

Submission on NDIS Access Changes

Blue Knot Foundation Submission

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Blue Knot Foundation – Response to Draft Consultation

About Blue Knot Foundation

Blue Knot Foundation is Australia's National Centre of Excellence for Complex Trauma. We provide specialist support services, workforce capability development, practice leadership, organisational development and evidence translation to improve outcomes for people affected by complex trauma and those who support them. Through direct engagement with victim-survivors, practitioners, organisations and systems, Blue Knot brings a unique perspective on the conditions required to translate policy commitments into meaningful recovery and healing outcomes.

Executive Summary

Blue Knot Foundation supports the objective of making NDIS access decisions more consistent, transparent, equitable and focused on the functional impact of disability rather than diagnosis alone. The proposed reforms however also pose a significant design challenge – an assessment which is standardised can still fail to measure the disability it is intended to assess.

For people with psychosocial disability associated with complex trauma, including people with complex dissociative conditions, functioning may be episodic, fluctuating, context-dependent, state-dependent and not immediately visible. A brief assessment in a structured environment may capture what a person can demonstrate at that point in time. This might miss whether the person can initiate, repeat, generalise and sustain that functioning safely and reliably in everyday life.

Blue Knot therefore recommends that the future access process assess both capacity and real-world performance, use longitudinal and multi-source evidence where required, recognise the functional significance of fluctuation and hidden disability, and apply a realistic test of permanence and treatment. Even though diagnosis should no longer operate as an automatic pathway to access, it should still provide contextual evidence that informs appropriate assessment and interpretation.

Priority Recommendations

- Assess real-world performance as well as capacity in a standardised environment.
- Add an explicit principle of ecological validity, longitudinal validity and multi-source evidence.
- Assess whether a person can initiate, perform safely, repeat, generalise and sustain an activity, not simply whether they can demonstrate it once.
- Use a mandatory approach to fluctuation and non-apparent disability where functioning is episodic, state-dependent, complex or context-sensitive.

- Ensure no single score, tool, assessor or brief observation is determinative, in situations in which the disability requires broader evidence.
- Give appropriate weight to longitudinal evidence and observations from people who know the applicant's functioning over time, with the applicant's consent.
- Retain diagnosis as relevant contextual evidence while making the final access decision on functional impairment.
- Strengthen supported decision-making, procedural fairness and opportunities to correct factual misunderstandings before an adverse decision is finalised.
- Apply a realistic permanence test that distinguishes improvement from substantial remediation of impairment, and which considers whether treatment is genuinely available and accessible.

Context: Functional Capacity and Real-World Functioning

The consultation paper proposes that, from 1 January 2028, access will move away from diagnosis-led pathways towards a standardised, evidence-based assessment of functional capacity and day-to-day impact. It defines functional capacity as a person's ability to undertake an activity in a standardised environment designed to minimise the impact of environmental and personal circumstances.

The World Health Organization's International Classification of Functioning, Disability and Health (ICF), distinguishes capacity from performance. Capacity concerns the highest probable level of functioning a person may achieve in a domain at a given moment in a uniform or standard environment. Performance concerns what the person does in their current environment i.e. their lived functioning and participation.

For NDIS access, capacity alone cannot identify whether a person experiences substantially reduced functional capacity in everyday life. A person may be able to perform an activity once with structure, prompting or extraordinary effort, yet be unable to initiate it independently, repeat it as often as needed in everyday life, transfer the skill to another setting, perform it safely, or sustain it to the same level or without significant recovery time.

A Practical Reliability Test

For each relevant activity, the access process should consider:

- Can the person initiate the activity without disproportionate prompting or external structure?
- Can they perform it safely, adequately and within a reasonable time?
- Can they repeat it as often as everyday life requires?
- Can they perform it across everyday settings, and with different people?
- Can they access the skill when stressed, overwhelmed, dissociated or otherwise symptomatic?

- What prompting, supervision, preparation, co-regulation, environmental modification or recovery time is required?
- What happens when those supports are not available?

Responses to Consultation Questions

Questions 1 and 2 – Guiding principles

The seven draft principles are a sound starting point, particularly the commitments to human rights, lived experience, evidence, person-centred and strengths-based practice, trauma-informed practice, accessibility and continuous improvement. Blue Knot recommends strengthening them in four areas.

1. Add ecological and longitudinal validity

Evidence should reflect functioning in ordinary life across relevant contexts and time, rather than performance during one optimised assessment encounter. The process should explicitly distinguish capacity from performance and explain how discrepancies are considered.

2. Add supported decision-making and procedural fairness

Applicants should be able to use a supporter or advocate, request communication adjustments, correct factual misunderstandings, understand the evidence being leveraged and respond before there is an adverse decision made. Difficulty explaining impairment should not be interpreted as absence of impairment.

3. Clarify that strengths-based does not mean support-minimising

People with complex trauma adapt to survive. Visible strengths, resilience or isolated achievements can coexist with profound dependence, exhaustion, risk and restricted participation. Strengths should inform support and participation without negating disability.

4. Retain diagnosis as relevant contextual evidence

Removing diagnosis lists should not make diagnosis irrelevant. A well-established diagnosis can inform likely mechanisms, course, risks, appropriate assessment methods and interpretation of observed function. The final determination should be functional, and interpreted using relevant disability-informed clinical knowledge.

Suggested additional principle – Ecologically valid, longitudinal and multi-source: The access decision-making process should assess reliable and sustainable functioning across time and real-life contexts. It should be capable of triangulating self-report, appropriately authorised collateral information, longitudinal clinical evidence and direct assessment. No single tool, assessor or brief observation should determine access in situations in which disability is fluctuating, episodic, state-dependent, complex or not immediately visible.

Question 3 – Fair, consistent, transparent, disability-informed and evidence-based assessment

A fair process should use standardisation to improve consistency while preserving the breadth of evidence required to make a valid functional determination. The assessment method should be demonstrably suitable for the disability cohort and for a high-stakes access decision.

This is particularly important for psychosocial disability associated with complex trauma and dissociation. For some people with Partial Dissociative Identity Disorder (PDID), Other Specified Dissociative Disorder (OSDD) or Dissociative Identity Disorder (DID), functional ability can be state-dependent. A person may appear articulate, organised and independent during an appointment but have substantially reduced access to the same knowledge, judgement, language, memory, executive control or self-protection at other times.

Complex dissociative conditions are often subtle and concealed. Changes in state may appear as a brief pause, confusion, loss of the thread of a conversation, shutdown, a change in presentation, or inability to complete a familiar task. The relevant issue for access is not the label but whether these patterns create substantial, enduring functional impairment.

Why a once-off assessment may underestimate disability

Protective presentation: A highly capable everyday self-state may attend the assessment while more impaired states are not observable.

Shame and minimisation: A person may conceal self-neglect, dependency, loss of control or other difficulties because disclosure feels unsafe, humiliating or threatening.

Appeasement: A person may agree with an assessor, provide the expected answer or avoid correcting misunderstandings where authority, disbelief or loss of support is feared.

Dissociative amnesia or limited awareness: Self-report may omit events, support received or periods of severe impairment not accessible to the presenting state.

State-dependent access to skills: Knowledge learned in therapy or daily living support may not remain accessible under stress or during another dissociative state.

Short-term overperformance: A person may prepare extensively, use extraordinary effort or deteriorate after an appointment; the assessment records the performance but not its cost or aftermath.

Structure supplied by the assessment: Clear questions, one-to-one attention and external sequencing may temporarily compensate for difficulties with initiation, planning, memory and managing overwhelming responses.

Rather than self-report being treated as unreliable, they mean that the disability itself may affect awareness, recall, disclosure and observed performance. The appropriate response is

respectful questioning, longitudinal evidence and triangulation instead of automatically discounting the applicant.

How evidence should be weighted

Evidence weighting should be discipline-neutral and evidence-sensitive. A practitioner, support worker, recovery coach, family member or other authorised person who has observed the applicant regularly across settings and over time may provide important evidence that cannot be generated during a once-off assessment. This should include:

- opportunity to observe the relevant function directly;
- duration, frequency and range of contact;
- specificity and consistency of functional examples;
- whether the evidence identifies the support used to achieve performance;
- whether it records variability, risk, recovery cost and functioning when support is absent;
- relevant clinical or disability expertise; and
- consistency with other evidence, while recognising that some discrepancies may be expected in fluctuating or state-dependent conditions.

Minimum assessment safeguards

- No threshold score or single standardised instrument should automatically determine access.
- Tools should be validated for the relevant disability cohort and intended high-stakes use.
- Assessors should review existing evidence before the appointment and identify genuine gaps rather than requiring unnecessary repetition of traumatic history.
- More than one contact should be available where presentation varies substantially, with reassessment where a result conflicts materially with credible longitudinal evidence.
- Assessment records should identify supported performance – prompting, personal assistance, co-regulation and environmental conditions. This should not be recorded as independent functioning.
- Decision reasons should explain how materially conflicting evidence was weighed.
- Assessors should receive competency-based training and supervision in psychosocial disability, trauma, dissociation, communication, fluctuating disability and supported decision-making.

Question 4 – Reducing administrative burden and improving equity

A streamlined process should reduce repeated proof and not the evidence to consider. For people impacted by complex trauma, repeated disclosure to people who are not familiar can be distressing, dysregulation and can also produce poorer-quality information.

- Create a reusable evidence portfolio that maps existing information to relevant functional domains and can be updated rather than recreated.

- Provide one evidence coordinator or contact person so applicants are not required to reconcile inconsistent requests from multiple decision-makers.
- Accept existing reports and records where they remain relevant and current, and only seek targeted updates where there is an information gap.
- Support the applicant to nominate a treating practitioner, advocate or supporter to clarify functioning or participate in case conferencing, with their consent.
- Offer written, telephone, video and in-person options, breaks, multiple shorter appointments and a trusted support person.
- Make provision for an assessment to be stopped or deferred where the applicant experiences acute distress, dissociation, acquiescence or communication difficulty impacting the information.
- Provide an expedited documentary pathway where there is clarity around substantial impairment while preserving the applicant's right to submit additional evidence.
- Provide a plain-language summary of the evidence being considered and an opportunity to correct factual errors before a decision around access.

Question 5 – Complex, episodic, fluctuating and communication-related needs

recommends that the assessment include specific consideration of changes in functioning over time and across different situations, particularly where a person's disability may not be immediately visible. This non diagnosis-specific design can improve assessment for a range of psychosocial, neurological, cognitive, pain, fatigue and other fluctuating conditions.

Assessment element	Required evidence	Why it matters
Range	Best, typical and lowest functioning	Prevents the most capable presentation from being treated as the person's whole pattern of functioning.
Pattern	Frequency, duration, triggers, predictability and recovery	Shows whether impairment is recurrent and materially restricts participation.
Reliability	Initiation, repetition, safety, time, quality and sustainability	Distinguishes possessing a skill from being able to use it reliably in ordinary life.
State access	Whether knowledge and skills remain accessible under stress, shutdown or dissociative state change	Captures state-dependent access and failures of generalisation or memory continuity.
Supports	Prompting, supervision, co-regulation, preparation and environmental modification	Avoids misclassifying supported performance as independence.
Risk	Relevant risks arising when functioning deteriorates	Captures consequences that may not be observable during assessment.

Corroboration	Longitudinal records and authorised reports from regular observers	Helps address incomplete recall, concealment and short-term overperformance.
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The process should also distinguish between 'not able' and 'will not'. There may be several reasons for what presents as avoidance, inconsistency or refusal such as disability, fear, cognitive overload, shame, or a trauma reaction. Assessors should test plausible explanations beyond behaviour alone.

Question 6 – Permanence, appropriate treatment and likely functional improvement

Blue Knot recommends a clear distinction between the possibility of improvement and the question of whether an impairment is permanent or likely permanent. People with long-term psychosocial disability may improve in safety, functioning, relationships and participation while continuing to experience permanent or likely permanent impairment.

For DID and related complex dissociative conditions, the treatment evidence base is developing and remains methodologically limited. Trauma- and dissociation-informed psychotherapy may enable meaningful improvements in symptoms and functioning, but improvement should not be treated as evidence that the underlying impairment is temporary or will be substantially remedied.

Recommended permanence test

Treatment should affect a permanence decision only where there is credible evidence that the specific intervention:

- is available and appropriate for the individual;
- can realistically be accessed and sustained;
- is tolerable and clinically suitable;
- is reasonably likely to substantially remedy the relevant functional impairment, rather than just improve symptoms or build capacity; and
- is likely to do so within a realistic period.

The existence of treatment, or evidence that some people improve is not adequate. Availability should mean real accessibility, taking account of specialist workforce availability, geography, waiting periods, cost, required frequency and duration, the person's ability to travel and engage, cultural and psychological safety, previous treatment history and whether mainstream systems provide the required intervention at the required intensity.

Distinguish treatment from disability-related capacity building

The terminology used in clinical literature should not determine funding responsibility. An intervention described clinically as psychotherapy may, in a particular context, have a functionally directed capacity-building purpose. The relevant question is what the intervention is intended to achieve for the participant and whether that purpose falls within NDIS or mainstream health responsibilities.

For people with complex dissociation, functionally directed work may include building the capacity to remain oriented, recognise internal states, manage overwhelming responses, communicate needs, maintain safety, improve continuity of memory and routines, tolerate assistance, develop workable relationships and use other funded supports. Such work can improve function without curing the underlying condition.

Functional examples across NDIS domains

NDIS domain	Possible dissociation-related functional barrier	Potential capacity-building focus
Communication	Shutdown, loss of speech, appeasement, state-dependent access to language or difficulty identifying and conveying needs.	Grounding/orientation, recognising activation, communication plans, help-seeking and supported expression of needs.
Social interaction	Threat expectation, distrust, rapid shifts between compliance, withdrawal or defensive responses.	Relational safety, boundaries, repair after conflict and capacity to tolerate appropriate support.
Learning	Dissociative amnesia, fragmented attention or difficulty transferring learning across states or under stress.	Internal communication, memory aids, repetition, reflective capacity and strategies for applying learning in daily contexts.
Mobility	Physical ability to travel may be intact while dissociation, panic, disorientation or inability to tolerate unfamiliar people makes travel unsafe or unreliable.	Orientation, trigger management, graded travel, safety planning and capacity to accept accompaniment.
Self-care	Self-neglect, body avoidance, loss of time or reduced access to adult self-care skills.	Routines, distress tolerance, prompting plans and improved recognition of bodily and health needs.
Self-management	Switching, amnesia, variable executive control, disrupted time sense, medication	Planning, risk management, routine building, decision

	errors or inability to sustain routines.	support and use of external aids and workers.
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Implementation and quality assurance

Before national implementation, the proposed access process and assessment tools should be independently piloted with people who have psychosocial, cognitive, episodic, fluctuating and non-apparent disabilities. A general disability sample alone will not establish fairness for smaller or complex cohorts.

- Include people with lived experience of complex trauma and complex dissociation, carers/supporters and relevant specialist clinicians in co-design and pilot evaluation.
- Test whether the assessment produces consistent and accurate decisions when used by different assessors.
- Compare standardised assessment findings with longitudinal, multi-source evidence and real-world support needs.
- Measure false-negative as well as false-positive access decisions.
- Audit whether gender, culture, language, remoteness, communication differences, trauma history and disability type affect outcomes.
- Publish data showing access decisions, reviews and overturned decisions for different disability groups and assessment approaches, while protecting people's privacy.
- Create a rapid correction pathway where new evidence demonstrates that an assessment captured an unrepresentative state or context.
- Review assessment tools periodically as evidence develops and modify or withdraw tools that demonstrate differential error or poor ecological validity.

Conclusion

The proposed reforms have the potential to reduce inequity associated with diagnosis-based access pathways. Their success will depend on whether the new process measures disability as it is experienced in everyday life rather than assuming that a standardised encounter provides a complete picture.

For people with psychosocial disability associated with complex trauma and dissociation, the central risk is that a brief assessment may mistake a protective or highly capable presentation for reliable functioning across time. A fair process should combine standardised information with longitudinal, contextual and appropriately authorised collateral evidence; assess performance as well as capacity; recognise the functional significance of fluctuation and state-dependent access to skills; and give appropriate weight to evidence from people who know the applicant's functioning over time.

These safeguards would not create automatic access for any diagnostic group. They would strengthen the NDIS's ability to make the functional determination intended by the reforms

using evidence capable of identifying substantial impairment when it is complex, fluctuating or not immediately visible.

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