



Consultation on NDIS Access Changes

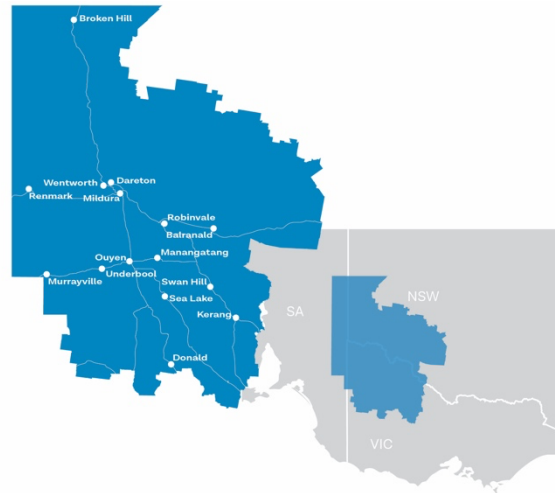
Submission to the Department of Health, Disability and
Ageing

Mallee Family Care | September 2026

www.malleefamilycare.com.au

1. About Mallee Family Care

Mallee Family Care (MFC) is a not-for-profit, place-based community services organisation headquartered in Mildura and delivering services across the Mallee region of north-west Victoria, south-west New South Wales and the Riverland of South Australia since 1979. With around 300 staff delivering more than 70 programs, MFC provides family support, child protection, foster and kinship care, financial wellbeing, family violence response, mental health services and disability support under the NDIS.



In the disability space, MFC delivers support coordination and specialist support coordination to around 184 active participants, early childhood services under the key worker model, and operates the Mental Health and Wellbeing Connect Centre for carers and families. MFC works with participants with complex and high support needs, including a substantial cohort living with psychosocial disability, co-occurring drug and alcohol use, and involvement with justice, child protection and clinical mental health systems, in communities with limited access to specialist services. MFC no longer delivers allied health services directly, which is itself an indicator of the viability challenges facing service delivery in thin regional markets. This experience directly informs the perspectives set out in this submission.

The perspectives in this submission draw on the practice experience of MFC's support coordination and specialist support coordination team. Examples have been de-identified and, where they could identify a person in a small community, reduced to the systemic point they illustrate.

2. What MFC supports

MFC welcomes the opportunity to contribute to the design of the future NDIS access process and supports the direction the Government has set. Access decisions based on diagnosis rather than functional impact have produced inconsistent outcomes, and MFC's practitioners see both sides of that inconsistency in their caseloads. A standardised, evidence-based assessment of functional capacity is a reasonable response to that problem, and the seven draft guiding principles are the right values to build it on.

MFC also recognises the Government's concern for the long-term sustainability of the Scheme, and does not contest the case for clearer boundaries between the NDIS and other systems of support.

MFC's concern is not the direction. It is that an access process designed around metropolitan assumptions of service availability, communication and capacity will not deliver the consistency and fairness it promises in the Mallee, and may widen the gap it is intended to close. This submission sets out where that risk lies and what would address it.

3. Summary of MFC's position

The principles are sound. The risk is in how they are lived out

Every principle in the draft describes an intent MFC shares. The examples in this submission show how each is already contradicted by administrative practice, and the principles as drafted contain no commitment to change that practice. A principle of proactive reach, placing responsibility on the system to find and engage people rather than on people to find the system, would give the others force.

The process must not assume capacity, or an advocate with capacity

The consistent experience of MFC's practitioners is that NDIS processes are conditional on a person being able to identify themselves, receive and respond to communication, attend an office, and understand what is being asked. Many participants can do none of these without support, and the system's response to that has been to withdraw the channels that supported them.

An evidence-based process is only equitable where the evidence can be obtained

A functional capacity assessment is fairer than a diagnosis list only if people can access one. In the Mallee, that depends on a thin allied health workforce, long waits, travel and cost. A process that requires evidence the region cannot produce reintroduces the inequity the reform is meant to remove.

Where treatment is not accessible, an impairment is permanent in effect

The definition of permanence now depends on whether an impairment is likely to be remedied by available and appropriate treatment. In practice, availability is a function of distance, cost and waiting time, and treatment that exists in Melbourne is not available to a participant who cannot get there.

Cross-system communication must trigger action, not wait for consent the person cannot give

Notifications from hospitals, health liaison officers and justice services should prompt the NDIA to act. At present they are declined where the participant has not initiated contact, including where the participant is unable to.

The region needs a guided entry pathway

Information on the NDIA website does not reach people who cannot navigate it. Mildura has no functioning single point of entry for people seeking to establish eligibility, and towns such as Ouyen, Robinvale and Walpeup have no NDIA, LAC or partner presence at all. A funded, local, person-to-person pathway from first enquiry through to an access decision is the single change that would most reduce burden.

4. Recommendations

MFC recommends that the future NDIS access decision-making process:

Recommendation 1

Adopt a principle of proactive reach. Non-response becomes a trigger for outreach, not grounds for suspending a plan.

Recommendation 2

Communicate in the form the person can use. Mail, shared household contact points and contact through a nominated provider.

Recommendation 3

Fund a local, person-to-person entry pathway in regional communities, with a presence beyond the regional centre.

Recommendation 4

Make evidence-based mean evidence-led. Qualified consideration of professional assessments, documented reasons for departing from them, and currency measured from submission.

Recommendation 5

Assess fluctuating and psychosocial disability across time, and do not discount need because of a co-occurring condition or another system's involvement.

Recommendation 6

Define availability of treatment by the person's actual capacity to access it.

Recommendation 7

Record circumstances at access, and measure by region who the process fails to reach.

Recommendation 8

Provide proportionate and culturally safe pathways, and sequence the Thriving Kids transition behind the local alternative.

The specific measures under each recommendation are set out against the relevant consultation question below.

MFC's responses are set out against the six questions in the consultation paper. MFC has not addressed matters of assessment tools and thresholds, which sit with the Technical Advisory Group, but would welcome the opportunity to contribute regional evidence to that work.

5. Questions 1 and 2 - the draft guiding principles

MFC supports all seven draft principles and does not propose removing any. Two observations follow from practice.

The first is that the principles describe an intent that current administrative practice already contradicts, and nothing in the draft commits the future process to closing that gap. A



participant in supported disability accommodation, supported by his coordinator and house staff, could not endorse a plan manager by phone because he could identify his birth month and day but not the year. Attending the local office in person with identification did not resolve it, because he had never held photo identification showing his date of birth. When the matter was eventually processed, he was informed that mail was no longer accepted as a communication preference, and that a shared household email address was not acceptable either. Each step of that process was consistent with a written policy. None of it was equitable, inclusive or accessible.

The second is that the principles are silent on whose responsibility it is to reach people. As drafted, they describe how the system should behave once a person has engaged with it. For the cohort MFC works with, engagement is the barrier. People who are homeless, without a phone or email, in hospital, or unwell in ways that make them unable to respond to a letter are not less eligible for that reason, but the current process treats non-response as a basis for withdrawing support. The principle of continuous quality improvement would be strengthened by an explicit obligation to monitor and report on people the process fails to reach.

MFC also notes that evidence-based decision-making, as described in principle three, is undermined in practice where professional assessments are reviewed by delegates without relevant qualifications, and where the outcome does not reflect the assessment. Practitioners report a planner acknowledging that a report had not been read, and another asking a coordinator to search a report for keywords rather than considering its content. A principle that commits the process to weighting professional evidence, and to recording reasons where a decision departs from it, would make the commitment to evidence real.

MFC recommends that the draft principles be amended to:

- Add a principle of proactive reach, placing responsibility on the access process to identify, contact and support people who cannot initiate or sustain contact themselves, including through trusted providers and community organisations. (Recommendation 1)
- Strengthen principle three so that professional assessments are considered by appropriately qualified staff, and reasons are documented where a decision departs from a professional recommendation. (Recommendation 4)
- Strengthen principle six so that communication is offered in the form the person can use, including mail, shared household contact points and contact through a nominated provider. (Recommendation 2)
- Extend principle seven so that the process is evaluated against the people it does not reach, with geographically disaggregated reporting of applications not completed and plans suspended for non-contact. (Recommendation 7)

6. Questions 3 and 4 — designing a fair process and reducing burden

The defining feature of the current access and reassessment process, as experienced by MFC's practitioners, is that it is conditional on an assumption of capacity. It assumes the person can receive and understand correspondence, respond within a set time, produce identification, attend an office, obtain and submit professional evidence, and describe their



own circumstances accurately. Where the person cannot, it assumes there is a nominee or advocate who can. Neither assumption holds for a large part of MFC's caseload, and the consequences fall hardest on the people the Scheme exists for, as detailed below.

Contact and non-response

The NDIA's practice of making a set number of contact attempts and then suspending a plan is, in a regional setting, a mechanism for removing support from the people least able to respond. MFC supports participants who have no fixed address, phone or email, and others who are in hospital or a mental health unit for months at a time. In one case a health liaison officer declined to act on a coordinator's notification that a participant had been transferred to Melbourne in a coma, because the participant had not provided consent. Non-response is very often the clearest evidence of need. A process built on this principle would treat it as a trigger for outreach rather than for suspension.

Communication channels

MFC's practitioners report that mail has been withdrawn as a communication preference, that shared household email addresses are refused, and that contact through a support coordinator or provider is declined even where the person has consented and the coordinator is present. Ageing nominees, nominees for whom English is a second language, and participants in shared housing or without reliable internet are all excluded by these settings. A process designed to reduce burden would accept communication in the form the person can use, and would allow a participant to nominate a trusted provider as a point of contact for the purpose of arranging assessment and correspondence.

Evidence currency and NDIA timeframes

It is worth noting that assessments in the region can take up to twelve months to obtain. MFC has had evidence rejected as no longer current because it was completed more than three months before the NDIA reviewed it, where the delay was on the NDIA's side. The participant is then asked to obtain updated evidence using whatever support coordination hours remain in a funding period. Currency should be measured from the date evidence is submitted, and a decision that departs from professional evidence should say why.

A guided entry pathway

The information needed to apply exists on the NDIA website in three parts. That is not the same as it being available. People without the capacity to find, read and act on it, without a carer to do so for them, or living in a town with no NDIA, LAC or partner presence, cannot use it. The organisation intended to fill this role in Mildura does not, in the experience of MFC's practitioners, provide guided support to people before they are on the Scheme. What is needed is a single, funded, local point of contact that walks a person from first enquiry through evidence gathering to an access decision, and which is present in the smaller towns of the region rather than only in the regional centre.

The language of the Scheme is a barrier in its own right. MFC's practitioners describe families going years without understanding what a funding category means, and support categories whose names bear no relationship to what they fund. A process that is transparent to participants must define its terms in language a person outside the sector can use.

For people whose functional impairment is severe and self-evident, the process should require the minimum evidence needed to confirm it and should not require the person to attend or



respond in person. MFC supports a fast-track pathway of this kind and would note that the people who qualify for it are frequently the same people the contact-based process is most likely to fail.

MFC recommends that the access decision-making process:

- Replace contact-based plan suspension with an outreach obligation, requiring the NDIA to attempt contact through known providers, hospitals or community organisations before any plan is suspended for non-response. (Recommendation 1)
- Retain mail as a communication preference, accept shared household contact points, and allow a participant to nominate a provider as a point of contact with consent. (Recommendation 2)
- Fund a local, person-to-person entry pathway in regional communities, with a physical presence beyond the regional centre, responsible for supporting a person from first enquiry to an access decision, and define key terms and support categories in plain language. (Recommendation 3)
- Measure evidence currency from the date of submission, and require documented reasons where a decision departs from a professional assessment. (Recommendation 4)
- Establish a proportionate pathway for people with severe and self-evident impairment that does not depend on the person initiating or sustaining contact. (Recommendation 8)

7. Question 5 — making the process work for all cohorts

MFC's specialist support coordination caseload is drawn largely from people living with psychosocial disability, frequently alongside drug and alcohol use, and often with concurrent involvement from justice, child protection or clinical mental health services. This cohort is named in the consultation paper's own list of people the process must work for. It is also the cohort for which a standardised, point-in-time, environment-neutral assessment carries the greatest risk of a wrong answer.

Fluctuating and episodic presentation

Participants in this cohort may spend six to eighteen months at a time in an extended care unit, and be well enough to engage only intermittently in between. A functional capacity assessment conducted on a good day does not describe their need. One conducted during an admission may not be possible at all. Some participants do not accept that they are unwell, and will not describe to an assessor a need that their coordinator, support workers and treating team all recognise. Others have learned what an assessment requires and present accordingly. In both directions, a single assessment conducted by a stranger is a poor measure, and collateral evidence from the people who support the person over time is the more reliable source.

Drug and alcohol use as a discount on need

Practitioners report NDIA delegates stating that community participation funding is reduced where drug and alcohol use is identified, on the basis that another system is responsible. The same pattern applies where justice services are involved. That is not a sign of a working process.



The relevant question is not whether another system could in principle respond, but whether the person's disability-related need is met. In MFC's experience, the NDIS support is what enables a person to reach the point of engaging with drug and alcohol services at all.

Environment stripped out

The new definition of functional capacity is deliberately environment-neutral. MFC understands the rationale. But for a person who lives with a disability that meaningfully reduces their function capacity, living forty minutes from the nearest service, without transport and without informal support, the environment is a substantial compounding factor to the disability. MFC asks that the TAG's work consider that the access process record environmental circumstances even where they do not bear on the eligibility decision, so that they are available to inform what follows.

The process should also allow evidence to be provided through Aboriginal Community Controlled Organisations and other culturally safe services, and should not require a person to attend an NDIA or partner office to be assessed.

In the same vein, practitioners note that a formally appointed guardian is sometimes treated as a reason a person does not need further support to engage with the Scheme. In practice, guardian decisions are routed through an inquiries inbox and the person may have no individual contact. Guardianship should not be treated as a proxy for capacity to engage.

Governments at all levels must also ensure that Foundational Supports are genuinely available for participants who are transitioned out of the Scheme or applicants who are deemed ineligible but have clear support needs. Families of children moved towards Thriving Kids report that supports have been withdrawn without a clear pathway to what replaces them. Whatever the merits of the boundary, the transition should not proceed ahead of the alternative being in place in the region.

MFC recommends that the access decision-making process:

- Provide for functional capacity to be assessed across time for people with fluctuating, episodic or psychosocial disability, drawing on collateral evidence from treating teams, support workers and coordinators rather than a single point-in-time assessment. (Recommendation 5)
- State expressly that co-occurring drug and alcohol use, or involvement with justice or other systems, is not a basis for discounting disability-related need. (Recommendation 5)
- Record a person's environmental and support circumstances at the point of access, and ensure they are considered appropriately for people living in rural and remote communities (Recommendation 7)
- Accept evidence and facilitate assessment through Aboriginal Community Controlled Organisations and other culturally safe providers, and treat guardianship or nominee arrangements as information about circumstances rather than evidence of capacity to engage. (Recommendation 8)
- Sequence the transition to Foundational Supports (including Thriving Kids) so that supports are available for all who need it, and that no participant loses NDIS support before appropriate local support is available. (Recommendation 8)

8. Question 6 — evidence of permanence and the role of treatment

The amended definition of permanence is based on whether an impairment is likely to be substantially remedied by available and appropriate treatment. MFC's submission on this question is that availability must be assessed in the person's actual circumstances, not in the abstract.

Treatment that exists but cannot be reached

For many MFC participants, the specialist treatment that might improve their impairment is in Melbourne or Adelaide. Reaching it means a return journey of up to twelve hours by bus, or flights of several hundred dollars, plus accommodation for the participant and, where required, a support worker. The NDIS does not consistently fund travel and accommodation for a support worker to accompany a participant to medical treatment, and state patient travel schemes reimburse after the fact, which is no help to a person who cannot pay up front. Where a person cannot practically or financially access the treatment, the impairment is, for them, permanent. A definition that treats such treatment as available will find people ineligible on the strength of care they will never receive.

Evidence that was never generated

A further cohort has no diagnostic trail because they were never assessed. Practitioners describe adults now in their fifties and sixties who moved through regional schools before developmental disability was routinely identified, whose only record is a school report describing them as easily distracted or a slow learner. Some are the carers of current participants and cannot themselves access the Scheme. An evidence framework that relies on a lifelong record of diagnosis and treatment will exclude people whose impairment is real, lifelong and unremedied because the region did not have the services to document it.

Who assesses the evidence

As noted above, MFC's practitioners report professional reports being overruled by delegates without relevant qualifications, judged against a pre-populated checklist, or searched for keywords rather than read. Occupational therapists in the region are in short supply, and their time is spent producing reports that are then disregarded. If the future process is to be evidence-based, the evidence must be considered by people qualified to consider it, and a decision that departs from a professional recommendation must be explained.

Practitioners report that where an occupational therapist cannot separate the functional effect of a psychosocial disability from the effect of drug and alcohol use, the NDIA treats the uncertainty as a reason to decline. That places an impossible burden on the assessor and the participant. The presence of a co-occurring condition should not raise the evidentiary bar for the disability that sits alongside it.

MFC recommends that the evidence framework for permanence:

- Define availability of treatment by reference to the person's actual capacity to access it, having regard to distance, cost, waiting time and the availability of support to travel, and treat treatment the person cannot practically access as unavailable. (Recommendation 6)
- Accept functional evidence of long-standing impairment without a historical diagnosis where the person's age, location or circumstances explain the absence of a record. (Recommendation 4)
- Require that professional assessments be considered by appropriately qualified staff, and that any decision departing from a professional recommendation record its reasons. (Recommendation 4)
- Provide that uncertainty about the relative contribution of a co-occurring condition is not itself a basis for finding that disability-related need has not been established. (Recommendation 5)

9. Concluding remarks

MFC would welcome the opportunity to discuss this submission with the Department and to contribute regional evidence to the work of the Technical Advisory Group. The people MFC supports are among those for whom the difference between a well-designed and a poorly designed access process is the difference between being connected to support and being lost to it, and MFC is committed to helping the Department get the design right for communities like the Mallee.

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