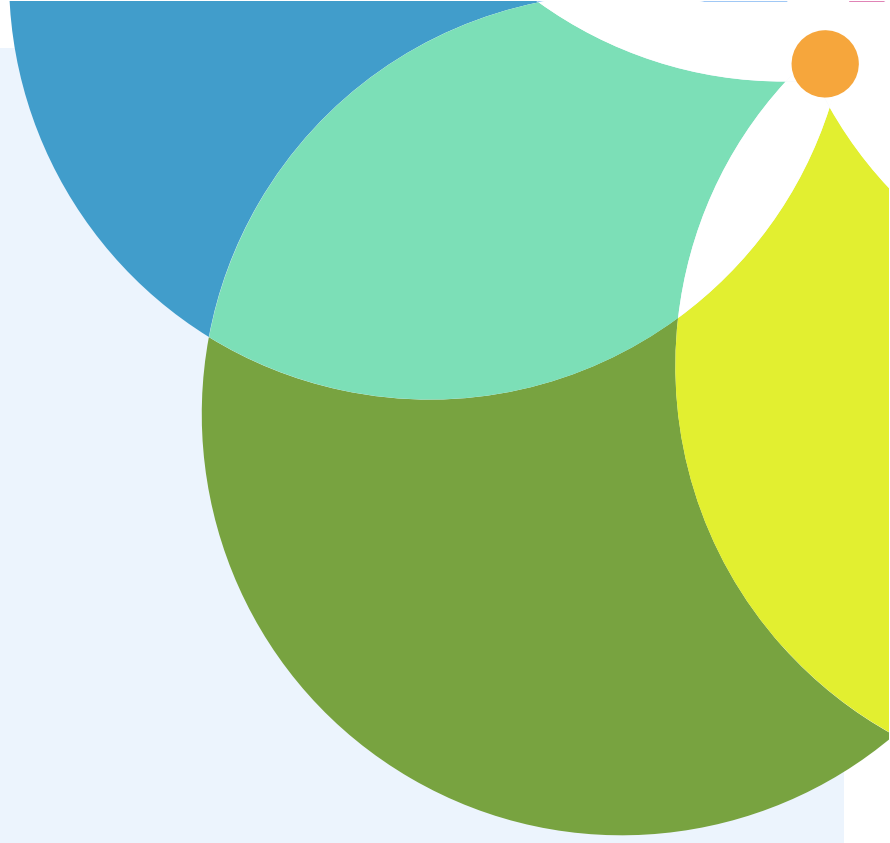




**Mental Health
Australia**



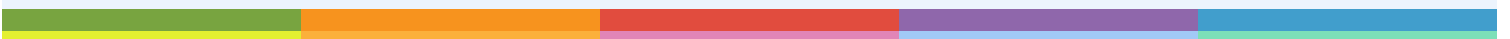
NDIS Access Changes Consultation

Submission to Australian Government Department of Health,
Disability and Ageing

2 October 2026

Mentally healthy people, mentally healthy communities

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Recommendations

Recommendation 1: MHA recommends a further element around supported decision making be added to Principle 6, recognising the importance of this practice for an equitable, fair and consistent approach

Recommendation 2: MHA recommends that the following sentence be added at the end of the explanation of principle 3: “If the evidence does not find that a standardised approach to eligibility assessment is valid and reliable for particular disability cohorts, consideration will be given to accommodations to the standardised approach to ensure validity and reliability for these cohorts”.

Recommendation 3: MHA recommends that the access design process should include meaningful participation by people with lived experience of psychosocial disability and their family, carers and kin.

Recommendation 4: MHA recommends that the wording in Principle 5 be more consistent with the recognition of personal circumstances in Principle 4 and the NDIS Amendment Act, and “in delivering consistent outcomes regardless of personal characteristics” should further stipulate “as far as possible”.

Recommendation 5: MHA recommends that TAG and DHDA review the evidence for the validity and reliability of assessment processes that exclude considerations of personal and environmental circumstances, and consider the extent to which personal circumstances must be considered in a robust and fair assessment process. This is line with the NDIS Amendment Act definition of functional capacity that excludes environmental and personal circumstances “as far as possible”.

Recommendation 6: MHA recommends that the Technical Advisory Groups’ analysis of the evidence of the validity and reliability of standardised assessment tools should be made public on the grounds of transparency, to support public trust and accountability for the new approach to access assessment.

Recommendation 7: MHA recommends that a pool of assessors with minimum psychosocial competencies is established and all applicants on ground of psychosocial disability are required to be assessed by an assessor with these minimum competencies.

Recommendation 8: MHA recommends that DHDA reviews the requirement to exhaust approved mental health treatments and consider changing this to approved psychosocial treatments.

Recommendation 9: MHA recommends that the new access process must include protections against applicant coercion in exhausting appropriate treatments an NDIS applicant consider would be detrimental to their mental or physical well-being.



About Mental Health Australia

Mental Health Australia is the national, independent peak body for the mental health sector. We unite the voices of the mental health sector and advocate for policies that improve mental health. Mental Health Australia represents 160 members, including organisations representing people with lived experience of mental health challenges, family, carers and kin, service providers, professional bodies, researchers and state and territory peak bodies.

This submission was developed through a webinar consultation and targeted engagement with Mental Health Australia's Members Psychosocial Network, other members and key stakeholders.

Introduction

Mental Health Australia (MHA) welcomes the opportunity to contribute to the Australian Government Department of Health, Disability and Ageing's consultation on NDIS Access. We recognise the stated intent of these reforms to "improve the consistency, transparency and fairness of access decisions", making "a clearer, more objective and evidence-based approach to determining access" that is "easier to understand and navigate for people with disability, their families and carers."ⁱ We also recognise the Government's intent through these reforms to ensure the long-term sustainability of the NDIS. This submission responds to the [consultation paper](#) outlining a high-level architecture for developing and implementing a new and standardised assessment approach to NDIS access.

Since inception of the NDIS, MHA has actively contributed to national policy development and implementation to improve equity and outcomes for people with psychosocial disability needing ongoing support through the Scheme. In our submissionⁱⁱ to the Senate Community Affairs Legislation Committee in June, we raised a number of concerns on the provisions of the NDIS Amendment (Securing the NDIS for Future Generations) Bill 2026. We argued caution about proceeding on some issues until further consultation was undertaken and alternative support arrangements in place.

Following passage of this legislation – with some important amendments – the Government is now seeking feedback on high-level design and principles for a new NDIS access system. This submission addresses the questions asked in the consultation paper and outlines MHA's views on key areas related to psychosocial disability that need to be considered in the design and implementation of a new and standardised NDIS access approach.

MHA has advocated for many years that the current access process is not working fairly for people with psychosocial disability. People with psychosocial disability have been disproportionately disadvantaged because of weaknesses in the current assessment process in understanding psychosocial disability, including difficulties in demonstrating or confirming permanence or likelihood of permanenceⁱⁱⁱ. MHA welcomes the Australian Government's recognition through the consultation paper of the weaknesses in the current system and commitment to a fairer, equitable and consistent approach.

The new standardised and consistent NDIS access assessment process must be inclusive of the particular requirements of people with psychosocial disability and their families, carers and kin. It must deliver more equitable access and not increase barriers to the NDIS for people with psychosocial disability.

This submission outlines key issues that MHA considers the Department of Health, Disability and Ageing (DHDA) and the Technical Advisory Group (TAG) need to address in the design of this new access system. These issues include:

1. What is the evidence for the validity and reliability of the proposed access approach and assessment tools for all disability cohorts and for psychosocial disability?
2. Can the new access process explain in clear, simple and understandable terms eligibility requirements for the NDIS related to psychosocial disability?
3. How will the new approach deliver a psychosocially competent assessor workforce?



There were 66,122 participants with psychosocial disability in the NDIS at June 30, 2026. These represent 8% of the total NDIS population, and 17.4% of the adult (19yo+) NDIS participant population. Past attempts by the NDIA to improve responsiveness to the particular needs of people with psychosocial disability have had little success. Our analysis as an active participant in reform advocacy, is that a major reason for this is that design focuses on the needs of the larger disability cohorts, and then the particular needs of other disability cohorts such as people with psychosocial disability are marginalised. The consultation paper offers some promise that the new access process will be more inclusive of the requirements of different disability cohorts such as psychosocial. **Standardisation cannot mean marginalisation for different disability cohorts.** MHA considers that this tension between standardisation and the more specific requirements of specific disability groups, such as psychosocial disability, needs to be carefully managed in this access design process.

A shared concern across the psychosocial disability sector is that NDIS eligibility-met rates have been declining over the last three to four years^{iv}. One in three psychosocial disability applicants met eligibility requirements in 2025-26 compared to two in three in 2022-23. At the same time, eligibility rates for other disability cohorts have remained consistent at around 8 out of 10 applicants (78%)^v. **The new access assessment system must deliver equity of access for all disability groups and address the technical issues currently resulting in such inequities in access. The new NDIS access process should not result in reduction in the number of people with psychosocial disability in the Scheme.**

MHA appreciates that the technical issues in this design process are complex. We repeat our position that the involvement of people with lived experience of psychosocial disability, their families, carers and kin and service provider organisations is imperative to strengthen the design and implementation process.

MHA recognises the important work of the Technical Advisory Group (TAG) in the analysis of the evidence base and the technical aspects of the design of the new access process. We welcome the inclusion of psychosocial expertise on the TAG, and encourage further engagement from the Australian Government and TAG with people with lived experience of psychosocial disability; families, carers and kin; service providers and researchers.



Response to Consultation Questions

Question 1. Do the draft guiding principles provide the right foundation for a future NDIS access process?

MHA supports the seven proposed principles as sound guiding principles for the access design process. We recommend additions to one principle and changes to two others, highlighting some inconsistencies in the drafting across the seven principles.

#	PRINCIPLE	SUPPORTED	RATIONALE
1	Aligned to NDIS Act and human rights of people with disability		Respectful of human rights and compliant with UN Convention on the Rights of People with Disabilities
2	Informed by lived experience including people with disabilities, families and carers		The lived experience of people with disability and their families, carers and kin is fundamental to improving the design process and reducing implementation challenges.
3	Evidence-based and consistent	 <i>suggested changes</i>	Use of research and lived-experience evidence will be critical to the validity and reliability of the processes and tools developed, and build support for the fairness of the new process. MHA notes the government's position that the design and implementation process will be responsive to the diverse disability cohorts in the Scheme. This is a critical element of this principle. The transparency of the evidence in the design of the standardised assessment approach will be a critical acceptance and success factor.
4	Person-centred and strengths based		Important principle of contemporary disability policy
5	Equitable, inclusive and safe	 <i>suggested changes</i>	Requirements of the new system



6	Transparent, proportionate and accessible	 <i>suggested changes</i>	Transparency could drive clearer understanding of who is eligible, why and required evidence. Highlights the need for supports in the access assessment process and the need for appropriate adjustments.
7	Continuous quality improvement		Recognition that settings will evolve and the importance of ongoing feedback and codesign in continuous improvement.

Question 2. Should any principles be added, removed or changed?

Additions

Element to be added to Principle 6

MHA recommends that a further element be included in Principle 6 around supported decision making – which is not yet appropriately covered in the existing Principles.

Supported decision making is an embedded practice in disability services and should be an explicit expectation of the new access process. It is a process where an individual receives help, information and communication tools they need from trusted supporters to make their own choices, rather than have someone else decide for them.^{vi} Supported decision making is different from substituted decision making such as a guardianship. A supporter does not take on legal capacity but acts an adviser.

Experience in the psychosocial disability and mental health sectors is that many people considering applying for the NDIS and those who are participants need assistance in understanding information, making informed choices and with appeals processes. The lack of information and clarity on eligibility, inequities in the lack of assistance with the application form and evidence preparation, and the need for support and advice through the assessment process, are well recognised ^{vii}. The inclusion of supported decision making as a principle would support explicit processes that would help meet the criteria of equity, fairness and consistency. It would equalise assistance in the access process between those who have informal supports to assist and those who don't, and contribute to the removal of the current “post-code lottery” in the NDIS access processes.

Many people with severe mental health challenges or psychosocial disability experience legal capacity and vulnerability issues when they are unwell. This new element would highlight the need to support applicants' decision-making capacities, where they consider they need such support.

Recommendation 1: MHA recommends a further element around supported decision making be added to Principle 6, recognising the importance of this practice for an equitable, fair and consistent approach.



Principles to be changed

Principle 3: Evidence-based and consistent

The explanation of Principle 3 assumes that contemporary evidence will confirm a reliable and valid method of assessment suitable across diverse disability cohorts. It assumes a positive outcome from an evaluation of the available evidence, to justify a standardised approach across all disability cohorts. MHA supports the need for the new access process to be evidence-informed, and awaits TAG's advice on whether the available evidence can demonstrate an approach that has validity and reliability for all disability cohorts.

This principle needs to allow for accommodations to a standardised eligibility assessment approach IF the evidence does not indicate that a standardised assessment process will be responsive to the needs of a particular disability cohort. MHA requests that TAG and DHDA provides their evidence for validity and reliability for assessment of functional capacity of people with psychosocial disability, if government is to rely on a standardised assessment process.

MHA members have feedback that there are a variety of assessment tools that can assess psychosocial functional capacity. They are not aware of a standardised assessment tool that has validity and reliability across all disability cohorts. A number of MHA members have used tools based on the WHO International Classification of Function (ICF).^{viii} MHA supports the use of the ICF as a well-tested and reliable conceptual framework and common language for the assessment of functioning. It offers a comprehensive, biopsychosocial framework for understanding disability as an interaction between health conditions, personal factors and environmental influences^{ix}. However, the ICF is not an assessment tool. Use of assessment and strengths-based tools such as WHODAS v2, I-CAN v6 and LSP 16 have been used in the NDIS assessment for a number of years. Each have their own strengths and weaknesses and variations for reliability for different disability cohorts.

MHA looks to the TAG to thoroughly examine the evidence on validity and reliability of possible tools across all disability cohorts. We encourage TAG to look specifically at the evidence of reliability and validity for possible assessment tools from a psychosocial disability perspective.

Recommendation 2: MHA recommends that the following sentence be added at the end of the explanation of principle 3: "If the evidence does not find that a standardised approach to eligibility assessment is valid and reliable for particular disability cohorts, consideration will be given to accommodations to the standardised approach to ensure validity and reliability for these cohorts".

Principle 4: Person-centred and strengths-based

MHA strongly supports the meaningful participation of people with disability and families, carers, kin, advocates and supporters proposed in this principle. We note that this wording is stronger than the "informed by" wording in principle 2.

MHA members' feedback is that one of the major gaps in the evidence on eligibility assessment processes is understanding of the lived experiences of people with psychosocial disability and their families, carers and kin. MHA recommends that the access design process should include meaningful participation of people with lived experience of psychosocial disability and their family, carers and kin. In addition, DHDA should fund studies into the eligibility assessment experience of people with psychosocial disability and their families, carers and kin pre and post implementation of NDIS access changes, as a component of meaningful engagement in the ongoing reform process.



Recommendation 3: MHA recommends that the access design process should include meaningful participation by people with lived experience of psychosocial disability and their family, carers and kin.

Principle 5. Equitable, inclusive and safe

MHA recommends that the wording in principle 5 needs to be more consistent with the wording in Principle 4 and the NDIS Act, to provide appropriate recognition of personal circumstances.

MHA notes that in attempting to articulate an equitable approach, principle 5 includes an unqualified exclusion of personal characteristics provided for in section 9B (1) (b) of the National Disability Insurance Scheme Amendment Act 2026 (The Act). Principle 5 excludes disability type, age, gender, cultural background, location or other personal characteristics on grounds of consistency. It indicates a total exclusion of these factors for the access decision making process. However, the final provisions of the NDIS Amendment Act 2026, provides a more qualified position on the exclusion of personal circumstances. Section 9B(1) (b) of the Act states, “A person’s functional capacity, in relation to an activity, is the person’s ability to undertake the activity, in a context that excludes, *as far as possible*, the impact of a person’s environmental and personal circumstances” [emphasis added]. This wording of “as far as possible” recognises some qualifications on personal circumstances, and should be included in Principle 5.

This would also be more consistent with Principle 4 that acknowledges the need to recognise individual circumstances. Principle 4 recognises individual circumstances in the understanding of the functional impact of disability: “while recognising strengths, capabilities and individual circumstances”.

MHA highlighted the importance of considering individual circumstances in assessing functional capacity in our submission to the Senate Community Affairs Legislation Committee on the NDIS Amendment Bill 2026.^x We recommended amendment of section 9B(1)(b) which refers to the exclusion of the impact of personal and environmental circumstances in considering a person’s functional capacity. The consideration of personal and environmental circumstances is essential for an assessment of functional capacity related to psychosocial disability and consistent with the ICF framework.

Feedback from MHA members is that total exclusion of personal characteristics will constrain the reliability and accuracy of assessors’ judgements. Disability type, age, cultural background, geographic location, family, carer and kin support context and other personal characteristics continue to be important elements in the determination of eligibility. The access assessment process should consider this flexibility in the consideration of personal characteristics, given the significance of such characteristics for people with psychosocial disability.

In their review of evidence for the validity and reliability of assessment processes, DHDA and TAG will need to consider the operationalisation of the definition of functional capacity in the NDIS Act, which recognises it is not possible to totally exclude personal circumstances. The new approach must be informed by this evidence and not disadvantage applicants due to the nature of psychosocial disability. Transparency about the outcomes of this evidence review will be important to the validity and reliability of the new assessment process for participants with psychosocial disability, and the overall fairness of the new approach.

The wording in principle 5 needs to be more consistent with s 9B (1) (b) of the Act and include “as far as possible”, recognising that personal circumstances cannot be fully excluded from a fair assessment process. It should also be more in line with the wording in Principle 4 around “recognising individual circumstances”.



Recommendation 4: MHA recommends that the wording in Principle 5 be more consistent with the recognition of personal circumstances in Principle 4 and the NDIS Amendment Act, and “in delivering consistent outcomes regardless of personal characteristics” should further stipulate “as far as possible”.

Recommendation 5: MHA recommends that TAG and DHDA review the evidence for the validity and reliability of assessment processes that exclude considerations of personal and environmental circumstances, and consider the extent to which personal circumstances must be considered in a robust and fair assessment process. This is line with the NDIS Amendment Act definition of functional capacity that excludes environmental and personal circumstances “as far as possible”.

The emphasis on cultural safety, psychological safety and trauma-informed practice in this principle is strongly supported.

Principle 7. Continuous quality improvement

MHA supports this principle. Continuous quality improvement is critical given the reality that the early versions of a standardised assessment process and assessment tools selected are likely to have limitations. The principle of continuous quality improvement provides for a developmental approach that builds on the analysis of strengths and weaknesses of emerging versions of the assessment process. It also recognises that continuous quality improvement will be improved by meaningful participation and feedback from people being assessed and their families, carers and kin. The principle commits the access decision-making process to ongoing monitoring, evaluation and continuous improvement. Data analysis, stakeholder feedback and implementation experience should be used to strengthen assessment approaches, workforce capability and decision-making quality over time.

A commitment to continuous improvement is a practical, realistic and sensible principle that acknowledges the intention to develop the assessment process over time to improve its utility and efficacy. On-going review, evaluation and changes to assessment practices will be critical to evolving the standardised assessment process to a more mature state than the first version.

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

MHA considers that DHDA need to address the following issues in designing the access decision-making process.

a) What is the evidence for the validity and reliability of selected assessment tools for all disability cohorts and for psychosocial disability.

A key factor the government must consider is the evidence of validity and reliability of selected assessment tools. MHA assumes the TAG will undertake an analysis of this evidence for all disability cohorts including psychosocial disability, and provide advice to DHDA on their assessment of this evidence. Their evaluation should be made public on transparency grounds.

MHA’s consultation with members identified that organisations are using a range of assessment tools for assessing functional capacity for people with disabilities. There is general support for the use of the ICF for classifying and naming functional capacities and incapacities. Members recognise the merits of this



international framework as it is the only universal (all disabilities) framework for a new design process. However, the ICF is a conceptual framework not an assessment process. A key issue will be the validity and reliability of the assessment tools that will be adopted for the access design process.

Members have provided feedback on operational limitations in WHODAS v2 and I-CANv6 assessment tools. WHODAS v2 has been an approved NDIS assessment tool for a number of years. Members feedback is that there are limitations with WHODAS v2 and I-CAN v6 tools in assessing people with psychosocial disability.

MHA and its members are not aware of a universal assessment tool for all disability cohorts that has been tested with people with psychosocial disability. We are open to such a tool, but the tool needs to be named and transparently evaluated by the TAG.

Recommendation 6: MHA recommends that the Technical Advisory Groups' analysis of the evidence of the validity and reliability of standardised assessment tools should be made public on the grounds of transparency, to support public trust and accountability for the new approach to access assessment.

b) The proportion of people who require psychosocial supports who should be supported through the NDIS

This is a fundamental consideration in designing an access process that is fair and disability informed, that is inherently related to the challenge above regarding validity and reliability of a universal assessment tool. The setting of a fair and appropriate eligibility threshold to determine the proportion of people who will receive supports through the NDIS has been an ongoing system issue, including for people with psychosocial disability.

To date, a population-norm based approach has been considered the most sensible and contemporary methodology for determining the target number of participants with psychosocial disability supported through the NDIS. There are two approaches that have been used determining the Australian population of people with a severe mental illness requiring psychosocial supports. The first is the historical methodology used by the Productivity Commission in its 2011, 2017 and 2020 reports on the NDIS and adopted by the NDIA^{xi}. This approach identified an estimated number of psychosocial participants, based on the 2003 Survey of Disability, Ageing and Carers (SDAC) and advice from a small group of mental health experts. The Productivity Commission in 2011 projected that there would be 57,800 participants with primary psychosocial disability in the Scheme at full roll out. This figure was subsequently adjusted by the NDIA for population growth, to an estimated number 65,000. The Productivity Commission Inquiries in 2017 and 2020 confirmed 65,000 as the estimated number of participants with psychosocial disability.

The second approach is the methodology used in the Analysis of Unmet Need for Psychosocial Supports Outside the NDIS, commissioned by the Commonwealth and State and Territory Governments^{xii}. Using the National Mental Health Service Planning Framework, this analysis estimated the Australian population of people all ages with severe mental illness requiring psychosocial supports was 398,000. DHDA and all state and territory governments have been involved in the development of these projections, which provides the only contemporary estimation of the Australian population norm for people with severe mental illness and psychosocial support need.

More specifically, there is a large national data base on the functional capacities of people experiencing significant and ongoing mental ill-health that is used as part of the Australian Mental Health Care Classification System^{xiii}. All public mental health services now collect functional capacity data on a regular basis through the standard use of the LSP16 screening tool. Information from this tool is used to classify categories of episodes of care needs and levels of funding. This is the largest Australian data base on



population-based psychosocial functional capacities. It could be a significant reference point for DHDA and TAG.

As at 30 June 2026, there were 66,122 people in the NDIS with primary psychosocial disability.^{xiv} This number of participants represents 17% of the estimated 398,000 Australians with severe mental illness who require psychosocial supports. All Australians with severe mental health challenges who need psychosocial supports should be able to get the supports they need. The access design issue for government is what proportion of those Australians with severe mental illness who require psychosocial supports should be supported through the NDIS, and by implication the proportion which should be supported through non-NDIS psychosocial supports. The issue is also the respective responsibilities of the commonwealth and state and territory governments in the provision of psychosocial disability support services in Australia.

Changes to the NDIS access process are occurring in the context of negotiations between the Commonwealth and state and territory governments on foundational supports. Changes to NDIS eligibility should not be implemented before appropriate foundational supports are established outside the Scheme – including for people with psychosocial disability. Availability of these supports outside the NDIS for people with psychosocial support needs is a relevant factor in determining access to supports through the NDIS as well as technical access considerations. These policy and financial issues are important context for DHDA's consideration of access criteria and thresholds to determine eligibility for the NDIS for people with psychosocial disability.

Further, MHA strongly asserts that the new NDIS access review process should not result in a reduction in the number of people with psychosocial disability in the Scheme. People with psychosocial disability have already faced disproportionate challenges in accessing the NDIS compared to other disability cohorts. The sector will continue to monitor access rates for people with psychosocial disability and hold government to account - comparing access rates before and after transition to the new access approach, and against the population level of need for supports identified through the Analysis of Unmet Need for Psychosocial Support.

c) Clear, simple and understandable information on access process, eligibility and evidence requirements

The NDIS Independent Review Panel in its report^{xv} noted the broad confusion about eligibility requirements, lack of information and inconsistent assessment practices.

The new Act and the Explanatory Memorandum makes a number of technical qualifications about appropriate treatments that help clarify expectations. However, they are difficult to find and unlikely to be known by the people with psychosocial support needs considering applying for the NDIS on grounds of psychosocial disability. For example, sections 25A (4) and 25A (5) provide for a rule making power to capture circumstances where it may be inappropriate to determine there are treatment options available for some classes of participants or classes of impairments. In addition the Explanatory Memorandum provides an example that this may include types of treatment options for people with psychosocial disability^{xvi}. Note 2 under proposed subsection 25 (1B), explains that a person may require on-going treatment for some permanent impairments to maintain functional capacity, even if a person has undertaken all appropriate treatment^{xvii}.

A key objective for the new access design process should be that clear, simple and understandable information, about the access process, eligibility and evidence requirements. Simple, clear and accessible language should be used to explain all aspects of the assessment process. MHA encourages DHDA to involve people with lived experience of psychosocial disability and their families, carers and kin in the drafting of this information and testing it with potential users. Clear, simple and understandable information on access process, eligibility and evidence requirements should be a key consideration in the access design process.



d) How will the new approach deliver a psychosocially competent assessor workforce?

MHA has advocated improved psychosocial disability competencies in the NDIS for many years. It has highlighted in its representations the inconsistent judgements of assessors, their lack of knowledge of severe mental illness and psychosocial disability and the need for training and minimum assessor competency levels. MHA members have reinforced through numerous consultations and representations, the need for improved psychosocial assessor competencies.

MHA members have identified a range of minimum competencies that assessors working with people with psychosocial disability should have. These include:

- Workforce with specialised psychosocial assessment rather than generalist assessment competencies.
- Knowledge of and experience of severe mental illness and psychosocial disability including a minimum number of years working with people with psychosocial disability.
- A relational approach where assessment practice skills are necessary to build rapid trust with applicants, reducing psychosocial stress in the assessment interview and building skills in the assessment of levels of functioning.
- Strong understanding of psychosocial disability and functioning over-time and draw on lived and family and carer experience to build this understanding, rather than solely relying on what they observe at an assessment interview.
- Competent in trauma informed practice and understanding of intersectionality.
- Understanding of the nature and impact of stigma, how this may affect an applicant in an assessment interview situation.
- Understanding of recovery-oriented practice that respond to and support emotional needs of participants during the assessment process.
- Understanding of the psychosocial eco-system, external to NDIS.
- Be able to identify the fluctuating nature of people's support needs from building an understanding of their history of using supports.
- Ability to use and triangulate additional sources of information at the point of access assessment, including the person's self-report, carers report, previous assessment reports.
- Recovery orientation and a focus on social inclusion and social determinants.
- Family and carer/supporter sensitive.

MHA considers that a minimum requirement for a consistent and fair access assessment process is a specialised pool of trained and psychosocial competent assessors.

Recommendation 7: MHA recommends that a pool of assessors with minimum psychosocial competencies is established and all applicants on ground of psychosocial disability are required to be assessed by an assessor with these minimum competencies.



Question 4a: How could the access decision-making process, including referral pathways, be designed to reduce administrative burden and make it easier and more equitable for people with disability, their families and carers to understand what information is needed and how decisions are made?

A key factor in making NDIS access more equitable for people with psychosocial disability is the establishment of appropriate psychosocial supports outside the Scheme. Administrative burden could be reduced if there were clear expectations on non-NDIS supports about explaining the new access process to the people they support, providing more standardised background information to the NDIA (with participant approval) and using more consistent screening tools for functional capacity. The administrative burden that falls on people with psychosocial disability and their families, carers and kin could be reduced by better information sharing and co-ordinating between the non-NDIS support system and the NDIS support system.

MHA members identified that the following ideas to reduce administrative burden and make it easier and more equitable.

1. **Stages:** Recognition of three stages in the access process and the need for the design process to build a response for each stage: Pre-access (thinking about applying); access application and interview stage; and post eligibility stage with different pathways for those who meet and do not meet eligibility requirements.
2. **No Exits without supports:** An equitable process should not allow for exiting from the Scheme without alternative supports and ineligible applicants should be supported to find alternative psychosocial supports. The new design process needs to determine eligibility but also work with those who are NDIS ineligible to source alternative supports. The access process should facilitate referral to alternative psychosocial supports.
3. **Part of broader psychosocial support systems:** MHA members and MHA strongly support the new access process being designed as part of the broader eco-systems of psychosocial supports. Referral pathways in and out of NDIS and non-NDIS supports should be included in the design process.
4. **Inclusion of families, carers and kin** in the design of and in the access assessment process. Families, carers and kin play very significant roles in the provision of informal support. They are also able to provide important historical information and assist assessors in understanding support needs when there are capacity or insight issues.

Question 4b: How could this support a proportionate approach to minimise the assessment burden on persons who are clearly eligible with very significant functional impairment?

Psychosocial disability is often described as an invisible disability, and evidence of psychosocial disability is more difficult to assess than other disabilities on the current NDIS lists. Eligibility for psychosocial disability is more difficult to assess than disabilities on the current lists.



Options to reduce the burden both for people with psychosocial disability applying for the NDIS and the NDIA could include:

- Consideration of participation in non-NDIS recovery-oriented psychosocial support services or psychiatric rehabilitation services for an extended period of time as indication of psychosocial disability that is permanent or likely to be permanent, and need for ongoing support. Specification of time period guidelines that applicants need to have participated in other recovery-oriented psychosocial support services or psychiatric rehabilitation services would provide applicants with some indication of NDIS expectations. It could also provide clearer guidance on what exhausting psychosocial treatments meant in specific time terms.
- More standardised reports from non-NDIS psychosocial and mental health service providers of the time period in which the applicant has participated in psychosocial recovery and psychiatric rehabilitation programs.
- Establishing referral pathways between NDIS and other psychosocial support providers including data sharing arrangements, more consistent language and processes for referrals in and out of both systems.
- A program of active engagement for “hard to reach” people with severe psychosocial disability – building on findings from the NDIS National Community Connector Program for people with psychosocial disability experiencing or at risk of homelessness.^{xviii}
- Funding of supported decision making to support equitable participation in the access process.
- Inclusion in the access assessment process for reports from applicants, family, carer and kin, existing service providers and health professionals on information they consider relevant to the access assessment process. This should include reports about the level and types of support provided by family, carers and kin.

Question 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?

There is considerable confusion about the evidence required to determine permanency or likelihood of permanency of psychosocial disability for NDIS access purposes. While clarifying some areas, the provisions of the Act and some of the notes of the Explanatory Memorandum create new questions that will require clarification as part of the new access design approach. MHA continues to have major concerns about the evidence requirements to demonstrate psychosocial permanence or likelihood of permanence. These issues are outlined in this section.

Appropriately defining psychosocial disability and psychosocial supports

The NDIS Act 2013 contains no definition of psychosocial disability. Sections 24 and 25 refer to impairments related to psychosocial disability. However, it provides no further guidance about the scope of this term for assessment purposes. To address this lack of a definition, the access approach needs a working definition that reflects the recognised elements of psychosocial supports in Australia. The design process will be hampered by this lack of definition and this may increase requests for eligibility decisions reviews. It is also reasonable given the consultation paper’s commitment to transparency that such elements are made public.



MHA considers that the new assessment process must develop a working definition of psychosocial disability and psychosocial supports that is consistent with the NDIS Amendment Act 2026. It considers that the definition of psychosocial support services developed by commonwealth and state and territory officials for use in the Analysis of Unmet Psychosocial Needs in 2024 is a suitable working definition.

This definition defines psychosocial supports as “non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community. These supports assist people with mental illness to:

- Manage daily living skills
- Obtain and maintain housing
- Identify client needs for other services, connect with and maintain engagement with these services
- Socialise, build and maintain relationships
- Engage and maintain engagement with appropriate education (including vocational skills) and employment opportunities.”^{xix}

This definition is now widely accepted for non-NDIS psychosocial supports. It classifies and allows quantification of the psychosocial supports funded through the Commonwealth Psychosocial Support Program and state and territory governments psychosocial programs. More significantly, these programs are the psychosocial “treatments” provided by the public mental health systems in Australia. They are the programs that people with severe and moderate psychosocial disability “exhaust” before they decide to apply for the NDIS because they need additional support.

Defining appropriate ‘treatments’ related to psychosocial disability

Historically and currently the NDIA has relied upon the professional judgement of psychiatrists, doctors and allied health professionals attesting that an applicant has exhausted appropriate mental health treatment. This reflected the definition of psychosocial disability in the Act, which was defined as an impairment associated with a psychiatric condition. The provisions in s24 and s25 were changed in amendment to the Act in 2023 to replace ‘associated with a psychiatric condition’ to ‘related to a psychosocial impairment’. Given this change, the treatments a person must have exhausted before applying to the NDIS for psychosocial disability should be the known psychosocial support services provided by governments and not mental health treatments. The evidence needed to prove permanence should be evidence of the likelihood of permanence of psychosocial disability and permanence of severe mental illness.

If DHDA decides to continue to require evidence of permanence of mental illness, the following issues need to be addressed:

1. The approved public mental health treatments that need to be exhausted to prove permanency need to be specified in NDIS Rules on Becoming a Participant.
2. The Rules need exemptions to allow for mental health treatments that are not provided in particular States and Territories, given the variation in mental health treatments across jurisdictions.
3. The Rules need to specify whether Medicare subsidised mental health treatments provided by psychiatrists, doctors and allied health professionals are included in the definition of public mental health services. Consideration needs to be given to the situation where a person cannot demonstrate that they have exhausted a particular mental health treatment because they could not afford to co-payment under Medicare arrangements or the travel costs to travel to where such treatments are available in their state or territory. Such co-payment requirements would not meet the fair and equitable criteria set in the principles in the consultation papers.



4. Protections against coercion of applicants to undertake treatments they consider would be harmful to their mental or physical well-being, in order to 'exhaust all appropriate treatments'. In MHA's consultation workshop and engagement with other stakeholders, major concerns were expressed about the risk of coercion that applicants may experience to exhaust specific treatments that the NDIS require, which the applicant considers would be detrimental to either their mental or physical wellbeing.
5. Clarification of how the new access process would manage situations where an applicant sought to get a particular treatment but the waiting list in their region is years long. MHA members commented that it is unfair and inequitable if participants are penalised because the public mental health system is not resourced to deliver these treatments in a timely manner.
6. The level of access to mental health treatments is lower in rural and remote areas. Similarly, MHA members commented that applicants should not be disadvantaged because of delivery gaps in treatments due to inadequate mental health funding. They identified this would not meet the fairness and equity principles in the consultation paper.

MHA members offered these additional suggestions on factors and evidence that would improve and simplify the evidentiary requirements:

- DHDA specify in the revised Becoming a Participant Rule, the period of time that approved treatments need to have been tried, before they are considered to have been exhausted. This should be specified for each approved treatment.
- NDIA publish a list of approved treatments for psychosocial disability on an annual basis, including exemptions in specific states and territories, due the public mental health sector in that state not providing those treatments.
- Clarify if Medicare subsidised treatments are considered publicly funded mental health treatments for the purposes of NDIS access.
- Allow applicants, and their families, carers and kin (with applicant approval), the option to provide background information of factors that they consider should be considered in the assessment process.

Recommendation 8: MHA recommends that DHDA reviews the requirement to exhaust approved mental health treatments and consider changing this to approved psychosocial treatments.

Recommendation 9: MHA recommends that the new access process must include protections against applicant coercion in exhausting appropriate treatments an NDIS applicant consider would be detrimental to their mental or physical wellbeing.



Conclusion

MHA has advocated against the significant NDIS access disadvantage experienced by people with psychosocial disability over the past decade. This consultation provides the opportunity to contribute to the development of the new access approach that aims to provide a more equal and fair approach to NDIS access. This paper recognises that the current system is not fit for purpose and a new approach is needed.

The new access approach needs to deliver a fairer, more equitable and more transparent system than the current approach. It must deliver this equity and fairness for all disability cohorts. The new approach must not reduce the number of people with psychosocial disability in the Scheme.

Our submission provides our response to the questions raised in the consultation paper. It raises a number of technical issues and considers the nature of the evidence required to demonstrate permanence or the likelihood of permanence of functional impairment related to psychosocial disability. It argues eligibility considerations need to be viewed in the broader context of the supply of psychosocial supports across Australia. Eligibility thresholds and evidence for such thresholds needs to estimate the contribution of the NDIS in the national psychosocial eco-system.

MHA believes strongly that the quality of the new access approach will depend substantially on the level of engagement of people of all disability cohorts including lived experience of psychosocial disability, families, carers and kin, service providers and health professionals. There are gaps in the evidence base that only people with disabilities and their families, carers and kin can help fill. The experience and expertise of all disability cohorts must be included in the next phases of this access development process.

This submission outlines Mental Health Australia and our members views on the issues the Australian Government and Technical Advisory Group need to consider in the design of the new access approach. We welcome any further opportunity to facilitate contribution of sector expertise to the design of the new access approach.

The new NDIS access approach must deliver a transparent and fair system for all people with disability, including psychosocial disability.



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