstream/community responsibility. **17B(2)(b)** will inevitably increase pressure on families, spouses, carers, and loved ones of all ages because planners may assume that unpaid supports are “reasonable alternatives”. MHCN’s carer and family stakeholders consistently state that they experience burnout, financial strain, reduced employment, and family issues as it is, and this will only increase if this proposal is passed. Planners must also consider whether participants have supportive families or safe communities and social networks, as those who do not will fall through the cracks. The impacts of this will compound for families and carers in rural, remote, and poorly resourced communities.

Schedule 1, Part 6, 73: Subsection 34(1) 1G-1K (Family etc. support)

The proposed amendments suggest that the NDIS can refuse funding when it determines that parents, carers, family, or informal supports should provide supports instead. The terminology used throughout is broad and highly subjective, and risks overemphasising the capacity of unpaid care to generate savings for the Scheme. MHCN is concerned that this will shift the NDIS to a means-tested framework that undervalues unpaid care and reinforces the outdated assumption that families should absorb the financial, emotional, and interpersonal impacts of disability support in private. If assessors are not experts in psychosocial disability, they will view their fluctuating, but no-less necessary, disability support needs as family labour.

Subsection (1G) creates a legal presumption that parents “are responsible for providing substantial care and support for their children”. This means that the NDIA will make decisions from the presumption that funded supports should not replace parenting unless justified, and that it is families who must prove why support should not be their responsibility. For psychosocial disability, this reduces their complex, often invisible and fluctuating needs to normal parenting responsibilities. For families and carers, this will mean constant mental health and suicide monitoring, managing emotional dysregulation and deescalation without support or training, and staying awake overnight in fear and distress for their child and themselves. A legal presumption of responsibility that is as broad and subjective as the current proposal will punish families and carers who are already overwhelmed but whom the NDIA views as managing their responsibilities.

Subsection (1H) defines “substantial care and support include supervision, personal care, transport, emotional support, and behavioural support”. This provision explicitly lists

supervision, emotional, and behavioural support, which directly targets participants with psychosocial disability, especially children with more than one disability. Because psychosocial disability packages often require these supports, this amendment attempts to define but ultimately blurs the lines between disability support and parenting. This effectively legislates family and carer burnout and financial crisis and must be repealed.

Subsection (1J) grants the CEO explicit powers to refuse supports if the purpose is to *“reduce parental burdens below what is reasonably expected”*. This will affect respite, access to support workers, school supports, behavioural supports, transport assistance, and in-home care should an assessor determine that the support benefits the parents. The proposal also does not acknowledge the relational aspect of psychosocial disability nor the reality that parental units differ, including single parents, disabled carers, low-income households, rural and regional dwellers, and CALD backgrounds. This subsection must be repealed as it delegitimises supports that preserve family stability. It also directly frames family and carer mental health as a preference not an essential part of effective care.

Subsection (1K)(a) identifies that some informal supports may be unsafe or inadequate for participants, and lists “material risks” of abuse, neglect, and harm. The threshold for this must be clearer because the current wording discourages early intervention and preventative support. When read with **Subsection (1K)(b)**, where the CEO should *“prefer maintaining informal supports instead of replacing them with funded supports”* unless there is clear risk *“or unsustainability”*, these amendments clearly prioritise unpaid care and informal networks over proper disability supports. Families and carers of loved ones with psychosocial disability often provide care and support that goes beyond what their financial, emotional, and educational capacity. MHCN is deeply concerned that the NDIA will conclude that this informal support is sustainable even though it is critically unsustainable for the families and carers.

Schedule 1, Part 7, (Plan suspension etc.)

The proposed reassessment and suspension powers come at the cost of protecting participants and their families and carers. The consequences of plan suspension can be devastating not only for participants but also for families, carers, and trusted supporters.

Section 40A (1) proposes that the CEO can suspend a person’s plan if they are satisfied that they have *“made reasonable attempts to contact the participants”*. The measures and number of times taken to contact the person and the safeguards must be clear to avoid missed communications. The proposed framework assumes that a lack of response means a person has disengaged. There are many reasons why a participant may not be reachable. People with psychosocial disability experience periods of distress, mental health crises, social and support withdrawal, unstable accommodation, family violence, and

trauma that can cause communication barriers.¹⁰ Where safe and consensual, the Bill could allow for the Agency to contact the person's trusted supporter or carer to confirm their whereabouts and status. Any non-contact process should include stronger safeguards than those outlined in the Bill. These can include:

- Documented efforts to verify a person's location, safety, circumstances, and wellbeing before enacting suspension protocols.
- Mandatory welfare and outreach processes involving relevant local services and supports.
- Additional protections for participants with psychosocial disability, cognitive impairment, acquired brain injury (ABI), or communication support needs.
- Recognition that disengagement or missed communication may be linked to disability, trauma, or crisis.
- Requirements that revocation decisions are based on clear evidence.

Section 40A (3-4) effectively outlines a suspension period of up to 118 days (90-day window for the participant to contact the Agency after suspension, and 28 days for the CEO to respond), which could last even longer if the CEO opts for subsection 4(b) and requires additional diagnostic, functional or psychosocial evidence. Several barriers can cause people with psychosocial disability to miss a 90-day deadline including the loss of support coordination during the suspension, social isolation, and difficulty navigating the NDIA. This means that, not only will there be people with approximately 118 days of no support but missing that 90-day window can turn a temporary suspension effectively into a cancellation. If the CEO opts for **subsection 4(b)** for a person with psychosocial disability, there will be extra costs for evidence, reports, and waitlists for treating professionals resulting in an even lengthier suspension, even if they did get in contact within the 90-day window. When a person's plan is suspended, they can lose access to support coordinators, advocates, transport, and the assistance that they need to get the plan reinstated. As **subsection 8** states that the CEO *"may (but need not) do one of the things mentioned in subsection 4...if the participant contacts the Agency more than 90 days after the suspension decision is made"*, MHCN's concern is that these procedures will amount to substantive exclusion.

MHCN recommends that the Bill acknowledge that a person's disability can factor into communication barriers. It must distinguish between a person choosing to leave the Scheme and a person who has become unreachable because they are vulnerable, unsafe, unwell, or unsupported. It should also require appropriate administrative expectations

¹⁰ Savaglio et. al. (2023). 'I literally had no support': Barriers and facilitators to supporting the psychosocial wellbeing of young people with mental illness in Tasmania, Australia. *Child and Adolescent Psychiatry and Mental Health*, 17(67), 9.

around accessible and accurate communication methods prior to suspension. To ensure that participants are heard and protected, the Bill must ensure their appeal rights remain intact.

Schedule 1, Part 8, Items 88–94 (Tightening meaning of permanence to reduce access where an impairment can be treated)

The meaning of permanence for the purposes of NDIS access introduces criteria for persons undertaking treatment before being eligible for access the scheme. For example, impairment/s are not permanent or likely to be permanent unless:

- The person has undertaken all appropriate treatment for the impairment or impairments (if any); and
- Any other treatment is unlikely to materially improve, reverse, or alleviate the impact of the impairment or impairments; and
- The impairment or impairments are likely to persist for the person's lifetime.

The proposed permanence tests outlined in **Items 88–94**, particularly those in **subsections 24 to 25** are concerning for their potential to exploit participants because it requires them to engage with “*all appropriate treatment*” before permanence is assessed. MHCN is concerned that this proposal will effectively force people to continuously engage with treatments, services, and approaches that do not work for them to meet the access threshold.

Subsection 25A(2) states that treatment can be deemed appropriate “*regardless of whether the person's individual circumstances restrict the person from accessing the treatment*” and notes that this also applies to financial and geographical circumstances, while **25A(3a)** exempts certain medical reasons. The language is concerning because it implies that because a treatment exists, even if it is not right for the participant, is too expensive, or geographically inaccessible, then it is still appropriate. For psychosocial disability, this can mean participants are forced to engage with treatments unsuitable to their specific experience of disability because they are deemed appropriate to the general perception of that disability.¹¹

MHCN's stakeholders have reported that, if they previously made the informed choice not to pursue a treatment option due to personal reasons, cultural safety, or possible

¹¹ Mental Health Australia. (2021). *Submission: Response to the Department of Social Services consultation on NDIS legislative changes*, 4.
https://www.mentalhealthaustralia.org.au/sites/default/files/docs/mental_health_australia_submission_-_dss_consultation_ndis_legislation_changes_-_7_oct_2021.pdf

psychological risks, that they will be declined because the treatment option exists even though it was not appropriate for them. Making an informed decision to decline a treatment option should not become a barrier to determining the permanence of their disability nor should the NDIS require people to engage in inappropriate treatment that risks trauma and harm.

The proposed reforms in **subsection 25(1)(c)(i)** risks enforcing a disempowering and deficit model. MHCN's stakeholders are concerned that, if they are "having a good day" when assessments occur, their support will be revoked. They are concerned that they will be expected to present "the worst version of themselves or their loved ones" to qualify. Intervention, support, and management are crucial for psychosocial disability, but there is a genuine fear among our stakeholders that assessors may perceive someone "doing well" and justify that their disability is not permanent. Replacing terms like "mitigating or alleviating" with "reducing" risks forcing people to present their conditions at requiring reduction rather than mitigation.¹² This does not align with established and globally-accepted definitions of disability.

Item 92 (25A, meaning of appropriate treatment etc.) outlines that the appropriate treatment outlined in **subsection 25(1A-B)** must be *"evidence-based and can be reliably expected to materially improve, reverse, or alleviate the impact"* of the impairment. These overlook the realities of invisible, episodic, and complex disabilities. MHCN is concerned that the development of prospective 'Foundational Supports' may be interpreted by assessors as examples of appropriate treatment, especially when psychosocial foundational supports are years away. MHCN therefore recommends that the definition of appropriate treatments *must* be determined with guidance from lived experience and clinicians before this Bill can be passed.

The parameters of appropriate treatment include the requirement in **25B(1b)** concerning *"any other treatment"* but do not outline what comprises any other treatments. It is unclear if this relates to those outlined in **Part 8, Items 88–94**. The parameters do not provide for the following treatment and assessment barriers:

- i. **Financial:** Many treatments, including trauma-informed psychiatry and specialist therapies are not covered by Medicare or the Disability Support Pension. They are prohibitively expensive and people on income support cannot afford the gap fees,

¹² Gooding, P., & West, A. (2023). Disability assessments and the algorithmic veil: lessons from the abandoned 'independent assessments' proposal for the National Disability Insurance Scheme. *Australian Journal of Human Rights*, 29(1), 44–64. <https://doi.org/10.1080/1323238X.2023.2203536> (p. 48)



travel, or ongoing therapy costs.¹³ Families and carers will be left to fund these costs, if they have the means.

- ii. **Access:** In regional and rural areas, access to available trauma-informed or preferred gender psychiatrists and specialists is slight, at just 1.8% of FTE psychiatry services.¹⁴ Regional and rural participants may only have access to their GPs, whose evidence could be rejected.¹⁵ Even in metropolitan areas, waitlists can be years long because supply does not meet demand. This can delay treatment and therefore delay application, resulting in higher numbers of vulnerable cohorts left without support. For participants who have attempted certain treatments long ago, these prior records may no longer be available to them, forcing them to reengage with treatments that have not worked for them.¹⁶
- iii. **Safety:** For prospective participants with psychosocial disability, engaging with the mental health system has already occurred and has likely led to acute distress, trauma, and hospitalisation. It ignores the expertise of treating doctors and the realities of chronic, treatment-resistant conditions.
- iv. **Accuracy:** This proposal risks prioritising the opinion of allied health professionals or therapists without specialist mental health expertise over the insight of clinicians who have ongoing therapeutic understandings of the person developed over many years. What one assessor may deem as an appropriate treatment simply because it exists may not be appropriate for that person. It risks developing an inaccurate misrepresentation of psychosocial disability as a cumulative and fluctuation condition.

In its current form, the Bill does not adequately embed procedural fairness or mandate trauma-informed practices within assessment and decision-making processes. A fair and rights-based Scheme must recognise that the ways decisions are made are just as important as the decisions themselves to preserve the safety and dignity of participants.

MHCN recommends that the proposed items in this section are amended to ensure that participants undertake assessments that are not only evidence-based but are clinically

¹³ Tamal, M. E. H., Hassan, K., Gasbarro, D., & Alam, K. (2026). The economic burden of mental health deterioration on Australian households: A longitudinal analysis of out-of-pocket healthcare expenditures. *Health Economics Review*, 16, 16. <https://doi.org/10.1186/s13561-026-00725-z>

¹⁴ Royal Australian and New Zealand College of Psychiatrists. (2025, June 19). *Government data confirms severe psychiatry workforce shortages*. <https://www.ranzcp.org/news-analysis/government-data-confirms-severe-psychiatry-workforce-shortages>

¹⁵ Mellifont, D., Hancock, N., Scanlan, J. N., & Hamilton, D. (2023). Barriers to applying to the NDIS for Australians with psychosocial disability: A scoping review. *Australian Journal of Social Issues*, 58(1), 3–22. <https://doi.org/10.1002/ajis4.245>

¹⁶ Royal Australian and New Zealand College of Psychiatrists. (2026). *Retention, destruction and disposal of patient health records*. <https://www.ranzcp.org/clinical-guidelines-publications/in-focus-topics/private-practice-resources/patient-health-records/retention-destruction-and-disposal-of-patient-health-records>

appropriate to their disability and are relevant to their lived experience. Assessors of psychosocial disability applications and those reviewing current participants must demonstrate that they have significant and deep understanding of this disability.¹⁷ Participants must also be legally protected to decline treatment that might harm them without losing access to the Scheme.

Schedule 1, Part 9, Proposed section 25B (Alternative support requirements)

This proposal risks creating circumstances where people are denied based on hypothetical supports that do not actually assist them, or on supports that they cannot access, or on supports that harm them. MHCN is concerned that people with psychosocial disability will be denied access because there are medications and chemical treatments available for some aspects of their mental health. Participants and families engaged in the mental health system understand that certain treatments can be medically inappropriate, unsafe, contraindicated, occasionally trialled and determined by clinicians to be unsafe due to adverse effects and clinical risk.¹⁸

Forcing people to pursue treatments that may cause significant harm to demonstrate that they have tried all appropriate treatment undermines the professional judgment of treating doctors and specialists and discredits the reality of chronic, complex, and treatment-resistant conditions.¹⁹ In some cases, compliance with treatment expectation could place a person's health or life at serious risk.

This proposal reinforces the broader concerns outlined above regarding the Bill's shift away from the social model of disability. If this section must be included, MHCN recommends that it be amended so that applicants are excluded *only when* alternative supports are *demonstrably* available and applicable to that person, are accessible, culturally safe, geographically accessible, and present a service that would be the equivalent of that provided under the NDIS.

Proposed subsection 25B(3) provides that an impairment is an excluded impairment if:

- The impairment was caused by a work-related injury;

¹⁷ Threlfall, D., Paterson, K., Donnelly, S., Beasley, A., McKenzie, E., & Ballenden, N. (2025). *Access denied: Psychosocial disability and the NDIS* (p. 10). Australian Psychosocial Alliance. https://img1.wsimg.com/blobby/go/27ab207b-baf2-495e-8234-0265bac6bdcf/downloads/e21cda9b-dd7c-417d-86d6-ec1d49bb9338/J30877%20APA%20%20Report%20Access%20Denied%202024-25_%C6%923_we.pdf

¹⁸ Mental Health Carers NSW. (2023). *Submission to the inquiry into community mental health services in NSW* (pp. 13–15). Mental Health Carers NSW. <https://www.mentalhealthcarersnsw.org/wp-content/uploads/2024/07/Submission-to-Join-Standing-Committee-on-thr-NDIS-23-February-2024.pdf>

¹⁹ Choi, I., Ranjit, A., & Waghorn, G. (2025). Supporting the recovery of NDIS participants with psychosocial disability: A narrative literature review. *Australian Journal of Social Issues*, 60(1), 1–20. <https://doi.org/10.1002/ajs.4.70005>

- Workers' Compensation Law provides compensation or other benefits for, or in respect to the impairment.

This proposal may limit the number of instances where a person becomes eligible for the Scheme and does not receive (or receives minimal support) under the Scheme because they have access to support through compensation schemes such as workers compensation or motor vehicle accident insurance (CTP). This can reduce situations where a person qualifies for the NDIS but cannot access supports because another system already funds parts of that care or compensation.

An area for concern is that these compensation schemes are primarily designed as injury compensation schemes, not lifelong disability support systems. The risk is that people may end up unsupported altogether if they become stuck between two systems, especially if a compensation payment does not fund lifelong disability support. Evidence from SafeWork Australia indicates that there were 146,700 serious work claims across Australia in 2023–2024 and the median compensation paid was \$16,300.²⁰ For someone with a permanent disability, a capped sum will not equate to ongoing sustainable disability support.

This proposal may create a gap in supports between systems. States and territories are responsible for and have different eligibility rules for workers compensation and CTP including coverage, payout limits, disability definitions, care arrangements, and restrictions around workers compensation.²¹ Individuals may therefore receive different outcomes depending on their location. Some states operate comprehensive no-fault CTP systems while others retain fault-based models. In jurisdictions with fault-based schemes, a person who cause the accident may receive limited or no compensation but remain eligible for the NDIS. In contrast, individuals in no-fault jurisdictions may be excluded from the NDIS because CTP technically provides supports, even though it may not full address their long-term disability needs.

Unlike serious work injury claims, there is no central collection of statistics on the number of motor vehicle accident claims across Australia. The impacts are anticipated to occur only to prospective participants who have received compensation. In the long term, this amendment may lead to unfair outcomes based on the interaction between state compensation law and Commonwealth disability legislation.

²⁰ SafeWork Australia (2025). Key Work Health and Safety Statistics Australia 2025.

²¹ Safe Work Australia. (2024). *Comparison of workers' compensation arrangements in Australia and New Zealand* (29th ed.). Australian Government. <https://www.safeworkaustralia.gov.au/doc/comparison-workers-compensation-arrangements-australia-and-new-zealand-2023>; Barry Nilsson Lawyers. (2024). *Australian CTP insurance schemes: A national overview and cross-jurisdictional guide*. <https://bnlaw.com.au/knowledge-hub/insights/australian-ctp-insurance-schemes-a-national-overview-and-cross-jurisdictional-guide/>

For MHCN's stakeholders, this amendment may shift financial pressure onto informal supports, families, carers, and mainstream services because people will not be able to access properly funded supports through either compensation schemes or the NDIS.

Conclusion

Mental Health Carers NSW recognises the importance of ensuring the long-term financial sustainability of the NDIS and supports reforms that strengthen the Scheme for future generations. However, many of the measures proposed in the current Bill pursue sustainability at the expense of the principles on which the NDIS was founded. As currently drafted, the Bill represents a significant shift away from the social model of disability and towards a restrictive, medicalised frameworks that reduces participant choice and autonomy, overlooks lived experience, and increases reliance on unpaid families and carers.

The cumulative effect of the proposed amendments would fundamentally reshape access, assessment, planning, and support arrangements in ways that have not undergone adequate consultation. Given the scale and significance of these changes, the Bill should not proceed in its current form.

Importantly, MHCN does not believe that financial sustainability and dignity should be in competition with one another. Many of the concerns we have identified in this submission can be address through targeted amendments that preserve the Scheme's viability *and* participant rights. This can be achieved by embedding the social model of disability, recognising the realities of psychosocial disability, protecting procedural fairness, and respecting lived experience and clinical expertise. The only sustainable way to do this is through careful and collaborative consultation to secure lasting and fair change.