SEEDS OCCUPATIONAL THERAPY

Functional Capacity Assessment

Erin Louise Calder

SAMPLE REPORT · FICTITIOUS PARTICIPANT

Participant	Erin Louise Calder
Date of birth	3 February 1992
Assessor	Nishadip K. Bal, Occupational Therapist
Practice	Seeds Occupational Therapy

Sample report — the participant and all personal details, scores and findings in this document are fictitious, created to demonstrate the Seeds Occupational Therapy Functional Capacity Assessment format. It does not describe a real person.

Contents

CHAPTER 1

Participant Overview and Assessment Context

Erin Louise Calder is a 34-year-old woman (born 3 February 1992) who lives in a rented single-storey unit in Altona North with her partner of eight years, Dominic (Dom). The couple have no children. Her sister, Bree, lives about fifteen minutes away in Newport and is her main support outside the relationship, particularly for appointments. Erin works three days a week in reception and administration at a veterinary clinic and holds a current driver's licence, which she uses for short, familiar routes only.

Erin was diagnosed with Autism Spectrum Disorder Level 2 (substantial support required) in November 2024 by a clinical psychologist, without intellectual impairment and without language delay. She was diagnosed with ADHD, combined presentation, in June 2023 by a psychiatrist, and takes stimulant medication on work days. She has a generalised anxiety disorder that has been present since around age 19. She also reports joint hypermobility, which has not been formally assessed; it is noted for completeness and is not relied on in this report.

This assessment was requested to support Erin's application for NDIS access and to inform planning should access be granted. It describes the functional impact of her impairments across daily life, the variability in her capacity, the informal support she currently relies on, and the supports that would reduce overload, stabilise her routines and protect the sustainability of her informal supports. Information sources included interviews with Erin, written collateral from Dom, the psychology and psychiatry documentation available, standardised measures administered for this assessment, and functional examples gathered across the interviews.

Erin describes her difficulties as lifelong. She managed school and early adulthood by masking heavily and was generally read as shy or quiet. Her first significant functional breakdown occurred at 27, when she left a full-time call-centre role after a sustained period of panic and shutdown. Her current pattern has worsened gradually over the last few years, and in early 2025

she reduced her work from four days a week to three after a run of missed shifts and post-work shutdowns.

Her main functional concerns are the cost of sustaining her work days, unreliable eating on those days, restricted community access and shopping, repeated failure to attend health appointments, domestic tasks that collapse onto her partner, and marked day-to-day variability with prolonged recovery after ordinary demands. Erin is articulate, insightful about her own triggers and motivated to build a more sustainable life. Her verbal ability and the roles she maintains can make her function appear more intact than it is; the effort behind them is disproportionate and is followed by predictable withdrawal. The central task of this assessment is to distinguish what Erin can do under managed conditions from what she can do reliably across a full day and week.

CHAPTER 2

Disability, Diagnosis and Impairment Profile

Erin’s primary impairment is Autism Spectrum Disorder Level 2, diagnosed in November 2024 by a clinical psychologist following comprehensive adult assessment, without intellectual impairment and without language delay. Autism is a lifelong neurodevelopmental condition. Its core features are lifelong, although functional impact can be reduced through strategies, support and environmental adaptation.

Functionally, her autism presents through sensory dysregulation, a high masking load, reduced tolerance for unpredictable environments, and a nervous system that recovers slowly after ordinary demand. She is hypersensitive to layered noise, fluorescent lighting, clothing textures and strong smells in enclosed spaces, and these sensitivities reliably produce distress, withdrawal and shutdown rather than mere discomfort. Her social communication is fluent but costly: interaction outside familiar, scripted contexts requires sustained conscious effort and is followed by depletion and rumination.

Her ADHD was diagnosed in June 2023 by a psychiatrist, who prescribes and reviews stimulant medication taken on work days. The diagnosis is formally established and interacts closely with her autism: the main functional expression is in task initiation, working memory, follow-through and time awareness. Medication improves her attention across a shift but suppresses appetite through the middle of the day, which contributes directly to the missed lunches described later in this report. On non-work days she does not take the medication, on her prescriber's advice, and her executive difficulties are more visible.

Her generalised anxiety disorder has been present since around age 19 — approximately fifteen years. It has persisted despite an SSRI trial in her twenties, which she discontinued, and periods of psychological therapy that helped while active but whose gains were not maintained once sessions lapsed. Its longstanding course is relevant to the functional picture, particularly because it compounds the impact of her autism and ADHD. The access reasoning in this report

does not depend on anxiety as the sole permanent impairment. It presents as anticipatory dread before leaving the house for anything unfamiliar, avoidance of appointments and busy environments, a hot, pressurised physical response in crowded or unpredictable places, and hours of rumination after social and work interactions.

Erin also reports joint hypermobility with occasional wrist and ankle aches. This has not been formally assessed, no functional motor impact was identified in this assessment, and it is not relied on for access. It is recorded because on harder days joint discomfort adds to her overall load.

Her earlier history is consistent with lifelong impairment managed by masking rather than a recent-onset condition. She left a full-time call-centre role in 2019, at 27, after repeated panic and shutdown that she did not then have language for. She has worked at the veterinary clinic since 2022 and reduced from four days to three in early 2025 when the four-day pattern stopped being survivable.

The three conditions amplify one another. Sensory overload raises her anxiety; anxiety narrows her tolerance for sensory input and erodes her access to coping strategies; and her executive difficulties make it harder to plan for, pace and recover from demand. She can complete most individual tasks in isolation, but the combined sensory, cognitive and emotional load makes ordinary adult routines unreliable without environmental control, informal support or long recovery time. Her impairments fall within the neurological, cognitive, sensory and psychosocial categories. Her neurodevelopmental conditions are permanent, and her longstanding anxiety further compounds the functional impact. Together, these impairments substantially reduce her functional capacity compared with peers. Her articulate presentation masks the disproportionate and unsustainable effort required to appear capable.

CHAPTER 3

Functional Capacity Summary

Erin is physically mobile and independent in the mechanics of basic self-care. She can walk long distances, manage stairs, drive short familiar routes, and bathe, dress, toilet and feed herself without physical assistance. This preserved physical capacity does not translate into reliable independence across daily life. Her main barriers are sensory dysregulation, executive dysfunction, chronic fatigue and anxiety-driven avoidance, which together reduce her ability to sustain work days, keep routines consistent, tolerate community environments, manage household and health demands, and recover after ordinary tasks.

She retains real ability in structured, familiar, low-stimulation conditions, particularly in the morning. On non-work days she can batch-cook simple meals before midday, complete a small errand at a quiet local grocer soon after opening, walk her regular loop at Cherry Lake, and manage light tidying in short bursts. She has held her three-day clinic role for four years, which shows genuine skill and commitment. Each of these depends on carefully managed conditions and planned recovery; each is fragile if the conditions change.

Her function drops sharply as sensory load, decisions and fatigue accumulate across the day. Work days show this most clearly. She gets through the shift by masking, then arrives home depleted. After roughly two of every three shifts she experiences a shutdown of one to three hours, described in the sensory chapter, during which her speech reduces, she retreats to a dark room, and dinner, showering and conversation become unavailable. The following day starts from a lowered baseline. Over the last month she missed two shifts through illness and exhaustion, ate a proper lunch on roughly one work day in three, and declined all three social invitations she received.

Variability is the defining feature of her profile, and judging her by a good day would overestimate her capacity. On a good non-work day she can cook, walk, do an errand and end the evening intact — a day that still stays inside familiar, low-demand tasks and includes

planned rest. On a hard day, usually the day after a difficult shift, she may not shower, eats from a narrow set of safe foods, cannot start any household task, and spends much of the day on the couch or in bed recovering.

What looks like independence often hides its cost and the substitution behind it. Dom cooks dinner on all three work nights and most other nights, does the main grocery shop, and has absorbed the household's vehicle and utilities administration after failures described in the domestic chapter. Bree accompanies Erin to health appointments she cannot face alone. Erin avoids asking for help because she does not want to be a burden, so support often arrives only after she has already shut down.

Her difficulties are not situational or recent. They are lifelong, previously hidden by masking, and have progressively outrun her compensations — first costing her a full-time role at 27, then a fourth work day in 2025. The gap between her physical capacity and her real-world reliability is wide, and understanding that gap is central to understanding her support needs.

CHAPTER 4

Self-Care and Daily Routines

Erin is physically independent in the mechanics of self-care. She can shower, dress, groom, toilet and feed herself without hands-on help, and her continence, transfers and mobility are intact. These preserved motor skills do not translate into reliable self-care across the week; the barriers are sensory load, executive fatigue, anxiety and shutdown.

Her mornings are tightly scripted on work days, and the script is what makes them possible. She wakes at the same time, eats the same breakfast, wears one of five identical work shirts she bought after finding a tolerable fabric, and leaves within the same ten-minute window. Disruptions — a missing item, an unexpected message, running late — tend to cascade, and she may then leave without eating or with her medication taken late. On non-work days the routine is looser and generally manageable, because there is no fixed deadline pressing on it.

Showering is completed most days but is effortful, and it is the first task to fall away under load. On shutdown days it is skipped entirely. Hair washing is deferred for days at a time because the combination of wet hair, the dryer's noise and the extra sequencing exceeds what she can tolerate after work; she washes her hair on non-work mornings when capacity is highest. Evening tooth brushing is skipped when she is depleted, and her dental care is around two years overdue, described with her wider health access in the next chapter. She cuts the tags out of all her clothing and avoids seams and stiff fabrics; clothing choice is a genuine sensory task, which is part of why she buys multiples of tolerated items.

Grooming outside the home carries its own barrier. At her last salon appointment, about a year ago, the combination of clipper and dryer noise, the mirror, and the expectation of small talk overwhelmed her; she asked the hairdresser to stop partway through and left with the cut unfinished. She has not returned. Dom now trims her hair at home. The episode is a compact example of how a task she can physically tolerate becomes unmanageable once its sensory and social load is added.

Eating is physically intact but unreliable in pattern. Breakfast is anchored to routine and almost always eaten. Lunch on work days fails on roughly two days in three, for reasons set out in the health and work chapters — appetite suppression from her medication, no capacity to prepare food the night before, and a staff room too loud to eat in. Dinner on work nights is provided by Dom. When she is overloaded, her food range narrows to a small set of safe items — plain pasta, toast, muesli bars, cheese and crackers — and on hard days she may eat only these.

Sleep is affected at onset. She takes one to two hours to fall asleep most nights, replaying the day's interactions, and wakes after six to seven hours. Melatonin has been trialled with inconsistent benefit. She rarely wakes overnight; the problem is getting to sleep and the quality of what follows. Her daytime fatigue is cognitive and sensory as much as physical, and it does not resolve with a single good night.

The overall picture is of self-care that is mechanically independent but conditionally reliable. It holds while the script holds and collapses when sensory load, work recovery or executive fatigue intrude. While she does not need help with motor components, her self-care in practice depends on routine protection, low demand and Dom's prompting. Recommended supports for these areas are detailed later in this report.

CHAPTER 5

Health Management and Daily Reliability

Erin takes stimulant medication for ADHD on work days, prescribed and reviewed by her psychiatrist. A phone alarm anchors the dose and it is usually taken, though on disrupted mornings it is occasionally taken late or missed, after which her shift is harder to sustain. The medication's appetite suppression through the middle of the day is a direct contributor to her missed lunches, and she does not reliably notice hunger until she is shaky or headachy in the mid-afternoon. She manages repeat prescriptions herself but has run out twice in the past year when the renewal task was repeatedly deferred.

Booking, attending and following through on appointments is significantly impaired, and this is one of the clearest patterns in her presentation. Her GP recommended review of a mole around five months ago; Erin has booked the skin-check appointment three times and cancelled it three times, and it remains outstanding. Each cancellation followed the same sequence — rising anticipatory anxiety in the days before, a poor night's sleep, and a morning on which the waiting room, the drive and the interaction together felt impossible. Dental care is around two years overdue for the same reasons, compounded by the sensory intolerance of the procedure itself.

When attendance is unavoidable, it is achieved with support. Earlier this year Bree drove Erin to a blood test and sat with her in the waiting room; Erin is clear that without her she would have rebooked again. She prefers telehealth wherever it is offered and uses it well, but telehealth cannot substitute for examinations, procedures or the outstanding skin check. Last winter she pushed through a chest infection for two weeks, minimising the symptoms to herself, until Dom booked a telehealth appointment on her behalf and antibiotics were prescribed. The pattern is delay, then reliance on someone else to bridge the gap.

Her engagement with psychology has lapsed. She saw a psychologist regularly until mid-2025, found it useful, and stopped when the psychologist moved practices; the executive task of

finding, contacting and establishing care with a new provider has stalled for over a year, despite her stated intention to return — a clean example of how her impairments block access to the very services that would help.

Her interoception is reduced. Hunger, thirst and fatigue register late, usually as headache, shakiness or irritability rather than as early cues she can act on. Hydration follows the same pattern as food. This makes self-initiated health maintenance unreliable: she cannot be assumed to notice, interpret and respond to her body's signals in time, and her health routines need external structure rather than depending on her noticing.

On the days after difficult shifts, her capacity for any health-related task is minimal. She does not make calls, book appointments, collect scripts or follow up referrals, and tasks deferred on those days tend to stay deferred until they become urgent or someone else absorbs them.

The boundary with the health system is clear. Diagnosis, treatment, medication and acute care remain the responsibility of mainstream health. Erin's barriers to using that system are disability-related—anxiety, sensory intolerance, and executive failure at the booking-and-attending step. Mainstream health services do not ordinarily provide the practical support required for Erin to attend, participate in, and follow through with care. The disability-related supports required to address these barriers are included in the recommendations.

CHAPTER 6

Domestic Life and Home Environment

Erin's domestic function is significantly impaired across meal preparation, shopping, cleaning, laundry and household administration. She retains the physical ability to do each task in isolation; what she cannot do is sustain them consistently across the week alongside work, recovery and the rest of adult life. The barriers are executive dysfunction, sensory load, the predictable collapse of her capacity across the day, and anxiety in the community settings that shopping and errands require.

The unit itself presents no physical barriers. It is single-storey, rented, with a walk-in shower and no steps, and no falls or environmental hazards were identified. The domestic difficulty is functional, not structural.

Meal preparation follows her capacity curve. On non-work mornings she batch-cooks simple meals before midday — the window in which planning and sequencing are available to her — and these are reheated across the week. On work days she cannot reliably cook safely or consistently: by the time she is home she is often depleted or in shutdown, and Dom cooks all three work-night dinners and most others. She avoids using the stove when she is home alone after work, a self-imposed control that followed a kitchen near-miss described in the risk chapter. Her food preparation is genuinely skilled when conditions allow, which is precisely why the reliability gap matters: the limiting factor is capacity, not competence.

Shopping is one of her most restricted tasks. She manages a small top-up shop at a quiet independent grocer early on weekday mornings, where the layout is known and the environment is calm. The main grocery shop is done by delivery or by Dom; Erin cannot reliably complete it independently, for the reasons set out in the community chapter, where an abandoned-trolley episode is described. A core task of independent living is therefore either substituted or environmentally engineered around.

Cleaning and laundry are partly held together by equipment and partly by Dom. The dishwasher and dryer are necessary adaptations rather than conveniences — without them the sequencing and hanging-out steps would fail far more often. Even so, dishes accumulate across work days, washing is done but folding is not, and clean clothes live on a chair for days. Bathroom cleaning has effectively transferred to Dom, because the chemical smells and sustained multi-step sequence exceed what Erin can tolerate; she avoids cleaning with chemicals when alone. Her tidying happens in short morning bursts on non-work days and stops when the burst ends.

Household administration shows the same unreliability despite genuine effort. Erin uses phone reminders, a shared list app with Dom and calendar alerts, and still misses things: the car registration renewal went unnoticed until a fine arrived earlier this year, and a utility bill was paid late before the couple moved their accounts to direct debit. Dom has since absorbed the vehicle and utilities administration. The failures are not carelessness — the reminder systems exist and are used — but her follow-through collapses when she is overloaded, and a task not actioned immediately is usually lost.

If Dom were unavailable even temporarily, a rapid decline in meals, shopping, cleaning and admin would likely occur, with the flow-on effects on nutrition, finances and health access described in this report. Erin's domestic support needs are disability-related. Her impairments directly prevent her from running the household reliably, and this gap is currently closed by informal support. Specific recommendations follow.

CHAPTER 7

Mobility, Transport and Physical Safety

Erin is independently mobile at a physical level. She walks her five-kilometre Cherry Lake loop without difficulty, manages stairs, carries shopping, and has had no falls. Her reported hypermobility produces occasional wrist and ankle aches but no functional motor impact was identified, and it has not been formally assessed. Pain is not a mobility barrier; she describes tension headaches after demanding days, which add to her load without restricting movement.

Her practical mobility in the community is nonetheless substantially restricted, by sensory overload, anxiety and fatigue rather than by any physical impairment. In busy or unpredictable settings she describes a hot, pressurised feeling, difficulty tracking what people are saying, and an urgent need to get out. The distinction matters because on any physical examination she appears fully capable, while her actual access to transport, appointments and ordinary public environments is markedly limited.

Driving illustrates the conditional shape of her capacity. She holds a current licence and drives the twelve-minute arterial route to work and to a small number of local, rehearsed destinations, usually early in the day. She does not drive on freeways, into multi-storey carparks, on unfamiliar routes or through school-zone periods, and she previews any new destination on street-view imagery before considering it. After difficult shifts she sits in her car for twenty to forty minutes before driving home, waiting until she can concentrate — a self-imposed control that reflects accurate insight into her own state. Her driving range is therefore real but narrow, and it does not extend to the appointments, shops and activities that sit outside it.

Public transport is avoided entirely. She can physically board and travel; the crowding, noise, waiting and unpredictability are what exceed her capacity, and she has not used a train or bus in several years. This closes off the destinations her driving range does not reach, so her independent radius is effectively the overlap of what she can drive to and what she can tolerate on arrival.

Transport to health care follows from this. Appointments inside her driving range on low-demand mornings are possible; anything else requires Bree or Dom to drive and accompany her, or is converted to telehealth, or is deferred — the pattern described in the health chapter.

There is no significant falls risk or equipment need. Safety concerns are primarily attentional: reduced attention under overload in the kitchen and the need to recover before driving after shifts. Her mobility needs are environmental, sensory and emotional. These result in a substantial practical access restriction despite intact physical mobility.

CHAPTER 8

Communication, Cognition and Self-Management

Erin's verbal fluency, insight and articulate self-report can give the impression of intact cognitive capacity. She describes her own functional pattern precisely, understands what helps and what does not, and has built an extensive compensatory system of alarms, calendars, shared lists and item trackers. This preserved verbal and intellectual capacity masks a substantial executive impairment that affects her daily reliability, organisation, memory and follow-through, and it is the reason others — including, historically, Erin herself — have misread her difficulties as laziness.

Her core difficulties are initiating tasks without immediate external pressure, holding tasks in mind over time, sequencing multi-step demands, and following through once the moment has passed. If a task is not actioned when it arises, it is usually lost, regardless of reminders; the registration fine and the repeatedly cancelled skin check, described earlier, are the pattern's clearest products. She misplaced her keys often enough that she now keeps a tracker on them, asks clients at work to email rather than tell her things because verbal instructions do not survive the shift, and treats her calendar as the only reliable memory she has — while acknowledging that entering things into the calendar is itself the step that fails when she is overloaded.

Her cognition degrades predictably with load and time of day. In the morning, unhurried, she plans and sequences well. By late in a work shift her processing slows, word-finding becomes effortful, and errors appear — the booking mistakes described in the work chapter cluster in the final hours of her shifts. After overload her speech itself reduces, sometimes to short phrases, until she has recovered; this is set out with her regulation profile in the next chapter. Learning genuinely new tasks is her area of severe difficulty: the clinic's new booking software took her several times longer to learn than her colleagues, and unfamiliar processes of any kind consume disproportionate capacity.

Decision-making is affected by choice overload. Open-ended decisions—what to cook, which product to buy, which provider to contact—stall her, particularly later in the day. She manages by pre-deciding wherever possible: the same breakfast, the same shirts, the same rehearsed routes. Her reliability is high within this pre-decided structure but drops sharply outside of it.

Rumination adds a further cognitive tax. She replays interactions from her shifts for hours afterwards, described in the work chapter, and this occupies exactly the executive resources that evening routines would need.

Her self-management across health, admin, household and pacing is reduced despite strong insight. The impairment is evident in the gap between her knowledge and her actual follow-through. Dom currently functions as the household's external executive for shared administration. The compensatory system Erin runs for everything else is operating at its maximum capacity; any added demand typically produces task failure.

CHAPTER 9

Sensory Processing, Regulation and Behaviour

Erin's sensory sensitivities are primary functional barriers rather than preferences. Sound is the dominant channel: barking, ringing phones, overlapping conversation and PA announcements are the defining load of her work environment and of most public spaces. Fluorescent lighting — at the clinic and in supermarkets — adds a visual strain she describes as a pressure behind the eyes. Clothing tags, seams and wet fabric are intolerable, which shapes her wardrobe as described in the self-care chapter. Perfume and cleaning chemicals in enclosed spaces produce nausea and avoidance, though predictable smells, including the clinic's disinfectant, are tolerated because they are expected. The pattern is consistent: intensity matters, but predictability matters more.

Her interoception is reduced. Hunger, thirst, fatigue and rising anxiety register late and bluntly — as shakiness, headache, heat or irritability — rather than as early signals she can act on. The health consequences are described in the health chapter; the regulatory consequence is that she often does not know she is approaching her limit until she is past it, which is why her strategies are so often applied after overload rather than before it.

Shutdown is her characteristic response to accumulated load, and it follows roughly two of every three work shifts. It has a recognisable shape: on the drive home or soon after arriving she stops being able to sustain conversation, her speech reduces to short phrases or single words, and she goes to the bedroom, lies in the dark, and is unavailable for one to three hours. It is not sleep and not chosen rest; it is a state in which initiation and regulation have shut down and return slowly. Dinner, showering and any evening task scheduled into that window do not happen. Meltdowns, by contrast, are rare and private — crying and pacing, at home, perhaps a few times a year — and there is no aggression, property damage or externalised behaviour of any kind. No behaviour support involvement is indicated.

She stims to regulate — rocking, pressing her hands together, and handling small textured objects — and suppresses this at work, which adds to the masking load. Her deliberate strategies include loop-style earplugs worn in one ear through desk shifts, sunglasses outdoors, noise-cancelling headphones on walks, and crochet with a familiar podcast in the evening, which is her most reliable downregulation activity. These tools reduce distress without removing it, and most are reactive: they manage overload that has already begun rather than preventing the accumulation.

Her masking is extensive and measured as such — her camouflaging score, reported in the standardised measures chapter, is high, with compensation and masking the strongest elements. Behaviourally it looks like rehearsing phone calls before making them, mirroring the tone of whoever is at the counter, holding a pleasant register through distressing interactions, and suppressing visible signs of overload until she is alone. Masking is the main reason colleagues and acquaintances underestimate her difficulty, and its cost is paid in the shutdowns that follow.

Her avoidance — of noisy venues, busy shops, unfamiliar routes, appointments — is best understood as capacity management rather than as a behavioural or motivational problem. Each avoided setting is one she has repeatedly been overwhelmed in. The avoidance is protective and it is also progressively narrowing her life, which is the tension the recommended supports are designed to address: reducing baseline load and building graded, supported access, rather than either forcing exposure or accepting the narrowing.

CHAPTER 10

Social Participation and Relationships

Erin lives with Dom, her partner of eight years. The relationship is stable and warm, and it is also carrying a substantial functional load, described fully in the informal supports chapter. The day-to-day texture of the relationship reflects her recovery needs: on work nights the couple's evenings are largely silent and parallel, with Erin recovering while Dom cooks and manages the house. Both describe the connection as strong; both also describe missing the shared activities — meals out, trips, ordinary weekend outings — that her capacity no longer stretches to.

Her wider social world is small, valued and effortful. Her closest friend, Priya, lives locally; the two aim for a monthly catch-up and in practice manage one every six to eight weeks, at a quiet café at opening time or on a walk. Her friend Sasha lives interstate and the friendship runs on text messages and voice notes, a format Erin manages well because it removes the real-time processing demand. She has not made a new friend in years and describes the prospect as unimaginable at her current capacity. In the last month she declined all three social invitations she received.

Attending events costs her disproportionately, even ones she wants. At her own birthday dinner last year — a small booking, chosen restaurant, people she loves — the noise and the sustained social demand overtook her partway through and she left early, then spent the next day recovering and ruminating about having left. The episode captures her social profile in miniature: genuine desire for connection, real ability to participate for a period, and a ceiling that arrives regardless of motivation, followed by a recovery and rumination cost that makes the next invitation harder to accept.

Her family relationships are warm at a distance. Her parents live in Ballarat and contact is mostly by phone; they are fond and well-meaning but read her difficulties as shyness and tiredness, and their reassurance that everyone struggles leaves her feeling unseen rather than supported. Bree is the family member who understands her presentation, and their relationship

is close and practically important. No safeguarding concerns, conflict of note or vulnerability to exploitation were identified in her current, stable circumstances; her high masking and difficulty asserting needs are noted as factors that could increase vulnerability in less familiar settings, but nothing in the available information suggests a current concern.

The rumination that follows social contact deserves its own weight. Hours or days of replaying interactions, auditing what she said and assuming negative judgements typically follow social contact, and this converts even successful participation into an extended cost. Combined with the sensory load of venues and the executive load of arranging anything, it reflects a recognised pattern in autistic adults who mask heavily, and in Erin's case the direction is clear: progressive withdrawal from relationships she genuinely values. Erin's stated wish is modest — to see her friend without paying for it for two days — and the supports that bear on it are set out in the recommendations.

CHAPTER 11

Learning, Work and Meaningful Daily Roles

Erin has real vocational capacity, sustained at significant personal cost. She has worked in reception and administration at a veterinary clinic since 2022, currently three days a week — Monday, Tuesday and Thursday, in shifts of about seven and a half hours. She reduced from four days to three in early 2025 after a run of sick days and post-work shutdowns made the four-day pattern unsustainable. Her work should be read as engagement in a role she has extensively engineered to be survivable, not as evidence of ordinary work capacity.

The demands of the role sit directly across her impairments. The front desk combines ringing phones, barking, fluorescent lighting, walk-ins, interruptions and distressed owners — a sustained sensory and social load with little control over pacing. She stays because the work is meaningful to her: she finds direct contact with the animals genuinely regulating, is good at the client-facing work, and values being reliable to a small team that values her. The days that include euthanasia appointments are the hardest, for the grief in the room as much as the workload, and on those days she takes her break alone in her car.

She sustains shifts through scripting and masking. Routine interactions run on well-worn scripts; phone calls are internally rehearsed; her register stays warm and steady whatever is happening internally. The cost surfaces on a curve across the shift. In the final hours her processing slows and errors appear — she double-booked appointments twice last quarter, late in shifts, caught and corrected without consequence — and by the drive home she is at or past her limit. The post-shift shutdowns, described in the sensory chapter, follow most shifts, and the day after a difficult shift starts from a lowered baseline.

Breaks do not function as recovery. The staff room is loud, so she eats in her car on better days and skips lunch on the rest — roughly two work days in three, compounded by her medication's appetite suppression. She has found that splitting her break into two shorter ones helps when the roster allows, but no adjustments are documented; the current arrangements rest on

informal goodwill and her own engineering. She is reluctant to formalise requests because she does not want to be seen as difficult, which is itself part of her presentation.

She has no current study and no plans she considers realistic. She mentions an interest in veterinary nursing qualifications as something she would pursue if her capacity were different — a useful marker of what preserved motivation looks like against present limits.

Responsibility for workplace adjustments should be stated clearly. Reasonable adjustments — a quiet space to eat, split breaks, predictable rostering, reduced sensory load where practicable — are the employer's responsibility under disability discrimination and work health and safety frameworks. The NDIS does not fund workplace modifications or the employer's obligations. What appropriately falls to the NDIS is building Erin's capacity to sustain work: the regulation, pacing, recovery and self-advocacy skills that would let her keep the role without the current collapse pattern, and the practical support that stops her work days from consuming everything around them. Those supports are set out in the recommendations. Without them, the trajectory is the one already under way — she has stepped down once, missed two shifts last month, and a further reduction or loss of the role is foreseeable, with consequences for income, structure and identity that would be far harder to rebuild than to prevent.

CHAPTER 12

Community Access and Participation

Erin's community access is restricted. Her participation is contingent on four conditions—early, quiet, familiar and short—and within these parameters she performs well: the Cherry Lake walking loop, the small local grocer, the library, and one quiet café. Outside those conditions, access is unreliable and largely avoided.

Supermarkets at ordinary hours are the clearest example. The lighting, PA announcements, trolley noise and queue proximity stack quickly, and on one attempt at a full shop last year the load peaked at the self-checkout queue; she left a full trolley in the aisle, sat in her car for forty minutes, and drove home without the shopping. She has not attempted a full shop since — the main shop is done by delivery or by Dom, as described in the domestic chapter. Shopping centres are avoided entirely. She has not been to a cinema in about three years. Restaurants are limited to the one quiet café at opening; her early exit from her own birthday dinner is described in the social chapter. In her twenties she regularly went to live music and loved it; she stopped by about 27, and names it without expecting it back — what she wants now, in her words, is "to do normal things without paying for them for two days."

Appointments belong on the same list, as the health chapter sets out: the environments are the barrier as much as the tasks. The haircut she could not finish, described in the self-care chapter, sits in the same category — an ordinary community task made unmanageable by its sensory and social load.

Her transport profile compounds the restriction. Her driving covers only short, rehearsed routes; public transport is not used at all; so her independent world is the small intersection of where she can drive and what she can tolerate on arrival, described in the mobility chapter. Anything beyond it requires Dom or Bree, or does not happen.

Even successful outings carry a recovery cost that limits their frequency. A demanding trip is often the only thing achieved that day, and the recovery pattern after work shifts, described

elsewhere, means her three non-work weekdays are already partly mortgaged to recovery rather than available for participation.

The consequence is participation well below what would be expected for an adult in her mid-thirties, leading to reduced access to health care, dependence on others for core errands, and a shrinking social world. Her current temporary strategies—avoidance, environmental control, and accompaniment—reduce distress but entrench the restriction. Building tolerance requires graded, supported, real-world practice, for which supports are recommended.

CHAPTER 13

Standardised Measures and Functional Interpretation

Standardised measures were administered to give structured support to the functional profile described throughout this report. They were selected to cover broad functional capacity, participant-prioritised performance, emotional distress, executive-function impact, perceived stress, participation restriction, life skills, camouflaging and carer strain, and they are interpreted alongside real-world examples rather than in isolation.

The WHODAS 2.0 profile is consistent with executive and participation impairment against preserved physical function. In cognition, Erin reported moderate difficulty concentrating for ten minutes, remembering important things and solving day-to-day problems, and severe difficulty learning a new task — consistent with her experience of the clinic's new booking software — with only mild difficulty understanding and holding conversation. Mobility ratings were none to mild throughout, confirming that her community restriction is not physical. Self-care ratings were mild for washing and dressing and moderate for staying by herself for a few days, which matches the finding that her routines are propped by Dom's presence; the measure understates the shutdown-day pattern of skipped showers and narrowed eating. Getting along ratings were mild with people close to her, moderate for dealing with strangers and maintaining friendships, and severe for making new friends. Life activities showed the most marked impairment: all four household items were rated severe, and the work items ranged from moderate difficulty in day-to-day work and doing important tasks well to severe difficulty getting all the work done and getting it done as quickly as needed. Participation ratings were severe for joining community activities, for the emotional impact of her condition and for the time it consumes, and moderate for environmental barriers, financial impact, family strain and relaxation, with mild difficulty living with dignity.

The COPM identified five occupational performance issues, each rated for importance, current performance and satisfaction out of ten. Getting through a work shift without shutting down

afterwards was rated importance 10, performance 3, satisfaction 2. Eating a proper lunch on work days was importance 9, performance 2, satisfaction 1. Completing the main grocery shop without Dom or delivery was importance 8, performance 2, satisfaction 2. Booking and actually attending health appointments was importance 9, performance 3, satisfaction 2. Seeing her friend for a monthly catch-up was importance 7, performance 4, satisfaction 4. Mean performance was 2.8 and mean satisfaction 2.2 — very low across activities she rates as highly important, and lowest in the areas of nutrition, community access and health attendance. A change of two or more points on re-administration is considered clinically significant, and the COPM will serve as a primary review measure.

The Work and Social Adjustment Scale totalled 27 out of 40, indicating substantial interference: home management 7, social leisure 7, work 6, private leisure 4 and close relationships 3. The spread matches the clinical picture — her most protected areas are the relationship and her solitary regulating activities, while household life, social participation and work sustainability carry the greatest interference.

The PSS-10 totalled 27 out of 40, a high level of perceived stress. DASS-21 equivalent scores were depression 18, anxiety 16 and stress 28, corresponding to moderate depression, severe anxiety and severe stress. These findings should be read in context: her distress is closely tied to permanent neurodevelopmental impairment, sensory overload, masking load and insufficient environmental support, and it functionally presents as reduced drive, heightened anticipatory fear, difficulty settling, and low tolerance for competing demands. She reports self-critical thinking — describing herself as lazy or broken on bad days — and does not report self-harm or suicidal ideation.

The Camouflaging Autistic Traits Questionnaire totalled 138 of a possible 175, a high level of camouflaging, with the compensation and masking components strongest. This is consistent with her scripted, rehearsed work presentation and is clinically important because it predicts that her needs will be underestimated by people who see only the managed surface, and it fits the post-shift collapse pattern.

The Weiss Functional Impairment Rating Scale (self-report) produced a completed-item total of 45, with the highest impact in the life skills, work, self-concept and social domains and the lowest in the risk domain — reduced daily reliability, not externalised risk-taking, is the problem. The Life Skills Profile (LSP-16) totalled 12 out of 48, with the elevations concentrated in maintaining an adequate diet, keeping up with household tasks and coping with day-to-day stress, while communication, self-presentation and public behaviour were preserved. The Zarit Burden Interview short form (ZBI-12), completed by Dom, totalled 17, in the mild-to-moderate range; he endorsed feeling that Erin is dependent on him, stress balancing her needs with his full-time work, and sometimes having insufficient time for himself, with no endorsement of anger or relationship strain.

Across the measures the pattern is consistent: preserved mobility, intact basic self-care mechanics and strong verbal function, with reliability dropping sharply wherever a task requires sustained effort, planning, sensory tolerance, community access or social interaction. The measures corroborate the interview and collateral evidence, indicate that the difficulties are persistent rather than episodic, and provide a defensible baseline for review.

CHAPTER 14

Informal Supports and Sustainability

Dom is Erin's primary day-to-day support, and his role has grown well past ordinary partner role-sharing into routine substitution for tasks her disability prevents. He works full time as a logistics coordinator, on site five days a week, and around that he cooks dinner on all three of Erin's work nights and most others, does the main grocery shop, has absorbed the household's vehicle and utilities administration after the failures described in the domestic chapter, and provides the prompting that keeps meals and showers happening on her shutdown days. On the evenings she shuts down he runs the household alone. This is a standing redistribution of essential daily tasks, not occasional help.

His ZBI-12 result, reported in the measures chapter, sits in the mild-to-moderate range, and its texture matters more than its total: he endorses her dependence on him and the strain of balancing her needs against full-time work, and he describes her, in his written collateral, as "running on empty" — his concern is for her trajectory as much as his own load. He does not report resentment or relationship strain, and the relationship is plainly a protective factor. The strain is nonetheless real, cumulative and currently unrelieved by any formal support.

Bree provides targeted support for appointment transport and accompaniment. As she works full time, she is not available for daily or household support. No wider practical network or backup arrangements are in place. If Dom were unavailable, a rapid decline in meals, shopping, household function and health access would be expected.

Erin's reluctance to ask for help shapes how the system actually operates. She does not want to be a burden, so she under-reports difficulty and pushes through until she has already shut down, at which point Dom takes over by observation rather than request. Support in this household is therefore reactive — triggered by collapse — rather than planned, which is a wearing and inefficient pattern for both of them.

The current arrangement is not sustainable as a long-term model. It depends on one person's continued capacity alongside full-time work and is already supplemented by a second family member. The purpose of funded support is to reduce the reliance on others to a level a partner can reasonably carry, making Erin's essential routines more independent. This is intended to reduce carer fatigue and protect the sustainability of the informal support system.

CHAPTER 15

Key Risks and Safeguarding Considerations

The risks in Erin's presentation include missed care, missed meals, attentional lapses, and carer strain. Each is foreseeable and currently managed by temporary strategies. Structured support is recommended to address these risks and prevent functional decline.

Kitchen safety under overload is the clearest discrete risk. In spring last year, after a Thursday shift, Erin put pasta on to boil and lay down in the dark bedroom intending to rest for a minute; she was woken by the smoke alarm to a boiled-dry, ruined pot. There was no fire and no injury, and her response was characteristically insightful — she now avoids using the stove when she is home alone after work. The current controls are that avoidance, her morning batch-cooking pattern, and Dom's cooking on work nights. They are adequate while all three hold; the residual risk sits in the gaps, when she is alone, depleted and needs to cook, and a low-cost technological control is identified in the recommendations.

Missed and delayed health care is a significant pattern. The skin check requested five months ago remains outstanding; dental care is overdue; and a chest infection went untreated for two weeks until Dom intervened. Current temporary strategies depend on others noticing the need for care. This pattern leads to preventable deterioration rather than proactive health maintenance.

Nutrition on work days is a chronic, compounding risk. Lunch is eaten on roughly one work day in three; the drivers are appetite suppression, an intolerable eating environment and interoception that reports hunger only after it has become a headache or shakiness. Poor intake degrades her regulation across the afternoon, which raises the likelihood of the post-shift shutdown, which in turn takes out the evening meal on the nights Dom is not there to provide it. The loop is well established and currently uninterrupted.

Employment sustainability is a risk of further decline. She has already reduced her hours, and errors have appeared late in shifts. A further reduction or loss of the role is foreseeable without intervention, which would negatively impact her income, structure, and identity.

Financial and administrative reliability carries ongoing low-level risk. The registration fine and the late utility bill were absorbed at modest cost; the controls now in place — direct debits and Dom's takeover of vehicle and utilities admin — are effective but transfer rather than resolve the underlying unreliability, and anything outside their coverage remains exposed.

Informal-support strain is the structural risk beneath the others. The arrangement described in the previous chapter rests on one person, with no reliable backup arrangement and limited relief from the support role, and Dom's measured strain is already mild to moderate. If his capacity lapses, the other risks in this chapter would escalate together.

Her psychological wellbeing warrants monitoring rather than alarm. Her measured depression is moderate and her anxiety severe, her self-talk on bad days is harsh, and her formal psychological support has lapsed for over a year. She does not report self-harm or suicidal ideation, and nothing in the available information indicates externalised risk. Her protective factors are substantial: insight, motivation, a stable and warm relationship, an engaged sister, valued work, and established regulating routines. The appropriate posture is preventive, and the response is set out in the recommendations.

No safeguarding concerns were identified. The overall risk profile is one of gradual, accumulating deterioration that is preventable now. The recommended response is proportionate and practical.

CHAPTER 16

NDIS Disability Requirements and Section 24 Clinical Opinion

In my clinical opinion, the available evidence supports that Erin meets the disability requirements under Section 24.

Her access rests on Autism Spectrum Disorder Level 2, diagnosed in November 2024 by a clinical psychologist following comprehensive adult assessment, and her ADHD, diagnosed in June 2023 by a psychiatrist. Her generalised anxiety disorder has been longstanding — present for around fifteen years — and compounds the functional impact, but the access reasoning does not depend on it. Autism and ADHD are lifelong neurodevelopmental conditions; her anxiety has persisted across settings and despite treatment, including a medication trial and periods of psychological therapy whose gains were not maintained. Her reported hypermobility is not formally assessed and is not relied on. The permanence requirement is met on the neurodevelopmental conditions alone and reinforced by the chronicity of the anxiety.

Her adult diagnosis dates should be read for what they are: late recognition of lifelong impairment, not late onset. Her history — a childhood presentation read as shyness, a masking-based adaptation through school and early work, a functional breakdown at 27 that ended a full-time role, and a stepwise reduction of work capacity since — is consistent with lifelong impairment that was masked rather than absent, first formally identified in adulthood, and the current picture reflects compensations progressively failing rather than a temporary or treatable episode.

Her impairments substantially reduce her functional capacity compared with ordinary expectations for an adult of her age. Her communication is verbally fluent but its real-world use is constrained by masking cost, rumination and post-overload speech reduction; she cannot sustain unscripted interaction without disproportionate effort and recovery. Her social interaction is markedly reduced: a very small social world, invitations routinely declined, no new relationships formed in years, and participation that fails partway even at valued events.

Her learning is impaired at the point of application — severe difficulty acquiring new tasks and processes despite intact intelligence. Her mobility is physically preserved while her practical mobility is substantially restricted: a narrow driving range, no public transport use, and community access confined to early, quiet, familiar and short. Her self-care is mechanically independent and unreliable in pattern — showers, hair care, dental care and eating all degrade under load, with lunch failing on most work days. Her self-management is the most reduced domain of all: severe household ratings across the board, administration that fails despite extensive compensatory systems, health appointments repeatedly booked and cancelled, and a household that runs on her partner's substitution.

The reduction is present across settings — home, work, community and health care — and across time, corroborated by her own report, Dom's collateral, the standardised measures and the treating documentation, and it persists despite an unusually well-developed set of self-devised strategies, adaptive equipment, environmental engineering and informal support. That her adaptations are intelligent and extensive, and still insufficient, is itself evidence of the underlying impairment's severity.

Her support needs are substantial and ongoing: to sustain nutrition and daily routines, complete shopping and household tasks, attend health care, access the community beyond a narrow envelope, maintain her employment, and re-establish therapeutic supports. Her informal supports currently meet much of this need at a level beyond ordinary partner or family expectation, and without them the foreseeable result is functional decline. On the totality of the evidence, Erin's impairments are permanent or likely permanent, substantially reduce her functional capacity across multiple Section 24 domains, and create ongoing disability-related support needs. In my clinical opinion, the available evidence supports that Erin meets the disability requirements under Section 24.

CHAPTER 17

Recommendations and Section 34 Reasoning

Erin's support needs include daily routines, nutrition, household management, community and health access, and work sustainability. Recommendations are targeted at addressing high masking, executive failure, and the current reliance on a single person. These aim to stabilise her cumulative fatigue pattern and build sustainable capacity.

Core Supports — Assistance with Daily Life

Community and in-home support is recommended at 6 to 8 hours per week for 12 months, then review. The intended shape is two rostered blocks on her work-day evenings, covering meal preparation, the kitchen reset and the routines that currently disappear into shutdown, and one flexible block used across the week for the main grocery shop, errands, appointment attendance and low-function days. This is co-support that works alongside her — practical assistance, task-sharing and sensory-aware pacing with a worker present — not personal care, not supervision, and not a takeover of her household.

The functional basis is established across this report. Work-night dinners are currently provided by Dom; lunch fails on most work days; the main shop cannot reliably be completed independently and the last unsupported attempt ended with an abandoned trolley; her WHODAS household items were severe across the board; and three of her five COPM priorities — lunch, shopping and appointments — sit directly inside this support's scope. The need is disability-related and exceeds ordinary partner expectation: Dom is already substituting these tasks around full-time work, with measured strain, and the arrangement rests on one person's continued availability. Rostered support also answers the specific problem that Erin does not ask for help until after collapse — support that arrives on a schedule does not depend on her requesting it at her worst.

A lower allocation was considered and would not answer the documented pattern: a single weekly block would cover the shopping substitution but leave the work-evening window —

where the nutrition, kitchen-safety and shutdown risks concentrate — unsupported, with Dom's substitution load effectively unchanged. Six to eight hours is the minimum that covers two of the three work evenings and the flexible community block; the third work evening deliberately remains with Dom, keeping the package supplementary to informal support rather than a replacement for it. The 12-month review is the step-down point if capacity building reduces the need.

This support reduces the risks of poor nutrition, kitchen incidents, household deterioration and carer fatigue, and it converts the household's reactive pattern into a planned one. It represents value for money because a modest weekly allocation prevents the higher-cost outcomes the risk chapter describes — health deterioration, loss of work capacity and informal-support breakdown. It is appropriately funded by the NDIS because the need arises from autism, ADHD and anxiety affecting task reliability, not from any gap a mainstream service or ordinary family arrangement could reasonably fill.

Capacity Building — Improved Daily Living (Occupational Therapy)

Occupational therapy is recommended at 2 hours per week for 12 weeks, then fortnightly for a further 6 months, reviewed against COPM, WHODAS and the functional indicators below. The intensive block should target her COPM priorities directly: a structured post-shift recovery routine to reduce shutdown frequency and depth; a work-day nutrition system built for her sensory profile, medication effects and environment, including portable safe foods and the car-break pattern she has already discovered; graded, supported re-entry to supermarket shopping; an appointment-attendance system that addresses the booking-and-cancelling loop, beginning with the outstanding skin check; a kitchen-safety routine paired with the assistive technology below; and energy and pacing structures that treat her interoceptive lag as a design constraint rather than relying on her noticing her limits.

Sessions should be scheduled in her morning capacity window, delivered substantially in her home and real-world settings rather than clinic rooms, and run in a low-demand, neurodiversity-affirming way, since supports experienced as additional demands will fail — a

pattern her history makes explicit. The stepped-down fortnightly phase supports generalisation and maintenance. This is capacity building in the strict sense: its aim is to increase what she can do independently or with less support, and mainstream, time-limited health OT does not provide the extended real-world practice this requires. Progress indicators are concrete: lunch eaten on most work days, shutdowns following fewer than half of shifts, at least one supported supermarket shop completed and repeated, the skin check attended, and COPM performance and satisfaction improving by two or more points. It represents value for money because each target, if achieved, directly reduces demand on the Core allocation and on Dom. Review at 6 months with repeat COPM and WHODAS should determine whether to continue, step down or close.

Capacity Building — Improved Daily Living (Psychology)

Psychology is recommended at fortnightly sessions for 12 months. Erin's previous therapy lapsed in mid-2025 when her psychologist moved practices and the executive task of re-establishing care stalled — a gap that should itself be read as evidence. This recommendation is for disability-related capacity building rather than general mental-health treatment: its targets are the anxiety that blocks appointments and community access, the post-interaction rumination that consumes her evenings and erodes her work and social capacity, recovery from masking, self-advocacy — including preparing her to raise reasonable adjustments with her employer — and sustaining the routines the other supports establish. Her DASS-21 profile of moderate depression, severe anxiety and severe stress, and her PSS-10 of 27, reflect distress that directly undermines her participation, and re-establishing structured psychological support is preventive against the deterioration pathway noted in the risk chapter. Telehealth delivery is appropriate where it supports engagement. Diagnosis, medication and the clinical treatment of mental ill-health — acute or otherwise — remain the responsibility of the health system. Review at 12 months should determine whether fortnightly frequency remains appropriate or can be spaced.

Support Coordination — Level 2

Support coordination is recommended at Level 2, 3 hours per month for 12 months. If access is granted this will be Erin's first plan, and her presentation predicts the implementation failures coordination exists to prevent: she has already lost a therapeutic support for over a year at the provider-establishment step, she books and cancels under anticipatory load, and multi-step arrangement tasks are where her executive function most often fails. The coordinator's role is to establish the OT, psychology and Core supports, secure service agreements, match workers to her sensory and communication profile, schedule around her morning capacity window, troubleshoot engagement barriers, and prepare for review. Level 2 rather than Level 1 is justified by the executive and anxiety barriers to self-management of a plan; Level 3 is not indicated — she has insight, a stable household, an engaged informal network and no crisis complexity. Three hours per month is a deliberately modest allocation matched to a single-household, four-support plan. Success looks like all supports established within the first quarter, nothing lost to coordination failure, and growing confidence in managing the plan herself. Review at 12 months should consider stepping down to Level 1 or exiting.

Consumables

Low-cost sensory consumables are recommended at approximately $400 per year: replacement filters and spares for the loop-style earplugs she already relies on through shifts, fidget and regulation tools, and sunglasses. These items are inexpensive, already proven in her daily strategy set, and directly enable the work, community and appointment participation this plan is built around. No formal review point is required; flexible ongoing use is appropriate.

Assistive Technology

Low-cost assistive technology up to $1,500 is recommended, assessed and trialled through the occupational therapy above. Priority items are a kitchen-safety solution compatible with the rental property — a plug-in stove timer or auto shut-off device, or a portable induction cooktop with automatic shut-off — which responds directly to the boiled-dry pot incident and would let her cook safely when alone; a smart speaker or equivalent reminder system for cooking timers,

medication and transition prompts; a visual task board for household routines; additional item trackers extending the system she already uses for her keys; and noise-cancelling headphones for community access. Each item addresses documented executive or sensory impairment, sits well under complex-assessment thresholds, and the OT should document trial outcomes. The value-for-money case is straightforward: the kitchen item alone is a very small cost against the type of incident it prevents.

Supports considered and not recommended

Personal care is not recommended. Erin is independent in all self-care mechanics; the documented inconsistency — skipped showers, deferred hair washing, missed meals — is driven by overload and initiation failure and is properly addressed through the Core prompting-and-co-support model and OT systems, not hands-on care.

High-intensity or daily support is not recommended. Her profile is one of conditional capacity, not pervasive incapacity, and lower-intensity supports have never been trialled; escalation without that trial would not represent value for money.

Behaviour support is not recommended. There are no behaviours of concern, no aggression, no restrictive practices and no externalised risk; her shutdowns and avoidance are regulation responses appropriately addressed through OT and psychology.

A transport budget is not recommended. She holds a licence and drives short familiar routes; her transport barrier is sensory and anxiety-based, the flexible Core block incorporates supported travel as part of activities, and if extending her driving range becomes a goal she chooses, it is properly addressed through occupational therapy rather than a funded budget. This can be revisited if her circumstances change.

Home modifications are not recommended. The unit is rented, single-storey and hazard-free, she has no falls history and no physical impairment; the kitchen risk is addressed through assistive technology and routine, not structure.

Specialist Disability Accommodation and Supported Independent Living are not recommended. Her housing is stable and her needs do not approach 24-hour or overnight support.

Workplace adjustments — a quiet eating space, split breaks, predictable rostering — remain the employer's responsibility and are not sought from the NDIS; the plan funds Erin's capacity to identify, request and use them.

Summary of funding and value

The recommended package comprises 6 to 8 Core hours per week for 12 months; occupational therapy at 2 hours per week for 12 weeks then fortnightly for 6 months; fortnightly psychology for 12 months; Level 2 support coordination at 3 hours per month for 12 months; approximately $400 per year in consumables; and up to $1,500 in low-cost assistive technology. The package addresses immediate functional need through Core, builds capacity in the priority areas through OT and psychology, protects implementation through coordination, and closes specific documented risks through the technology items. It is proportionate to the established impairments, targeted at the areas of greatest restriction — nutrition, household reliability, community and health access, work sustainability and regulation — and designed to reduce as capacity builds, with a review point attached to every element. It represents value for money because each component is priced against a specific, documented failure pattern whose continuation would cost more: health deterioration, loss of employment, carer breakdown and crisis-driven service access. All the recommended supports are most appropriately funded by the NDIS because they address the functional impact of permanent impairments — autism, ADHD and chronic anxiety — that substantially reduce Erin's capacity to participate in daily life compared with her peers, and are not the responsibility of the health system, her employer or her family.

CHAPTER 18

Implementation Priorities, Review Points and Final Clinical Opinion

Immediate priorities are to stabilise Erin's cumulative fatigue pattern and reduce the reliance on others. The first 90 days should establish rostered Core blocks, commence occupational therapy, and re-establish psychology. These changes aim to improve the conditions under which Erin currently functions.

Sequencing matters to this participant specifically. New workers entering her home are themselves a demand, so introductions should be gradual, rosters predictable, and the worker pool small and stable; a rotating cast would convert the support into another source of load. Support must be rostered and proactive rather than contingent on her asking, because the consistent evidence is that she does not ask until after she has already shut down. And every provider should be briefed that her articulate, composed presentation is the mask, not the baseline — the risk of underestimating her needs on first meeting is high and predictable.

The early occupational therapy work should take its targets straight from the COPM: the post-shift recovery routine and the work-day nutrition system first, because they interrupt the loop — poor intake, deeper depletion, shutdown, lost evening — that drives most of the week's difficulty; the kitchen-safety technology trialled early for the same reason; and the appointment system built around a concrete first win, attending the outstanding skin check. A three-month interim check should look for lunch eaten on at least two of three work days, any reduction in shutdown frequency, the skin check attended, all supports established and running, and a repeat COPM on the two or three most active goals. Minimal movement at three months should prompt scrutiny of scheduling fit, worker match and whether the supports are being experienced as help or as demand — not automatic escalation.

From three to six months, the work should extend outward: graded, supported supermarket re-entry; supported attendance moving toward independent attendance for routine appointments; and the first supported social goals, beginning with making the monthly

catch-up with her friend actually monthly. Core hours should hold steady through this phase — community capacity-building consumes energy, and withdrawing domestic support while demanding exposure work would simply relocate the collapse. At six months, COPM and WHODAS should be repeated as the formal review of the therapy block. Indicators of progress are shutdowns following fewer than half of shifts, lunch on most work days, at least one repeated supported shop, the appointment loop broken for routine care, COPM movement of two or more points on prioritised goals, and Dom reporting reduced substitution.

From six to twelve months, the focus shifts to durability: consolidating routines so they survive bad weeks; self-advocacy work through psychology and OT so that Erin can raise split breaks, a quiet eating space and predictable rostering with her employer — the adjustments remain the employer's to provide, and the plan's role ends at preparing her to seek them; and testing step-downs, with OT moving to maintenance if gains hold. At twelve months a full review should repeat WHODAS, COPM, WSAS and PSS-10, with DASS-21 where clinically useful, and assess the package element by element. Sustained progress would look like household WHODAS items moving from severe toward moderate, mean COPM performance and satisfaction at or above five, shutdowns the exception rather than the rule, no further loss of work days across the year, and Dom's ZBI-12 stable or lower. Supports should be adjusted to the evidence in either direction — not withdrawn because twelve months has elapsed if the functional picture has not shifted, and not continued at full intensity if capacity has genuinely built.

If these supports are not funded, the foreseeable consequences follow directly from the documented pattern rather than from speculation. The nutrition-shutdown loop continues, and with it the established work trajectory — she has already lost one day, missed two shifts last month, and the foreseeable next step is a further reduction or the role's end, taking income, structure and identity with it. The skin check and the dental care are likely to stay deferred until something forces the issue. Dom continues substituting for as long as his capacity holds; if it lapses, the household's function is likely to drop sharply rather than gradually. Her world keeps

narrowing along the line it has followed since her twenties. None of this presents as a crisis until late; each element is preventable now at modest cost.

In my clinical opinion, Erin presents with permanent impairments — Autism Spectrum Disorder Level 2, ADHD and chronic generalised anxiety disorder — that substantially reduce her functional capacity compared with ordinary adult expectations. Her presentation is defined by the gap between conditional ability and real-world reliability: she can complete many tasks under managed conditions, but cannot sustain them across ordinary days and weeks without disproportionate cost, shutdown and substitution by others. Her informal supports operate beyond ordinary partner role-sharing and carry measured strain. The recommended supports are specific, modest, matched to documented failure patterns, and structured to reduce if capacity improves. In their absence, her functioning, employment, health access and informal support sustainability are likely to continue on the downward trajectory described in this report.

SEEDS OCCUPATIONAL THERAPY

Standardised Assessment Results and Summary

Erin Louise Calder

At a glance

COPM · PERFORMANCE

2.8 / 10

Very low

Mean rating of current performance across the five occupational performance issues.

COPM · SATISFACTION

2.2 / 10

Very low

Mean rating of satisfaction with current performance across the same issues.

WSAS · TOTAL

27 / 40

Substantial interference

Work and Social Adjustment Scale — self-rated interference across five areas of daily life.

Detailed results for each measure follow on the next pages.

APPENDIX · STANDARDISED RESULTS

COPM — Canadian Occupational Performance Measure

Five occupational performance issues were identified and rated for importance, current performance and satisfaction out of ten.

PERFORMANCE · MEAN

2.8 / 10

How well these activities are currently performed.

SATISFACTION · MEAN

2.2 / 10

How satisfied Erin is with how these activities currently go.

Occupational performance issue	Importance	Performance	Satisfaction
Getting through a work shift without shutting down afterwards	10	3	2
Eating a proper lunch on work days	9	2	1
Completing the main grocery shop without Dom or delivery	8	2	2
Booking and actually attending health appointments	9	3	2
Seeing her friend for a monthly catch-up	7	4	4

A change of two or more points on re-administration is considered clinically significant.

APPENDIX · STANDARDISED RESULTS

WSAS — Work and Social Adjustment Scale

Self-report measure of the impact of difficulties across five areas of day-to-day functioning. Item scores are summed to a total out of 40.

Area of functioning	Score
Home management	**7**
Social leisure	**7**
Work	**6**
Private leisure	**4**
Close relationships	**3**
Total	**27** / 40

APPENDIX · STANDARDISED RESULTS

Additional standardised measures

Totals and descriptors for the remaining measures administered for this assessment.

Measure	Result	Descriptor
PSS-10 — Perceived Stress Scale	**27** / 40	High level of perceived stress
DASS-21 — Depression	**18**	**Moderate**
DASS-21 — Anxiety	**16**	**Severe**
DASS-21 — Stress	**28**	**Severe**
CAT-Q — Camouflaging Autistic Traits Questionnaire	**138** / 175	High level of camouflaging
WFIRS — Weiss Functional Impairment Rating Scale (self-report)	**45**	Highest impact in the life skills, work, self-concept and social domains
LSP-16 — Life Skills Profile	**12** / 48	Elevations in maintaining an adequate diet, keeping up with household tasks and coping with day-to-day stress
ZBI-12 — Zarit Burden Interview short form (completed by Dom)	**17**	Mild-to-moderate range

DASS-21 values are equivalent scores. The WFIRS result is a completed-item total.

Authorisation

This functional capacity assessment was prepared by the undersigned. The opinions expressed reflect my clinical judgement, based on the assessment activities and source material described in this report.

Nishadip K. Bal (Nisha)
Occupational Therapist · AHPRA: OCC0001752238
Seeds Occupational Therapy · nisha@seedsoccupationaltherapy.com.au

Signed on 6 July 2026