Designing NDIS Access Changes to meet the Needs of People with Psychosocial Disability

Consumers of Mental Health WA

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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' 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 Australian Government Department of Health, Disability and Ageing's *webpage* on the NDIS Access Changes Consultation:

"The Department of Health, Disability and Ageing (the department) wants your feedback on how people are assessed to see if they can access the National Disability Insurance Scheme (NDIS). The proposed changes aim to make access decisions clearer, fairer and more consistent. They would focus on how a person's disability affects their everyday life, rather than only on their diagnosis.

In the 2026-27 Budget the Government announced changes to protect the National Disability Insurance Scheme (NDIS) for people with permanent and significant disability now and into the future. On 14 May 2026 the NDIS Amendment (Securing the NDIS for Future Generations) Bill was introduced to Parliament.

Your feedback will help the Technical Advisory Group (TAG) develop advice for the Australian Government."

The consultation closes on 2 October 2026.

3. Introduction

CoMHWA welcomes the opportunity to provide feedback to the Department of Health, Disability and Ageing on how people are assessed to see if they can access the National Disability Insurance Scheme (NDIS). People with psychosocial disability, including those who are current NDIS participants, have had cause to develop fears around the possibility of their exclusion from NDIS access as a consequence of recent NDIS changes, the history of low rates of access for people with psychosocial disability, uneven understandings of psychosocial disability across NDIS/National Disability Agency (NDIA) systems and staff, and the Federal Government's stated intention to reduce the number of people in the NDIS by 160, 000 over the next four years.[1] In this context, given the current lack of supports outside of the NDIS for people with psychosocial disability, CoMHWA's central concern is that design of the access decision-making process must embed protections to mitigate the risk of leaving people with psychosocial disability with no supports. The process should be developed around a strong understanding of psychosocial disability, with testing undertaken to show it is appropriate for use prior to its rollout in practice. CoMHWA feels that the best way to ensure the process is relevant, fair, accessible, inclusive of, and appropriate for people with psychosocial disability is to include them, alongside other people with disability representing a diverse range of experiences, in robust co-design of the process.

We base our submission on:

- Ongoing consultation with CoMHWA's consumer reference and advisory groups, including our NDIS reference group that is comprised of 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).

[1] 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

4. Discussion

4.1 Guiding Principles

4.1.1 Do the draft guiding principles provide the right foundation for a future NDIS access process?

The proposed key principles outlined in the consultation paper[2] are:

1. *Aligned to the NDIS Act and the human rights of people with disability*
2. *Informed by lived experience, including people with disability, families and carers*
3. *Evidence-based and consistent*
4. *Person-centred and strengths-based*
5. *Equitable, inclusive and safe*
6. *Transparent, proportionate and accessible*
7. *Continuous quality improvement*

CoMHWA finds most of the concepts included in these principles to be important contributing factors towards a good foundation for a future NDIS access process, but feels that they could benefit from more specific focus and greater clarity, and that there are some additions and changes that could improve them. We discuss possible changes in our response to the next question.

We feel particularly strongly about principles including upholding the human rights of people with disability, and being informed by lived experience, though we do feel this latter could be strengthened, as we outline below. The process being guided by lived experience expertise should be a top priority, and we do not feel this should stop at just involvement or engagement of people with lived experience.

4.1.2 Should any principles be added, removed or changed?

Principle 1 “aligned to the NDIS Act and the human rights of people with disability” should state simply that the access decision-making process should uphold Australia’s human rights obligations. The access decision-making process will inherently be constrained by the legislation of the NDIS and does not need to state its alignment as part of a principle.

[2] Australian Government Department of Health, Disability and Ageing. (2026). *Consultation on NDIS access changes.* https://consultations.health.gov.au/disability-and-carers-group/ndis-access-changes-consultation/user_uploads/public-consultation-paper---ndis-access-changes---pdf-2.pdf, pp. 5-6.

Principle 2 “Informed by lived experience, including people with disability, families and carers” should be amended to signal that the process is *guided by* lived experience, including people with disability, families and carers. CoMHWA feels it is important that the process should be co-designed with people with disability, including people with psychosocial disability, and this would align better with the NDIS’s own commitments to codesign of reform with people with disability.[3] Being informed by or consulting with people with disability is not co-design. This rephrasing would compel action to enable lived experience expertise to guide the development of more truly accessible, equitable, and disability-informed access decision-making.

Principle 4 could include acknowledgement of the importance of recovery-oriented approaches, which are strongly tied to ideas of supporting strengths, and look outside of medical models of diagnosis and treatment. This would enable a process that focuses on individual choice, control, and connection to what is meaningful for them, including connection with supports within and beyond the NDIS.

Most of these principles combine several key concepts that should be principles in and of themselves, which compromises clarity and increases the risk that important aspects of the principles will be overlooked. For instance, principle 3 currently covers two distinct concepts, that of being evidence-based, and that of ensuring consistency, and does not make clear why these have been grouped together. There is an assumption in this principle that what there will be a consistent evidence-base relevant to diverse cohorts, which we do not feel is necessarily true. Similarly, principle 6 groups together concerns about transparency, proportionality and accessibility, and while transparency is an important aspect of accessibility, proportionality is not explicitly explained in the description of this principle.

Principle 5 combines equity and inclusion considerations, which should be one principle, with a variety of safety considerations, which we feel could be better explicated as separate principles. Equity and inclusion are certainly ways to ensure safety, but including such a broad range of considerations in this principle means that the specific focus of these concepts may be overlooked. We feel that it is important for a principle of culturally safety and responsiveness be articulated properly in order to ensure the needs of First Nations people with disability are met, noting the role of access to needed supports in maintaining social and emotional wellbeing, and in progressing reforms and meeting targets relating to Closing the Gap.[4]

[3] NDIS. (2024). *Co-designing reform NDIS*. https://engage.ndis.gov.au/page/co-design

[4] Australian Government. (2020). *National Agreement on Closing the Gap.* https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap

Focusing a principle on how the process can be trauma-informed and supporting would enhance awareness of the importance of building a process that does not contribute to distress and harm. NDIS participants often describe accessing and engaging with NDIS processes as highly distressing and sometimes retraumatising. People with psychosocial disability often have complex histories of engaging with supports and services, particularly within the mental health system, where some have had experiences of having their rights removed through involuntary treatment, coercion or restrictive practices, and they are put in the position of having to recount and rehash these experiences as part of the process of access.

In addition, CoMHWA feels a principle should be added around participant safeguarding. This principle would be aimed at ensuring that a person is not left with no supports, enabling explicit acknowledgement of the risks attendant upon removing or denying access to needed supports for people with disability.

Recommendation 1: Principles should be amended to reflect that the process:

- safeguards participants' access to supports
- is guided by lived experience, including people with disability, families and carers
- is supportive, trauma-informed and recovery oriented
- is culturally safe and responsive.

4.2 Access decision-making process design

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

1. Opportunities to address barriers for people with psychosocial disability

The design of this process represents an opportunity to address barriers to access for people with psychosocial disability. There are a range of by now well-documented[5] and prominent access barriers for people with psychosocial disability that make access uneven and unfair in current processes, which include:

- lack of understanding of psychosocial disability
- the perception that the NDIS should not, or cannot, support people with psychosocial disability[6]

[5] Threlfall, D., Paterson, K., Donnelly, S., Beasley, A., McKenzie, E. and Ballenden, N. (2025). Access Denied: Psychosocial disability and the NDIS. Australian Psychosocial Alliance (APA). https://psychosocialalliance.org.au/campaign, p. 10

Hancock, N., Scanlan, J.N., Mellifont, D., & Hamilton, D. (2022). Examination of NDIS Access barriers for people living with Psychosocial disability: Final report. https://mhcc.org.au/wp-content/uploads/2022/04/National-Survey_Barriers-to-NDIS-access_-Report.pdf

[6] Threlfall et al., 2025, p. 11.

- uneven understandings of psychosocial disability which lead to high variation in decision-making based on which staff are involved[7]
- higher barriers to access for people for psychosocial disability[8]
- confusion about access and decision-making processes
- processes not being informed by lived experience or by expert views
- inappropriate, onerous and often inaccessible evidence requirements for people with psychosocial disability.[9]

These factors inform the fears of people with psychosocial disability that a future access process may continue to raise barriers for them, or even exclude them from access. CoMHWA has also heard concerns that efforts to standardise the process that will lead to a rigid set of criteria that does not take into account the differences and diversity between different experiences of disability and psychosocial disability.

Creating a clear understanding of psychosocial disability and its place in the NDIS is a crucial first step to addressing access barriers and assuaging these concerns. A clear and consistent message to all personnel involved in access decision-making process design, implementation and ongoing delivery must be sent to drive home that the NDIS must support people with psychosocial disability and that, as per the NDIS review, this is "core business."[10] The access process must not discriminate against people with psychosocial disability, and so must be a process that is fully informed about the nature and impact of psychosocial disability and associated stigma. It should avoid replicating issues within the current process that lead inconsistent and poor decision-making around access for psychosocial disability, and largely exclude people with psychosocial disability from access to NDIS supports.[11] The NDIA is undertaking an internal access review that is exploring practice factors impacting on access rates of people with psychosocial disability, and we feel the results of this review in highlighting issues with the access decision-making process ought to be considered in the design of this process. However, we share the concerns of the Australian Psychosocial Alliance that this has lacked engagement with people with psychosocial disability, and wonder how accurate a view the review can develop around the real issues and barriers as a result.[12]

[7] Threllfall et al, 2025, p. 10.

[8] Ibid.

[9] Hancock, et al., 2022, pp. 32-38.

[10] NDIS Review. (2023). *Working together to deliver the NDIS Independent Review into the National Disability Insurance Scheme Final Report.* https://www.ndisreview.gov.au/sites/default/files/resource/download/working-together-ndis-review-final report.pdf, p. 128.

[11] Threlfall et al, 2025.

[12] Australian Psychosocial Alliance. (2026). *Access Denied: Update Newsletter 3.* https://psychosocialalliance.org.au/campaign-1

2. **Including mechanisms for ensuring it is led by and embeds the views, experiences, and perspectives of people with psychosocial disability**

The design of the process cannot be disability informed, and incorporate an appropriate understanding of psychosocial disability, if it is not guided by the views, experiences and perspectives of people with psychosocial disability. As one participant has told us, in the NDIS:

"There is a real ignorance about what life is like with psychosocial disability."

CoMHWA believes that co-design, or ideally, co-production, of the access decision-making process with people with disability is the most effective way to ensure it is disability-informed and meets the needs of all prospective applicants. We feel that a process led by a technical advisory group without adequate and appropriate representation of people with disability and lived experience cannot enable development of a process that embeds lived experience. The technical advisory group does not presently include people with lived experience in designated roles in the group. While some of those in the group may have personal lived experience, we note that their inclusion in this group is described and designated in terms of their academic and/or clinical expertise. CoMHWA feels there must be additional, designated roles for people with disability within this group.

In addition, people with psychosocial disability's own perspectives and account of their experiences should be explicitly and formally included when they are going through the access-decision making process. NDIS participants have shared that they do not feel that their voices have been well represented in the access process or in what is written about them. They do not have, for instance, the opportunity to respond to reports written about them. When reports are produced from a functional capacity assessment, participants should have the opportunity to respond to this, have their response documented, and have this be considered as part of the access process.

The deficit-based language often used in reports, combined with not being able to see their own perspectives represented in documentation, means that it is often a distressing experience for participants to read what others write about them. In the words of another participant:

"it's one thing to know you have mental health challenges, and to be living with them. But it's another thing to read about your experiences through other eyes. And to add to that, other professionals often misinterpret or state things in reports that are quite uncomfortable to read. Because that is not necessarily who you are on a day-to-day basis."

It is important that those writing about people's capacity and experiences of disability should remain mindful to use respectful language, and should expect that participants will see what is written about them.

A formal process of discovery of what language those applying for access would prefer be used about them and their experiences, could inform more respectful and appropriate documentation and reports.

3. **Ways to build flexibility into the process and account for the diversity and specificity of particular experiences of disability such as psychosocial disability**

The process cannot sacrifice nuance and inclusion for the sake of consistency, and so the pursuit of a standardised and consistent approach should not result in the exact same process being applied in the exact same way for all people. It is important to retain flexibility and enable responsiveness to diverse circumstances, needs, or experiences of disability. Feedback from current participants and other people with psychosocial disability indicates their desire for a distinct approach to be developed for people with psychosocial disability, as they have concerns that a standardised, general approach will not have the capacity to recognise their experiences and needs appropriately. At the very least, the access-decision making process must be able to adapt and flex to enable a nuanced approach that is developed, tested and proven to be effective, fair, and accurate in its ability to include psychosocial disability before it is rolled out.

The diversity within and across experiences of psychosocial disability must also be recognised. Experiences of mental health challenges vary significantly even within diagnostic labels and do not of themselves correlate to specific, predictable or similar experiences of psychosocial disability. People with similar diagnostic labels may have very different, (in the language of the NDIS) "functional capacity" in different areas and consequently, distinct needs for support. Experiences with treatment, medications and engagements with services and support systems can also contribute to disability and 'impairment.' For example, side effects of medications and other treatments may have ongoing effects. Some consumers have had experiences of immense harm in service systems, including harms experienced as a result of treatment (such as involuntary treatments) which have caused ongoing distress, trauma, and impacts to daily functioning and functional capacity.

These, alongside other aspects of psychosocial disability that can differ from other disabilities, have not been well accounted for in access processes to date. The often cyclical, episodic and/or fluctuating nature of experiences of psychosocial disability mean that any functional capacity assessment, and underlying conceptualisations of functional capacity, should be designed with explicit recognition of the contextual and fluctuating nature of capacity, as well as the episodic nature of many people's experiences of mental health challenges.[13] One way the process could account for this is by recognising substantially reduced

[13] Choi, J., Ellem, K. and Drayton, J. (2025), Supporting the Recovery of NDIS Participants With Psychosocial Disability: A Narrative Literature Review. Aust J Soc Issues, 60: 1038-1051. https://doi.org/10.1002/ajs4.70005

capacity when a person is experiencing episodic challenges when it comes to determining eligibility, something that has not been previously recognised in the access process.

The concept of recovery in mental health is relevant here as it is something that has been explicitly recognised by the NDIS in connection with psychosocial disability,[14] and it is unique to psychosocial disability inasmuch as 'recovery' is understood quite differently when it comes to discussing, for instance, physical health. There is a need to create a process that fulfills the promises of the NDIS *Psychosocial Disability Recovery-Oriented Framework*, as pointed out in a recent study on the implications of NDIS legislative changes for people with psychosocial disability. The study describes that "this includes acknowledging that recovery does not equate to cure or the absence of support needs, and enabling flexible support intensity that responds to variable functioning without requiring repeated demonstrations of permanence."[15]

Given recent amendments to the *NDIS Act 2013* defining functional capacity as a person's ability to undertake an activity "in a context that excludes, as far as possible, the impact of the person's environmental and personal circumstances,"[16] careful consideration must be given to how the access decision-making process can be designed to recognise the very real impact of context, circumstances, and environment on a person's ongoing functioning, experience of disability, and need for supports. A process that assesses capacity across a single occasion of assessment, without considering a person's history, context, and environmental and personal circumstances, is not an accurate assessment. Capacity at time of testing may not reflect overall capacity and actual ongoing capacity to do task/s without support. The impact of experiences of executive dysfunction, mental load, overwhelm, sensory input of an environment or even sensory overwhelm on particular days, must be considered as a part of this, affecting fluctuations in capacity, and also in support needs. A person may be able to perform a task on one day, but not others, because of the impact of these experiences, and the effect of their context and circumstances. People with psychosocial disability have shared that they feel concerned that assessments will not capture the context and impact of such experiences even though these are significant factors that affect their functioning and inform their need for support.

Psychosocial disability is often 'hidden,' invisible, or not able to be immediately seen or recognised. As a consequence, people with psychosocial disability note feeling like they are required to perform an expected

[14] NDIA. (2021). *NDIS Psychosocial Disability Recovery-Oriented Framework*. https://www.ndis.gov.au/media/3957/download?attachment

[15] Chang, K. Y. J., Hollier, J., H. Kim, I. Yen, & J. Smith-Merry. (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. https://ses.library.usyd.edu.au/handle/2123/35096, p. 45

[16] National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Act 2026 (Cth). https://www.legislation.gov.au/C2026A00066/latest/text

version of impairment to access or maintain their supports because of the lack of recognition of psychosocial disability. Furthermore, due to encounters with stigma and misunderstandings of mental health and psychosocial disability, many people with psychosocial disability have learned to 'mask' in social or public situations, which is to say they perform a socially accepted appearance of normalcy so as to avoid others thinking that they have mental health challenges or disability. Assessors and others involved in the access process should understand masking and how it might happen in this context. One participant wondered:

"Are we going to have to try to 'perform' dysregulation? This is really worrying for people that are partially recovered, or who mask very well."

CoMHWA feels it is essential that extensive testing of the process and any associated tools (such as that used for functional capacity assessment) be undertaken to ensure they are appropriate and reliable for assessing eligibility of people with psychosocial disability.

4. **Capability for the process to recognise that disability, functional capacity and support needs often arise from intersecting experiences of disability**

People with psychosocial disability often have other co-occurring conditions, impairments or disabilities that intersect with, interact with and determine their functional capacity and support needs. NDIS access processes have been constrained in their ability to recognise how a person's functional capacity limitations might be a consequence of the interaction of many factors, and not solely attributable to one impairment. CoMHWA has questions regarding how functional capacity assessments can fulfil promises around holistic assessment of capacity when they must still identify the impairment/s for which a person met the NDIS access criteria, given that support planning, per the recent changes, must identify that there is a direct link between the need for a support and eligible impairments.[17] It is important that tensions between the promises of a more holistic approach and the constraints of the legislation be navigated carefully in the new access decision-making process such that this process does not expect people to attempt to compartmentalise their experiences of disability in ways completely unreflective of the complexities of their lived experiences.

5. **How eligibility thresholds will be defined, communicated and will account for diverse experiences of disability**

[17] National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Act 2026 (Cth). https://www.legislation.gov.au/C2026A00066/latest/text

Eligibility thresholds and how the NDIS will define functional capacity for people with psychosocial disability must be clearly defined and communicated to participants and prospective participants. There must also be information and transparency around how the tool/s used to assess functional capacity will work, and what evidence exists to show these are reliable instruments to assess functional capacity for people with psychosocial disability. Generally, clarity is required around what is being evidenced when the consultation paper mentions the need for the process to be evidence-based: it is measurement of functional capacity, or the access decision-making process itself (unlikely as this is in the process of being designed and so cannot yet have an evidence base demonstrating its effectiveness)?

6. Avoiding harms associated with automated decision-making

In order for the process to be transparent, disability informed and fair, CoMHWA feels that automated decision-making should not be the basis of the access decision-making process. Many people with disability, and their representative organisations, have made clear their position that automated decision-making should not be used in this system.[18] For people with psychosocial disability, additional concerns regarding the possibility that bias can be present in automated decision-making processes, including bias stemming from mental health stigma that might lead to more people with psychosocial disability being denied access. Recent analysis of algorithmic systems in the NDIS revealed that they "risk replicating well-documented instances of algorithmic harm experienced in other areas of social welfare provision."[19] As a recent study undertaken by the Every Australian Counts campaign showed, "there is strong concern that automation and standardised tools further distance decision-making from lived realities. These reflections highlight frustration with systems that reduce disability to impairment categories or scores."[20]

7. Need for transparency and clarity in communication, information and support for preparation to apply for access

Transparent, timely information and clear statements of what is needed and what will be asked at points throughout the process is needed. To ensure transparency, the NDIA must be prepared to define and provide information about how it defines eligibility and the process and rules it uses to make decisions, and it must also explain how this is appropriate and adequate to understand psychosocial disability. The questions/tasks/areas for assessment applicants can expect to encounter during functional capacity

[18] People with Disability Australia. (2026). *Consultation for Guidance on Transparency in Automated Decision Making*. https://pwd.org.au/wp-content/uploads/2026/07/Consultation-for-Guidance-on-Transparency-in-Automated-Decision-Making.pdf

[19] van Toorn, G. & Carney, T. (2025) *Decoding the algorithmic operations of Australia's National Disability Insurance Scheme*. *Australian Journal of Social Issues*, 60, 21–39. Available from: https://doi.org/10.1002/ajs4.342

[20] 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/

assessments should be provided ahead of time. Appeal pathways must be readily available, clear, and accessible.

8. **Need for the process to remain accessible across diverse contexts and environments**

The access decision-making process should be designed to be accessible to people with disability across diverse contexts, locations and environments, including (but not limited to):

- **Regional, rural and remote locations.** Barriers to access are higher for people in these locations because of lower access to support, information and specialists that they need to understand and navigate applying for access.[21]
- **Custodial settings.** People with disability and people with mental health challenges are overrepresented in prisons, and enabling access to NDIS support can strengthen transitions back into the community and reduce likelihood of re-entering the justice system. Seeking NDIS access is a difficult process in these settings, given their constraints, and there is a lack of consistency in pathways enabling access, which vary based on the specific prison a person is in, and the staff with whom they are engaging.[22]

To ensure a fair, consistent, transparent, disability-informed and evidence-based access decision making process for people with psychosocial disability, CoMHWA offers the following recommendations:

Recommendation 2: Create dedicated roles for people with lived experience expertise on the Technical Advisory Group, including a role for a person with lived experience of psychosocial disability.

Recommendation 3: Co-design, co-evaluate and test the process with people with psychosocial disability to ensure it is led by their lived experience and that it is a valid and appropriate process for determining eligibility. Testing the process should include testing across a range of environments and contexts to ensure equitable access to NDIS for people with psychosocial disability.

Recommendation 4: Build in ways to embed the perspectives of those applying for the NDIS throughout the access decision-making process, through strategies including documenting and using preferred

[21] Mellifont, D., Hancock, N., Scanlan, J.W. & Hamilton, D. (2023) Barriers to applying to the NDIS for Australians with psychosocial disability: A scoping review. *Australian Journal of Social Issues,* 58, 262–278. https://doi.org/10.1002/ajs4.245

[22] Doyle, C., Dodd, S., Dickinson, H., Yates, S. & Buick, F. (2026). *'There's not just a gap, there's a chasm': the boundaries between Australian disability services and prisons.* https://www.unsw.adfa.edu.au/sites/default/files/documents/The%20boundaries%20between%20Australian%20disability%20services%20and%20prisons%20report_1.pdf

language to represent their experiences, and by offering opportunities to make a documented response to reports.

Recommendation 5: Ensure the process is based in a strong understanding of psychosocial disability, accounts for the diverse experiences of people with psychosocial disability, and is founded on a strong understanding of the continued inclusion of people with psychosocial disability in the NDIS, to address existing barriers to their access.

Recommendation 6: Measure consistency in relation to equity and fairness rather than in terms of adherence to a rigid standardised framework that remains the same regardless of disability, context and circumstances. Accordingly, prioritise flexibility and capacity for the process to recognise, respond, and adapt to the needs of diverse people with disability, psychosocial disability, and intersecting experiences of disability.

Recommendation 7: Avoid use of automated decision-making tools in the access decision-making process.

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

CoMHWA strongly supports measures to reduce administrative burden on people with disability, as this is large cause of distress currently and raises barriers for access for people with psychosocial disability. CoMHWA has often heard from people with psychosocial disability that the access process appears to be dominated by a sense of suspicion towards people with disability, which means that they have experiences of having prove and re-prove their eligibility even in the most clear of cases. People with psychosocial disability in particular, often encounter intersecting and compounding issues such as their account of their needs, their experiences, and their perspectives not being believed, and not being seen as trustworthy or reliable sources of information on their own lives. CoMHWA is opposed to the re-assessment of existing NDIS participants, who have already had to prove they have a permanent or likely permanent disability. However, we understand that legislation requiring reassessment of participants has now been passed, meaning this process should be designed to enable existing participants to be reassessed in a way that minimises the burden on them, as well as the impact of the process in causing distress. Many participants with psychosocial disability encountered challenges in securing access to the NDIS, a process which for many involved revisiting and recounting highly distressing or traumatic experiences, which combined with

the stress caused by the difficulty of the process itself, and the chance that they may lose access to supports essential for living their lives, mean a very high risk of retraumatisation. Clear, timely, individualised communication with participants who are going to be reassessed, and connection to supports to enable them to understand and undergo reassessment of eligibility, will help to reduce distress and enable preparation for the process.

The NDIA might consider how it can use information it already has around existing participants that indicates significant functional impairment and clear eligibility, define what categories of information that may be, and integrate this into re-assessment such that those process for existing participants can be fast, not place upon them a requirement to go through the entire process again, and easily reconfirm their eligibility.

Being clear about minimum thesholds for evidencing eligibility is an essential first step in minimising assessment burden. For incoming participants, rather than requiring all people to provide the same amount and types of evidence, an approach that stops requiring evidence as soon as existing available evidence has proven permanency may reduce administrative burden.

CoMHWA offers the following recommendations to reduce administrative burden and improve clarity around what is needed and how decisions are made:

Recommendation 8: Design the access decision making process with a view to minimising burden of reassessment on existing participants, including consideration of how the NDIA can source and use information it already has in the reassessment process.

Recommendation 9: Clarify and communicate eligibility thresholds and minimum requirements for evidencing eligibility for people with psychosocial disability.

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

The process must be proactively supportive, flexible, responsive to context, and enable tailored pathways for meeting the needs of people with diverse needs and experiences of disability, including psychosocial disability. CoMHWA feels that the process should avoid rigid standardisation of pathways through access decision-making including avoiding reliance on rigidly standardised tools within the process. Instead, it must build in flexibility and nuance around supporting different disability cohorts, including capacity to make adjustments and accommodations to meet needs throughout the process.

Impact of the process and risks for people with psychosocial disability

Individuals' experience of the process should be a central consideration in its design, understanding and accounting for the reality that it can cause stress and have deep impacts, including trauma, on people who have gone through it. The relationship between NDIS and non-NDIS support systems is fragmented, disconnected and complex, and for people with psychosocial disability, the virtual lack of psychosocial supports outside of the NDIS means that they will be going in to the process of attempting access or being reassessed for eligibility in the knowledge that they will have no supports should they be found to not meet eligibility criteria. This makes the stakes extremely high, and increases likelihood that they will experience distress, and, in real terms, that they will be harmed by, and worse off as a consequence of this process if it results in them losing supports.

NDIS access decision-making processes must ensure that NDIS access is not restricted on the basis of imagined or ideal access to alternative supports when those supports are, in reality, not yet funded, implemented and proven to meet needs, or where they are not accessible or not available to individuals because of their location or other contextual factors. In circumstances where NDIS access may be withdrawn because of the identification of alternative support systems that the assessor feels would better support the participant, there must be some process for confirming that the supports are right for that participant, and validating that the participant is actually able to access the alternative supports in question quickly and easily, and, crucially, in an ongoing manner. Identification of the implications of removal of NDIS support for participants is needed, particularly where this carries risk. A process for assessing risk, and a process for participants themselves identifying risks and escalating where they are in urgent need of supports that have been removed must be created to avoid the very likely harms attendant upon removing supports from large amounts of people.

The need for a specific integrated pathway and supports for people with psychosocial disability into and across NDIS and non-NDIS supports

Because of the factors described, better understanding of, attention to, and a specific pathway through the access decision-making process for people with psychosocial disability is required. To create this pathway, referral and support options must be fully mapped and understood for people with psychosocial disability, given the complexity of interactions between the NDIS and the mental health system including public/mainstream supports and community mental health. Consideration must also be accorded to the current state of psychosocial and mental health supports: foundational supports and psychosocial supports outside of the NDIS are yet to be fully designed and are years away from development and implementation. It is essential that the process is able to guarantee continuity of supports before access is restricted. The

NDIS and the mental health system should ensure NDIS supports are provided concurrently with essential community mental health and clinical supports for people with psychosocial disability.[23]

Attention must be paid to what psychosocial disability need in order to be supported through the access decision-making process and to navigate referral pathways. CoMHWA continues to support calls for the development of a workforce of psychosocial recovery navigators with training and competency in understanding psychosocial support systems and options, referral pathways outside of NDIS and support options within the NDIS for people with psychosocial disability. Several NDIS Review recommendations (4.1, 7.1)[24] advise the establishment of psychosocial recovery navigators, who would work with people with psychosocial disability to develop and implement plans to connect with supports and providers, and who would be especially useful during the access stage because they would enable strong referral pathways and ensure that the access process works well for people with psychosocial disability.

Beyond this, staff involved in the decision-making process, including any functional capacity assessments, must have the training and experience to ensure they understand psychosocial disability and are able to work with people with psychosocial disability in respectful, responsive, and non-discriminatory ways. CoMHWA has heard from many participants with psychosocial disability that they feel anyone undertaking or involved with an assessment of their function capacity, eligibility, or support needs should have specific knowledge, skill and experience around psychosocial disability. When they have encountered staff without such knowledge and experience, they experience barriers to access and to getting the supports they need. One participant said:

"These depend on your engagement with the person undertaking this, and their background knowledge. We don't have the appropriate specialists to do this. It seems like it is all so general and it needs specialised knowledge."

To ensure the access decision-making process, as well as referral pathways, works well for people with psychosocial disability, CoMHWA offers the following recommendations:

Recommendation 10: Build in supports throughout the process to ensure access decision-making is a supportive, relational, trauma-informed, responsive, and flexible process, and that all involved personnel and staff are appropriately trained and have an understanding of psychosocial disability.

[23] Commonwealth of Australia, Department of the Prime Minister and Cabinet. (2023). *Working together to deliver the NDIS Independent Review into the National Disability Insurance Scheme Final Report.* https://www.ndisreview.gov.au/sites/default/files/resource/download/working-together ndis-review-final-report.pdf, p. 73.

[24] Ibid, p. 135.

Recommendation 11: Develop an integrated pathway for people with psychosocial disability into and across NDIS and non-NDIS supports, with dedicated support from a psychosocial recovery navigator.

Recommendation 12: Provide people with psychosocial disability with access to assessors with specific training and experience in psychosocial disability when they are required to undergo functional capacity assessment.

4.3 Evidence requirements

4.3.1 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?

The consultation paper describes that further engagement will take place in the future to determine final eligibility thresholds, but CoMHWA notes that this is a challenging question to answer without information about how eligibility is going to be defined, and without a specific definition of substantially reduced functional capacity. When such definitions are created, this question must be revisited to enable more informed responses, and it is essential that those definitions are tested and proven to be appropriate for psychosocial disability. It is CoMHWA's position that, whatever the final eligibility thesholds might be, and whatever other evidence requirements may apply, it is crucial that a person's own experiences of psychosocial disability, impairment/s and impacts on functioning, as well as their sense of why they require access to NDIS supports, is included as evidence.

Research, alongside feedback CoMHWA has long heard from people with psychosocial disability, points to the problematic nature of NDIS conceptualisations of permanency when it comes to psychosocial disability, as these contravene contemporary understandings of recovery and ignore the episodic and fluctuating nature of mental health challenges and of functional capacity impacts.[25] This must be kept in mind when exploring evidence requirements demonstrating permanency to ensure that these do not exclude people with psychosocial disability altogether. It is essential for the development of inclusive approaches to evidencing permanency that variability and fluctuation over time should not be taken as evidence that an impairment is not permanent.

[25] Williams, T., & Smith, G. (2021). Mental Health and the NDIS: Making It Work for People With Psychosocial Disability, in: *National Disability Insurance Scheme: An Australian Public Policy Experiment*, pp. 161–191. https://link.springer.com/chapter/10.1007/978-981-16-2244-1_9

Wilson, E., R. Campain, S. Pollock, L. Brophy, and A. Stratford. 2021. "Exploring the Personal, Programmatic and Market Barriers to Choice in the NDIS for People With Psychosocial Disability." *Australian Journal of Social Issues* 57(1), 164–184. **https://doi.org/10.1002/ajs4.154**.

As such, ways of exploring the impact of a person's impairment/s over time must be included, and these should be mindful of the degree of access individuals may have to different providers/practitioners, mental health supports, and their access to records of same. Practices and providers may close, practitioners can retire or move away, or participants themselves may have moved and be no longer able to access records. People with psychosocial disability have, in the past, been forced to go to significant expense and trouble in securing evidence of their eligibility, including the need to obtain pricey specialist reports and psychiatric assessments, which are hard to access and place an exhausting burden on prospective participants of having to coordinate appointments and requirement.[26] Many simply have not been able to afford to engage with clinicians in an ongoing manner. The new process should avoid burdensome evidence requirements. Scope for what should be taken as evidence of history of seeking support connected with psychosocial disability should be mindful of access considerations and include ability for evidence from different sources. It should include options such as history of:

1. **GP engagement**. This would open up more possibilities for evidencing history of impact of impairment/s for more people as consumers often have better access to GPs than to other, more expensive and less available specialists or mental health supports.
2. **Engagement with public or private mental health systems and services**. When a person is given a diagnosis that is recorded on their health/mental health record, this remains on that record for a lifetime. While we understand and support a move away from a largely diagnosis-based approach to determining eligibility, we would also like to highlight that diagnosis is routinely treated as permanent in practice in public mental health systems given the impossibility of removal of the diagnostic label, once applied.
3. **Engagement with other disability, mental health, or community programs and supports.**
4. **Engagement with public and government support systems for people with disability, such as access to the Disability Support Pension (DSP)**. Access to the DSP, in particular, indicates a person has already, at minimum, met the "medical rules" (if not the more specific "manifest medical rules") for access, demonstrating the persistence of a condition causing impairment over a period of time, which has been "diagnosed, reasonably treated and stabilised," and for which the person must have completed all "reasonable and suitable" treatments.[27]

[26] 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/

[27] Services Australia. (2026). *Medical rules*. https://www.servicesaustralia.gov.au/medical-rules-for-disability-support-pension?context=22276 https://www.servicesaustralia.gov.au/manifest-medical-rules-for-disability-support-pension?context=22276

5. **Clinical, professional and/or support worker engagement**, noting that while these should not be required evidence, there should be some scope to consider evidence from these sources where individuals indicate that this is their preference. CoMHWA has also heard from some NDIS participants with psychosocial disability who have reports, records and evidence who say they want the evidence they have to be able to considered in determining eligibility and evidence of permanence should this be reassessed. The requirements must be mindful that those who have not access NDIS are unlikely to have easy access to support workers. However, existing participants have said that ability to provide evidence from support workers should be possible when they are reassessed. Some people with psychosocial disability have trusted relationships with clinicians, mental health support professionals, allied health professionals, or support workers, and note that evidence from those they trust, who are qualified and experienced in supporting people with psychosocial disability, and who have a solid understanding of their individual needs and circumstances is preferable to evidence from assessment conducted by a person they have not previously met, and who has no specific experience with or knowledge of psychosocial disability.
6. **Other engagements with intersecting service and support systems showing need for supports.** While we understand the difference between support needs assessments and access assessments, including functional capacity assessments, it is nevertheless the case that assessment of a person's need for supports across areas of their lives, and their reduced capacity to complete tasks and function without those supports, is necessary evidence.

Appropriate treatment

Ensuring choice, access and availability

Appropriate treatment provisions for people with psychosocial disability must be understood in the context of what they can realistically access through the public system (taking into consideration the person's location, access, and personal circumstances), and with a view to preserving human rights and avoiding coercive and restrictive approaches. Access cannot be considered in theoretical terms only. In many cases, 'appropriate treatment' is prohibitively expensive, only available in well-resourced metropolitan areas, and subject to a long waitlist (during which time the person is going without supports). For participants in regional, rural and remote areas of WA, location is central in determining their access in real terms. If the only way they can access a given treatment involves travel to Perth, this is not going to be accessible for a high percentage of people, given:

- The distances involved, including distances beyond 3000 kilometres (if travelling by car, an over 30-hour drive) for some towns in the north Kimberley region.

- The time needed for travel.
- Travel is expensive, even with access to a car, given the distances involved.
- The lack of support for travel to access treatment, with the Patient Assisted Travel Scheme (PATS) providing only partial financial subsidies for some qualifying treatments to WA country residents,
- Other support and access needs which are difficult/impossible to meet depending on individual circumstances.

The ability of the person to, in actuality, access 'appropriate treatment' must be one of the central considerations in deliberating whether the treatment in question is likely to improve the functional impact of the impairment.

There is a risk of relying on or reducing psychosocial disability to a mental health diagnosis if appropriate treatment is defined in terms of diagnosis-specific treatment pathways. There is a lack of clarity currently about how 'appropriate treatment' will be determined and defined, given the shift away from access being based on diagnosis lists. Even when considering diagnosis-based treatment, there is no clear, standardised pathway for each diagnosis that is universally agreed and followed. What is seen as appropriate treatment and made available varies at a jurisdictional level, and even at a local level between different mental health professionals and clinicians. Consumer-led recovery approaches offer a different perspective again, as they challenge a biomedical framework and its associated ways of conceptualising and assessing what is seen as appropriate treatment, as the NDIA itself acknowledges in its Psychosocial Disability Recovery-Oriented Framework.[28]

CoMHWA was pleased to note that recent legislative amendments explicitly exclude restrictive practices in the definition of appropriate treatment: "appropriate treatment does not include restrictive practices involving seclusion, chemical restraint, mechanical restraint, physical restraint or environmental restraint." Yet, it is imperative that rules concerning the access process and appropriate treatment do not inadvertently have the effect of increasing rates of restrictive practices, particularly chemical restraint, which national strategies are in place to attempt to eliminate.[29] A person's own experiences with, and preferences around treatment must be a central consideration, in order to avoid coercing people into pursuing treatment they do not want. The side effects of access to certain medications and treatments, and the impact of such side effects on a person's life, must also be considered. This varies considerably from individual to individual, as different people respond to, for instance, a particular medication, in very

[28] NDIA. (2021). *NDIS Psychosocial Disability Recovery-Oriented Framework*. https://www.ndis.gov.au/media/3957/download?attachment , p. 5.

[29] National Mental Health Commission. (2023). *Reducing Restrictive Practices.* https://www.mentalhealthcommission.gov.au/lived-experience/contributing-lives%2C-thriving-communities/reducing-restrictive-practices

different ways. A major concern is around pressuring people with psychosocial disability and mental health consumers to undergo invasive, high-risk treatments or treatments with significant side effects, such as Electroconvulsive Therapy (ECT), or antipsychotic medication. Given the scale of impact of side effects for some medications, their right to refuse to pursue a treatment must be preserved. Under no circumstances should 'appropriate treatment' rules mean that a person is denied NDIS access because they cannot access the means to undergo, or do not consent to undergo, a specific treatment.

Relationship to improvements to functional capacity

Whether a treatment improves the functional impact of an impairment appears to be a separate consideration to the question of permanency, and treatment improving functional capacity should not be seen as necessarily being evidence that impairment is not permanent. Some treatment may provide temporary improvement that either is not sustained over the long term, or that requires ongoing/repeated access to treatment to sustain its effects (as can for instance, be the case with many medications and other interventions such as Transcranial Magnetic Stimulation (TMS) used as treatment for mental health challenges). NDIS legislation explicitly notes that "a person may require ongoing treatment for some permanent impairments in order to maintain functional capacity in relation to an activity, even if the person has undertaken all appropriate treatments for the impairment."[30] Treatment may also provide some improvement in functional impact in some areas of a person's life and not others, or even enable improved functioning in some areas while actively reducing functioning in others.

Treatment cannot be defined in such a way as to include supports that might improve functioning in different areas of a person's life. There are many current participants with psychosocial disability whose functioning has improved because of access to NDIS supports, but those supports are not 'treatment,' and participants have told CoMHWA they are concerned their improved functioning or recovery will be taken as evidence that the supports that enable that very functioning are no longer required. One participant described fears that: "if you are recovered because of supports, then this is not going to be captured," and another noted that "supports are not a cure."

CoMHWA offers the following recommendations about evidentiary requirements and appropriate treatment rules:

Recommendation 13: Include as evidence a person's own accounts of their experiences of psychosocial disability, impairment/s and impacts on functioning, and why they require access to NDIS supports.

[30] National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Act 2026 (Cth), s91.

Recommendation 14: Permit provision of evidence from a diverse range of sources for the purposes of demonstrating engagement over time with services and supports for psychosocial disability, including engagement with GPs, public or private mental health systems and services, other disability, mental health, or community programs and supports, government support systems for people with disability, such as the Disability Support Pension (DSP), Clinical, professional and/or support workers and other intersecting service and support systems showing need for supports.

Recommendation 15: Define appropriate treatment as treatment available through and paid for by the public system, that a person can access and afford, and that they freely consent to access without fear of losing supports.

Conclusion

People with psychosocial disability have experienced a sharp increase in stress and deep loss of trust towards the Government, the NDIA and the entire NDIS system around the recent amendments to the NDIS Act 2013. Participants are feeling justifiably insecure around their continued access, given that the explicit aim of the redesigned access process is to shift tens of thousands of participants off the NDIS. CoMHWA urges the Technical Advisory Group to consider the needs of people with psychosocial disability when designing the new access process, so that it does not replicate the pitfalls of past and current approaches which have had the effect of disproportionate exclusion of people with psychosocial disability. Their ongoing exclusion, in a context where there are few other supports in place, will cause significant distress and harm.

4.4 Summary of Recommendations

Recommendation 1: Principles should be amended to reflect that the process:

- safeguards participants' access to supports
- is guided by lived experience, including people with disability, families and carers.
- is supportive, trauma-informed and recovery oriented
- is culturally safe and responsive.

Recommendation 2: Create dedicated roles for people with lived experience expertise on the Technical Advisory Group, including a role for a person with lived experience of psychosocial disability.

Recommendation 3: Co-design, co-evaluate and test the process with people with psychosocial disability to ensure it is led by their lived experience and that it is a valid and appropriate process for determining eligibility. Testing the process should include testing across a range of environments and contexts to ensure equitable access to NDIS for people with psychosocial disability.

Recommendation 4: Build in ways to embed the perspectives of those applying for the NDIS throughout the access decision-making process, through strategies including documenting and using preferred language to represent their experiences, and by offering opportunities to make a documented response to reports.

Recommendation 5: Ensure the process is based in a strong understanding of psychosocial disability, accounts for the diverse experiences of people with psychosocial disability, and is founded on a strong understanding of the continued inclusion of people with psychosocial disability in the NDIS, to address existing barriers to their access.

Recommendation 6: Measure consistency in relation to equity and fairness rather than in terms of adherence to a rigid standardised framework that remains the same regardless of disability, context and circumstances. Accordingly, prioritise flexibility and capacity for the process to recognise, respond, and adapt to the needs of diverse people with disability, psychosocial disability, and intersecting experiences of disability.

Recommendation 7: Avoid use of automated decision-making tools in the access decision-making process.

Recommendation 8: Design the access decision making process with a view to minimising burden of reassessment on existing participants, including consideration of how the NDIA can source and use information it already has in the reassessment process.

Recommendation 9: Clarify and communicate eligibility thresholds and minimum requirements for evidencing eligibility for people with psychosocial disability.

Recommendation 10: Build in supports throughout the process to ensure access decision-making is a supportive, relational, trauma-informed, responsive, and flexible process, and that all involved personnel and staff are appropriately trained and have an understanding of psychosocial disability.

Recommendation 11: Develop an integrated pathway for people with psychosocial disability into and across NDIS and non-NDIS supports, with dedicated support from a psychosocial recovery navigator.

Recommendation 12: Provide people with psychosocial disability with access to assessors with specific training and experience in psychosocial disability when they are required to undergo functional capacity assessment.

Recommendation 13: Include as evidence a person's own accounts of their experiences of psychosocial disability, impairment/s and impacts on functioning, and why they require access to NDIS supports.

Recommendation 14: Permit provision of evidence from a diverse range of sources for the purposes of demonstrating engagement over time with services and supports for psychosocial disability, including engagement with GPs, public or private mental health systems and services, other disability, mental health,

or community programs and supports, government support systems for people with disability, such as the Disability Support Pension (DSP), Clinical, professional and/or support workers and other intersecting service and support systems showing need for supports.

Recommendation 15: Define appropriate treatment as treatment available through and paid for by the public system, that a person can access and afford, and that they freely consent to access without fear of losing supports.



Consumers of Mental Health WA

12 / 275 Belmont Avenue, Cloverdale WA 6105

9258 8911 | admin@comhwa.org.au | ABN: 95 581 286 940