Developmental Educators Australia

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DEVELOPMENTAL EDUCATORS AUSTRALIA (DEA) SUBMISSION

Joint Standing Committee on the Inquiry into the
Integrity of the National Disability Insurance Scheme (NDIS)
April 2026

1. About Developmental Educators Australia (DEA)

Developmental Educators Australia (DEA) is the national peak body representing Developmental Educators (DEs) in Australia.

> ***Developmental Educators*** *are the only allied health professionals with qualifications specifically focused on disability. They work alongside people with disability to co-design and deliver supports that are person-centred and outcome-focused. They aim to build capacity to achieve goals, strengthen functional skills, and enhance social and community participation; whilst fostering connection, inclusion, understanding, and independence.*

The NDIS Pricing Arrangements and Price Limits (PAPL) includes Developmental Educators (DEs) as a Recognised Profession for the provision of therapeutic support across the lifespan.

This inclusion places DEs alongside Occupational Therapists, Speech Pathologists, Psychologists and confirms their eligibility to deliver Capacity Building – Improved Daily Living supports.

As a National peak body, DEA is responsible for upholding professional standards, codes of ethics, continuing professional development (CPD) requirements, and membership compliance. It also safeguards the integrity of the Developmental Educator designation and provides sector-wide guidance to governments, the NDIA, and service providers.

2. Introduction

DEA welcomes the opportunity to contribute to this inquiry. Non-compliance, fraud, and sharp practices threaten the financial sustainability of the NDIS, place participants at risk, distort the market, and undermine legitimate professions and service providers. Such practices also detrimentally impact public perception of the NDIS and its broader social licence.

This submission will provide a response to each Term of Reference. It will also incorporate reforms as outlined by the Minister for the NDIS, the Hon. Mark Butler, in his National Press Club address on 22 April 2026.

3. Summary of Recommendations

Based on the issues and reforms outlined in this submission to the Joint Standing Committee on the Inquiry into the Integrity of the National Disability Insurance Scheme, Developmental Educators Australia makes the following recommendations:

R1 - Strengthen verification mechanisms for providers Introduce a more robust, outcomes-informed verification system that complements existing registration processes and better distinguishes between administrative compliance and genuine service quality.
R2 - Introduce minimum standards for high-risk supports Establish clear, enforceable minimum qualification and competency standards for providers delivering high-risk or complex supports, ensuring participants receive appropriately skilled care.
R3 - Recognise peak body professional registration as an integrity mechanism Formally recognise accredited peak body membership as part of the Scheme's integrity framework to reduce duplication and strengthen professional accountability.
R4 - Strengthen goal-setting processes to reflect participant need Ensure planning processes prioritise participant aspirations and functional needs over service availability, reducing system-driven goal distortion and improving alignment with genuine participant outcomes.

R5 - Strengthen minimum qualification requirements across the workforce

Define role-specific minimum qualifications for disability support roles, including:

- Foundational roles: structured training and supervised practice
- Capacity-building roles: recognised tertiary qualifications or equivalent
- Specialist roles: discipline-specific accreditation and ongoing professional development

R6 - Improve audit system transparency and consistency

Introduce mechanisms for benchmarking, reviewing, and publicly reporting auditor performance to ensure consistency, reduce variability in interpretation, and strengthen trust in audit processes.

R7 - Establish oversight and accountability for auditors

Create independent monitoring and review processes for approved auditing bodies to ensure auditors are held to clear performance and ethical standards comparable to providers.

R8 - Cap and scale audit costs for providers

Implement a sliding scale for audit costs based on provider size, participant numbers, and risk profile to ensure proportionality and reduce barriers for small providers and sole traders.

R9 - Reduce barriers for small providers and sole traders

Streamline registration requirements to support workforce diversity and innovation while maintaining appropriate safeguards, particularly for low-risk supports.

R10 - Better utilise underrepresented allied health disciplines

Improve workforce utilisation by recognising and integrating underutilised professions, such as Developmental Educators, to reduce bottlenecks and expand capacity-building approaches.

R11 - Shift toward outcomes-based measures of safety and quality

Complement compliance-based regulation with outcome-based measures that focus on:

- participant wellbeing and dignity
- functional capacity gains
- independence and community participation
- participant-reported experience and outcomes

R12 - Reform incentive structures embedded in billable hour models

Review pricing and KPI structures to reduce over-reliance on billable hours and support models that value:

- capacity transfer
- indirect supports
- step-up/step-down intervention
- functional and long-term outcomes

4. TOR 1 - Nature and Extent of Non-Compliance

Registration within the NDIS is a regulatory safeguard that enhances oversight and accountability but is not, in itself, a reliable indicator of service safety or quality. Safety is more accurately understood as an emergent property of workforce capability, organisational culture, participant empowerment, and effective regulatory monitoring.

4.1. Non-compliance across registered and unregistered providers

There is no publicly available comparative statistic quantifying non-compliance rates between registered and unregistered NDIS providers. However, structural differences in regulation indicate that registered providers are subject to significantly higher levels of oversight, audit, and compliance monitoring, while unregistered providers operate with comparatively limited regulatory scrutiny. However, available data suggests that registration status alone is not a reliable indicator of compliance.

- The ACCC's February 2026 report documented 'sharp' practices among *registered* providers, including price-fixing behaviours, coercive contracting, and misuse of market power.
- The ANAO's audit findings identified significant compliance failures among *registered* providers, including poor record-keeping, inappropriate billing, and failure to meet quality standards.
- The NDIS Commission's quarterly compliance data consistently shows enforcement action across both registered and unregistered providers.
- Team DSC found that of $13.4 million in alleged fraud under investigation by the NDIS, $6.8 million involved unregistered providers (around half), despite them comprising ~94% of providers and receiving 42% of plan-managed payments.

Although the idea that "registration = safety" in the NDIS is appealing, it does not hold up well under scrutiny. Registration improves formal oversight, but it is not a reliable indicator of safety and quality of care.

5. TOR 2 - Impacts of Non-Compliance on Participants and Families

Non-compliance within the NDIS can have direct and cascading impacts on people with disability and their families. These impacts are not only regulatory concerns but can translate into real risks in safety, wellbeing, autonomy, and system trust.

5.1 Coercive contracts and restrictive service agreements

Market mechanisms assume equal bargaining power, but disability support relationships are inherently structurally unequal. This is especially true where participants have complex needs, services are scarce (thin markets), or urgent support is required.

Some NDIS participants report situations where service or consent arrangements limit genuine choice and control, despite that being a core principle of the Scheme. This practice concern has been raised in policy, advocacy, and inquiry contexts.

To secure service provision participants are often required to sign agreements that undermine genuine informed consent and shift service provision from participant-led to provider-driven. Participants often feel unable to refuse conditions without risking loss of services.

This includes agreements that

- cannot be negotiated
- bundle multiple services together
- restrict switching providers
- impose rigid cancellation or notice terms

5.2 Reduced quality and safety of supports

When providers do not meet required standards (clinical, ethical, or operational), participants may experience:

- inappropriate or low-quality therapy/supports
- missed or poorly implemented interventions
- inadequate risk management
- neglect of person-centred goals

This can directly affect health, functioning, and safety.

5.3 The current billable hour model

When billable hours become the dominant Key Performance Indicator (KPI), it naturally shifts behaviour toward maximising utilisation rather than maximising outcomes. This leads to a decrease in the more flexible, responsive supports that often matter most for genuine capacity building.

Peer-reviewed research confirms that the use of billable hours as a primary performance indicator creates direct tension with quality outcomes.

Research has shown that participant-led funding models can push providers to prioritise billable activities above all else. A 2025 integrative review highlighted the tension between delivering cost-effective supports and maintaining enough billable hours to remain viable.

Industry commentary also suggests this pressure can leave workers feeling disconnected from their core purpose of building participant capacity and independence. In practice, these dynamics risk limiting genuine choice and control for participants, while reinforcing patterns of dependency rather than progress.

Step-up/step-down supports, informal environment coaching, and scaffolding across settings (home, community, work) are harder to "package" into neat hourly units, so often get deprioritised or skipped, even if they are likely to be more effective in the long-term.

The current billable hour model has a number of knock-on effects:

- Over-reliance on specialists instead of building capability in families, support workers, or community networks
- Reduced ecological validity; skills learned in sessions don't always generalise to real life
- Practitioner burnout from tightly packed schedules with little room for reflection, collaboration, or indirect work
- Client dependency rather than progression toward independence

A more balanced model would shift KPIs toward things like:

- Demonstrated functional outcomes (what the person can do now vs before)
- Capacity transfer (skills enhancement for carers/support workers)
- Intensity modulation (appropriate stepping up and stepping down as needed)
- Use of indirect supports (training, environment modification, collaboration)

5.4 Goals shaped by service availability not participant need

In many cases NDIS goals are being shaped by what services are available rather than by what participants actually need or want. Rather than starting with the individual's aspirations and designing flexible supports around them, planning has drifted toward fitting goals into existing service offerings and billable categories.

This has led to generic or provider-aligned goals, where the focus is on what can be delivered within current systems rather than what would genuinely build independence or capacity. Over time, that dynamic risks narrowing choice and control, with participants adapting to the market instead of the market adapting to them.

When goals are shaped by service availability, participants end up relying heavily on one or two dominant allied health disciplines, even when a broader mix of expertise would be more effective.

This can unintentionally sideline other qualified professionals-such as Developmental Educators-whose skill set is ideally suited to capacity building across environments. When such roles are underutilised or excluded, the system loses opportunities for more holistic, interdisciplinary support, and participants miss out on approaches that emphasise skill generalisation, independence, and real-world application.

These dynamics also contribute to perceived workforce shortages and delays in service access. When supports are concentrated among a narrow discipline group, demand becomes bottlenecked. Other qualified professionals are available but underutilised.

This in-turn creates the impression of a workforce gap, when in reality it's often a distribution problem. Certain disciplines are over-relied upon while others, such as Developmental Educators, are overlooked. The result is longer wait-times for participants, reduced responsiveness, and slower progress toward goals, despite there being capacity elsewhere in the system.

5.5 Plan funds exhausted without genuine capacity built

All too often participants are experiencing rapid depletion of budgets, little or no functional progress, and repeated cycles of unnecessary therapy.

This pattern can ultimately lead to plans being fully spent without meaningful gains in independence or capacity. When funding is channelled into high-frequency, billable sessions, within a narrow set of disciplines, there is a risk that supports are maintaining engagement rather than building sustainable skills.

Without a strong focus on skill transfer, environmental change, and stepping up and down of supports over time, participants may see limited functional progress despite significant investment. This can leave individuals reliant on ongoing services, with little reduction in support needs or increased autonomy.

6. TOR 3 - The effectiveness of policies to improve scheme integrity, safeguard participants and tackle non-compliance.

The NDIS was designed as a marketised system with regulatory safeguards, but in practice it leans heavily toward registration status, audit compliance, and provider self-reporting.

This creates a structural imbalance; the system regulates *processes* more than it governs *outcomes*. Therefore, safety becomes about documented compliance + registration status rather than verified participant wellbeing and quality of life.

6.1 Registration measures compliance, not quality.

Registration with the NDIS Quality and Safeguards Commission is primarily about:

- meeting minimum standards
- passing periodic audits
- demonstrating systems and documentation

This can show that a provider can *demonstrate compliance at a point in time*. It does not demonstrate if a provider can consistently deliver safe, high-quality, person-centred care.

In practice, harm often arises from poor clinical reasoning, relational issues (e.g. coercion, neglect) or day-to-day practice gaps. These elements are not easily captured in audit processes.

6.2 Audit processes can be superficial or inconsistent.

Audits are:

- periodic (not continuous)
- dependent on documentation
- variable in rigor across auditing bodies

This creates a "tick-box compliance" risk, where organisations prepare for audits rather than embed quality practices. They can appear compliant on paper but not necessarily in practice.

6.3 Unregistered ≠ unsafe

The NDIS allows unregistered providers as a way to enhance participant choice and control and increase market flexibility.

Many unregistered providers:

- are qualified allied health professionals
- adhere to professional standards via peak bodies (e.g. DEA)
- operate ethically outside the registration system

Meanwhile, some registered providers, who meet minimum standards, deliver poor participant experiences. Therefore, registration status is a weak indicator of participant safety.

6.4 Outcomes-based safety model

Safety is relational and contextual; not just regulatory. Real safety in disability services depends on participant empowerment and voice, continuity of care, trust and communication, and responsiveness to changing needs. These are dynamic, relational factors that registration alone cannot guarantee. The core premise of this model is that safety is demonstrated by outcomes, not compliance activity. Outcome-based safety measures focus on:

- participant wellbeing and dignity
- functional outcomes (health, participation, autonomy)
- experience of care quality
- real-world harm prevention and responsiveness

Strengths of this model:

- aligns with disability rights principles (autonomy, dignity)
- captures real-world effectiveness
- better detects systemic harm and neglect
- encourages innovation and responsiveness

Weaknesses:

- harder to measure consistently
- requires stronger data systems and longitudinal tracking
- can be influenced by external social factors (not just provider performance)

6.5 Peak body membership as a protective factor

Peak body membership can function as a protective factor for people with disability through its impact on workforce quality, accountability, and system advocacy.

Unlike registration, peak body membership with organisations such as DEA provides direct integrity mechanisms that reduce risk and ensure professional accountability.

- qualification verification
- specialised training in disability practice
- continuing professional development requirements
- ethical oversight
- complaints pathways

- professional standards of practice
- enforcement mechanisms
- Scope of Practice and Core Competencies
- clinical supervision
- evidence-based practice expectations
- peer accountability structures

This helps reduce variability in practitioner competence and supports more consistent, safer care for people with disability.

Whilst there is limited direct causal evidence that peak body membership itself reduces risk for people with disability, there is strong indirect and converging evidence from workforce regulation, professional governance, and quality-of-care research that supports the mechanism.

6.6 Professional regulation is associated with lower safety risk

Across health systems, research consistently shows that stronger professional governance structures (professional membership, peer oversight, codes of conduct) are linked to:

- lower rates of clinical error
- improved adherence to evidence-based practice
- improved participant safety outcomes

6.7 Clinical governance frameworks reduce adverse events

Research shows that structured clinical governance systems (e.g. supervision, practice standards, continuous learning) reduce:

- preventable harm
- unsafe variation in care
- inappropriate interventions

Peak bodies support these mechanisms by providing:

- discipline-specific guidelines
- supervision frameworks
- competency standards

6.8 Workforce capability is a key determinant of safety

A consistent finding across disability and allied health literature is that higher workforce training and competency leads to better quality care and fewer adverse outcomes.

Inquiries (including the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability) have highlighted that risk increases when workforce standards are uneven, oversight is fragmented, and service quality is difficult for participants to assess. Peak body membership helps reduce this fragmentation by standardising practice expectations, reinforcing shared professional norms, and providing external accountability pathways.

Allied health peak bodies contribute to protective mechanisms by strengthening competence, ethical practice, and clinical governance, thereby indirectly reducing risk for people with disability.

6.9 Registration barriers for small organisations and sole traders

The current NDIS registration requirements create significant barriers for small organisations and sole traders. The process is resource-intensive requiring extensive documentation, compliance systems, audits, and ongoing reporting, all of which can be difficult to sustain without dedicated administrative capacity.

For smaller providers, the cost and complexity of meeting these standards can outweigh the benefits of registration, particularly when operating at low volume. As a result, many capable practitioners either remain unregistered or exit the system altogether, reducing diversity in the provider market.

This has flow-on effects for participants; fewer provider options, less innovation in service delivery, and reduced access to flexible, community-based supports. It can also reinforce reliance on large organisations that are better equipped to manage compliance, even if they are less adaptable to individual participant needs.

6.10 A critical accountability gap- who audits the auditors?

While providers are subject to rigorous external audits, the auditing bodies themselves-often approved by the NDIS Quality and Safeguards Commission-operate with comparatively less visible scrutiny. Questions arise around consistency of audit decisions, variability in interpretation of standards, and the transparency of auditor performance.

Without strong, independent oversight of auditors, there's a risk of uneven compliance expectations, regulatory burden without proportional quality gains, and reduced trust in the system. For providers, particularly smaller organisations, this can create uncertainty and defensiveness, rather than fostering genuine quality improvement.

Strengthening this layer of accountability could involve clearer benchmarking of audit practices, routine review of auditor performance, and more transparent mechanisms for providers to raise concerns or challenge inconsistencies.

7. TOR 4 - Legislative and Other Reforms Required

DEA proposes the following reforms, aligned with the government's integrity agenda:

7.1 Cap audit costs with a sliding scale

Audit costs should be proportionate to:

- participant numbers
- organisation size
- risk profile

A provider with 10–20 participants should not face the same audit cost as one with thousands.

7.2 Introduce transparent auditor compliance monitoring

To ensure registration does not create a new area of non-compliance

- auditors should be subject to quality monitoring
- audit decisions should be reviewable
- accountability for poor-performing auditors should mirror the accountability required for approved providers.

7.3 Recognise peak body professional registration as an integrity mechanism

A further reform opportunity is to recognise peak body professional registration as a legitimate integrity mechanism within the NDIS.

Many professions already operate under established peak bodies with their own codes of ethics, competency standards, continuing professional development requirements, and complaints processes. Formal recognition of these frameworks could reduce duplication, particularly for practitioners who are already accountable to robust professional governance.

This approach would allow the system to leverage existing safeguards rather than relying solely on provider-level compliance and external audits. It could also support a more diverse workforce by lowering entry barriers for qualified practitioners, such as Developmental Educators, while still maintaining quality and accountability.

Done well, this would shift the emphasis from purely organisational compliance toward professional responsibility and practice integrity, while preserving participant safety and trust.

7.4 Strengthen minimum qualification requirements

Strengthening minimum qualification requirements would help rebalance the system toward quality, consistency, and genuine capacity building.

At present, variability in workforce entry standards can lead to uneven service quality, particularly when less-qualified roles are used to deliver complex supports. Clear, role-specific minimum qualifications would help ensure participants receive support from appropriately trained professionals.

This does not have to exclude non-degree pathways, but rather defining fit-for-purpose competencies. For example:

- foundational roles: structured training and supervised practice
- capacity-building roles: recognised tertiary qualifications or equivalent
- specialist interventions: discipline-specific accreditation and ongoing professional development

Importantly, this would also support recognition of underutilised professions, such as Developmental Educators, whose training is specifically geared toward functional skill development and independence.

Combined with recognition of peak body registration, stronger qualification requirements could shift the focus from volume-driven service delivery to a more skilled, accountable, and outcomes-oriented workforce without necessarily increasing overall system cost.

8. Conclusion

The integrity of the National Disability Insurance Scheme is fundamental to its long-term sustainability, public trust, and ability to deliver on its original intent: enabling people with disability to achieve meaningful choice, control, and improved quality of life.

This submission has outlined how current structural and regulatory settings can produce unintended consequences, including variable service quality, inefficiencies in workforce utilisation, and limitations in participant outcomes. It has also highlighted that compliance-based assurance alone is insufficient to guarantee safety, quality, or effectiveness in practice.

In response, Developmental Educators Australia Inc. has presented a suite of practical, evidence-informed reforms that strengthen integrity while supporting a capable and diverse workforce. These include enhanced verification mechanisms, recognition of professional peak body governance, strengthened minimum qualification requirements, improved audit transparency, and reforms to reduce structural barriers for smaller providers.

Collectively, these measures support a shift from process-driven compliance toward outcomes-based accountability, where integrity is demonstrated through participant wellbeing, functional improvement, and real-world impact rather than documentation alone.

DEA reiterates its support for the Government's commitment to restoring trust, addressing fraud and non-compliance, and ensuring the ongoing viability of the Scheme. We emphasise that strengthening integrity should not reduce access or innovation, but rather improve the alignment between funding, workforce capability, and participant outcomes.

DEA welcomes continued engagement with the Committee, Government, and sector stakeholders to further refine and implement reforms that ensure the NDIS remains a world-leading system that is safe, equitable, and genuinely participant-centred.

Submission Acknowledgement:
This submission was prepared for Developmental Educators Australia by contributing author – Zoe Lawder. The author is a Practising Member of DEA.

The views expressed represent DEA's position.

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