



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

Senate Community Affairs Legislation Committee

May 2026



Acknowledgement of Country

MIFA acknowledges the Traditional Owners of the country throughout Australia and their continuing connection to land, sea and community. We pay our respect to them and their cultures and the Elders, past and present.

Recognition of Lived Experience

MIFA recognises and value the expertise of people, families and carers with living experience of mental health challenges. We uplift and amplify marginalised voices to create a more inclusive future for all.

About MIFA

The [Mental Illness Fellowship of Australia](#) (MIFA) is a leading national mental health organisation established in 1986. For four decades, MIFA has operated at the intersection of people, practice, and policy, providing government with trusted frontline intelligence on what works in Australia's mental health system and where the gaps persist.

Through our federation of community mental health [member organisations](#), MIFA connects frontline service delivery with national reform priorities. We lead and amplify lived experience nationally through platforms including [Finding North](#), [Out From the Mist](#), and [Schizophrenia Awareness Week](#). Our federation delivers psychosocial supports, support coordination, and psychosocial recovery coaching to Australians experiencing moderate to high need mental health challenges across the country.

MIFA has a direct and substantial interest in this Bill. The Australians we represent, people living with moderate to high need mental health challenges, their families and carers, and the community organisations that serve them, are among the most significantly affected by the reforms it proposes. This submission draws on four decades of frontline delivery experience, national policy expertise, and the voices of people with lived experience of psychosocial disability.

Contact

James Maskey
Chief Executive Officer
Mental Illness Fellowship of Australia
james.maskey@mifa.org.au | 0404 688 795
www.mifa.org.au



Contents

Executive Summary	3
1. The Process Is Inadequate	6
1.1 The paradox to name	7
2. The Bill's Internal Contradiction on Psychosocial Disability	7
2.1 What the evidence says	7
2.2 Why the proposed mitigation does not hold	8
2.3 What this means in real terms	9
3. The Foundational Supports Gap	9
3.1 What this means in real terms	9
3.2 The specific gap for psychosocial disability	10
3.3 Australians already outside of the system	10
3.4 The risk that must be named: Partners in Recovery, Day to Day Living, and the pattern	11
4. The Permanence Test: A Framework for the Wrong Population	12
4.1 The new framework and its logic	12
4.2 Why this framework is ill-fitted to high need mental health challenges	13
4.3 The access to treatment problem	13
5. A Framework Asking for Trust the Process Has Not Earned	14
5.1 What is in this Bill versus what is left to future rules	14
5.2 The informal carer burden this Bill creates	15
6. Support Coordination and Psychosocial Recovery Coaching	15
6.1 The scale of the market change	15
6.2 The specific risk for the community mental health sector	16
6.3 The cumulative effect that has not been modelled	16
7. The Provider Market and Thin Community Infrastructure	17
8. Summary of Recommendations	18
Closing Statement	19
Reference List	20



Executive Summary

The Mental Illness Fellowship of Australia (MIFA) is a national mental health organisation established in 1986. For four decades, MIFA has operated at the intersection of people, practice, and policy. Our federation of community mental health member organisations delivers psychosocial supports, support coordination, and psychosocial recovery coaching to Australians with high need mental health challenges across the country. This Bill affects the people we represent directly, significantly, and in some cases, irreversibly.

MIFA has said publicly, and reaffirms in this submission, that the NDIS must be financially sustainable. A scheme that grows without discipline will lose the community confidence it depends on, and a scheme that loses community confidence will ultimately fail the people it was built to serve. The Government is right to act.

What we contest is not the need for action. It is who this Bill acts on, in what sequence, without what foundations in place, and through what process. This Bill is being presented as protecting the NDIS for future beneficiaries. MIFA does not dispute that framing. What the evidence in this submission demonstrates is that the people positioned as future beneficiaries and the people this Bill acts on now are not separate populations. They are the same people, at different points in their lives. Reform that harms current participants to protect future ones is not protection. It is displacement.

MIFA has five substantive concerns, which this submission addresses in turn. MIFA has not addressed the fraud and governance provisions in Schedules 2 and 3, and is not positioned to assess their adequacy within the timeframe available for this inquiry. Our concerns are confined to the measures that carry direct and disproportionate consequences for people with psychosocial disability, their families, and the community organisations that serve them.

Concern 1: The consultation window is structurally inadequate.

The Government produced a 289-page Explanatory Memorandum to accompany this Bill and gave the sector fifteen days to respond to it in May 2026. That Memorandum states explicitly that two of the Bill's most consequential measures, the budget reset for social, civic and community participation funding, and the changes to reasonable and necessary supports “*should not be considered to have undergone specific consultation to date.*” The Senate Committee, and consequently Australia’s disability community, are being asked to scrutinise, in fifteen days, provisions affecting more than 390,000 current NDIS participants that the Government's own department acknowledges it has not consulted on.

Concern 2: The Bill contradicts its own evidence base on psychosocial disability.

The Explanatory Memorandum acknowledges that participants with a primary disability of psychosocial disability commit 30 per cent of their total plan budget to social and

community participation, the highest proportion of any disability group in the scheme (NDIA, 2026). It acknowledges that community participation is foundational to recovery for this cohort, and that it builds belonging, confidence, skills and social networks, and reduces isolation (NDIA, 2022). It then proposes to cut those budgets by 50 per cent, without a specific impact assessment for this cohort, and without mitigation measures that are practically adequate for people with high need mental health challenges and psychosocial disability. The EM's own evidence on why group settings and core budget flexibility do not work for this population makes the inadequacy of those mitigations plain.

Concern 3: The foundational supports architecture for people with psychosocial disability does not exist.

The Government has honoured its own sequencing principle for children. Eligibility changes for the Thriving Kids cohort will not take effect until foundational supports are operational. No equivalent protection applies to adults with psychosocial disability. The remaining \$6 billion in Foundational Supports, of which the Commonwealth has provisioned \$3 billion in the 2026-27 Budget subject to matching by states and territories, has no agreed model for this cohort, no confirmed implementation timeline, and no demonstrated readiness in any jurisdiction. The Bill proposes to tighten eligibility for a population the EM itself acknowledges has nowhere else to go.

Concern 4: The permanence test is ill-fitted to the reality of high need mental health challenges.

New section, 25A, requires a person to have undergone all appropriate treatment before their impairment can be found permanent. For people with high need mental health challenges, whose treatment landscape is contested, whose responses are variable, and whose presentation is episodic and fluctuating, this test creates real eligibility risk. The framework has coherent logic for physical impairments with clear treatment pathways. But this coherent logic does not translate to psychosocial disability. Compounding this, the EM explicitly dismisses geographical and financial access barriers to treatment as irrelevant to the permanence assessment, an assumption that fails people in regional and remote communities and those for whom system failures, not personal choices, have constrained treatment access.

Concern 5: The Bill is a framework, not a completed reform, and it asks for trust the process has not earned.

The most operationally consequential provisions for people with psychosocial disability do not yet exist. The functional capacity threshold that will determine NDIS eligibility will be developed by a Technical Advisory Group yet to be established, and set through NDIS rules yet to be written. The rules under section 25A(5), which will determine how

the permanence test applies to people with psychosocial disability specifically, have had, by the EM's own admission, no specific prior consultation. These are not implementation details. They are the substance of the reform for this cohort. The Committee is being asked to pass enabling legislation whose most consequential content has not been designed, let alone consulted on.

Taken together, these concerns point to a common failure. This Bill reduces support for a vulnerable population before alternative infrastructure exists, without adequate consultation, and on a timeline that precludes meaningful scrutiny. That is not sustainable reform. It is risk transfer. The people this Bill most affects are the least positioned to absorb what it gets wrong.

#	Recommendation	In brief
1	Extend the consultation process	No measure that has had no prior consultation should be enacted until a genuine, accessible, community-led process is completed.
2	Defer SCCP/CBDA reductions for psychosocial disability	A specific impact assessment must be completed and adequate non-NDIS supports must be operational before budget reductions proceed for this cohort.
3	Apply the sequencing principle to adults with psychosocial disability	Eligibility tightening must not proceed until Foundational Supports for this cohort are funded, designed and operational in all jurisdictions.
4	Ensure the permanence test is fit for high need mental health challenges	Rules under section 25A(5) must be co-designed with people with lived experience and the community mental health sector before finalisation.
5	Co-design a psychosocial stream in the commissioned model	A dedicated psychosocial stream must be co-designed with Psychosocial Recovery Coaches, lived experience, and community mental health providers.
6	Cumulative impact assessment for psychosocial disability	A published cumulative impact assessment across all measures in this Bill is required for this cohort before the Bill proceeds.
7	Protect provider viability in thin markets	A specific market analysis is required for community mental health providers in regional, rural and remote areas.

1. The Process Is Inadequate

The Bill was introduced to Parliament on 14 May 2026. Submissions for this Inquiry close 29 May 2026. The Committee reports 16 June 2026. That is a fifteen-day submission window for legislation of genuine constitutional and human rights significance, affecting more than 774,000 current NDIS participants and an indeterminate number of prospective ones.

To understand why that matters, MIFA considers what the Government's own 289-page Explanatory Memorandum (EM) states about prior consultation, in relation to two of the Bill's most consequential measures:

EM, Section 5.3.2: Budget reset for social and community participation supports:

"This measure should not be considered to have undergone specific consultation to date."

EM, Section 5.3.3: Changes to reasonable and necessary supports:

"[T]his measure was not the topic of specific consultation."

These are not procedural technicalities. The Social, Civic and Community Participation Supports budget cut will directly affect 393,401 NDIS participants, 52 per cent of the entire scheme (NDIA, 2026). The changes to 'reasonable and necessary' affect the foundational decision-making framework for every planning outcome in the NDIS. Both carry direct and disproportionate consequences for the 63,131 participants whose primary disability is psychosocial disability (NDIA, 2026).

The Government committed explicitly, as a condition of NDIS reform, to genuine and accessible consultation with the disability community. The NDIS Review stated that changes of this nature should be co-designed in accordance with 'nothing about us, without us.' The United Nations Convention on the Rights of Persons with Disabilities, which Australia has ratified, and which the EM invokes as its human rights framework, requires that persons with disabilities be involved in the development and implementation of legislation that affects them.

It is therefore not merely inconsistent but structurally contradictory for the Government to invoke a human rights framework requiring genuine participation while allowing fifteen days for scrutiny of measures that have not been specifically consulted on. For people experiencing high need mental health challenges, who may require supported engagement with complex legislation, and for whom further exclusion from the scheme creates its own acute stress, a fifteen-day window is not functionally a consultation.

1.1 The paradox to name

Minister Butler confirmed at the National Press Club on 22 April 2026 that genuine community consultation is a precondition for further NDIS reform. The EM reaffirms this in describing future implementation. And yet the Bill that initiates those reforms proceeds through a Senate inquiry, with a two-week turnaround, without having consulted on its most significant measures. Poorly sequenced reform produces consequences that are not accidental. They are predictable. What a compressed inquiry prevents is not inconvenience to the sector. It is the surfacing of knowledge that departmental modelling does not hold and cannot replicate. That knowledge gap does not fall on the Government. It falls on the people the legislation is supposed to serve.

RECOMMENDATION 1

Extend the consultation process

The Committee should seek an extension to the submission deadline and reporting date. No measure identified in the EM as having had no specific prior consultation should be enacted until a genuine, accessible, and community-led consultation process has been completed. This applies at minimum to the SCCP/CBDA budget reductions and the reasonable and necessary changes.

2. The Bill's Internal Contradiction on Psychosocial Disability

2.1 What the evidence says

The Bill's most immediate financial impact on people with high need mental health challenges comes through the proposed cut to Social and Community Participation (SCCP) budgets by 50 per cent, and a 10 per cent reduction to Capacity Building Daily Activity (CBDA) budgets. These are legislated reductions applied through ministerial determination, commencing from October 2026 (Department of Health, Disability and Ageing, 2026). These are not incidental or discretionary elements of a support package for this population. For many participants with psychosocial disability, they are the core substance of an NDIS plan.

The EM acknowledges this directly. Participants with a primary disability of psychosocial disability commit 30 per cent of their total plan budget to SCCP, the highest proportion of any disability group in the scheme (NDIA, 2026). The EM explains why. People with psychosocial disability “*may require less support with activities of daily living compared to someone with a physical disability*” but “*may experience significant barriers to accessing the community*” (Department of Health, Disability and Ageing, 2026, para 9.3.1). NDIA (2022) research finds that community participation for this cohort “*provides a sense of belonging, increases confidence, builds skills and social networks and reduces isolation.*”



This evidence is not contestable. The evidence that community participation is therapeutic, recovery-supporting, and functionally necessary for people living with high need mental health challenges is strong, consistent, and reflected in two decades of psychosocial recovery literature. The Government’s own data reflects it. And the Bill proceeds to cut those budgets anyway.

2.2 Why the proposed mitigation does not hold

The EM offers two mitigation arguments. Firstly, participants can access group supports at lower prices, and secondly, Core budget flexibility allows participants to compensate. Neither holds for people with high need mental health challenges.

The EM acknowledges, citing its own NDIA research, that barriers to community participation for people with psychosocial disability include that *“mainstream options are not inclusive, and difficulties in finding the right support from providers to facilitate genuine inclusion, with some participants deferring to disability-specific options for a safer experience”* (Department of Health, Disability and Ageing, 2026; NDIA, 2022).

In plain terms, the Government's own evidence confirms that group settings are not equivalent for this population. For many people with high need mental health challenges, the individual therapeutic relationship with a known and trusted support worker is not an optional premium. It is the mechanism through which participation becomes possible at all.

The Core budget flexibility argument is equally hollow. For participants whose plan is structured primarily around SCCP, because their functional limitations are in community access rather than daily living tasks, there is no meaningful Core buffer to draw on. The EM’s own utilisation data is instructive. Non-SIL participants use 86 per cent of their SCCP budgets on average (NDIA, 2026). High utilisers, by definition, the participants most dependent on SCCP, will face a spending cut that maps closely to the 50 per cent budget cut, not the smaller ‘effective’ reduction the EM projects across the scheme as a whole.

What the EM’s own evidence acknowledges	What the Bill does
Psychosocial participants commit 30% of plan budgets to SCCP, the highest of any disability group (NDIA, 2026)	Cuts SCCP budgets by 50% for all 393,401 participants with SCCP funding, commencing October 2026
SCCP is foundational to recovery: it builds belonging, confidence, skills, social networks and reduces isolation (NDIA, 2022)	Assumes group supports and Core budget flexibility will compensate; offers no specific mitigation for psychosocial disability
People with psychosocial disability face specific barriers to community participation and often require individually tailored support for a ‘safer experience’ (Department of Health, Disability and Ageing, 2026)	No specific impact assessment for this cohort has been conducted or published

Budget reset has had no specific consultation (Department of Health, Disability and Ageing, 2026)

Proceeds to legislation regardless

2.3 What this means in real terms

The people whose SCCP budgets are being reduced are not generalisations in a policy model. They are people managing schizophrenia, bipolar disorder, depression, PTSD, and the complex intersecting vulnerabilities those conditions produce. Many live alone. Many have fractured family relationships. Many have experienced long periods of social isolation that NDIS-funded community access has painstakingly begun to reverse.

A 50 per cent cut to SCCP funding does not simply mean fewer hours of community access support. For a person experiencing high need mental health challenges, reduced supported community participation may mean withdrawal from the social networks that provide early warning of relapse, loss of structured routine that supports medication adherence, and retreat into isolation that, over time, increases acute crisis risk, emergency department presentations, and hospital admissions. The EM acknowledges that budget reductions will likely lead to reduced community access for participants and proceeds with the reduction regardless (Department of Health, Disability and Ageing, 2026).

The economic argument for community participation investment is well established. Research consistently demonstrates that psychosocial support programs produce benefit-cost ratios exceeding 3:1 through reduced hospitalisations, improved housing stability, and greater workforce participation (Productivity Commission, 2020; KPMG & Mental Health Australia, 2018). Flatau et al. (2026) documented the broader economic value of psychosocial supports across downstream savings in health, justice, and welfare systems. Reducing SCCP budgets for this population does not save the NDIS money in any durable sense. It shifts cost to emergency departments, state mental health services, and the informal caring responsibilities of families.

RECOMMENDATION 2

Defer SCCP and CBDA reductions for participants with psychosocial disability

Budget reset measures should not proceed for participants with a primary disability of psychosocial disability until a specific, published impact assessment has been conducted for this cohort in genuine consultation with people with lived experience and the community mental health sector, and until adequately scaled non-NDIS psychosocial supports are operational and accessible in all jurisdictions.

3. The Foundational Supports Gap

3.1 What this means in real terms



The Government's justification for tightening NDIS eligibility rests substantially on the Foundational Supports commitment. That people who exit or are prevented from accessing the NDIS will have a viable alternative ecosystem of supports. MIFA does not dispute the importance of building that ecosystem. The NDIS was never intended to be the sole source of support for people with disability in Australia.

The problem is sequencing. The NDIS Review was explicit, stating that changes to NDIS access "*should only be implemented once widespread foundational supports are in place*" (NDIS Review, 2023). The Government has honoured this principle for children. Thriving Kids eligibility changes will not take effect until January 2028, once the program is fully operational. No equivalent sequencing protection applies to adults with psychosocial disability.

3.2 The specific gap for psychosocial disability

The \$10 billion Foundational Supports commitment is directed primarily at children. Thriving Kids accounts for \$4 billion. The remaining \$6 billion is described in the EM as "*further Foundational Supports to be delivered,*" subject to future negotiation between the Commonwealth and states and territories. In the 2026-2027 Federal Budget, the Commonwealth has provisioned \$3 billion for Foundational Supports. However, within this \$3 billion, there is no agreed model for adults with psychosocial disability, no published funding allocation specifically for psychosocial supports, no confirmed timeline, and no demonstrated implementation readiness in any jurisdiction (Department of Health, Disability and Ageing, 2026).

The EM acknowledges that only 4 per cent of all disability funding in Australia is currently spent on supports outside the NDIS (NDIA, 2026). It acknowledges that the availability of disability services outside the NDIS has diminished since the NDIS was rolled out, and that this was "*particularly problematic for... people with psychosocial disability*" (Department of Health, Disability and Ageing, 2026). It invokes the NDIS Review's 'oasis in the desert' framing, noting people with psychosocial disability have come to rely on the NDIS because there is "*nowhere else to go.*" The proposal is to tighten eligibility before the surrounding landscape has been irrigated.

The sequencing failure in plain terms:

The Government has applied the 'supports must exist first' principle to children. It has not applied it to adults with psychosocial disability. This is the difference between reform that is orderly and reform that simply displaces unmet need from one underfunded system to another.

3.3 Australians already outside of the system

There are approximately 500,000 Australians living with moderate to high need mental health challenges who are outside the NDIS and without adequate psychosocial supports



(Department of Health and Aged Care, 2024; Grattan Institute, 2025). Their families and carers carry much of what the system does not. Together, they represent more than one million people.

The Bill tightens NDIS eligibility while the Foundational Supports architecture for this cohort remains undefined. Those who are currently in the scheme and whose eligibility is reassessed downward will join the 500,000. Both groups will need support from a community mental health system that is already under-resourced, that relies substantially on NDIS revenue to sustain its workforce, and that will simultaneously face reduced funding through the SCCP and support coordination reforms in this very Bill.

Mental ill-health accounts for approximately 15 per cent of Australia's total disease burden but receives around 7 per cent of government health expenditure (Australian Institute of Health and Welfare, 2023; Productivity Commission, 2020). The community tier being invoked as the backstop for NDIS eligibility tightening is chronically underfunded. The proposal is to create the overflow before the infrastructure to absorb it exists.

3.4 The risk that must be named: Partners in Recovery, Day to Day Living, and the pattern

Minister Butler spoke at the National Press Club on 22 April 2026 about Partners in Recovery and Day to Day Living, noting that “*we don't need to reinvent the wheel*” when those programs worked well. MIFA acknowledges the Minister's genuine familiarity with this evidence base. But acknowledgement is not a funding commitment.

Partners in Recovery operated from 2013 to 2019, supporting approximately 35,000 Australians with serious and persistent mental health challenges through coordinated service access across provider consortia nationally, before being decommissioned as participants transitioned into the NDIS. Day to Day Living operated from 2012 to 2019, funding community-based psychosocial support for people with high need mental health challenges outside the NDIS.

Partners in Recovery was evaluated as effective, recovery-oriented, and valued by participants and providers (Cheverton & Janamian, 2016). Day to Day Living produced demonstrated outcomes in housing stability, community participation, and reduced acute presentations. Both were wound down without equivalent replacement.

The structural risk with Foundational Supports is not that the Government will fail to acknowledge the importance of psychosocial recovery supports. It is that the next National Mental Health and Suicide Prevention Agreement will treat those programs as proof of concept without funding their future at equivalent scale. Australia's federal architecture creates persistent incentives for cost-shifting between Commonwealth and states (Scharpf, 1988; Productivity Commission, 2025). A National Agreement without binding, jurisdiction-specific accountability will not resolve this. It will repeat it (Rosenberg et al., 2023).

Structural risk	What it means for people with psychosocial disability
Cost-shifting	Federal architecture incentivises Commonwealth and states to attribute responsibility to each other. Without binding accountability, psychosocial support investment remains aspirational.
Path dependency	Hospital-centric crisis models are embedded in funding, workforce, and governance. A new Agreement that does not structurally disrupt this will replicate it in updated language (Pierson, 2000; Hall, 1993).
The PiR/Day to Day Living risk	Both programs were effective, evidenced, and widely valued. Both were wound down without genuine replacement. The risk is that the next Agreement honours them as proof of concept without funding their future at scale.
Foundational Supports gap	No agreed model, or timeline for psychosocial Foundational Supports for adults. Eligibility tightening proceeds ahead of any demonstrated readiness.

RECOMMENDATION 3

Apply the sequencing principle to adults with psychosocial disability

Eligibility tightening measures affecting people with psychosocial disability should not proceed until the Government can demonstrate that Foundational Supports for this cohort are funded, designed, and operational across all jurisdictions. The Committee should seek specific evidence on implementation readiness before recommending the Bill proceed in its current form.

4. The Permanence Test: A Framework for the Wrong Population

4.1 The new framework and its logic

New section 25A defines ‘appropriate treatment’ as treatment that is evidence based, regularly undertaken in Australia, and can reliably be expected to improve, reverse or alleviate the impact of an impairment. A person must be found to have undergone all appropriate treatment before their impairment can be found permanent. For physical impairments with linear treatment pathways, this has coherent logic, as illustrated in the EM’s ‘Matiu’ example, where permanence is established through an exhaustive treatment history with clear specialist advice.



The EM acknowledges that people with psychosocial conditions “*may require ongoing or intermittent treatment throughout their lives*” and inserts a note to this effect. MIFA acknowledges this provision. However, it does not resolve the fundamental problem.

4.2 Why this framework is ill-fitted to high need mental health challenges

The treatment landscape for high need mental health challenges is fundamentally different from the treatment landscape for physical disability. Psychiatric treatment is characterised by significant individual variability in response, contested evidence bases for specific interventions, and a clinical reality in which the absence of full treatment response does not establish permanence or indicate that further treatment is warranted.

Under the new framework, a person’s eligibility will turn partly on whether an assessor concludes there are further evidence-based treatments available that have not been pursued. For high need mental health challenges, that determination cannot be made with the clinical clarity available for a physical impairment. The question of whether a person has “*undertaken all appropriate treatment*” for schizophrenia, treatment-resistant depression, or complex PTSD has no simple or defensible answer. Assessors making these determinations will require specific, deep expertise in psychosocial disability. They will need to understand the episodic, fluctuating nature of high need mental health challenges, including the fact that a person may present as relatively functional at assessment and significantly impaired at other times.

The rules to be made under section 25A(5), which will determine how the permanence test applies to people with psychosocial disability, have not been developed or consulted on.

4.3 The access to treatment problem

The EM states that ‘a person’s personal and environmental circumstances, including financial and geographical circumstances, are not relevant in considering whether a person has undertaken all appropriate treatment’ (Department of Health, Disability and Ageing, 2026). The rationale given is that ensuring access to mainstream treatment is the responsibility of other systems. This is a policy aspiration, not a description of reality.

Australia’s mental health system is characterised by precisely the access failures this provision assumes away. Mental ill-health accounts for 15 per cent of the total disease burden but receives approximately 7 per cent of government health expenditure (Australian Institute of Health and Welfare, 2023, 2024; Productivity Commission, 2020). Penalising people for the failure of systems they depend on is not consistent with the human rights framework the EM invokes. It is a particularly acute risk for people in rural and remote communities, for First Nations people, and for those whose presentation has made sustained treatment engagement difficult through lack of available services rather than lack of will.

The United Nations Convention on the Rights of Persons with Disabilities, which Australia has ratified and which the EM invokes as its human rights framework, requires that persons with disabilities have access to the health services they need without discrimination. Article 25 explicitly states that the right to health services must be provided as close as possible to people's own communities. A permanence test that treats inaccessible treatment as equivalent to declined treatment does not merely fall short of that standard. It inverts it, penalising people for the failure of the very systems the Convention requires governments to provide.

RECOMMENDATION 4

Ensure the permanence test is fit for high need mental health challenges

Rules under section 25A(5) must be developed through genuine co-design with people with lived experience of psychosocial disability and community mental health providers before finalisation. The Committee should seek specific advice on how assessors will be trained to apply the permanence test to episodic and fluctuating presentations, and how the test will operate where appropriate treatment is theoretically available but practically inaccessible.

5. A Framework Asking for Trust the Process Has Not Earned

5.1 What is in this Bill versus what is left to future rules

Minister Butler's second reading speech confirmed that a Technical Advisory Group will be established to advise on the appropriate threshold and assessment methods for substantially reduced functional capacity, and that this advice will then inform NDIS rules. The Bill legislates the framework. It does not contain the rules themselves.

This matters. It means the Committee is being asked to pass legislation whose most operationally consequential provisions, including the functional capacity threshold that will determine NDIS eligibility, and the circumstances that determine how the permanence test applies to people with psychosocial disability, do not yet exist.

The EM is explicit: *"several other key changes will be implemented through the design and development of legislative instruments, including 'circumstances which go to determining whether an individual has undertaken all appropriate treatment for the purposes of determining whether an impairment is permanent'"* (Department of Health, Disability and Ageing, 2026). These instruments will be made outside the current parliamentary process.

The Disability Representative Organisations made this point in their joint statement on 14 May 2026: the Bill's *"highly technical content, with substantial elements left to future rules, operational decisions and implementation arrangements, requires careful and detailed analysis."* MIFA endorses that characterisation. For the psychosocial disability cohort, the rules that will define their treatment obligations, their eligibility threshold, and their access to

support coordination are not yet written. A fifteen-day submission window to scrutinise a framework Bill whose operational detail is deferred to future instruments is not adequate legislative scrutiny.

5.2 The informal carer burden this Bill creates

The EM acknowledges that SCCP budget reductions “are likely to increase informal caring responsibilities, which may impact levels of social and economic participation for female carers” (Department of Health, Disability and Ageing, 2026). It notes that 67.7 per cent of primary carers were women in 2022 (NDIA, 2026). It then describes this as a matter for future consideration in the design of market reforms.

MIFA names this more plainly. When a person with high need mental health challenges loses supported access to their community, the support does not disappear. It is absorbed, informally and without compensation, by the people closest to them, many of whom have already structured their own employment and social participation around existing caring responsibilities. The EM identifies this dynamic and frames it as an equity issue requiring monitoring. MIFA submits that it is a foreseeable harm requiring prevention.

Families caring for a person with high need mental health challenges carry substantial loads already, including managing medications, attending appointments, responding to crisis presentations, and navigating a fragmented system. For many, the NDIS-funded community participation their family member receives is also what provides them respite, structured time in which they can work, rest, and maintain their own health. A 50 per cent cut to SCCP budgets transfers informal labour onto families, with no corresponding investment in carer support. That is a cost the EM acknowledges, and the Bill ignores.

6. Support Coordination and Psychosocial Recovery Coaching

6.1 The scale of the market change

The EM is candid that the preferred option, commissioning a new support coordination and connection service with capped program expenditure from mid-2028, “would create significant change to the support coordination market” and “is likely to reshape’ it, including the possibility of new entrants and the exit of a significant number of existing support coordination providers” (Department of Health, Disability and Ageing, 2026). There are approximately 10,000 support coordination providers in the current market, of whom only 4,783 were registered as at December 2025 (NDIA, 2026).

For community mental health organisations that have built psychosocial recovery coaching and support coordination capacity over years, in many cases, over decades, this is not an abstract market adjustment. It is an existential business risk, presented without a defined model, a confirmed funding envelope, or a clear implementation timeline.



The EM acknowledges that “*decisions about trade-offs would be informed by further analysis of commissioning processes, market readiness and cost benefits*” (Department of Health, Disability and Ageing, 2026). Those decisions have not been made.

6.2 The specific risk for the community mental health sector

MIFA member organisations have built therapeutic relationships with participants over years, relationships that are not transactional but clinically significant. Therapeutic alliance, continuity of relationship, and lived experience alignment in support workers are among the most significant predictors of recovery outcomes for people with high need mental health challenges (Productivity Commission, 2020; National Mental Health Commission, 2022). A commissioned service model operating within capped program funding and standardised service specifications may not preserve these features.

The EM acknowledges that a capped model will require “*trade-offs across service intensity and scope*” and that “*people with more complex needs*” may receive lower intensity support within the funded envelope (Department of Health, Disability and Ageing, 2026). People with psychosocial disability and complex presentations are, by definition, among those with the most complex needs. A model that delivers lower intensity support to the highest complexity participants will produce worse outcomes for that cohort. The economics may appear tidy. The human cost is not.

6.3 The cumulative effect that has not been modelled

The support coordination reform does not operate in isolation. It intersects directly with the SCCP budget reductions, the New Framework Planning rollout, and the eligibility changes in this Bill. A participant with psychosocial disability will simultaneously face a cut to their SCCP budget, a possible eligibility reassessment, a transition to new framework planning, and a change in how their support coordination is delivered. The EM acknowledges the interconnectedness of the reforms but has not published a cumulative impact assessment for the psychosocial disability cohort. MIFA is deeply concerned that the cumulative effect will be significantly worse than any single measure modelled in isolation.

RECOMMENDATION 5

Co-design a dedicated psychosocial stream in the commissioned model

The design of the new support coordination and connection service must include a dedicated stream for psychosocial disability, co-designed with people with lived experience, Psychosocial Recovery Coaches, and community mental health providers.

Transition arrangements must protect continuity of therapeutic relationships. The model must not resolve funding trade-offs by delivering lower intensity support to the highest complexity participants.

RECOMMENDATION 6

Commission a cumulative impact assessment for psychosocial disability

A published cumulative impact assessment across all measures in this Bill is required for participants with primary psychosocial disability before the Bill proceeds. The interaction of SCCP reductions, eligibility tightening, New Framework Planning, and support coordination commissioning must be assessed as a whole for this cohort.

7. The Provider Market and Thin Community Infrastructure

The EM acknowledges that significant reductions to NDIS supports could result in “increasing provider viability risks, provider exits and workforce impacts,” and that should providers withdraw from regions or specialised service types, this would ‘further exacerbate existing thin markets and increase risks to continuity of support’ (Department of Health, Disability and Ageing, 2026). This analysis was used to justify a more moderate approach. But the underlying dynamic applies to the measures the Government has chosen to proceed with.

The NDIS workforce is highly casualised (Department of Health, Disability and Ageing, 2026). Community mental health providers are heavily dependent on NDIS revenue. The combination of SCCP budget reductions and support coordination market restructuring will create financial pressure on community managed organisations that is structural, not peripheral. The EM explicitly acknowledges that SCCP budget reductions ‘may exacerbate provider viability in already thin markets’ in regional areas (Department of Health, Disability and Ageing, 2026).

Community mental health organisations are not interchangeable units of service delivery. They are embedded local institutions with community relationships, cultural knowledge, and histories of navigating the specific vulnerabilities of the populations they serve. When those organisations exit a market, the relationships, the workforce, and the community trust they have built are not replaced by the next provider on a platform list. That loss is not captured in any cost model.

RECOMMENDATION 7

Protect community mental health provider viability in thin markets

The Committee should seek a specific market analysis for community mental health providers delivering psychosocial supports, support coordination, and Psychosocial Recovery Coaching in regional, rural and remote areas. The Government must demonstrate how continuity of service will be maintained in thin markets through the transition to commissioned models.

8. Summary of Recommendations

The Committee's scrutiny of this Bill should be informed by the following seven recommendations, each addressing a specific process or substance concern identified in this submission.

RECOMMENDATION 1

Extend the consultation process

The Committee should seek an extension to the submission deadline and reporting date. No measure that has had no specific prior consultation should be enacted until a genuine, accessible, and community-led process is completed.

RECOMMENDATION 2

Defer SCCP and CBDA reductions for participants with psychosocial disability

Budget reset measures should not proceed for participants with a primary disability of psychosocial disability until a specific impact assessment is published and until adequately scaled non-NDIS psychosocial supports are operational and accessible in all jurisdictions.

RECOMMENDATION 3

Apply the sequencing principle to adults with psychosocial disability

Eligibility tightening must not proceed until the Government can demonstrate that Foundational Supports for this cohort are funded, designed and operational. The Committee should seek specific evidence on implementation readiness in every jurisdiction.

RECOMMENDATION 4

Ensure the permanence test is fit for high need mental health challenges

Rules under section 25A(5) must be developed through genuine co-design with people with lived experience and the community mental health sector before finalisation. The Committee should seek specific advice on assessor guidance for episodic presentations and treatment access barriers.

RECOMMENDATION 5

Co-design a dedicated psychosocial stream in the commissioned model

The design of the new support coordination and connection service must include a dedicated psychosocial stream, co-designed with lived experience, Psychosocial Recovery Coaches, and community mental health providers, with explicit continuity protections for therapeutic relationships.

RECOMMENDATION 6

Commission a cumulative impact assessment for psychosocial disability

A published cumulative impact assessment across all measures in this Bill is required for the psychosocial disability cohort before the Bill proceeds.

RECOMMENDATION 7

Protect community mental health provider viability in thin markets

A specific market analysis is required for community mental health providers in regional, rural and remote areas, with a clear government account of how continuity of service will be maintained through the commissioned model transition.

Closing Statement

MIFA has engaged constructively with NDIS reform for years. We will continue to do so. We understand that a scheme that is not sustainable cannot serve anyone well, and that the Government is right that doing nothing was not an option.

But reform done in haste, without adequate consultation, without ensuring alternative infrastructure exists before existing supports are reduced, and without a specific account of what these changes mean for the most vulnerable participants in the scheme, is not sustainable reform. It is risk transfer. The people who pay the price for poorly sequenced reform are seldom the people with institutional standing in the policy process.

The pattern this Bill repeats is a known one. Several consecutive national mental health plans over thirty years each identified the same gaps, committed to the same solutions, and each failed to resolve them because the structural conditions that produced the gaps were not addressed (Productivity Commission, 2020; Rosenberg et al., 2023). Tightening NDIS eligibility while underfunding community alternatives does not break that pattern. It deepens it.

MIFA is willing to give evidence at a public hearing and to provide the Committee with further information on any matter raised in this submission.



Reference List

- Australian Institute of Health and Welfare. (2023). *Mental health conditions and substance use disorders a leading cause of disease burden in 2023*. <https://www.aihw.gov.au>
- Australian Institute of Health and Welfare. (2024). *Expenditure on mental health services*. Australian Government.
- Cheverton, J., & Janamian, T. (2016). The Partners in Recovery program: mental health commissioning using value co-creation. *Medical Journal of Australia*, 204(S7). <https://doi.org/10.5694/mja16.00124>
- Department of Health and Aged Care. (2024). *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme: Final report*. Australian Government.
- Department of Health, Disability and Ageing. (2026). *National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026: Explanatory Memorandum*. Australian Government.
- Flatau, P., Kaleveld, L., Callis, Z., & Koppers, D. (2026). *Capturing the economic value of psychosocial supports*. Centre for Social Impact, University of Western Australia. <https://doi.org/10.60836/tbyr-r819>
- Grattan Institute. (2025). *Bridging the gap: Meeting the needs of Australians with psychosocial disability*. <https://grattan.edu.au/report/bridging-the-gap-meeting-the-needs-of-australians-with-psychosocial-disability/>
- Hall, P. A. (1993). Policy paradigms, social learning, and the state: The case of economic policymaking in Britain. *Comparative Politics*, 25(3), 275-296.
- KPMG & Mental Health Australia. (2018). *Investing to save: The economic benefits for Australia of investment in mental health reform*.
- National Disability Insurance Agency. (2022). *'Getting out into the world': Pathways to community participation and connectedness for NDIS participants with intellectual disability, on the autism spectrum and/or with psychosocial disability*. NDIA.
- National Disability Insurance Agency. (2026). *Explore data*. <https://data.ndis.gov.au>
- National Disability Insurance Scheme Review. (2023). *Working together to deliver the NDIS: Final report*. Australian Government.
- National Mental Health Commission. (2022). *Vision 2030: Blueprint for mental health and suicide prevention*. Australian Government.



Pierson, P. (2000). Increasing returns, path dependency, and the study of politics. *American Political Science Review*, 94(2), 251-267.

Productivity Commission. (2020). *Inquiry report: Mental health*. Australian Government.

Productivity Commission. (2025). *Inquiry report: Mental health and suicide prevention agreement review*. Australian Government.

Rosenberg, S., Salvador-Carulla, L., & Rosen, A. (2023). Mental health reform in Australia: Unfinished business. *BJPsych International*, 20(4), 99-101.

Scharpf, F. W. (1988). The joint-decision trap: Lessons from German federalism and European integration. *Public Administration*, 66(3), 239-278.