Submission to the Inquiry into the Integrity of the National Disability Insurance Scheme

Consumers of Mental Health WA

April 2026

Consumers of
Mental Health WA

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1. Acknowledgement of Country

Consumers of Mental Health WA proudly acknowledge Aboriginal people as Australia's First Peoples and the Traditional Owners and Custodians of the Land and Water on which we live and work. We acknowledge Western Australia's First Nation's communities and culture and pay respect to Aboriginal Elders past, present and emerging.

We recognise that Sovereignty was never ceded and the significant and negative consequences of colonisation and dispossession on Aboriginal communities.

Despite the far-reaching and long-lasting impacts of colonisation on First Nations communities, Aboriginal people remain resilient and continue to retain a strong connection to culture. We acknowledge the strong connection of First Nations Peoples to Country, culture and community, and the centrality of this to positive mental health and wellbeing.

2. Preamble

2.1 About the Respondents

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress). We are a not-for-profit, systemic advocacy organisation independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

2.2 Request for Feedback

CoMHWA works to uphold the dignity and human rights of consumers, through providing advocacy in leading change with and for consumers. We appreciate notification of the outcomes of our submission to this consultation in order to understand and communicate the difference made through our work.

Please provide feedback via the contact details on this submission's cover page.

2.3 Language

CoMHWA uses the term mental health 'consumer' throughout this submission. Mental health consumers to refer to people who identify as having a past or present lived experience of psychological and emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include "peer", "survivor", "person with a lived experience" and "expert by experience".

This definition is based on consumers' call for respect, dignity and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

CoMHWA endorses the Indigenous Australian Lived Experience Centre's (IALEC) universal definition of lived experience for First Nation communities:

A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.

People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples' ways of understanding social and emotional wellbeing.

This definition recognises that there are fundamental differences to how Aboriginal and Torres Strait Islander people experience and define mental health challenges and suicide compared to mainstream definitions.

2.4 About the consultation

Reproduced from the Joint Standing Committee on the National Disability Insurance Scheme's Inquiry webpage:

Date referred: 25 March 2026

Submissions close: 24 April 2026

Reporting date: 02 July 2026

Terms of Reference:

The Joint Standing Committee on the National Disability Insurance Scheme will inquire into and report on:

1. *the nature and extent of non-compliance, including fraud and sharp practices, in the National Disability Insurance Scheme;*
2. *the impacts of non-compliance on NDIS participants and their families;*
3. *the effectiveness and adequacy of successive government policies to improve scheme integrity, safeguard participants, and tackle non-compliance; and*
4. *any legislative or other reforms required to strengthen scheme integrity.*

3. Introduction

CoMHWA welcomes the opportunity to provide feedback to The Joint Standing Committee on the National Disability Insurance Scheme concerning the integrity of the NDIS. As the peak body in WA for mental health consumers, we focus in this submission on providing feedback informed by the experiences of consumers and of NDIS participants with psychosocial disability.

Participants commonly encounter provider non-compliance, which can impact them in a variety of negative ways: producing intense distress, compromising their choice and control, and undermining their ability to access supports they need. Policies to address non-compliance in the NDIS have typically taken the approach of increasing top-down regulatory authority and oversight and increasing penalties for non-compliance. They have neglected other mechanisms such as increasing natural safeguards and involving participants as co-regulators. Successive reform in this area should focus on co-design with participants, engaging participants in regulatory and safeguarding approaches, and seeking to increase participant autonomy, choice, and control.

We base our submission on:

- One to one discussions with consumers who are accessing NDIS for psychosocial disability supports or who are in the process of seeking NDIS access.
- Ongoing consultation with CoMHWA's consumer reference and advisory groups, including our NDIS reference group whose membership comprises NDIS participants with psychosocial disability.
- Ongoing data collection and input from CoMHWA's Individual Advocacy and Peer Pathways (service navigation) programs.
- Ongoing consultation with consumers in Western Australia on joint priorities for an improved mental health system.
- Consumer representation in relevant settings, including but not limited to: Primary Health networks (WAPHA), WA regional equivalents of the Local Health Networks (regional mental health services under the WA Health Board structure), the Mental Health Commission and the health complaints agency, Health and Disability Services Complaints Office (HaDSCO).

This submission addresses the Terms of Reference of the Inquiry under relevant subheadings.

4. Discussion

4.1 Non-compliance in the National Disability Insurance Scheme and its impact on NDIS participants with psychosocial disability

Most NDIS participants CoMHWA has spoken with have, over the course of their time accessing the NDIS, encountered provider and worker non-compliance. Non-compliance appears to be widespread. Equally widespread are participant experiences of harm and distress as a consequence of non-compliance. The rhetoric around non-compliance and fraud often places pressure on participants themselves, who say that they often feel as though they are blamed and that they will suffer negative consequences when providers do something wrong.

Types of provider non-compliance participants have experienced include:

Improper charges/use of participant funding

This common type of non-compliance often takes the form of:

- Charging for support that was not delivered. One participant had an experience of a provider recently cancelling an appointment with her last minute but charging her nevertheless.
- Overcharging for supports. Participants have noticed that some providers have charged more for NDIS supports than for comparable supports outside of the NDIS. Recently, increasing fuel costs have led some providers to attempt to charge more for travel or supports that involve them needing to travel, in contravention of NDIS rules governing what they can charge. Some participants also spoke about the experiences of raising an issue with overcharging but never having the provider remedy the issue/credit funds back to them.
- Participants being told they have to pay a ‘gap fee’ over and above what the NDIS will fund to purchase a support.
- Providers using up participants’ funding, leaving them without support later on.

The impact of these types of non-compliance are negative effects on participants’ budget and plan, which is a cause of distress. It means they don’t have access to funds they are meant to have to purchase needed supports, and they have concerns about what this will mean for them around their next plan review, and how it might impact future plans and budgets. They also carry anxieties that they will be blamed for the activities of the providers/workers and either financially penalised or that restrictions to their funding or their ability to manage their funding will be imposed.

Misrepresentation of provider/worker capability and expertise

Participants can encounter providers who do not have the training, experience or expertise they advertised. It is challenging to find providers who have particular expertise and experience working with people with psychosocial disability, but that experience is highly prized by participants. Many participants have engaged providers who claim to have proficiency in relation to working with people with psychosocial disability only to discover that such claims are exaggerated or untrue.

One participant noted that agencies can sometimes send workers that don't have the training/capabilities desired, despite the participant flagging their need for this kind of support ahead of time. Another participant told us about her experiences with agencies offering high-intensity support services employing people without advanced qualifications and providing no training to enable quality provision of high intensity supports. This participant has had poor experiences of support, including coercion, as a result. Another participant explained that because she has had plans with larger budgets, her experience is that some providers have misrepresented their capabilities and approach so that she will engage them to provide supports. As a result, she received poor quality support, which has caused enduring harm.

Conflicts of interest

Participants have experiences of support coordinators linking participants to support workers who are employed by the same overarching provider the coordinator is with. This has the effect of constraining choice, prioritising profits over participant's ability to control their supports and make an informed choice about the right provider for them.

Failing to work with participants and undermining participant control

Participants have also spoken of being pressured into signing documents, such as service agreements, and of documents being signed without their consent. A troubling example of this was from one participant who described having a provider prepare a positive behaviour support plan that included restrictive practices, without her input. She had not seen her plan prior to its implementation, despite a declaration on the plan that it was prepared with her. This was made worse by the many inaccuracies she noticed within her plan, which incorrectly described her mental health experiences, her goals, and her preferences.

Improper record keeping and mishandling of participant information

Participants have told us of providers either not recording information, or recording incorrect information, on their files. This impacts participants' ability to get support in line with their needs, and can create issues and complications around their plans and access to supports in future.

Some providers are inappropriately accessing or sharing private and confidential participant information. One participant recounted that she once had a provider disclose to her details of support provided to another participant, including personal details of that participant's life and support needs. The participant told us how this led her to feel concerned about whether her own information was being shared by the provider without her knowledge or consent. Troublingly, CoMHWA has heard from participants who have had negative experiences with providers who have accessed their personal information to make unwanted contact.

4.1.1 The impact of the fear of accidental non-compliance on participants

Complicated rules and legislative frameworks governing the NDIS make it challenging to understand what is and is not compliant, leaving participants perpetually in fear of accidentally doing something wrong. This is linked to the way participants say the Scheme makes them 'prove their disability' over and over again, as participants feel that they are constantly under suspicion of defrauding the Scheme. Participants feel their place in the NDIS is precarious. These feelings are shared by many participants with diverse experiences of disability.[1] For participants with psychosocial disability, however, the feeling of precariousness is amplified by social stigma about mental health challenges, and the fact that psychosocial disability can be a hidden disability. Both factors play into harmful views that psychosocial disability is not a 'real' disability and therefore should not qualify for NDIS access and support.

Changes in definitions of NDIS supports, including the introduction of lists of NDIS supports and non-NDIS supports have increased fears of non-compliance by making it more challenging for participants to understand the supports on which they can use their funding. Lists were meant to make this clearer, but feedback CoMHWA has heard indicates these have not worked as envisioned, with participants recounting more confusion than ever around NDIS supports. Participants describe being placed in a challenging no-win position where they are reluctant to spend all of their funding despite their need for supports, because they have no sense of surety about what they can purchase. This stress is compounded by their acute awareness that underspending of their budget is viewed unfavourably when it comes to plan reviews, and may result in funding reductions.

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[1] Brown, M., D'Cruz, K., Oliver, S., Winkler, D. & Douglas, J. (2025). Understanding the NDIS experience: a qualitative study on participant perspectives. *Brain Impairment* 26, IB24103. https://doi.org/10.1071/IB24103

4.2 The effectiveness and adequacy of successive government policies to improve Scheme integrity, safeguard participants, and tackle non-compliance

While there are some changes resulting from policies to improve Scheme integrity, safeguard participants, and tackle non-compliance that have been positive for some participants, overall, the adequacy of government policies is compromised by two key factors:

1. the overall paternalistic approach of such policies that does not seek to maximise participant autonomy, control, choice and rights, and
2. understanding integrity and safeguarding primarily in terms of how they can be mechanisms for limiting the costs of the Scheme. It is too early to speak to the actual impacts of the recently passed National Disability Insurance Scheme Amendment (Integrity and Safeguarding) Bill 2026, but the same issues are evident in that legislation.

4.2.1 Paternalistic safeguarding approaches

CoMHWA believes that safeguarding in the NDIS has largely reinforced and perpetuated a paradigm in which people with disability are seen through the lens of deficit, which constructs them as especially or naturally vulnerable, and as therefore in need of protection. As the final report from The Royal Commission into Violence, Neglect and Exploitation of People with Disability has documented, people with disability commonly have experiences of abuse, neglect and violence within service and support systems.[2] This is not because of any inherent vulnerability, but rather, is a consequence of ableist social relations and systems that present barriers to their full participation in society, and enjoyment of rights and dignity. Deeply unequal social and institutional power relations, such as those between NDIS participants, providers, and the NDIA itself can indeed increase the relative vulnerability of participants, something that could be described as a kind of pathogenic vulnerability (the result of “dysfunctional or abusive social relationships, socio-political oppression and injustice”).[3] It is true that within the context of such power dynamics, rules and regulations must enable protections for participants from providers who might take advantage of their power in that dynamic, compromise safety, and act in ways that are not aligned with the support that participants want.

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[2] Commonwealth of Australia Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2023). *Final Report - Volume 3, Nature and extent of violence, abuse, neglect and exploitation*. https://disability.royalcommission.gov.au/publications/final-report-volume-3-nature-and-extent-violence-abuse-neglect-and-exploitation

[3] Davy, L., Robinson, S., Idle, J., & Valentine, K. (2025). Regulating vulnerability: policy approaches for preventing violence and abuse of people with disability in Australian service provision settings. *Disability & Society*, 40(4), 1039–1060. https://doi.org/10.1080/09687599.2024.2323456

That said, safeguarding that focuses largely on regulatory compliance does not address issues of power dynamics and can therefore exacerbate pathogenic vulnerability, causing harm. A recent analysis of regulatory approaches in the NDIS described that "by focusing on service quality and compliance, the Framework and Commission perpetuate a narrative of inherent vulnerability which fails to address situational and pathogenic vulnerabilities."[4] One example of issues this can lead to in practice is the ways in which the NDIS has intersected with guardianship and administration legislation and processes in WA. CoMHWA has heard about reports from functional capacity assessments being used in Tribunal hearings around guardianship or administration to make the case that a person does not have the capacity to make decisions and exercise control over their own lives. Such reports routinely focus on deficits because of the ways in which access to supports has been structured through the demonstration of deficit and need for support across different life domains. While such reports were never intended to be used outside of the context of the NDIS, that they are used in this way indicates the ways in which NDIS processes must explore safeguarding beyond a top-down regulatory power dynamic that works to disempower participants. This also speaks to the ways in which participants with psychosocial disability encounter intersections between NDIS, mental health legislation and systems, and guardianship and administration legislation that have profound implications on their lives, rights, and access to supports. Nuanced considerations of how they are impacted by Scheme changes and policies are required and can really only be developed through engagement with participants themselves.

Participants have consistently articulated their desire to be meaningfully involved in safeguarding mechanisms, and for approaches to support and increase their autonomy and agency, rather than seeing them as passive recipients of protective regulation. The approach to Scheme integrity and safeguarding has not worked to empower participants in these ways, but has predominantly sought to increase the authority and powers of the NDIS commission and the NDIA to identify and take action to sanction non-compliance, introducing higher penalties for non-compliance. This is reflected in recent policy changes, including the NDIS (Integrity and Safeguarding) Bill 2026, which, among other things:

- Introduces duties for NDIS providers and key personnel to ensure provider compliance
- Introduces criminal offenses and increased civil penalties and for non-compliance
- Expands the NDIS Commission's powers to issue banning orders, gather information, investigate providers and take anti-promotion action.

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[4] Ibid.

An essential safeguarding consideration is to seek to empower participants, support autonomy, and thereby address the very inequalities that can lead to harm, otherwise safeguarding can inadvertently increase vulnerability.[5]

The role of NDIS participants as potential co-regulators in the NDIS is undermined by a system that focuses on compelling on-paper compliance from providers, while confining participant participation to complaints-making.[6] Even this is problematic as participants find that complaints mechanisms are not reliable or effective in enabling them to raise safeguarding or compliance issues and have these resolved. Participants have long found that raising complaints comes with a long wait before they get a response, and this sometimes feels futile because it is rare that engaging in this process results in real change.

4.2.2 Prioritisation of cost efficiency in policy

Legislative changes to the NDIS have been accompanied by rhetoric around improving the sustainability of the NDIS, understood in terms of limiting the growth in costs of the Scheme.[7] Such changes therefore appear to have cost savings as a key motivation, despite policy changes being framed as getting the Scheme 'back on track' and realigning it with its original intent. Participants feel that the NDIS has drifted further away from its initial purpose, and that this focus on financial sustainability comes at the cost of participant choice and control.[8] The participants with psychosocial disability CoMHWA has spoken with have told us that they are worse off as a result of these changes. Recent news[9] that the Government's expenditure review committee asked the Ministers of Health and the NDIS to find ways to dramatically cut cost growth in the NDIS, indicates that financial considerations will continue to be the primary motivator for NDIS legislative 'reform.' This was confirmed by Minister Mark Butler's speech at the national press club in April 2026, which made reference to a suite of changes to come aimed at reducing expenditure – including

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[5] Davy et al, 2025.

[6] Ibid.

[7] See mentions of sustainability and growth in spending in second reading speeches of recent legislative amendments in:

Commonwealth. *Parliamentary Debates*. Senate, 26 November 2025, National Disability Insurance Scheme Amendment (Integrity and Safeguarding) Bill 2025 Second Reading, Speech. (Senator Anthony Chisolm). https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansards%2F28888%2F0186%22

Commonwealth. *Parliamentary Debates*. Senate, 27 March 2024, National Disability Insurance Scheme Amendment (Getting the NDIS Back on Track No. 1) Bill 2024 Second Reading Speech. (Bill Shorten, MP). https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansardr%2F27626%2F0059%22

[8] Hummell, E., Foster, M., Burns, K., & Rimmer, S. H. (2026). Policy shifts and drifts: From intention to implementation of Australia's National Disability Insurance Scheme. Australian Journal of Public Administration, 85, 71–90. https://doi.org/10.1111/1467-8500.12689

[9] Kehoe, J. & Kinsella, L. (2026). NDIS cuts loom amid Treasury productivity push. *Financial Review Online*. https://www.afr.com/policy/economy/ndis-cuts-loom-amid-treasury-productivity-push-20260323-p5ro0g

removal of social and community participation supports.[10] This is deeply distressing for participants, who rely on those supports to live their lives.[11] Media discourse about NDIS costs in the lead up to this speech often speculated on whether savings in the NDIS could be found by transitioning people with psychosocial disability out of the Scheme,[12] and in the wake of the speech, people with psychosocial disability are left to speculate about how they might be affected by efforts to reduce numbers of participants to meet the Government's modelling projection and presumptive target of only 600 000 NDIS participants by the end of the decade. People with psychosocial disability face repeated public questioning of their right to access the NDIS and the harmful and inaccurate view that there are too many people with psychosocial disability in the NDIS.[13] In reality, there are far fewer of them in the Scheme than originally projected, and they have recently encountered reduced access to the NDIS.[14]

4.2.3 Policy reforms constraining the access, choice and control of people with psychosocial disability in the Scheme

Recent reforms have left people with psychosocial disability worse off in the NDIS. The Every Australian Counts campaign recently released findings from a survey of participants with psychosocial disability, which highlights that they "consistently link the tightening of NDIS access for people with psychosocial disability to a range of broader systemic and policy changes."[15]

A major issue in this regard was the introduction of lists defining NDIS supports that constrained, significantly, the reasonable and necessary criteria used to define NDIS supports. Plans are less able to recognise and reflect the individualised needs of participants, and supports are less aligned with individuals' needs. Upcoming changes in assessment and planning are causing worries for participants as they seem likely to introduce even more prescriptive administrative approaches to the creation of plans and budgets, rather than enhancing the capacity for planning to respond to individual needs and

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[10] Butler, The Hon. Mark. (2026, 22 April). *Minister Butler speech at the National Press Club – 22 April 2026*. https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-butler-speech-at-the-national-press-club-22-april-2026?language=en

[11] Women with Disabilities Australia. (2026, 7 April). *Statement: Our lives are not a budget problem to be solved.* https://wwda.org.au/2026/04/07/our-lives-are-not-a-budget-problem-to-be-solved/

[12] For example: Ison, S. (2026, 15 April). Mental Illness tops NDIS Reviews. *The Australian*.

[13] Threlfall, D., Paterson, K., Donnelly, S., Beasley, A., McKenzie, E. & Ballenden, N. (2025). *Access Denied: Psychosocial Disability and the NDIS.* Australian Psychosocial Alliance. https://psychosocialalliance.org.au/campaign, p. 35.

[14] Ibid, p. 36.

[15] Every Australian Counts. (2026). *"Speaking up": The voices of NDIS participants with psychosocial disability on NDIS Reform: Community Survey Report 2026*. https://everyaustraliancounts.com.au/psychosocial-disability-community-survey-report/

circumstances. Misalignment of plans with needs will contribute to underutilisation of plans and leave more participants without needed supports.

Mandatory registration

Requiring providers of some types of supports to register in order to keep providing services has enabled greater options for supports for Agency-managed participants, and increased regulatory oversight of particular kinds of supports. Yet, it is also a consequence of this policy that participant choice and control have been undermined by restricting options within the market. The ability to access unregistered providers is important to many participants who have had positive experiences with such providers, and are better able to find providers with the right expertise and who operate nearby in their area.[16]

Plan and budget management

The imposition of different forms of control over participant spending through plan management mechanisms, while a safeguarding mechanism, also restricts choice and control, especially if participants' ability to be able to manage their own plans is removed against their wishes. Under agency-managed plans, participants may only engage only with registered providers.

4.2.4 On-paper compliance at the cost of quality support

Policy changes have caused providers to prioritise compliance, but CoMHWA hears from participants that this has not been accompanied with concern for genuinely improving their experience. Participants with more complex support needs have shared that they are having a difficult time finding providers who will provide them supports as some providers are becoming more risk-averse in the wake of increased regulation and compliance pressure. This represents a safeguarding issue of its own as it means these participants are left without support for extended periods of time.

4.2.5 Addressing structural integrity issues in the NDIS

The integrity of the NDIS is compromised by structural issues, which some recent changes have exacerbated. For example, increased administrative compliance burdens and mandatory registration have the effect of concentrating and narrowing the market as larger providers are in the position to absorb more of the costs associated than are smaller providers. This can then lead to fewer choices for participants, and participants having no choice to engage with larger providers who might not have the tailored skills and capabilities they are looking for, or with whom they might have negative experiences. The pricing model in

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[16] Yates, S., Dickinson, H., & West, R. (2024). 'I've probably risk assessed this myself': Choice, control and participant co-regulation in a disability individualised funding scheme. Social Policy & Administration, 58(1), 1–17. https://doi.org/10.1111/spol.12940

the NDIS is constraining safety and quality, and affecting choice and access to supports. The Independent Health and Aged Care Pricing Authority review of NDIS pricing found that providers don’t have enough resources to cover costs, invest in staff training, and take steps to ensure quality and safety of supports, and that some businesses are leaving the Scheme.[17]

Avenues to address and remedy issues with decision-making quality within the NDIA must be prioritised, as unchecked, these can present a threat to the integrity of the Scheme. Administrative Review Tribunal decisions often reverse decisions of the NDIA,[18] but proposed changes to assessment and planning will serve to restrict the powers of the ART. This move would weaken the integrity of the NDIS as it would mean fewer checks and balances on the power of the NDIA, fewer options for recourse for participants seeking to question the NDIA’s decisions, and lead to the continuation of poor decision-making. Another indicator of poor decision-making concerns issues with access decisions, with drastic declines evident in numbers of ‘access met’ decisions for people with psychosocial disability, despite NDIS eligibility criteria not changing.[19]

4.2.6 Effective policy measures

Provider fraud crackdowns are generally supported by participants.[20] Participants who have experienced provider fraud and non-compliance have told CoMHWA that measures to address this in the past have often been ineffective, and that they have seen providers they have had poor experiences with continue their operations with little to no consequence even after they have raised complaints. The public register of providers subject to compliance actions and banning orders represents an excellent way of improving transparency and offers a resource that participants can use to make informed decisions about providers they engage. Public communications about providers who have been subject to banning orders is another positive move that has enabled transparency and kept participants informed.

CoMHWA was pleased to see stronger whistle-blower protections in the NDIS (Integrity and Safeguarding) Bill 2026, and feels this will contribute positively to ensuring the integrity of the NDIS.

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[17] Independent Health and Aged Care Pricing Authority. (2025). *A fresh approach to NDIS pricing: Exploring opportunities for pricing reform A snapshot of what we’ve heard*. https://www.ihacpa.gov.au/sites/default/files/2025-09/A_fresh_approach_to_NDIS_pricing_A_snapshot_of_what_weve_heard.pdf

[18] See data from last financial year, which shows that a full 73% of cases resulted in change to or overturning of NDIA decisions:

Administrative Review Tribunal. (2025). ART Caseload Report: For the period 14 October 2024 to 30 June 2025. ART Caseload Report 2024-25

https://www.art.gov.au/sites/default/files/2024-12/ART_Caseload_2024-25.pdf

[19] Threlfall et al., 2025, p. 10.

[20] Chang, K. Y. J., Hollier, J., Kim, H., Yen, I., & Smith-Merry, J. (2026). *Recent and proposed changes for the NDIS: What does it mean for people with mental health support needs?* Centre for Disability Research and Policy, The University of Sydney. https://doi.org/10.25910/sq4b-7a88

4.3 Legislative or other reforms required to strengthen Scheme integrity

4.3.1 Recommendations

1. Immediately introduce statutory requirements to co-design legislation and other reforms with people with disability.

Genuine and extensive co-design of all future reforms with people with disability, including people with psychosocial disability, is the only way to ensure integrity and restore trust in the Scheme. Integrity in the NDIS should be defined by participants.

2. Embed people with psychosocial disability into NDIS governance.

Governance-level involvement of people with lived experience is essential for ensuring that lived experience voices and expertise informs strategy, planning and decision-making from the start.[21] It can enable transformative shifts in power relations that ensure safeguarding balances regulation and policy compliance, with increasing the autonomy, choice and control of participants. This should include representation on the NDIS Reform Advisory Committee. [22]

3. Engage participants as active co-regulators in the NDIS.

Restoring the integrity of the NDIS hinges not on increasing top-down regulatory authority alone, but restoring participant control. In many ways, this goes back to the original intent of the NDIS: "the NDIS was established to increase choice and control in the context of previous experiences of poor quality, block funded services. Therefore, many clients desired as much control as possible over the delivery of their services, especially when they perceived services from registered providers to be inflexible and inadequate. In other words, these clients felt their services were safer and better quality when they had *more* freedom to co-regulate."[23]

As one participant put it:

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[21] Hodges, E., Leditschke, A. & Solonsch, L. (2023). *The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All*. Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia. https://nmhccf.org.au/our-work/discussion-papers/the-lived-experience-governance-framework-centring-people-identity-and-human-rights-for-the-benefit-of-all

[22] Threlfall et al., 2025, p. 13.

[23] Yates, S., Dickinson, H., & West, R. (2024). 'I've probably risk assessed this myself': Choice, control and participant co-regulation in a disability individualised funding scheme. *Social Policy & Administration*, 58(1), 1–17. https://doi.org/10.1111/spol.12940, p. 13.

> *“participants should be engaged in all levels of compliance and there should be feedback from participants that are on panels. ‘Nothing without us is for us:’ unless we are in leadership roles then it won’t work. Unless you are going through the day by day struggles you can’t truly understand.”*

Participants should be supported to be involved with plain-English, accessible how-to guides and other informational resources, and, above this, overt capacity building support to understand their options and rights within the Scheme and what to do when they experience poor practice, support, misconduct or non-compliance.[24] This could increase the desirable outcome of participants practicing self-advocacy. Additionally, access to government-funded NDIS advocacy services is also essential, as the complexity of the NDIS means that participants must be able to access support to navigate the Scheme. CoMHWA consistently hears that demand for services offering individual advocacy around the NDIS is high while resourcing and availability is low or does not meet demand, pointing to a need to fund more of these services.

4. Investigate and monitor the impact of policy changes on people with psychosocial disability – and do this with people with psychosocial disability.[25]

Monitoring the impact of changes is essential to understand whether they are achieving the effects intended. There are times when changes introduced impact participants with psychosocial disability differently than they do other participants, whether this is because of the ways in which the Scheme interacts with legislation and mental health service systems, because of factors affecting particular kinds of supports that many participants with psychosocial disability access, or other intersections of their experiences. As the ones most affected by changes in the Scheme, efforts to investigate and understand impacts must look first to participants themselves.

Understanding the impact of policy changes provides information to help identify and address structural issues undermining participant choice and control. A Scheme with integrity is one where participants have choice and control around the supports they engage through the Scheme. Choice is a key element of safeguarding, and can sometimes be the only one available to participants when other forms of ensuring compliance and accountability fail. One participant told us that on one occasion when he raised issues with a provider, they replied that if he wasn’t happy with the service, he should go elsewhere. However, if no other options are available, participants are not able to make such a move.

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[24] Ibid.

[25] Threlfall et al., 2025, p. 13.

5. Invest in developing NDIS workforce expertise and capability in working with people with psychosocial disability.

This will enable more participants to make choices in seeking providers that are right for them and access quality supports that meet their needs.

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