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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
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Canberra ACT 2600

Dear Committee Secretary,

APS submission to the Inquiry into the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026

The Australian Psychological Society (APS) is the largest peak professional body for psychologists in Australia. We welcome this opportunity to provide a submission to the Senate Standing Committees on Community Affairs Committee's Inquiry into the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 (the Bill).

Psychologists play a central role in the NDIS as providers of assessment of abilities and functional capacity, psychology and behaviour supports, and as practitioners whose clinical evidence underpins access and planning decisions for many participants in receipt of a range of services and supports involving other disciplines. A significant proportion of our members provide services to people with psychosocial disability, intellectual disability, neurodevelopmental conditions including autism, acquired brain injury, and other disabilities under the NDIS. Psychologists' work also extends to the translation of assessment into practical supports, the provision of psychoeducation, and coaching families and service providers in the implementation of NDIS supports.

Previous independent research has demonstrated significant return on investment of the NDIS, which has been estimated to be at least $2.25 for every $1 spent across the Scheme.[2] Nonetheless, the APS understands the policy objective underpinning the Bill of ensuring the long-term sustainability and integrity of the NDIS. The APS is strongly committed to ensuring that reforms achieve genuine sustainability without inadvertently undermining access to evidence-based psychological support for the Australians who need it most. We also assert that the contribution of psychologists to the NDIS returns much more than the 0.9% of total Scheme expenditure attributable to psychologist-specific items.[1]

1. Preliminary Concerns: Process and Consultation

1.1 The rush to legislate undermines sound policy

The APS is concerned that the timeline for this Bill does not permit the level of analysis, consultation and scrutiny warranted by reforms of this magnitude. We note, for example, that some disability groups such as people living with intellectual disability have been excluded from consultation on the Bill in the absence of easy English versions of materials and being provided with the time and resources to enable their participation via supported decision making.

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The Bill makes sweeping changes to eligibility, planning, funding and governance that will directly affect more than 774,000 participants,[3] family members, and the providers who serve them. Many of the consequential provisions in the Bill override or substantially modify the legal effect of recent Federal Court decisions. Such changes, and their significant effect on the human rights of participants (e.g., restricting people's fundamental rights to control their own bodies and have autonomy in relation to health decision-making by excluding people who refuse treatment: proposed new s 25A(3)), demand careful consultation with professional bodies, participants, and the disability community.

The APS notes that the Impact Analysis accompanying the Bill explicitly acknowledges that some key measures not subject to "specific consultation", including the resetting of Capacity Building Daily Activities (CBDA) budgets and the tightened "reasonable and necessary" criteria (pp. 259-260).[4] That acknowledgment is itself cause for concern.

We are also concerned that the full social impact of the Bill has not been considered. In particular, the foreseeable but inappropriate shifting of care to caregivers, parents and family members and away from reasonable and necessary formal supports as a result of this Bill will have a deep and harmful effect which will be difficult to reverse. This must be understood in the context of recent findings showing that almost 60% of Australian parents are experiencing elevated levels of psychological distress.[5] Of note, rates of distress are even higher in parents of children with disabilities who experience additional demands associated with navigating complex systems, coordinating supports and appointments, and managing financial pressures. If the changes in the Bill result in increased requirements for families providing informal supports, this will exacerbate already unacceptably high levels of distress that may lead to unintended consequences and increased costs on other systems such as health, justice, and child safety.

The APS calls on the Committee to recommend that no provision of this Bill that materially affects participant entitlements be brought into operation before adequate consultation has been completed.

1.2 Deferring operative content to future Rules is inadequate

The APS has raised this concern in previous submissions, and we raise it again here. The Bill defers many of its most significant operative effects to category A or category D NDIS rules which are yet to be made. This includes decisions about:

- the methods and thresholds for assessing functional capacity (s 9B);
- the class of providers for which NDIS registration will be required (s 10C);
- the circumstances in which a person is taken to have completed "all appropriate treatment" for the purposes of the permanence test (s 25A);
- the records to be retained by participants and providers (s 45B); and
- maximum amounts, intensities and worker-to-participant ratios for specific supports (s 33(2EA)).

Legislating a framework while leaving the substance to subordinate instruments which in many cases have little oversight, falls short of good regulatory practice. The use of such instruments does not allow Parliament (and this Committee) or affected professions or communities to assess the true impact of what is being enacted. Importantly, it creates significant uncertainty for participants, providers and treating clinicians who are often in a position of supporting participants and prospective participants to navigate questions of NDIS eligibility and access to supports.

The APS urges the Committee to recommend that provisions whose operative effect depends substantially on future rules be brought into force only after those rules have been made and publicly consulted upon.

2. Key Concerns in the Bill

The APS focuses below on four areas where the Bill will directly or disproportionately affect participants who receive, or should receive, psychology supports through the NDIS and the psychologists providing those services.

2.1 The "All Appropriate Treatment" Test, Psychosocial Disability and Early Childhood Supports (new sections 24(5), 25(1B) and 25A)

The Bill amends the permanence criterion for NDIS access to require that a person has undertaken "all appropriate treatment" before their impairment can be considered permanent. Appropriate treatment is defined as treatment that is evidence-based, regularly undertaken in Australia, and can reliably be expected to "improve, reverse or alleviate" the impairment. Critically, the Bill expressly provides that a person's financial and geographic circumstances are irrelevant to whether appropriate treatment has been undertaken.

The APS is particularly concerned about the application of this test to people seeking NDIS access on the basis of psychosocial disability, intellectual disability, or neurodivergent conditions such as autism. For many mental health conditions that give rise to psychosocial disability (including treatment-resistant depression, schizophrenia and severe post-traumatic stress disorder), psychological therapy is the primary, or a primary, evidence-based intervention.[6] The Bill's logic therefore positions NDIS eligibility as conditional on a prospective participant having first exhausted psychological treatment. This is problematic for several reasons:

- First, in terms of psychosocial disability, evidence-based psychological therapies are unfortunately frequently inaccessible to people with severe and persistent mental illness. This is due to gaps and limitations in the funding of psychology services as well as geographical and sociocultural inequities in accessing supports. For example, despite ongoing APS advocacy for reform, Medicare-subsidised psychology services through the Better Access Initiative are limited to 10 sessions per calendar year. The Better Access Initiative is not designed for psychosocial disability and does not allow psychologists to provide the level and intensity of support which is required. The APS has also, on multiple occasions, expressed its concern that current mental health funding and policy settings create significant financial barriers for accessing support while increasing demands on psychologists in ways which threaten the sustainability of their practices.[7–9]

  The proposition that people currently eligible (or who in the future under current criteria would be eligible) for NDIS services could be shifted to mainstream health or mental health services is fundamentally flawed both clinically and with respect to the practical availability and structures supporting such services.

  The Department of Health, Disability and Ageing's recent Psychology Supply and Demand Compendium Report has also identified that persistent and growing workforce shortages will continue to limit access to psychologists, particularly outside metropolitan areas.[10,11] The explicit exclusion of financial and geographic barriers from the permanence assessment therefore means that a person who cannot access adequate psychological treatment due to systemic gaps in the mental health system may be found ineligible for the NDIS not because their condition is treatable, but because the treatment was never practically available to them.

- Second, the concept of "appropriate treatment" cannot be appropriately applied to the nature of psychosocial disability nor neurodevelopmental conditions. Many disorders that give rise to psychosocial disability and disability arising from a neurodevelopmental condition, are characterised by episodic fluctuation, partial treatment response, and a need for ongoing psychological and multidisciplinary support. The biomedical model underpinning these provisions implies that intellectual disability and neurodivergent conditions may be "cured" or that remediation is an appropriate goal. This is directly inconsistent with community expectations and the emphasis on neurodiversity-affirming practice which is part of the Psychology Board of Australia's competencies for psychologists.[12]

- The Bill contains a legislative note in amended s 24(4) acknowledging that some permanent impairments "require ongoing treatment to maintain a person's functional capacity" and cites psychosocial conditions as an example. A further example is neurodevelopmental conditions characterised by regression over time such as Rett syndrome. Given this note is interpretive and not a substantive statutory protection, its interaction with the "all appropriate treatment" test will generate significant uncertainty and litigation.

- Third, the category D NDIS rules that will specify circumstances in which a person is taken to have completed all appropriate treatment require only consultation (and not agreement) with states and territories and does not require consultation with the professions that assess and treat these conditions. Given the high stakes involved for individuals, we strongly call for those rules to be developed and reviewed with direct and meaningful input from the APS, other relevant professional bodies and the disability community.

- Finally, we are concerned that decisions made under these proposed provisions are further removed from both evidence-based practice (as properly understood) and the provision of person-centred supports because of the operation of new section 17B, which embeds policy considerations about the financial sustainability of the Scheme directly within individual funding decisions. The APS considers that it is inconsistent with the intention and principles of the Scheme to require decision-makers to prioritise sustainability considerations (both explicit and implicit) alongside existing statutory principles of supports being "reasonable and necessary".

The APS recommends:

- An explicit recognition in the Bill that financial and geographic barriers to accessing psychological treatment are relevant to determining whether all appropriate treatment has been undertaken;

- That the Bill provide that NDIS rules specifying exemptions for psychosocial conditions be developed and reviewed in direct consultation with psychology and other relevant professional bodies;

- That the Bill clarify that conditions characterised by episodic and fluctuating function, including neurodevelopmental conditions, schizophrenia, bipolar disorder, and treatment-resistant depression, are capable of giving rise to permanent impairment consistent with the access criteria, notwithstanding that ongoing treatment may be required; and

- That the Bill clearly state that certain conditions (e.g., intellectual disability) are characterised by life-long impairment to functioning requiring long-term support and that persons with these conditions should not ordinarily be subject to reassessment.

2.2 The Direct Causation Test and Co-occurring Mental Health Presentations (new section 34(1)(aa); amended section 32L(2))

The Bill replaces the existing causal nexus requirement with a requirement that reasonable and necessary supports address needs arising "directly" from the participant's eligible impairment. This means that the impairment must be the "direct and immediate source, cause or origin" of the need, not merely a contributory cause. The proposed amendments in the Bill are explicitly intended to overturn the Federal Court's 2026 decision in *Eastham*.[13]

The APS recognises the policy intent to prevent NDIS funding from being used for needs that are more appropriately addressed by mainstream health or other systems. However, as drafted, the provision will create significant clinical and practical difficulties where participants present with both an eligible impairment and a co-occurring mental health condition.

A substantial proportion of NDIS participants have co-occurring mental health conditions that impact their functional capacity. These include:

- people who accessed the NDIS for intellectual disability or autism who also live with anxiety, depression or other mental health conditions;
- people who accessed the NDIS for acquired brain injury or physical impairment who have developed PTSD or depression in response to their injury or its sequelae; and
- people who accessed the NDIS for a developmental or physical disability whose mental health presentations are clinically inseparable from, and functionally exacerbated by, their primary eligible impairment.

The example of Nykolai provided in the Explanatory Memorandum to the Bill (p. 27) illustrates this clearly: a participant with cerebral palsy who also has ADHD cannot receive NDIS-funded support for the ADHD because it did not meet the access criteria.[14] Psychological support targeting ADHD-related behaviour and executive function difficulties, which are directly relevant to daily living in the context of cerebral palsy, would not be funded under this test.

The reality is that, in many complex presentations (arguably the majority of people seeking access to the NDIS), the eligible disability and the co-occurring mental health condition interact dynamically and synergistically. The direct causation test does not accommodate this interaction. It will require psychologists providing reports in support of NDIS applications and plan reassessments to frame their conclusions in terms that satisfy a legal causation test rather than accurately reflect the participant's holistic functional presentation and associated support needs. It will also have a disproportionate impact on First Nations participants, who are more likely to experience chronic co-occurring conditions.

The APS recommends:

- That the Bill require that NDIS rules developed under the new reasonable and necessary framework include explicit guidance that, where a co-occurring mental health condition significantly contributes to functional impairment arising from an eligible impairment, psychology supports addressing the co-occurring condition satisfies the direct causation test; and
- That the Bill include a mechanism for psychologists and other treating providers to offer evidence about the interaction of eligible and ineligible impairments, and that delegates be required to give that evidence appropriate weight.

2.3 The Evidence Hierarchy for "Effective and Beneficial" Supports (new sections 34(1E) and (1F), 32(2EA))

The Bill introduces a mandatory evidential hierarchy for assessing whether a support is "effective and beneficial": published, peer-reviewed, generalisable research ranks highest; evidence of effectiveness for people in similar circumstances ranks second; evidence of demonstrated outcomes for the individual participant in previous plans ranks third. The Explanatory Memorandum states explicitly that the CEO "may decide they are not satisfied that a support is, or is likely to be, effective and beneficial if there is limited or no published or peer reviewed evidence, even if there is evidence of effectiveness of the support either generally or for the participant in particular" (p. 53).[14]

Additionally, the Bill (at new s 33(2EA)) provides for Ministerial powers to set maximum amounts, maximum intensities and maximum worker-to-participant ratios for individual supports or classes of supports. The Explanatory Memorandum's Marco example (p. 51) explicitly contemplates a maximum of 25 therapy hours per discipline per year.[14]

The evidence hierarchy, as structured in the Bill, does not reflect how evidence-based psychological practice operates. Psychological practice standards require practitioners to integrate the best available research evidence with their expertise and the individual circumstances of the client, including evidence of what has and has not worked for that person in the past.

Subordinating demonstrated individual outcomes to population-level randomised control trial (RCT) evidence is inconsistent with the principles of evidence-based practice, including as expressed in the Psychology Board of Australia's competencies for psychologists, which require a balance between (i) the best possible research evidence – which may or may not be from RCTs, (ii) professional expertise, and importantly, (iii) the characteristics, values and preferences of each client.[12,15] The approach proposed under the Bill disregards the second and third co-equal pillars of evidence-based practice.

Many psychological interventions used in disability settings are adapted from standard protocols to meet the specific needs of participants with disability (e.g., cognitive, communication, and physical capacities). The peer-reviewed evidence base for adapted psychological therapy with disability populations is growing but remains less developed than evidence for mainstream clinical populations. An evidence hierarchy that privileges population-level generalisability will systematically disadvantage interventions that are individually tailored and appropriate, even where practitioners can demonstrate their effectiveness for the participant. The APS is particularly concerned that inflexible application of an evidence hierarchy is inappropriate for Aboriginal and Torres Strait Islander peoples, given the cultural biases and limitations of scientific sources of evidence.[16,12]

The proposed power to limit the maximum intensity of supports is equally concerning. Psychology supports for complex disability presentations, including complex trauma, severe treatment-resistant mental illness, or behaviours of concern often involving the use of regulated restrictive practices (e.g., chemical, physical or mechanical restraint, or seclusion), frequently require sustained engagement over an extended period. Setting a maximum therapy support intensity without consideration of a participant's individual circumstances and needs would be expressly contrary to evidence-based practice, functionally inadequate for many participants, and adverse to the intention of the Scheme. The appropriate duration and frequency of psychological intervention is a professional determination, not an administrative one, and should not be displaced by a ministerial decision without consideration of an individual participant's circumstances and needs.

The APS recommends:

- That the provisions in the Bill establishing an evidence hierarchy for "effective and beneficial" assessments be amended to state that evidence of demonstrated effectiveness for the individual participant carries substantial weight, and cannot be displaced by the absence of population-level RCT evidence;
- That before any instrument is made under s 33(2EA) in relation to psychology supports, the Minister be required to consult with the APS and other relevant professional bodies; and
- That any such instrument be subject to parliamentary disallowance and regular review.

2.4. SCCP Budget Reductions and Participants with Psychosocial Disability (new section 34A)

The Bill provides for ministerial determinations that reduce funding for specified groups of supports by a set percentage when plans are next reassessed or renewed. Cuts to Capacity Building Daily Activity (CBDA) supports, the category through which psychologists and other allied health professional provide the majority of their supports, have already been announced.[17] However, the Impact Analysis to the Bill has modelled even larger cuts to Social, Civic and Community Participation (SCCP) budgets by 50% under these new provisions.[4]

The Impact Analysis also shows that participants with psychosocial disability have the highest proportion of their total NDIS budgets committed to SCCP of any primary disability group (30% compared to a scheme average of 21%). Their average annualised SCCP budget is $18,700, meaning the 50% reduction will remove approximately $9,350 per participant on average from this cohort.

The APS is concerned that this reduction is being applied uniformly, without recognition that SCCP funding serves a fundamentally different purpose for participants with psychosocial disability than for other disability groups. For people with severe and persistent mental illness, social and community participation is not an ancillary or lifestyle support; it is a core component of psychosocial recovery. Evidence-based recovery frameworks, including the National Framework for Recovery-Oriented Mental Health Services,[18] consistently identify community connection, meaningful activity and social participation as therapeutic imperatives for this cohort. Reducing SCCP funding by 50% will directly impede the goals and capacity-building trajectories of some of the NDIS's most vulnerable and socially isolated participants.[19,20]

The Impact Analysis acknowledges that the decision to reset SCCP budgets "was not the topic of specific consultation." This is especially concerning given the known disproportionate impact on people with psychosocial disability.

The APS recommends:

- That proposed section 34A be omitted from the Bill, but if this is not agreed, that:
- That the support determination mechanism be subject to a specific functional impact assessment developed in consultation with psychology and mental health professional bodies before being applied to participants whose primary disability is psychosocial or who present with behaviours of concern (and who might be subject to regulated restrictive practices); and
- That the Bill be amended to require the Minister, in making a support determination, to consider the specific therapeutic function and purpose of SCCP for participants with psychosocial disability and not merely the general participant safety consideration currently provided for in new s 34A(3).

3. Conclusion

The APS does not oppose the principle that the NDIS must be financially sustainable and properly targeted to people with significant and permanent disability. We recognise the very real policy challenges the Bill is attempting to address. However, the Bill as currently drafted contains multiple provisions that will disproportionately, suddenly and adversely affect participants and the psychology services that support them.

Taken together, the permanence test, the direct causation requirement, the evidence hierarchy for effective and beneficial supports, and the uniform application of SCCP/CBDA budget reductions represent a significant and unexamined risk to the mental health and wellbeing of NDIS participants, those seeking access to the NDIS, and the family members and carers of Australians with disability. Those risks have not been adequately assessed or consulted upon, in part because of the pace at which this legislation has been developed. As such, the APS calls on the Committee to recommend that:

1. The commencement of provisions in the Bill whose operative effect depends substantially on future NDIS rules be delayed until those rules have been developed in consultation with all key stakeholders, and allowing for sufficient time for implementation;
2. Professional bodies, including the APS, be afforded a formal and standing consultative role in the development and review of rules to be made under the Bill, including relating to appropriate treatment, evidence requirements and therapy supports intensity caps;
3. The specific functional and social impacts of this Bill on participants with psychosocial disability be assessed through a targeted impact study before provisions affecting this cohort commence; and
4. The effect on the proposed reforms in the Bill and yet-to-be-developed rules on the outcomes, experience and wellbeing of participants be subject to formal evaluation, with mechanisms to address cases of individual and systemic harm which arise from these amendments.

This submission has focused on key provisions of the Bill with direct impact on psychologists and their clients. The APS holds concerns about multiple other provisions in the Bill for which there has been insufficient time for detailed consideration and comment. The APS endorses the submission made by Allied Health Professions Australia (AHPA) on other matters in the Bill which substantially and adversely affect allied health supports more generally.

The APS is willing to engage further with the Committee, Department and the NDIA on any of the issues raised in this submission. We consent to our submission being made publicly available. If any further information is required from the APS, I can be contacted through the National Office on (03) 8662 3300 or by email at z.burgess@psychology.org.au.

Yours sincerely

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Chief Executive Officer

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