Australian Psychosocial Alliance

Australia's leading providers of psychosocial support services

A Recovery-Shaped NDIS

Australian Psychosocial Alliance (APA) submission to the NDIA review panel

19 May 2023

Contents

About the Australian Psychosocial Alliance

The Australian Psychosocial Alliance (APA) includes Flourish Australia, Mind Australia, Neami National, One Door Mental Health, Stride Mental Health, Open Minds and Wellways Australia. We are specialist providers of community-managed mental health and wellbeing services in Australia, with the majority of us being registered NDIS providers with a particular focus on psychosocial disability.

Members of the APA have extensive experience providing recovery-oriented care and support which focuses on personal goals, participation in the community and living a meaningful life. We have evidence of what works, and combine this with service delivery wisdom, to provide recovery-oriented services that support people to manage their symptoms and build their capacity to participate in society and manage their lives. This includes support to sustain a tenancy, build the skills to live independently, find fulfilling work, and build social connections.

The people who access our supports come from diverse communities across Australia, with each of our organisations having a clear commitment to promoting community inclusion and participation. We have experience providing services to marginalised, such as LGBTIQ+ individuals, culturally and linguistically diverse communities, and Aboriginal and Torres Strait Islander people, as well as young people. We recognise the value of lived experience and seek to co-design services and approaches wherever possible.

About the Submission

This submission has been led by the APA, in consultation with sector and lived experience representatives, and we would like to acknowledge their contribution in helping us to develop and shape the submission. The submission has been developed through the following engagements:

- Interviews with lived experience representatives
- Two workshops with sector representatives
- Survey circulated to APA staff, lived experience representatives and sector representatives.

The list of stakeholders consulted has been provided in Appendix A.

1 Executive Summary

This submission aims to support the NDIA in realising the full potential of the Recovery-Oriented Framework launched in 2021. It strives to provide the NDIA with tangible opportunities to implement new and improved approaches for supporting people living with a psychosocial disability within the Scheme and enable them to achieve the full potential of the support the NDIS aims to provide.

What is unique about people living with a psychosocial disability and why must the NDIA take action to support them within the NDIS?

A person living with a psychosocial disability can encounter many challenges on their road to recovery. It can often be taken for granted the ease with which many of us undertake everyday tasks and the skills we use to tackle challenges that emerge in our lives. For people living with a psychosocial disability, this is often not the experience. They may face many forms of stigma, discrimination, and societal barriers that can increase their vulnerability to hardship, including poverty, violence and homelessness. Without effective support, people with psychosocial disability may experience significant social and emotional repercussions, including becoming isolated from their families and community, struggling to engage in activities they enjoy and difficulty undertaking day-to-day tasks. Psychosocial disabilities can also put extreme pressures on families and carers and place further pressure on some of the most vulnerable members of Australian society.[1]

People living with a psychosocial disability face unique challenges on their road towards recovery. Many experience fluctuating episodes of unwellness which can come on quickly and suddenly. If they do not receive the support they need at these times, their recovery outlook may become worse in the long term. People with a psychosocial disability may also feel they must advocate for themselves to 'prove' their disability, since it is often invisible. This can have the unintended consequence of forcing people to relive their worst times, placing them at risk of becoming more unwell. Furthermore, the invisible nature of psychosocial disability can often lead to discrimination and judgement in society. This can increase their need for safe, inclusive environments in which they feel understood and accepted to properly engage with support providers and services and make progress on their road to recovery.

The Australian Psychosocial Alliance (APA) strongly supports the inclusion of people with psychosocial disabilities in the NDIS and advocates for the redesign of the Scheme to better meet their needs. Psychosocial disability should remain in the NDIS, as many people with mental ill-health require long-term support in-line with their own personal recovery journey to live a full and meaningful life in the community. However, with the right support, many people with psychosocial disability also have the capacity to improve their functionality and progress their recovery over time. Significant reform to the Scheme is needed to ensure this specialist support is recovery-oriented and delivers appropriate and evidence-based support required to enable participants to live a meaningful life, as envisaged by the NDIS at establishment.

> **It is vital that the NDIS recognises and implements approaches which are responsive to the unique needs of this cohort.** It must do this by providing people living with psychosocial disabilities the choice and control to take action towards their vision of recovery by providing the reasonable and necessary means for them to do that. We must ensure that the concept of recovery is not only recognised but also operationalised within the Scheme.

[1] Royal Australian and New Zealand College of Psychiatrists. (2016). *The economic cost of serious mental illness and comorbidities in Australia and New Zealand*.

The APA proposes a range of solutions the NDIS can implement to support recovery for people with psychosocial disabilities

This submission proposes pragmatic and evidence-based actions which the NDIA can implement to improve outcomes for NDIS participants living with psychosocial disabilities. These are framed as 'opportunities' to operationalise recovery within the NDIS and enable longer term sustainability of the Scheme. Figure 1 | Table of recommendations included in this submission summarises these opportunities, with consideration of the broader systemic enablers necessary to support the delivery of this model, and Figure 2 (overleaf) provides a summary of the intended outcomes of implementing these opportunities.

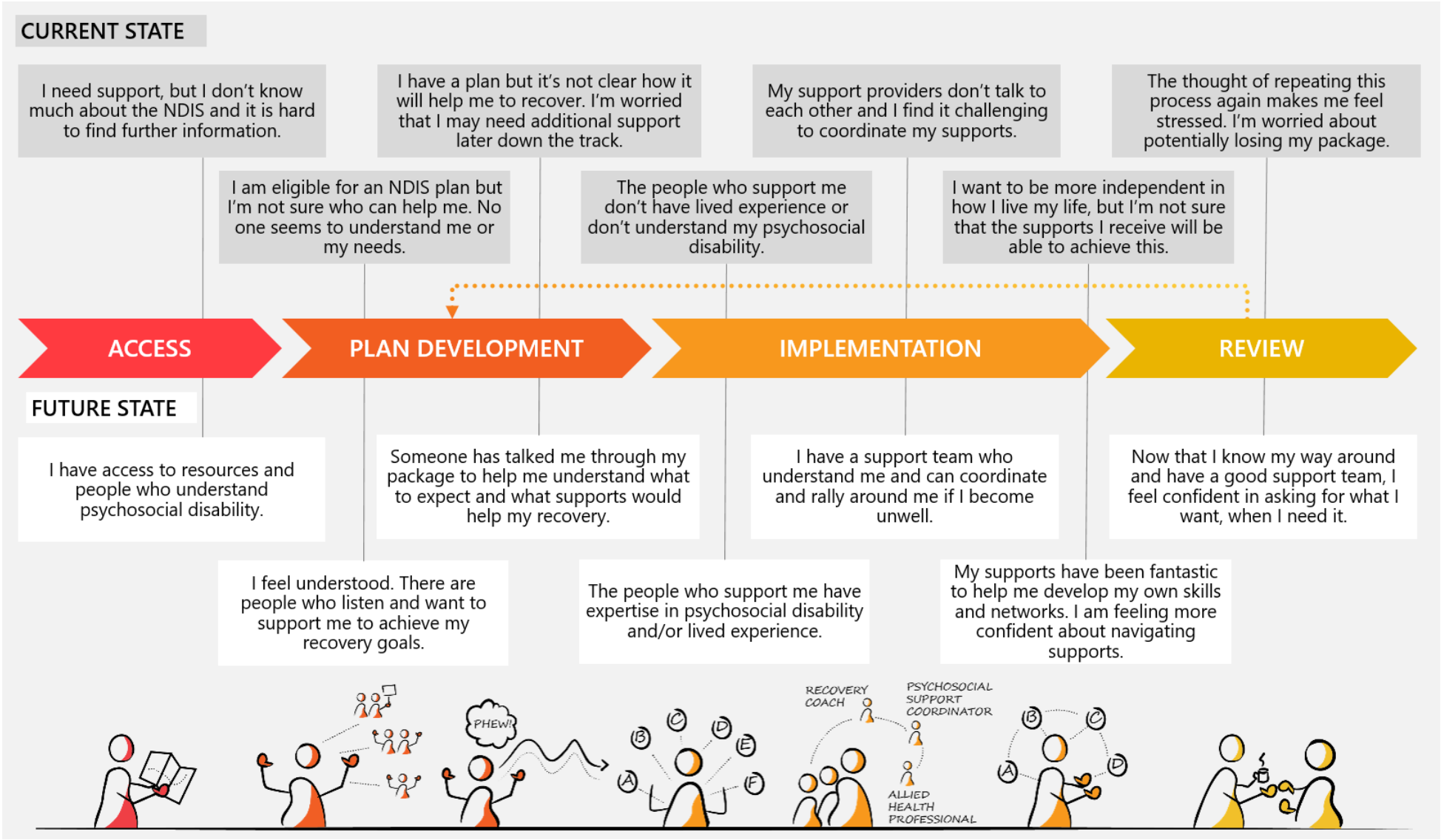
Figure 1 | Table of recommendations included in this submission

Service model for a recovery-oriented NDIS	
Opportunity 1: Specialist psychosocial recovery plans Facilitate a collaborative process for participants to engage with psychosocial experts in developing a Recovery Plan, which is personalised, evidence-based and outcomes-driven	**Opportunity 2: Flexible support packages** Include flexible funding options to ensure participants can access individualised supports that align with their changing needs
Opportunity 3: A service mix to drive psychosocial recovery Review the service mix to incorporate more Capacity Building supports for participants to develop their independence and skills	**Opportunity 4: Coordinate support between service providers** Establish clear guidelines and protocols to enable effective mobilisation of support among service providers
Opportunity 5: Rethinking check-ins and reassessment Facilitate more opportunities to check-in and provide bespoke, long-term support to aid participants' progress towards recovery goals	**Opportunity 6: Building a coordination team around the participant** Connect participants with a coordination team with psychosocial expertise to provide holistic, specialised and recovery-oriented support
Opportunity 7: Leveraging lived experience expertise Engage the psychosocial disability lived experience workforce by proactively collaborating on service design, and investing in peer workforce and skills programs	
Broader systemic enablers	
Addressing workforce capability, quality and sustainability	Integration of recovery-oriented home and living supports for people with psychosocial disability
Coordination with the broader system and supports outside of the NDIS	Market regulation and provider registration

We invite an ongoing dialogue with the NDIA about implementation of these recommendations

Within these solutions, there are increments of change. Some opportunities can be implemented without substantial change to existing NDIS systems, others will require varying levels of adjustment or reform to current operations, legislation and supporting systems. The APA recognises that opportunities highlighted within this submission must also bring the lens of equity, cultural safety and human rights to their implementation in order to most effectively support the intersectional and diverse nature of this cohort. The submission aims to provide a view of what is necessary to provide the right kind of support and invites an ongoing conversation with the NDIA to determine how to best implement these changes.

Figure 2 | Current and future state for a NDIS participant with psychosocial disability



2 Glossary

2.1 What is meant by 'psychosocial disability'?

The Productivity Commission's Final Report on Mental Health[2] defines a psychosocial disability as "an impairment or restriction, arising due to mental illness, that can limit an individual's ability to function, think clearly, enjoy full physical health or manage their social and emotional welfare."

2.2 What is meant by 'psychosocial support' and 'provider'?

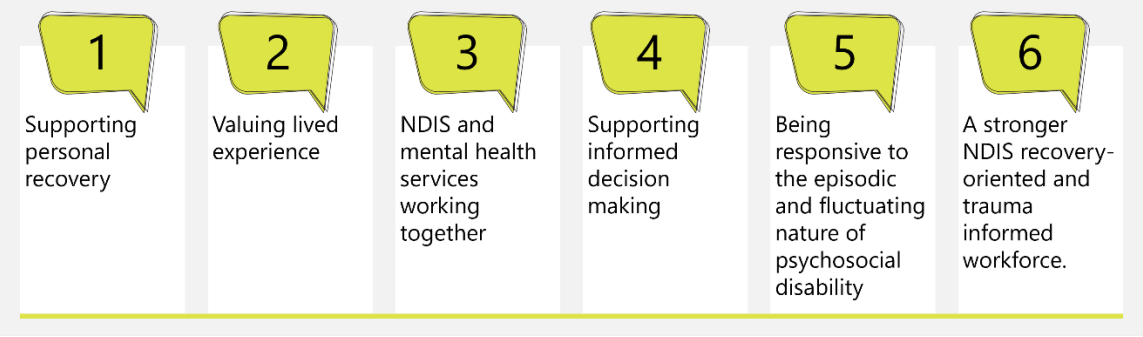
As per the Productivity Commission's Final Report on Mental Health[2], a psychosocial support addresses a person's emotional, social, mental and spiritual needs. Supports include a range of services to help people manage daily activities, rebuild and maintain connections, build social skills and participate in education and employment. NDIS-funded supports are delivered to participants by a 'provider' i.e. a person, business or organisation with different areas of expertise and experience.[3]

2.3 What is meant by 'recovery'?

Recovery in the context of this submission refers to mental health recovery, as distinct but complementary to clinical recovery which focuses on treating symptoms. Consistent with the NDIS Psychosocial Recovery Oriented Framework (the Recovery Framework)[4] and World Health Organisation[5], we define recovery as a unique and personal experience in which an individual gains control of their identity and life, has hope for their life, and is living a life which is meaningful to them. This includes acknowledging recovery processes are strongly embedded within a person's familial, social, and economic environments. Recovery is personal to the person experiencing mental ill health and psychosocial disability[6], and the pathway to recovery may look different for each person.

2.4 The Psychosocial Disability Recovery-Oriented Framework

The Psychosocial Disability Recovery-Oriented Framework (the Recovery Framework) demonstrates the NDIA's commitment to reshaping the NDIS to better support the recovery journey of people living with a psychosocial disability. It sets out six principles:



[2] Productivity Commission. (2020). *Vol. 1, Productivity Commission Mental Health Inquiry Report.*
[3] National Disability Insurance Agency. (2022). *What is a provider?*
[4] National Disability Insurance Agency. (2021). *National Disability Insurance Scheme: Psychosocial Disability Recovery-Oriented Framework.*
[5] World Health Organisation. (2021). *Guidance on community mental health services: promoting person-centred and rights-based approaches.*
[6] Price-Robertson, R., Obradovic, A., & Morgan, B. (2016). *Relational recovery: Beyond individualism in the recovery approach. Journal of Groups in Addiction & Recovery, 11(2), 108-120.*

3 The importance of recovery for people with psychosocial disability

3.1 People with psychosocial disabilities face unique challenges which require specialised supports

The overall cost of severe mental illness (SMI) in Australia is estimated to be $56.7 billion.[1]

Despite being the third most common disability experienced by participants in the National Disability Insurance Scheme (NDIS or the Scheme), psychosocial disability is an area of disability that remains misunderstood, with people impacted experiencing poorer outcomes compared to participants with other physical and intellectual disabilities.[7] As at 30 June 2022, people who had a primary and secondary presentation of psychosocial disability made up almost 18% of all participants in the Scheme, with many more people likely living with mental health issues.[8]

Unlike many physical and intellectual (cognitive) disabilities, psychosocial disabilities are often invisible, episodic and can be difficult to recognise. When interacting with support services, people living with psychosocial disability may:

- Present as though they are well, placing the onus on the individual to emphasise their own needs, including the often re-traumatising experience of recounting what their worst day looks like.
- Face barriers to realisation of their personal recovery goals.
- Experience changes in needs and symptoms over time, with periods of increased need for support.

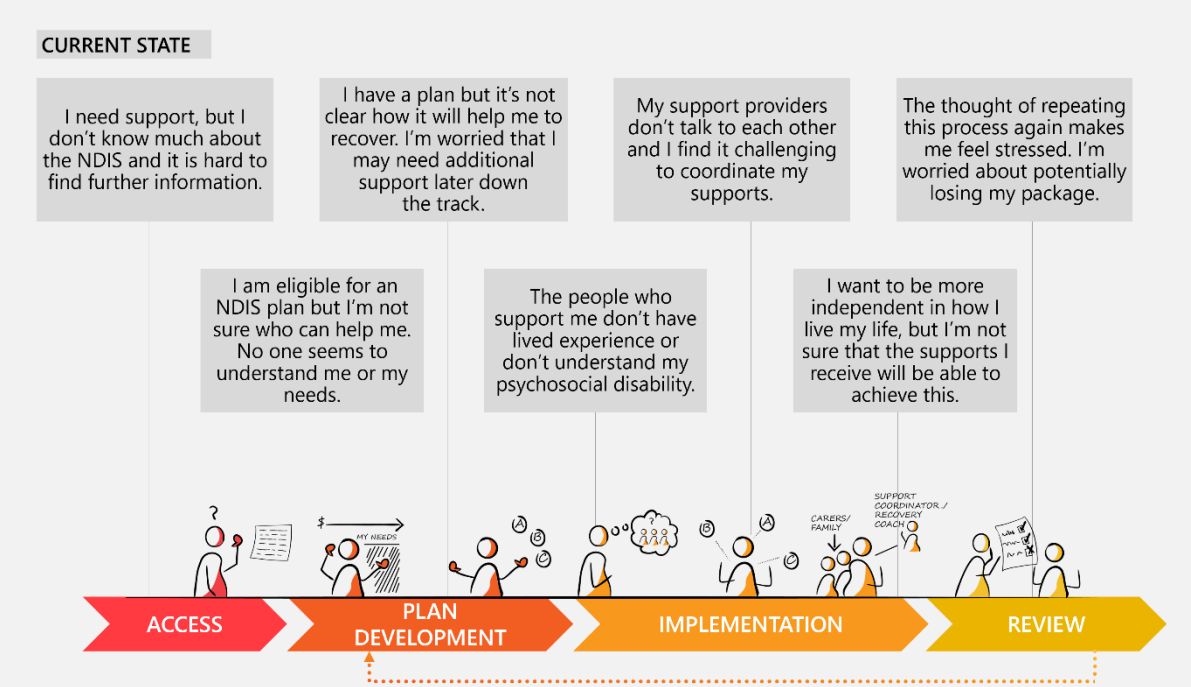
An essential aspect of psychosocial disability is that no two people and no two conditions look the same. This means that symptoms, precipitating factors for phases of unwellness, and crucially, helpful supports will be different for everyone. While psychosocial disabilities arising from mental ill health may be considered 'permanent' in that they are persistent, debilitating and long-lasting, this does not mean people are not able to recover a life that is meaningful to them. The concept of 'recovery' – the ability to live a rich, full life alongside their disability – is a critical outcome of effective support.

"When things go badly… I don't really feel that I'm able to talk to people about it. I think that it's a real sense of shame that these are the things that I should be able to manage myself, and guilt… that I'm letting people down. Or letting myself down."[9]

lived experience representative

[7] National Disability Insurance Agency. (2022). *Psychosocial Dashboard*.
[8] National Disability Insurance Agency. (2023). *'A Real Say in the Solutions'*.
[9] Kokanovic, R., Brophy, L., McSherry, B., Hill, N., Johnston-Ataata, K., Moeller-Saxone, K., and Herrman, H. (2017). *Options for Supported Decision-Making to Enhance the Recovery of People Experiencing Severe Mental Health Problems. Melbourne: Melbourne Social Equity Institute, University of Melbourne.*

Figure 3 | Current state for a NDIS participant with psychosocial disability



For a support ecosystem to be psychosocially supportive and recovery-oriented, it must be:

- Co-designed for the unique needs of psychosocial disability cohorts, with an understanding of how support for psychosocial disability differs to other disabilities.
- Mindful of the person's lifeworld, including their familial, social, and economic environment, and understanding the impact of these environments on the person's recovery.
- Able to support people to the extent necessary to make their own decisions.[10]
- Inclusive of a peer workforce with a lived experience of mental health challenges.
- Delivered by a skilled, trauma-informed workforce who are qualified to deliver recovery-oriented support for people with psychosocial disabilities safely and in a way which supports the achievement of personal recovery goals.
- Flexible, versatile, evidence-based and person-centred, designed to support an individual's needs over time, with the understanding that these are likely to fluctuate.

[10] Brophy, L., Brasier, C., Fossey, E., Jacques, M., (2022). *MHV ROPDS stage 3 report.*

3.2 The NDIA has made significant progress to support participants with psychosocial disability

Acknowledging some of these key differences in the needs of people experiencing a psychosocial disability, the National Disability Insurance Agency (NDIA) has sought to make substantial changes to the Scheme. In recent years, the NDIA has implemented several initiatives with the goal of improving support provision to people experiencing a psychosocial disability.

Since 2021, a raft of amendments have been introduced to the Scheme, including:

- The introduction of legislative changes which clarify that 'episodic and fluctuating' impairments can be considered permanent when determining eligibility to the Scheme, including for people with psychosocial disability.
- The launch of the Psychosocial Disability Recovery-Oriented Framework (the Recovery Framework), outlining principles and practices to support NDIS participants living with psychosocial disability in their personal recovery to live a meaningful life.
- The introduction of Recovery Coaches – NDIS funded workers with mental health knowledge whose role is to help people with psychosocial disability better navigate and utilise the services available.
- The introduction of the new NDIA Engagement Framework, developed with disability sector representatives to strengthen engagement and incorporate co-design approaches.
- The launch of the NDIS Workforce Capability Framework and associated tools and resources to provide guidance of attitudes, skills and knowledge expected of NDIS workers.

Despite the Scheme's commitment to these principles, participants still face challenges which can undermine or hinder their recovery progress. There is more to be done to ensure people with a psychosocial disability can be better supported in their recovery through the NDIS.

4 Operationalising the Recovery Framework within the NDIS

The APA recognises that tangible, implementable and pragmatic recommendations are needed to support the NDIS in its ongoing journey to become recovery-oriented. We have developed a proposal for a service model which, if implemented, would improve coordination of support and outcomes for participants with psychosocial disability within or accessing the NDIS. The service model outlines seven opportunities and four systemic enablers which can be actioned individually and are designed to work as an ecosystem.

4.1 Intended outcomes of the service model

1. **Participants feel supported to focus on recovery.**

   This service model provides responsive supports that will increase participants' sense of stability within the Scheme, encouraging them to focus on their recovery journey instead of worrying about losing their plan provision.

2. **Participants can flex their support packages to respond to their needs.**

   Providing flexible budgets means participants can access supports that are appropriate for their changing needs. Sudden increases in need are responded to and therefore less likely to result in a debilitating episode which risks increasing a person's need for support. It also ensures packages are well-utilised.

3. **Participants can navigate the system more independently.**

   Better coordination and alignment of supports guided by specialised coordination roles will enable participants to build capability to navigate the system and their budget allocation decisions more independently over time.

4. **Participants are supported in their recovery by lived experience expertise and a skilled recovery-oriented workforce.**

   Participants are recognised as experts in their own lives. A workforce that understands psychosocial disability and strongly incorporates a lived experience workforce, in combination with opportunities for training, supervision and capability-building, will better support and empower participants in their personal recovery.

5. **Participants will build a therapeutic alliance with coordinators and providers.**

   Providing specialist coordination roles and ensuring support providers are recovery-appropriate will result in the development of stronger therapeutic relationships, leading to better recovery outcomes for participants, opportunities for early intervention and decreased risk of disengagement during periods of ill health.

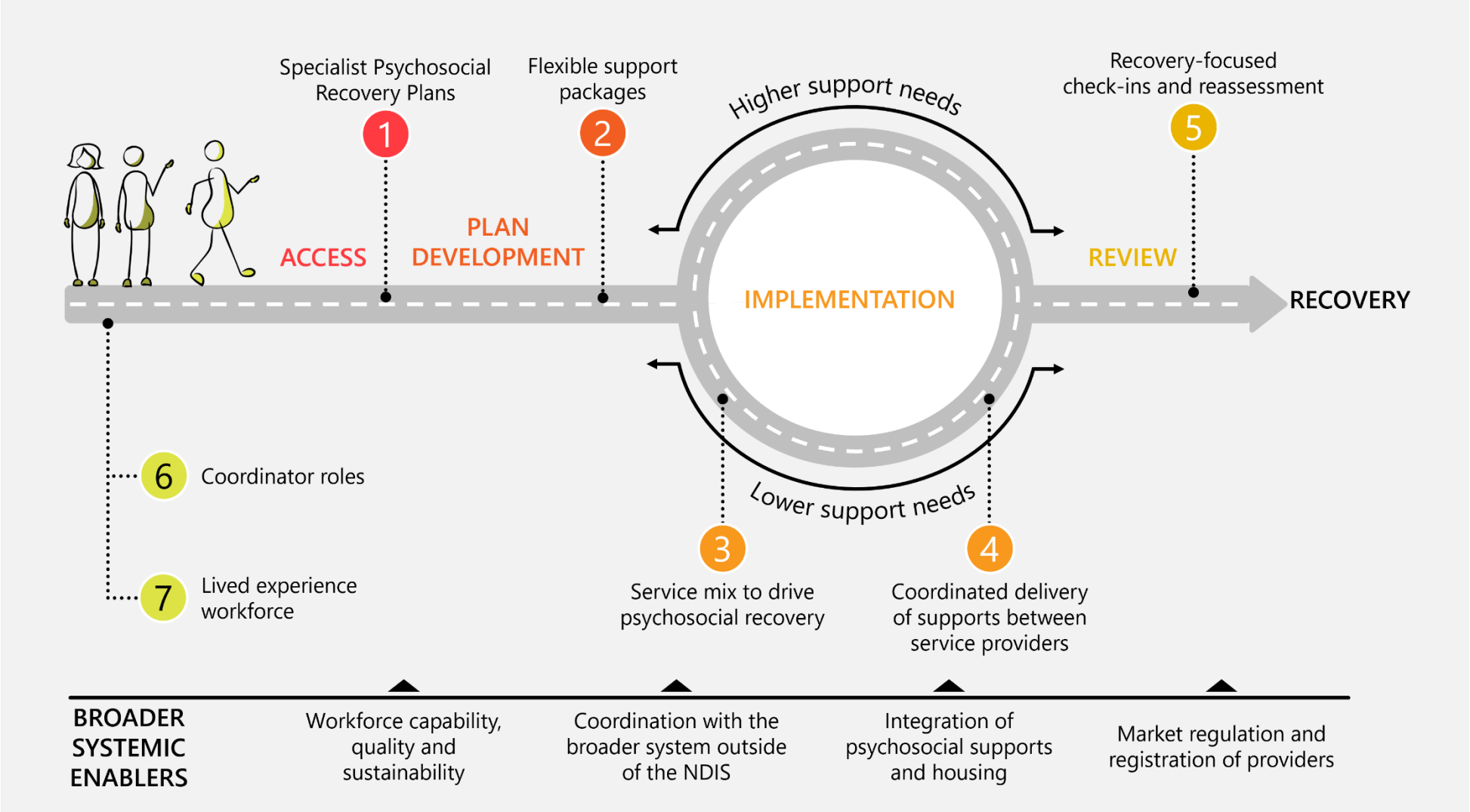
6. **Participants' supports are appropriate, recovery-oriented and evidence-based.**

   The introduction of a specialised Recovery Plan that is developed and managed with the support of specialised coordinator roles will lead to the delivery of coordinated, evidence-based interventions. This will lead to better outcomes for participants as well as improved use of budget allocations.

4.2 Service model for a recovery-oriented NDIS

This journey map below lays out seven opportunities and four systemic enablers for operationalising recovery in the NDIS.

Figure 4 | Service model opportunities for a recovery-oriented NDIS



4.2.1 Opportunity 1: Specialist Psychosocial Recovery Plans

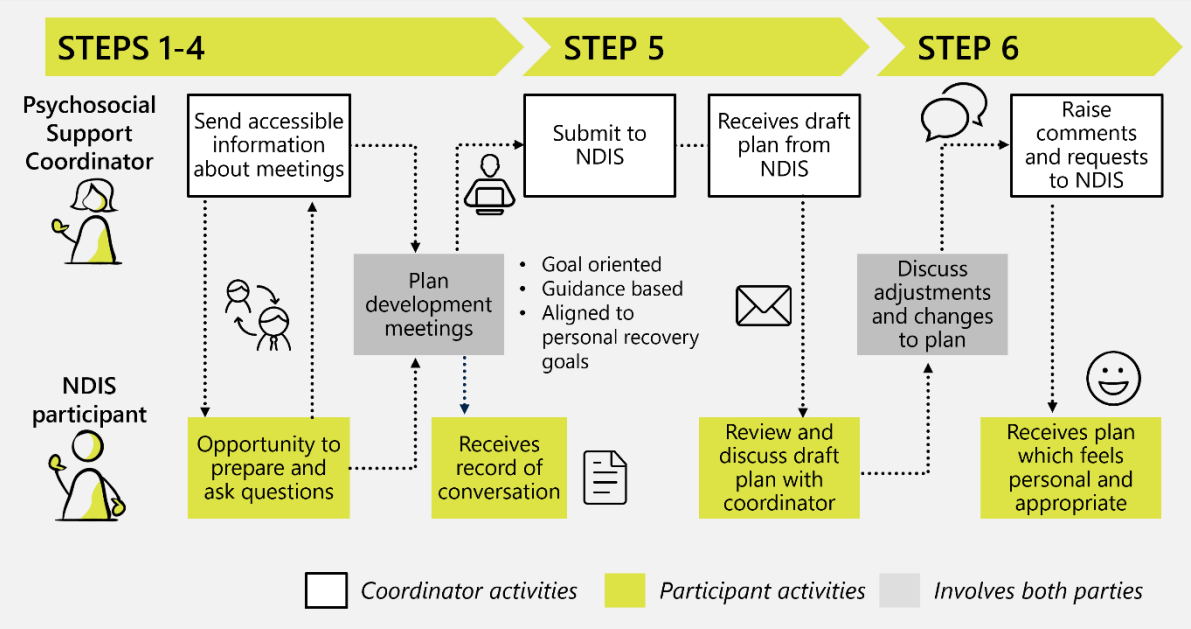
Prior to being granted entry into the Scheme, it is important to ensure people are aware of their eligibility, and informed of the relevant services and supports available to them. However, many people currently face inconsistent assessment outcomes and bureaucratic barriers in navigating entry, which can undermine their sense of control and agency over their recovery journey. While not addressed in this submission, it is crucial to also reassess accessibility measures to optimise opportunities for eligible individuals to enter the Scheme, for example, through assertive and proactive outreach, and functional assessment (rather than diagnostic assessment). Such measures are crucial to ensure participants feel empowered from the outset, as soon as they access the Scheme, to further engage in plan development.

A fit-for-purpose Recovery Plan is critical to ensuring people living with psychosocial disabilities receive the specialist, recovery-oriented support they need. From a participant's perspective, current funding decisions can lack emphasis on recovery and can sometimes look confusingly unrelated to their goals after they are approved.

> "You have to delve into your darkest days and relive them rather than think about recovery."
>
> lived experience representative

The current planning process could be revised to better suit participants' unique circumstances and ensure appropriate arrangements are made to enable them to work towards their recovery goals. Figure 5 captures the proposed process for eligible participants, which aims to ensure that Recovery Plans are designed to connect participant goals to evidence-based supports that work well together, and increase visibility and ownership for the participant, their family/carers and engaged services. Participants are engaged throughout the process, with Psychosocial Support Coordinators (PSCs) available for any assistance that participants may require in building the skills necessary to develop, understand, implement and use their plans in the most optimal manner to achieve their goals. Although Local Area Coordinators (LACs) will not be extensively involved in plan development, they should be informed throughout to carry out important administrative tasks to ensure a smooth transition from access to plan development stages.

Figure 5 | Proposed process post-eligibility to develop a psychosocial Recovery Plan



The proposed process to develop specialist recovery plans is outlined below.

1. **An agenda, instructions and other relevant information for plan development meetings will be provided to the participant ahead of time.** This will provide foresight and important advice about the type of questions which will be asked and the information which will be needed, as well as the types of supports which may benefit their recovery. This communication should be strengths-based in tone and be the first opportunity to begin developing a relationship between participant and their Psychosocial Support Coordinator (PSC). These initial interactions and materials are necessary to support the participant to make decisions and respect their right to have choice and control over important decisions relating to their treatment and care, in accordance with recovery-oriented practice.[11]
2. **Recovery Plans will be driven by the participant's personal recovery goals and developed in collaboration between the participant, Psychosocial Support Coordinator (PSC) roles, and the participants' nominated supporters**. Participants will work with coordinators that have expertise in psychosocial disability, are able to understand their needs and ask the right questions regarding what helps and what causes them to become more unwell. The PSC (see Section 4.2.6) is responsible for facilitating the implementation of the interventions outlined in the plan.

"I always feel thankful for what I get rather than the feeling that I have the right and entitlement. So, because I feel like that, I'm very reticent to ask for anything specific. I keep all my goals really general."[12]

lived experience representative

3. **Recovery Plans will connect goals to evidence-based supports**. The planning process will be supported through a functional assessment by an allied health professional (such as an occupational therapist) and a PSC with the expertise to link the participants' recovery goals with appropriate services and clear outcome measures. Service provision should be viewed as a whole, ensuring that all support providers are aligned around shared goals.
4. **Participants come away from meetings with tangible next steps**. Clear and straightforward templates are completed together to ensure all parties are aligned on the agreed priority goals. Handouts give guidance around next steps, and contact details are provided if the participant needs to reach their PSC.
5. **Post-meeting, the NDIA will provide a view of draft Recovery Plans.** The NDIA will increase transparency of their decision-making by providing draft copies of plans and increasing communication with participants and PSCs. This will allow an opportunity for participants and their PSCs to identify and discuss proposed changes or issues, making it easier to clarify and make changes to plans before they are finalised.
6. **The final Recovery Plan specifies care team members that will support the participant in their recovery journey.** It will also include the evidence-based interventions selected by the participant to aid in achieving their personal recovery goals, enhancing their day-to-day functioning, and achieving sustained recovery. The plan specifies check-in timelines that will take place between providers and PSCs. It should also specify clear outcome measures linked to recovery goals which can be compared to baseline functional assessments.

[11] Kaplan, D., McGrath, D., (2018). *Optimising support for people with psychosocial disabilities participating in the NDIS.*
[12] Wilson, E., Campaign, R., Pollock, S., Brophy, L., Stratford, A., (2021). *Exploring the personal, programmatic and market barriers to choice in the NDIS for people with psychosocial disability.*

IMPLEMENTATION ACTIONS AND CONSIDERATIONS	
✓	**Development of a specialist Psychosocial Recovery Plan should be done in collaboration** between the participant and their chosen supports, the Psychosocial Support Coordinator, and the NDIA.
✓	**Implementation can consider a two-phase approach to achieve the gold standard acknowledging current systemic barriers.** Phase 1 could be managed by specialised providers who can engage PSCs that have the expertise to assist participants in plan development. The responsibility can be shifted to the NDIA once workforce capabilities have been developed around psychosocial disability to enable recovery and plan flexibility.
✓	**There is a need for detailed process design to ensure transparency in communications between NDIA decision-makers, participants and coordinators.** This is essential to ensure the transition of responsibility in a phased approach is seamless and stress-free as possible for participants, service providers and those involved from the NDIA.
✓	**Service co-design is required to determine the information participants might require at certain time points in the process, and to ensure the mechanisms are in place to make this consistent across LACs/PSCs.**
✓	**A baseline should be established around recovery outcome measures** for participants already in the Scheme. This approach should be trialled with a small cohort of existing participants to understand differences in outcome from baseline, following provision of support under the new recovery plan.

4.2.2 Opportunity 2: Flexible support packages

> "There's no wriggle room if things get worse. If I need more support, it can take another four to five months to get it sorted."
> lived experience representative

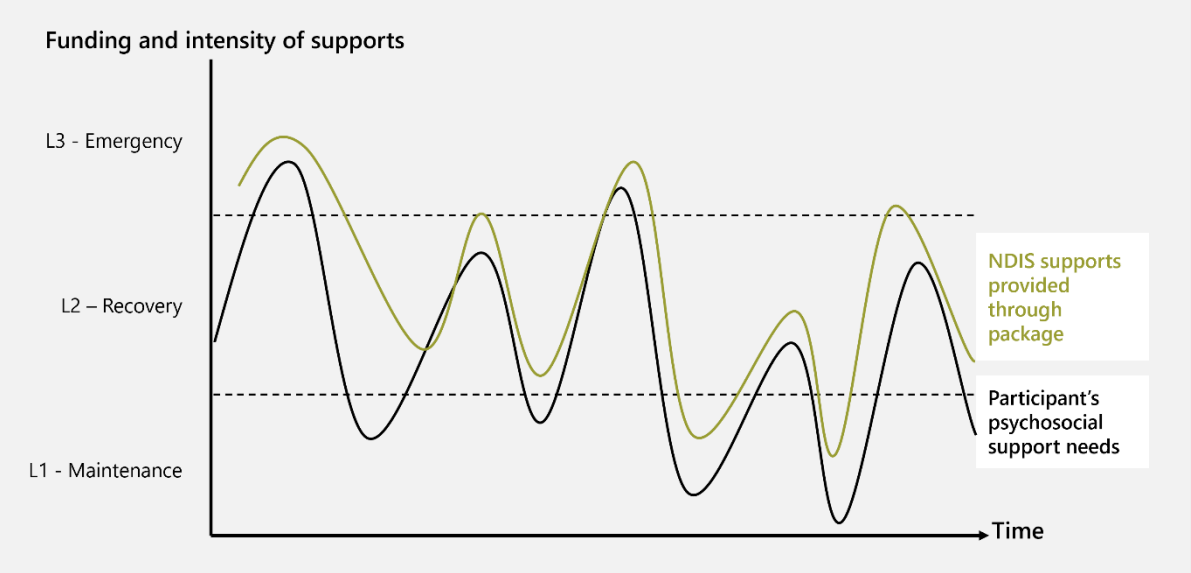
Current service provision relies on a framework where support packages are predetermined and periodically reviewed. This approach can be incompatible with the needs of individuals living with psychosocial disability, who may experience sudden and rapid changes in their support requirements as episodic events occur. Due to the static nature of plans, participants report finding themselves in crisis when supports cannot meet their needs, with some ending up in the Emergency Department, where they may experience treatment which surpasses the cause of their presentation as the most distressing event in that scenario.[13] Unfortunately, the current system does not provide a suitable mechanism for an appropriate response during these periods, which can result in significant setbacks to participants' recovery progress and quality of life.

The NDIS could employ a mechanism for an adaptable funding model, which enables people living with psychosocial disability to flex their needs up and down based on levels of intensity of support they require, as per Figure 6. As understanding of participants' needs develops over the course of multiple interactions, support workers and coordinators would be able to better anticipate the timing and the level of support in alignment with the participants' psychosocial state.

By implementing this funding model, individuals would be able to access support as soon as they need it, particularly during periods of higher support need, which can help to minimise periods of unwellness and ensure that deterioration is identified early. This would help to reduce the risk of individuals completely disengaging from support when they are in remission and encourage ongoing engagement with their support services.

[13] McIntyre, H., Loughhead, M., Hayes, L., & Procter, N. (2023). *Research project update: NDIS and the emergency department: emerging themes (MIND Australia and the Mental Health and Suicide Prevention Research and Education Group, University of South Australia, Adelaide)*

Figure 6 | Variable periods of support funding and intensity with an adaptable funding model



Step change-inspired support packages would consist of the following:

- **Implement an adaptable funding approach**. This would involve the pre-approval of funding for a base 'Maintenance' or 'L1' level, which will provide lower intensity support for individuals who are stable. During periods of crisis or increased support needs, participants' funding packages can be flexed up accordingly. At the 'Emergency' level, the NDIS and clinical mental health systems may both be required and should be coordinated to ensure a smooth transition from one to the other, as stated in the Applied Principles and Tables of Support (APTOS) agreement.[14]
- **Design individualised packages of support for each level**. Participants will have access to different types of supports or budgets, depending on their needs at a given time. Types of supports will be discussed and agreed with the Psychosocial Support Coordinator ahead of time. Regular reviews and assessments would also need to take place to ensure that the level of support provided is appropriate and responsive to changing needs. There might also be timeframes agreed around duration for 'emergency' level budgets to be in place, based on a person's previous experiences of episodes of increased need.
- **Extend the duration of plans to be in place for 36 months**, in recognition of the long-term nature of psychosocial recovery. This will increase participants' sense of security and reassurance for participants, ensuring they do not have to reassert their needs or re-tell their story as often.
- **Design a process to enable timely response to participants' changing needs**. This could include close contact between a participant and their Psychosocial Support Coordinator or Recovery Coach, rapid reviews of plans by the NDIA, and early warning systems between core service providers.

"The three and a half years I've been on NDIS, I could never get it right. I chose to give up fighting to get the money I need. I can't keep doing this. This is killing me."[13]

lived experience representative

[14] Department of Social Services. (2021). *The Applied Principles and Tables of Support to Determine Responsibilities NDIS and other service.*

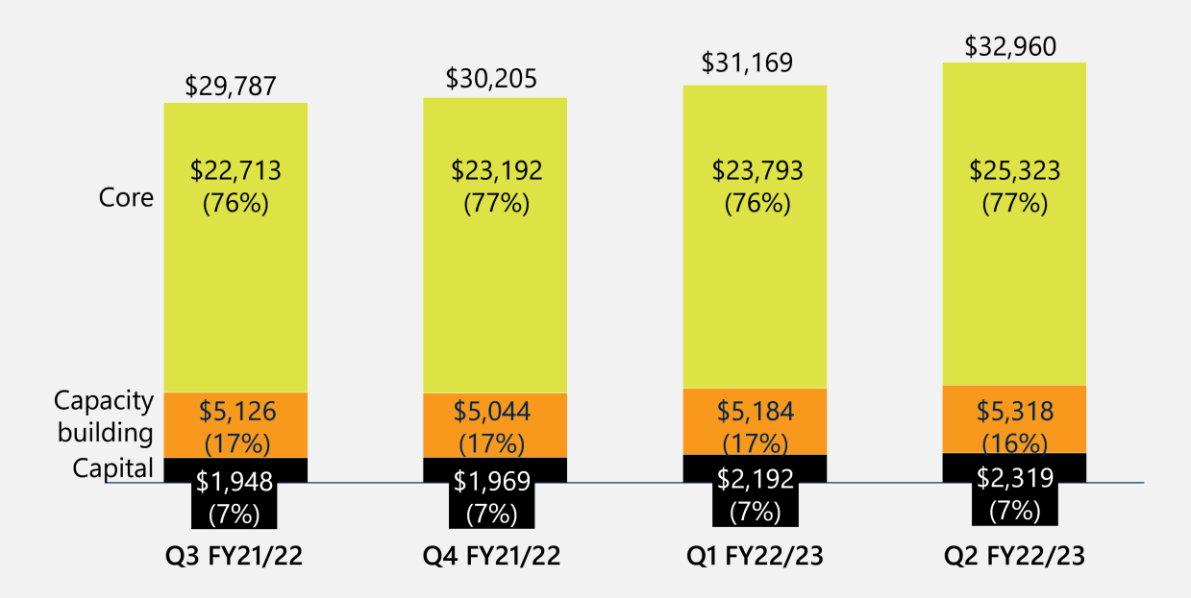
IMPLEMENTATION ACTIONS AND CONSIDERATIONS	
✓	**Recovery Plan design should plan for adaptable funding** alongside the participant from the development of their first plan. Revisiting this with participants periodically will also help PSCs to develop a deeper understanding of the individuals' needs and patterns over time.
✓	**Detailed process design around 'stepping up' to emergency packages should be a collaborative process** between participants, specialist coordinators and the NDIA. A potential approach could be a base funding package with pre-approved 'contingent' funding to enable timely access during periods of increased support needs.
✓	**Baseline data around plan utilisation should be collected** to compare participant spend and aggregate savings over time.
✓	**Key service providers must be consulted around a proposed pilot model**, with detailed process and service design put in place through a collaborative process including participants.

4.2.3 Opportunity 3: A service mix to drive psychosocial recovery

Psychosocial supports play a vital role in enabling people living with mental illness to live well, recover, and combat stigma. However, Figure 7 shows that the current provision of supports through the NDIS are mainly focused on maintenance-oriented and reactive 'core' supports, which fall short of promoting recovery and helping people to meet their personal goals.

While still important to enable participants to complete activities of daily living, core supports do not facilitate growth or community participation, and long-term recovery programs are often inaccessible through these supports. In comparison, Capacity Building supports which are more recovery-oriented and assist participants to build their independence and skills, currently make up a relatively small proportion of a participant's total NDIS-funded supports. There is also a shortage of services tailored to the needs of psychosocial consumers, where an estimated 290,000 people in Australia have an urgent need for psychosocial support, only 64,000 can access this through the NDIS.[15]

Figure 7 | Core supports currently make up over 75% of the average payments for people with psychosocial disability.[16]



[15] National Disability Insurance Agency. (2022). *Access Snapshot 5: NDIS and Other Services Supporting Your Mental Health.*
[16] National Disability Insurance Agency. (2023). *Explore data.*

Review of service mix and provision of support to promote recovery

A review of the service mix and provision of supports for people with psychosocial disability is needed to better support and build participants' capacity in line with their personal recovery goals. These supports must be provided within the framework of long-term, recovery-oriented and flexible services. Additionally, these should be accompanied by systems and practices that empower participants to exercise greater autonomy and decision-making authority in their recovery.

Some elements for consideration could include reviewing the provision of evidence-based supports, incorporating community-based interventions, strengthening informal support networks and reviewing the capacity and capability of providers to deliver supports.

Reviewing the provision of evidence-based supports that build capacity

The provision of Evidence-Based Interventions (EBIs) and psychosocial supports can create significant opportunities for participants to achieve their recovery goals, better understand and manage their conditions, and ultimately decrease their reliance on outside supports over time.[17]

These supports can include a range of interventions:

- Supported employment programs (e.g., Individual placement and support (IPS))[18]
- Outreach treatment and support services[19]
- Supported accommodation, such as the Housing First model, congregate staffed housing and on-site staffing[20] (see Section 5.2 for further details on housing supports)
- Supported education opportunities, such as recovery colleges and recovery-based mental health education plans[20]
- Cognitive remediation[20]
- Cognitive behavioural therapy for psychosis and illness self-management.[17]

Incorporating community-based supports

There is strong evidence to support the effectiveness of community-based supports for people with psychosocial disabilities.[20] Community-based supports place an emphasis on enhancing a person's quality of life through a bio-psycho-social lens focusing on the social determinants of health.[21] They consider social support, cultural identity, education and employment, housing, access to healthcare, discrimination and stigma, and physical environment. Facilitating these supports in group settings with a focus on integration into the mainstream society has been suggested to promote independence in daily personal activities. It also promotes inclusion of people with disability to expand opportunities for community participation and employment.[11] Opportunities to participate and connect with the wider mainstream community are important for people with psychosocial disability to engage as citizens in society and build a stronger sense of self.

Social and community-based supports do not necessarily need to be specialised for a psychosocial cohort and can be supplemented by informal forms of support including family networks. These supports might include:

- Social skills and cognition training, and peer support/consumer networking[17,20]
- At the service level, supported accommodation, education, or employment[20]

[17] The University of Melbourne and Mind Australia. (2016). *Effective evidence based psychosocial interventions suitable for early intervention the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery.*
[18] Bond, R.G., Drake, E.R., Becker, R.D., (2012). *Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US.*
[19] Rosen, A., Mueser, T.K., Teesson, M., (2007). *Assertive community treatment-issues from scientific and clinical literature with implications for practice.*
[20] Killaspy, H., Harvey, C., Brasier, C., Brophy, L., Ennals, P., Fletcher, J., & Hamilton, B. (2022). *Community-based social interventions for people with severe mental illness: A systematic review and narrative synthesis of recent evidence. BMC Psychiatry, 21(1), 133.*
[21] Australian Institute of Health and Welfare. (2022). *Social determinants of health.*

- At the individual level, it may mean access to services that promote mainstream community participation, family interventions, peer-led/supported interventions and social skills training.[20]

Strengthening informal support networks

Living with or caring for someone with psychosocial disability can place strain on individuals and relationships, creating significant emotional and practical challenges. As such, recovery should also consider the participant's familial, social (including cultural) and economic environments, in conjunction with the supports they receive through the NDIS. It is crucial to provide support that acknowledges and recognises the value of informal support networks in a person's psychosocial recovery, particularly through targeted assistance to family member and carers. Recognising the unique needs of carers and providing them with necessary capacity-building resources and support can alleviate stress associated with caregiving. It can also improve the quality of life for both the participant and their carer while also promoting overall mental and emotional well-being.

These supports, inclusive of some mentioned above, include:

- Family psychoeducation and support[22]
- Training for carers and others in behaviour management strategies.[11]

Reviewing the capacity and capability of providers to deliver supports

Providers should:

- Understand participants' recovery goals in the supports they offer and be able to measure outcomes against these recovery goals.
- Be able to support long-term engagements and offer flexible levels of provision based on the needs of the participant.
- Be trained and skilled in the provision of psychosocial supports (explored further in Section 5.1),
- Embed culturally safe practices in support delivery and consider a more targeted engagement approach for cohorts, such as participants in rural and remote communities, Aboriginal and Torres Strait Islander communities, Culturally and Linguistically Diverse (CALD) populations and individuals with significant trauma.

IMPLEMENTATION ACTIONS AND CONSIDERATIONS	
	**Undertake a comprehensive market scan and review of support providers** currently available in the market. This should include gaps analysis and consultation with providers to understand blockers and pain-points preventing diversity of provision in the market.
	**Identify existing providers with capability to provide psychosocial supports** in the market, conduct consultation around responsive and recovery-oriented service models to understand enablers and blockers.
	**In addition to the service mix, consider tailoring service delivery for cohorts where targeted engagement may be needed**, such as participants in rural and remote communities, Aboriginal and Torres Strait Islander communities, Culturally And Linguistically Diverse (CALD) populations and individuals with significant trauma.[11]
	**Establish an expert panel to identify and recommend evidence-based assistive technology and support services for participants**, to ensure they can access the right supports tailored to their individual needs. The panel can work with the NDIS to ensure the identified services are included in the NDIS price guide and are available to those who require them.

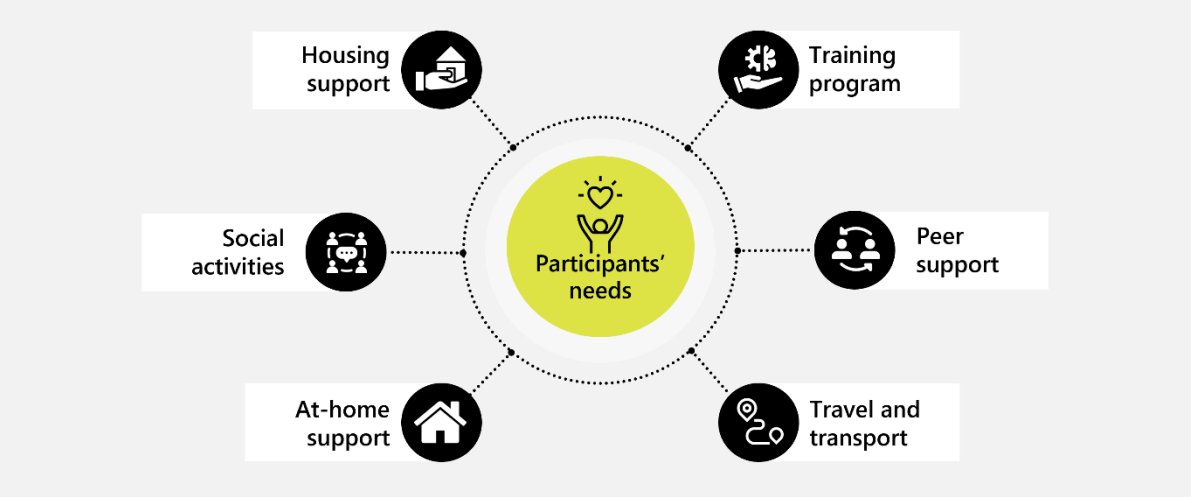
[22] Pharoah, F., Mari, J., Rathbone, J., & Wong, W. (2010). *Family intervention for schizophrenia.*

4.2.4 Opportunity 4: Coordinate support between service providers

People with psychosocial disabilities may work with multiple service providers with diverse areas of expertise (many outside of psychosocial) who may be handling different aspects of their care and support Figure 8 | Coordination of supports essential for participants' recovery. Fragmented or inappropriate services resulting from poor coordination can contribute to duplicated effort and reduced accountability, which can have adverse effects on participants' recovery outcomes. This makes effective coordination crucial to ensure supports are not inadvertently operating at crossed purposes or undermining recovery goals.

Effective coordination between the person living with psychosocial disability and providers ensures that participants receive personalised and holistic support through a cohesive, evidence-based care plan for the person.

Figure 8 | Coordination of supports essential for participants' recovery.



Holistic, coordinated support across providers could be achieved by:

- **Supporting participants to build their knowledge and capacity to navigate the market.** Empowering people to make their own decisions with regards to choosing supports and providers in line with their recovery goals. Workers who engage with participants should be trained in supported decision-making and recovery, enabling them to actively listen and effectively respond to the needs and preferences of participants.[10]
- **Ensuring providers are clear on their role in supporting each participant**. Providers should have a view and broad understanding of the recovery outcomes and goals associated with the support they provide.
- **Establishing clear guidelines and protocols for communication and handover of care between different providers.** This might include implementing regular meetings or forums between different support services to discuss and coordinate care plans for shared clients and could be built into the funding of a participant's individualised package.
- **Developing a shared database or information system** to improve communication and collaboration between different support services. Implement adequate data security and informed consent protocols for the sharing of participant recovery goals between providers.
- **Exploring funding models which incentivise case coordination**. More flexible funding approaches such as bundled payments and shared savings models could encourage providers to work together and coordinate care to ensure that the participant receives the most appropriate and effective treatment.
- **Ensuring there is consistent training and skills across support provider roles** to ensure quality and safety of supports being provided to participants.
- **Conducting regular evaluations of the effectiveness of support against recovery goals and identifying areas for improvement**. This information would be used to help identify emerging trends

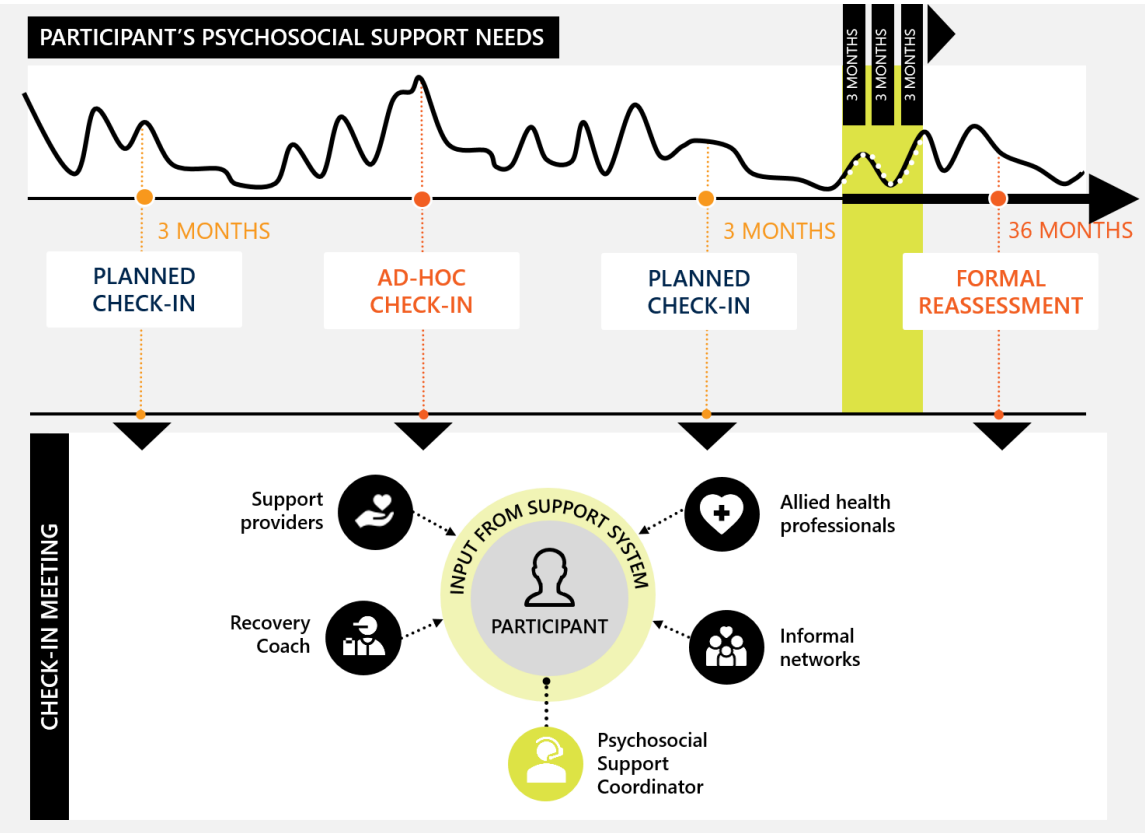
and changes in the needs of individuals living with mental illness. This information can be used to adjust and adapt support services and coordination processes to better meet the evolving needs of individuals and the cohort more broadly.

IMPLEMENTATION ACTIONS AND CONSIDERATIONS	
	**Identify key providers of recovery-oriented psychosocial support** to participate in the co-design of a pilot model for coordination across providers with a small pool of participants in the NDIS.
	**Design a detailed service and process plan for the provision of communications** between support providers and mechanisms for responding to changing participant needs.
	**Explore opportunities to enable support providers to effectively coordinate their supports.** A potential approach could be to make the Recovery Plan accessible to support providers as the default, with an option to opt out if the participant does not consent, noting that strong consent protocols will need to be in place.
	**Implement adequate data security and informed consent protocols** for the sharing of participant recovery goals between providers, including the implications of giving or not giving consent to share their recovery plans.
	**Engage organisations such as NDIS Quality and Safeguards Commission** to open discussions around specific quality assurance for proactive psychosocial support provision.

4.2.5 Opportunity 5: Rethinking check-ins and reassessment

For individuals with psychosocial disabilities, the plan reassessment (previously called plan review) process can be traumatic. Distress associated with these meetings is often linked to fear that achieving recovery goals may lead to the removal of supports, without consideration of the fluctuating nature of psychosocial disability. Lived experience representatives stated that this can create a disincentive for individuals to strive for recovery outcomes. The plan reassessment process can also be retraumatising for participants as they are compelled to continually re-tell their story and justify why they need support.

Figure 9 | Timeline of reassessment for NDIS participants with psychosocial disability



Rethinking check-ins and reassessment for people with psychosocial disability

To address these issues, Figure 9 shows a model that will observe the following:

- **Regular check-ins will be conducted every three months** to ensure that participants feel their needs are being adequately met, and to check-in on progress towards specific outcomes measures and overall recovery goals. During these check-ins, there may be opportunities to make minor adjustments and flex current supports to reflect support needs within the approved limits of the plan. An ad-hoc check in may also be required during periods of higher support needs.

  Protocols should also be established for facilitating ad-hoc check-ins with Psychosocial Support Coordinators (PSCs) to quickly respond to any changes in a participant's needs. Integrating lived experience expertise (e.g., Recovery Coach) in these touchpoints is crucial to minimise instances where interactions may cause the participant distress in recounting any traumatic experiences.

- **A reassessment process will be formally conducted towards the end of a participant's plan**. The reassessment process should include a review of the participant's recovery goals and outcomes over the course of their Plan, and identify any changes in circumstances as well as future steps to support their recovery. An ad-hoc reassessment process may also occur if major changes are required to the Recovery Plan or packages.

- **The voices of participants, supported by support coordinators with lived experience or trained in psychosocial disability as needed, will be valued in the planning and reassessment process**. The input of other support providers can also assist to gain perspective on the appropriate level of support that someone needs at a given time.

- **Extended duration of plans** (see Opportunity 1: Specialist Psychosocial Recovery) to provide participants with a greater sense of security and alleviate concerns around underutilisation. Participants who use their packages sparingly should not be penalised for being healthy but instead have the option to shift down to their 'L1' maintenance package.

IMPLEMENTATION ACTIONS AND CONSIDERATIONS	
✓	**Explore potential for extending the duration of Recovery Plans to 36 months** (see also Opportunity 1: Specialist Psychosocial Recovery Plans, and Opportunity 2: Flexible support packages).
✓	**Co-design the reassessment process and meeting** with LACs, PSCs and people with lived experience to understand what is necessary to build psychological safety.
✓	**Test quarterly mini-reassessment check-ins** with a limited cohort of psychosocial participants.

4.2.6 Opportunity 6: Building a coordination team around the participant

Coordination is essential for effective recovery plans in the NDIS, but service coordinators may lack training and awareness of the needs of people with psychosocial disabilities. To address this, a specialist coordination team can provide holistic and recovery-oriented support with the expertise to assist participants with specialised treatment, care and services for psychosocial disability. The team consists of the participant themselves alongside a Psychosocial Support Coordinator (PSC), a Recovery Coach (RC) role, and an allied health professional (e.g., Occupational Therapist), each with specific roles that have been reimagined to better support and measure participant progress.

> "Getting an understanding of what I can and can't access has been really challenging. It's all dependent on your support coordinator."
>
> lived experience representative

A coordination team to support participants in their recovery

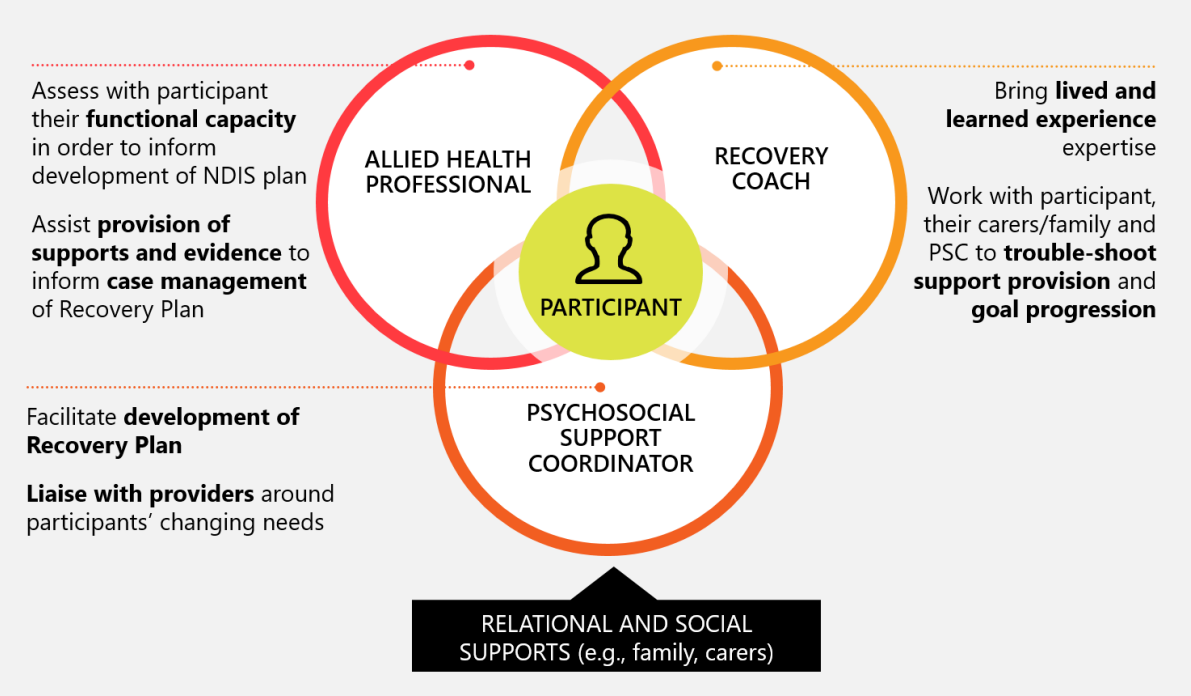
This model is designed to build a team to rally around the participant, and to support the development of relationships between participants and support providers. The aim is to promote development of therapeutic alliance, a recognised factor in improved mental health outcomes[23], to create a sense of ongoing support and enable greater capacity for participants to make decisions in their recovery.

The model will increase accountability and consistency in quality and safety of supports provided. The participant and their coordination team collaborate in co-designing, implementing, and reviewing the Recovery Plan together. It is important that the process also involves and consults the input of the participant's nominated informal networks, which may include family, carer, or an independent advocate, in recognition of their importance in helping to counter any potential power imbalances and provide supported decision making. The coordination team also hold support providers accountable for outcomes, playing a key role in ensuring an aligned and coordinated effort to deliver recovery results for the participant.

> "I feel that carers won't be hanging around to care if they're unable to liaise in a productive manner with the medical staff…"
>
> lived experience representative

[23] Howgego IM, Yellowlees P, Owen C, Meldrum L, Dark F. (2003). *The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management*.

Figure 10 | Primary supports in participant's coordination team.



The Psychosocial Support Coordinator's (PSC) role will include the following responsibilities:

- Develop Recovery Plans (see Opportunity 1: Specialist Psychosocial Recovery) with participants, collaborating with the participant to identify and establish personal recovery goals.
- Bring specialist and deep understanding of evidence-based psychosocial disability supports to recommend appropriate support providers and evidence-based interventions.
- Provide coaching and support the participant to make decisions about their support and progressively build participant's capacity to navigate the NDIS market independently.
- Utilise their expertise in psychosocial disability to establish a strong therapeutic alliance, and help facilitate positive relationships between the participant, their informal supports, and support team.
- Conduct reassessment conversations in collaboration with participants, liaising with Recovery Coaches and allied health professionals to help inform decision-making.
- Monitor support delivery and progress against goals through ongoing assessments with the Recovery Coach, participant and service providers.
- Liaise with providers around the participants' changing support needs.

Building on the concept of the existing Recovery Coach role within the Scheme, the reimagined Recovery Coach's (RC) role:

- Brings lived and/or learned experience expertise and could be introduced after the Recovery Plan has been implemented and the relationship with the PSC has been established.
- Will check in with the participant on a regular basis, and work alongside the participant to support them to make progress towards their recovery goals.
- Aims to understand what is working well and what could be improved about support provision from the participant's perspective.
- Will collaborate with the participant, their carers/family and PSC to address barriers to support provision and goal progression.

The allied health professional's role (eg. OT) will:

- Be introduced at the establishment of the first plan and will check in ahead of each formal reassessment meeting.
- Use specialist knowledge to assess with the participant their functional capacity and needs as evidence to inform development of their NDIS plan.
- Establish a baseline from which to measure progress and outcomes.
- Work alongside the PSC to assist in providing capacity building supports to enable participants' social and community participation, and provide evidence used to inform to case management of the participant's Recovery Plan.

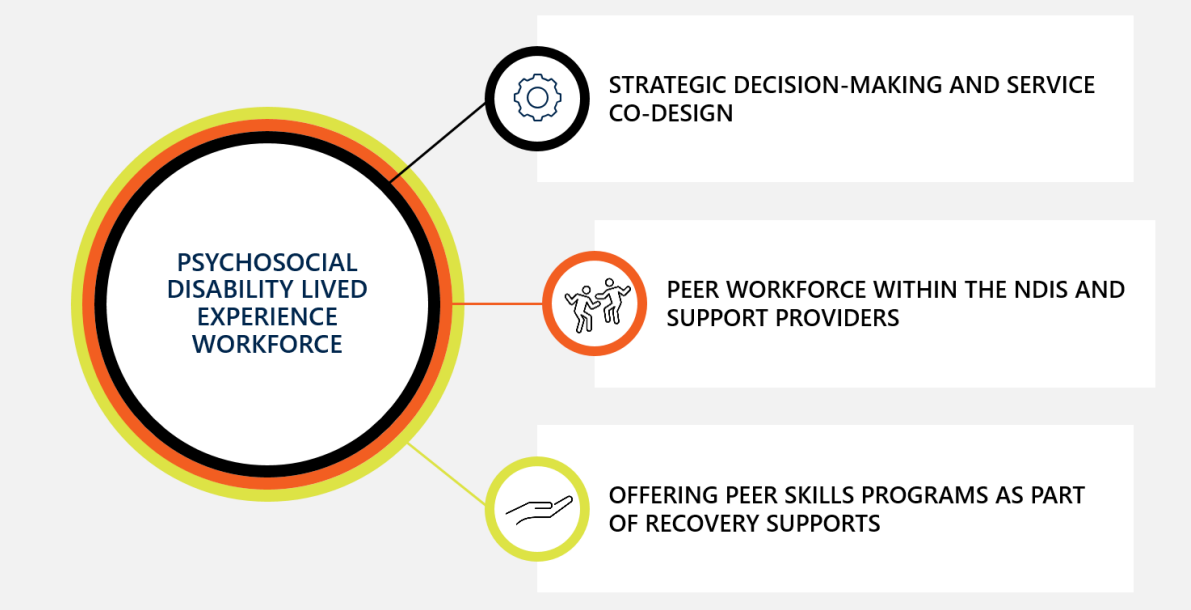
IMPLEMENTATION ACTIONS AND CONSIDERATIONS	
	**Review the existing capacity and capability within the NDIA to deliver the coordinator team** to support participants with psychosocial disability, especially for the roles of the Psychosocial Support Coordinator (PSC) and the Recovery Coach (RC).
	**Engage with agencies and services with specialist expertise in recovery-oriented** supports to deliver the coordination team. By partially shifting the onus of expertise from the NDIA to a specialist provider, participants can be better and more reliably supported on their recovery journey and guided in navigating the NDIS. Working towards the longer term, the NDIA could build capacity, capability, and expertise to provide these coordinated support roles.
	**Implement rules to prevent conflicts of interest in recommended providers and self-referrals,** particularly regarding the role of the PSC in recommending supports and providers to participants, to promote transparency in the market and informed participant choices.
	**Give participants the option to choose whether they want a RC who have lived and/or learned experience with psychosocial disability**. It is also important to recognise participants may also have other needs and prefer their support coordination team to include people with similar lived and/or learned experience expertise from diverse cultures and/or backgrounds (e.g., LGBTIQ+, Aboriginal and Torres Strait Islander, CALD communities).

4.2.7 Opportunity 7: Leveraging lived experience expertise

Lived experience of psychosocial disability must be incorporated at every level of a Recovery-oriented NDIS. The Mental Health Productivity Commission and the Royal Commission into Victoria's Mental Health System have released recent reports emphasising the importance of incorporating lived experience understanding into the design of Australia's mental health system. Various national and state plans have recommended continued expansion of lived experience work.

> "Lived experience gives you more compassion and empathy to better support a person with psychosocial disability. People who aren't trained or have no experience themselves just can't relate."
>
> lived experience representative

Figure 11 | Pathways to a well-equipped Psychosocial Disability Lived Experience Workforce



Integrating lived experience into every aspect of the NDIS Recovery Model

- **Establish and engage a specialist psychosocial disability lived experience group** to guide the co-design and implementation of the Psychosocial Recovery Plans. This builds on the NDIA engagement framework by ensuring there is representation of psychosocial disability on lived experience panels and that their expertise is used in the design of psychosocial supports. This would include service co-design aspects such as the reassessment process, the role of PSCs and redesigning support or budget packages.
- **Further develop a peer workforce within the NDIS and support providers** with roles such as support coordination and specialist support coordination, consumer leadership, peer support work, education and training, advocacy, consulting and advisory roles.[24] This would enable people with lived experience to engage meaningfully and contribute their expertise in the workforce, with flow-on benefits for workforce capability, service users and their families. Developing a peer workforce should include robust training and supervision in peer support, which would be incorporated into unit pricing, as well as developing clear ethical guidelines to guide both the organisation and lived experience workers in their practice.
- **Offer peer skills programs as part of the recovery supports** to employ participants into the lived experience workforce. This could also involve the establishment of Peer-led Evaluation. Regular monitoring and evaluation should be conducted to measure outcomes for both participants and key workers and ensure that lived experience workers are being supported in safe and sustainable

[24] Brophy, Minshall, Fossey, Whittles and Jacques. (2022). *The Future Horizon: Good Practice in Recovery-Oriented Psychosocial Disability Support – Stage Two Report.*

practices. This can be achieved through feedback and performance reviews conducted by other peer support workers.

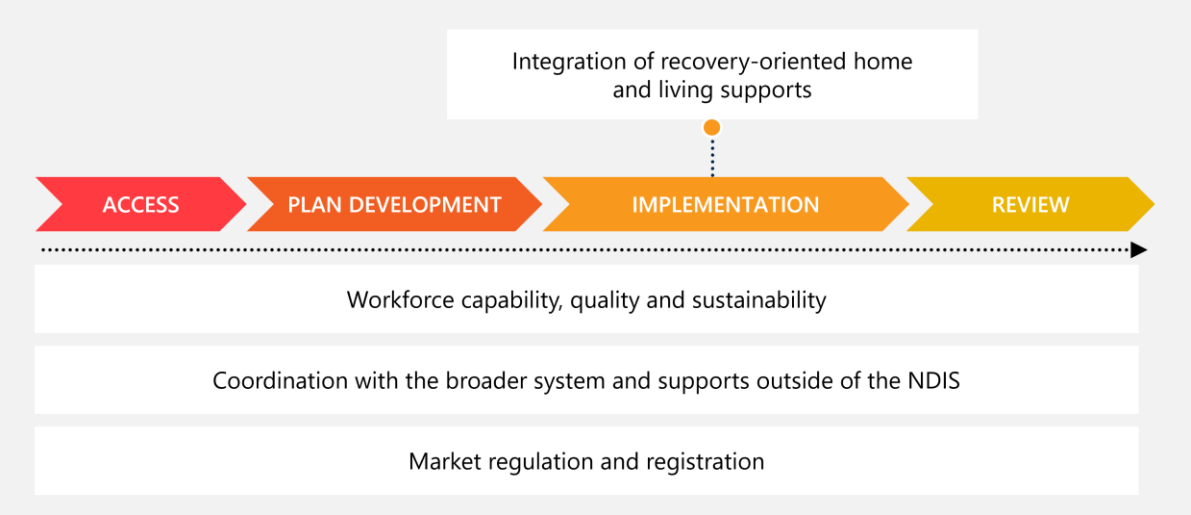
IMPLEMENTATION ACTIONS AND CONSIDERATIONS	
	**Create a well-defined and organised process for recruiting staff**, which gives priority to individuals who have lived experience. The NDIA could engage with organisations such as Australia Network on Disability (AND) with job access services and employment programs, such as Disability Employment Service (mental health specialist providers) to help facilitate the recruitment of individuals with lived experience of psychosocial disability.
	**Undertake a learning and development strategy** aimed at supporting lived experience workers, along with chances for growth and development in their careers. This should be implemented by the NDIA in consultation with service providers.
	**Set clear roles and responsibilities** for lived experience workers, and make sure they are seamlessly integrated into the overall organisational structure. Identification of core competencies and skills should be incorporated into guidelines and the NDIS Workforce Capability Framework and be administered among service providers.
	**Develop appropriate policies and procedures** that prioritise the creation of a safe working environment and enable sustainable professional development and supervision for lived experienced roles within the NDIA and service providers. These should also address any ethical concerns related to sharing personal experiences.

5 Systemic enablers for recovery

In addition to the opportunities outlined in Section 4, it is also important to address some of the broader systemic factors that will enable successful implementation of the Recovery Framework. These also acknowledge the role of a participant's relational, social and economic environment in their recovery. While we acknowledge that broader systemic challenges are deeply complex and require a sustained and collaborative effort from all sector stakeholders, there are some immediate and longer-term opportunities for the NDIA to address them to better support NDIS participants with psychosocial disability. Figure 12 highlights some systemic enablers for recovery, which include:

- Workforce capability, quality and sustainability,
- Integration of recovery-oriented home and living supports for people with psychosocial disability,
- Coordination with supports outside of the NDIS, and
- Consideration of market regulation and registration of providers.

Figure 12 | Broad systemic enablers driving the successful implementation of the Recovery Framework.



5.1 Addressing workforce capability, quality and sustainability

Developing workforce capability is critical for provision of generalist as well as specific psychosocial supports for NDIS participants. The Recovery Framework prioritises the development of a more capable NDIS workforce that is recovery-oriented and trauma-informed. However, many workers supporting those with psychosocial disabilities lack the necessary training and expertise, including Local Area Coordinators, NDIS planners, and support workers. The NDIS National Workforce Plan[25] also acknowledges this issue. Insufficient knowledge of psychosocial support needs can further lead to ineffective spending on packages intended to aid in a participant's recovery.

A sustainable funding approach will enable higher-quality support and opportunities for capability-building within the workforce. While the current funding model does include a training and capability-building component in unit pricing for workers, it does not go far enough to enable providers to properly upskill their workforce to support the psychosocial cohort sustainably or recognise their qualifications and experience appropriately. This has contributed to workers leaving the sector and a drop in the quality of

[25] Department of Social Services. (2022). *NDIS National Workforce Plan: 2021-2025.*

services.[26] This issue is heightened in areas with few service providers, such as regional, rural, and remote areas, where people already experience difficulty getting the support they need.[11]

BROAD OPPORTUNITIES TO CONSIDER AND FURTHER EXPLORE
Build upon and expand the NDIS Workforce Capability Framework (the Capability Framework) with consideration of skills needed to support the psychosocial disability cohort.
Build psychosocial expertise and skills within the NDIA and externally with partners and support providers, such as through credentials and training opportunities, to enable workers to better understand and support participants in their personal psychosocial recovery. A 'credentialling' model could be explored for different roles to help participants and providers to recognise and realise a multi-disciplinary support mechanism that collective contribute to safe and effective evidence-based supports.
Introduce a tiered registration/accreditation approach for certain supports that require deep expertise. This would promote consistency, quality assurance and safety in supports that require more skilled workers to deliver, such as for complex care supports, specialist case coordination and Supported Independent Living (SIL). • **Registration for providers delivering more complex supports, embedded in regulation**, would also enable transparency and would support participants to action choice and control in the supports they receive. Furthermore, providing incentivisation and appropriate funding model for these specialist skills could contribute to greater workforce sustainability. • **Alternatively, another option could be to enable Psychosocial Support Coordinators (PSCs) to have a reporting role in support provision** to enhance quality assurance and promote market regulation for providers.
Explore alternative funding models and pricing to better support recovery-oriented outcomes and enhance workforce sustainability, as recommended by the 5 Year Productivity Inquiry.[27] This includes supporting sustainable capacity building; staff wellness; service quality and safety; ongoing professional development supervision; and incentivisation opportunities to develop qualified and experience workers, especially in regional, rural and remote communities. Appropriate pricing in funded packages could incentivise more investment in these areas to enable the desired level of quality in the workforce.
Engage peers and people with lived experience into the workforce, drawing upon their expertise in psychosocial supports and creating a pipeline of opportunities for professional training, development and supervision, to support NDIS participants with a psychosocial disability.
Enable and ensure providers delivers evidence-based supports to better support psychosocial recovery for participants and financial sustainability of the Scheme in the longer term through more effective spending of packages.

5.2 Integration of recovery-oriented home and living supports for people with psychosocial disability

Housing and suitable accommodation play a vital role in achieving psychosocial recovery goals.[28] Around 36% of participants with psychosocial disabilities have "where I live" as a goal, compared to 18% of all NDIS participants[29]. Despite this, Supported Independent Living (SIL) funding does not adequately cater to psychosocial disability needs; only 4.6% of participants with a primary psychosocial disability have access to SIL packages[30]. Access to housing supports is also limited by SIL eligibility criteria that exclude many people with psychosocial disabilities, as well as a decrease in SIL funding in recent years.

[26] Productivity Commission. (2020). *Vol. 1, Productivity Commission Mental Health Inquiry Report.*
[27] Productivity Commission. (2023). *5-year Productivity Inquiry: Advancing Prosperity. Recommendations and Reform Directives.*
[28] Brackertz, N., Borrowman, L., Roggenbuck, C., Pollock, S., & Davis, E. (2020). *Trajectories: The interplay between housing and mental health pathways.*
[29] National Disability Insurance Authority. (2022). *Report to disability ministers for Q1 FY23 Quarterly report, 179.*
[30] Australian Institute of Health and Welfare (AIHW). (2021). *Psychosocial disability support services*

Integration of psychosocial support and housing supports enhance psychosocial recovery. The transition of funding from SIL to Flexible Core carries a potential threat to the development of certain capability building services that aid in the recovery process. This is because certain services that aid in psychosocial recovery, such as de-escalation intervention during a decline in mental health, alcohol and other drug support, peer learning activities and support, and community-building or group support within the residence, are not explicitly funded under the new arrangement.

To better support people with psychosocial disabilities in residential settings, the NDIA should explore holistic approaches that integrate housing and mental health supports, provide consistent and flexible support, and respond to episodic incidents. While this may require investment, it could generate long-term savings and most importantly, support participants' psychosocial recovery. For instance, an evaluation of the Housing and Accommodation Support Initiative (HASI), which offers psychosocial and tenancy support in partnership with clinical mental health services, showed that the cost savings exceeded the program delivery costs, with a net saving of approximately $86,000 per person over five years. HASI participants also reported a 73.7% decrease in contact with community mental health services and a 74% decrease in hospital admissions related to mental health.[31]

BROAD OPPORTUNITIES TO CONSIDER AND FURTHER EXPLORE	
✓	**Embedding community and peer support services in NDIS-funded housing supports** as part of an evidence-based recovery approach.[17] Increased opportunities for social inclusion alongside psychosocial supports have been shown to improve outcomes for participants with psychosocial disability, for example, in the Haven Foundation model through shared communal spaces (lounge, garden, kitchen and computer facilities) and a range of activities including walking groups, tennis clubs and coffee groups.[32]
✓	**Reviewing eligibility criteria requirements and operational guidelines for NDIS-funded housing supports** to ensure they can appropriately support people with psychosocial disability in their recovery and that housing supports are integrated with evidence-based psychosocial supports. This could also include access to irregular support funding (where flexibility and increased support may be required as psychosocial state fluctuates or when episodes arise) and amending eligibility requirements to better acknowledge characteristics of psychosocial disability. For example, an eligibility requirement under the current guideline for SIL is "active disability support for more than 8 hours per day to complete daily activities"[33], which does not recognise the episodic nature of psychosocial disability.
✓	**Improving integration of psychosocial and housing supports, enabled by an appropriate funding model.** A recovery-oriented approach to housing for people with psychosocial disability involves placing more emphasis on capacity building in addition to activities of daily living. While funding through Flexible Core can provide long term housing supports for example, it needs to be coupled with capacity building supports and evidence-based psychosocial interventions to promote recovery.
✓	**Incorporating flexibility in the intensity level of housing supports and supporting improved transitions as support needs change.** Providing a sustained baseline level of psychosocial supports in conjunction with housing, with flexibility to ramp up, would enable participants to access timely support as episodic incidents arise which may require more intensive and multidisciplinary support. The consistency of baseline supports is also an early intervention approach that can prevent participants from declines in wellbeing and increased psychological stress[34] associated with hospitalisation and thereby enable participants to reduce their reliance on the Scheme in the longer term.

[31] NSW Health. (2022). *Evaluation of Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI).*
[32] Lee, Giling, Kulur, and Duff. (2013). *Exploring the impact of housing security on recovery in people with severe mental illness. Summary Report.*
[33] National Insurance Disability Authority. (2022). *Supported independent living.*
[34] Bernard P. Change, M.D., Ph.D., (2019). *Can Hospitalization be Harmful for your Health? A Nosocomial Based Stress Model for Hospitalization.*

5.3 Coordination with the broader system and supports outside of the NDIS

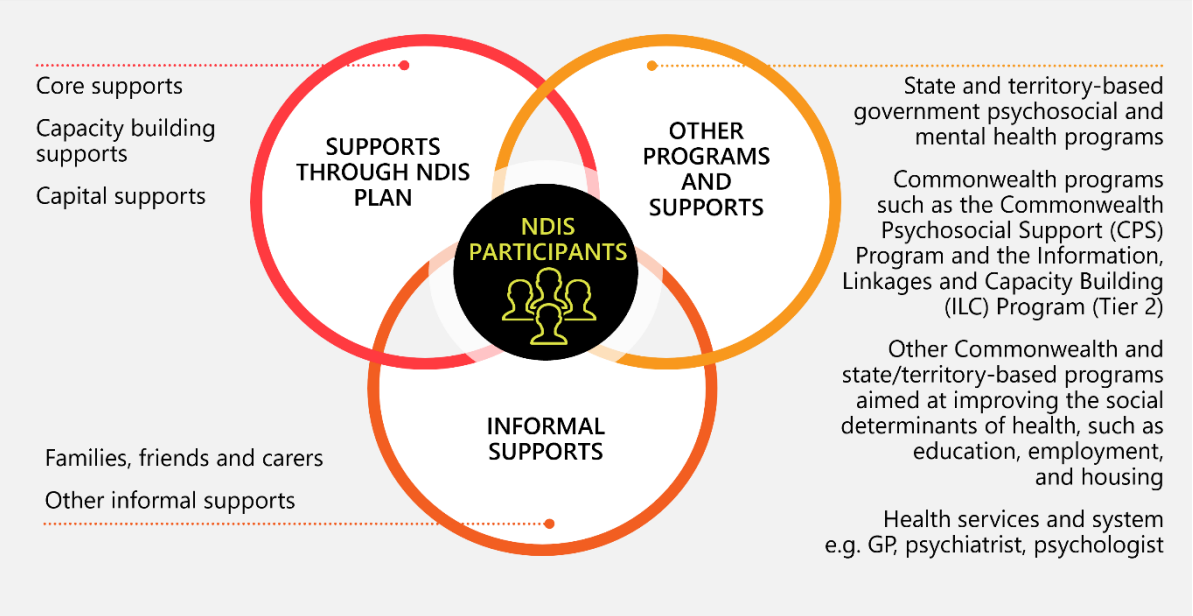
Coordination and understanding of supports outside of the Scheme can enable the NDIA to adopt a more integrated and holistic approach to support participants' recovery.

To better support people with psychosocial disability in their recovery, it is important to consider the interface between the NDIS and the broader mental health system, including other Commonwealth programs and state or territory-based programs, depicted in Figure 13.

Currently, there is limited integration and coordination of supports provided through and outside of the NDIS, creating challenges in supporting recovery of people with psychosocial disability. An example of this is the limited integration of housing and mental health policies across state, territory, and Commonwealth, which has contributed to poor housing and health outcomes for people with mental ill-health.[35] Data collection on outcomes or providers is also limited and inconsistent across jurisdictions.

System gaps between the NDIS and the broader health system also pose a risk to the recovery of people with psychosocial disability. This is especially evident in the transition from hospital and emergency departments into the community, where many people remain hospitalised without an appropriate discharge strategy or are discharged without appropriate supports in the community.[34] This can create a feedback loop whereby participants who are not adequately supported through their packages enter hospital settings which may further contribute to emotional and psychosocial distress.

Figure 13 | NDIS participants' core means of support in the broader system.



[35] Australian Housing and Urban Research Institute. (2019). *Trajectories: the interplay between mental health and housing pathways.*

BROAD OPPORTUNITIES TO CONSIDER AND FURTHER EXPLORE	
✓	**Exploring and defining Tier 2 services** that would provide psychosocial support to those who are not eligible for the NDIS, and that are recovery-focused and trauma-informed with strong links to state mental health services and the NDIS.
✓	**Reviewing the interface of the NDIS with other programs**, such as the Commonwealth Psychosocial Support (CPS) Program; Information, Linkages and Capacity Building (ILC) Program (Tier 2); state- and territory-based psychosocial support programs; and other Commonwealth and state/territory-based programs aimed at improving the social determinants of health, such as education, employment, and housing, to identify coordination opportunities and address gaps. This could also include exploring opportunities to streamline registration and standards across these programs.
✓	**Aligning the bilateral agreements in the National Mental Health and Suicide Prevention Agreement and the NDIS Agreements** to better integrate and coordinate systems and supports for participants across states and territories. This could be further supported by leveraging existing relationships and knowledge from support providers who operate in different jurisdictions and understand other supports in the market.
✓	**Exploring data collection opportunities on providers and participants across different programs,** including associated outcomes, goals and metrics.

5.4 Market regulation and registration

The market for psychosocial disability supports within the NDIS faces challenges due to limited availability of quality, psychosocial-specific supports for participants. Sole traders and small business currently make up a large proportion of providers in the market, and there are a number of unregistered providers delivering more complex supports. This can result in inconsistent and lower quality supports which can hinder participants' recovery progress. The market also lacks high-quality supports that emphasise cultural safety and trauma-informed practices necessary to effectively engage with diverse communities, such as LGBTIQ+ identity groups, people from CALD backgrounds, and Aboriginal and Torres Strait Islander communities.[11]

It is important to acknowledge the presence of unregistered providers in the market does give participants more choice and control, especially given that smaller businesses and sole operators can often offer more affordable and flexible services. However, the lack of information available to participants about the quality of these services and supports is a concern, which severely constrains the decision-making ability of participants. The NDIS Code of Conduct, which outlines the standard for providers, has not been updated since the Recovery-Oriented Framework was introduced, and there is little accountability to maintain a standard in the psychosocial service provision market that promotes recovery.

The current pricing structure and limits have also constrained the ability of service providers to meet sector demand in delivering safe and high-quality NDIS supports, which further limits participants' choice and control over supports. The assumptions underpinning the pricing model have undermined significant costs, which involves ensuring staff supervision at a reasonable management ratio, and safety and quality activities (e.g., formal qualifications and experience of workers, cost of NDIS accreditation, compliance requirements, and reporting to the NDIS Quality & Safeguards Commission).[36] With rising service delivering costs and limited price increases, providers are increasingly facing financial pressure, making it difficult to sustain support coordination services in the long-term and ensure continuity of supports for participants. If the pricing structure is not adjusted to meet the increased operating costs, this could contribute to a reduction in the provision of NDIS support or registered providers exiting the market altogether.

[36] Australian Psychosocial Alliance. (2023). *NDIS 2022-23 Annual Pricing Review Submission.*

BROAD OPPORTUNITIES TO CONSIDER AND FURTHER EXPLORE	
	**Consider introducing transparent feedback mechanisms into the marketplace to provide participants with greater choice and control.** For example, sharing complaint and feedback information in provider directories to help people make informed decisions about the effectiveness and quality of offerings they select.
	**Consider further elaborating on the definition of 'safe and competent' service provision within the NDIS Code of Conduct** to include detail about capabilities necessary for supporting a psychosocial cohort.
	**Introduce a tiered registration/accreditation approach for supports that require deep expertise, as described in Section 5.1**, especially for complex care supports, SIL and specialist coordination.
	**Review the current pricing structure to account for the actual costs (including financial and human resources) of providing safe and quality services,** the specialty skills in delivering psychosocial supports, and the needs and preferences of participants with psychosocial disability. This could be achieved by increasing base prices for registered providers or provide loading on base prices for registered providers to recognise the additional costs of delivering higher quality supports, including the costs of compliance with practice standards.[36]
	**Ensure PSCs are well-equipped as brokers and supporters in service selection** to assist participants in overcoming market barriers associated with lack of choice, while also ensuring that funding outcomes and conflicts of interest are appropriately managed.[37]
	**Implement preferred provider arrangements to streamline service delivery and reduce costs by leveraging the buying power of the NDIS.** By working with preferred providers who have demonstrated their ability to meet NDIS standards and requirements and are suitably qualified to deliver specialised supports, the NDIS can negotiate better prices and quality of services, which can result in better outcomes for participants.
	**Partner with rural, remote and First Nation communities to pilot alternative commissioning approaches to improve access of supports.** As traditional service models may not be suited to meet the unique needs and challenges of these communities, it is crucial to work with local communities, and their specialist organisations, to trial different service delivery approaches. By partnering with these communities, the NDIA can evaluate the pilot program and use insights gained to inform future service delivery approaches in rural, remote and First Nation communities.

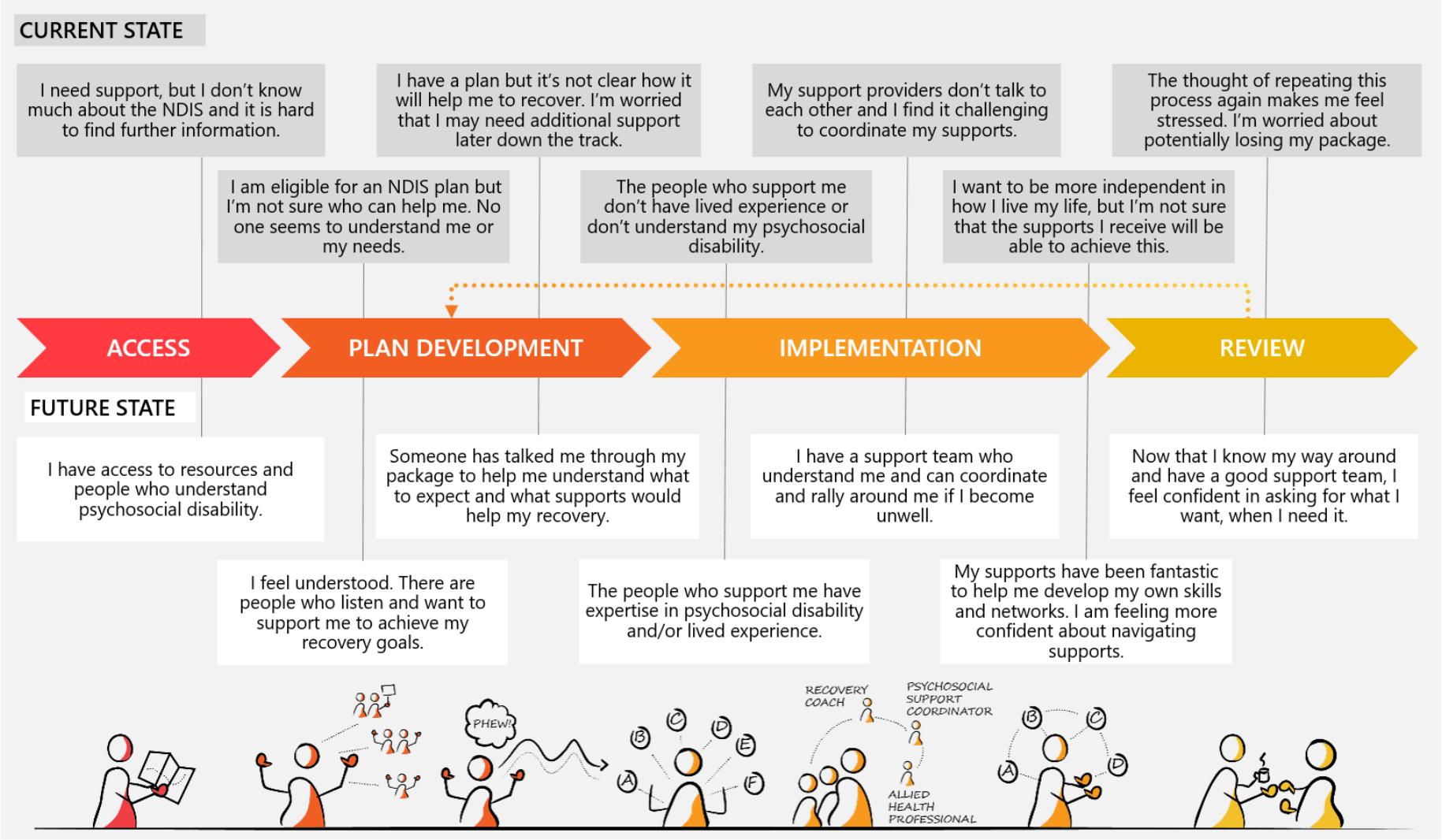
[37] Wilson, E., Campaign, R., Pollock, S., Brophy, L., Stratford, A., (2021). *Exploring the personal, programmatic and market barriers to choice in the NDIS for people with psychosocial disability*.

6 The future of a recovery-oriented NDIS for psychosocial participants

The APA has identified seven opportunities and four systemic enablers for operationalising recovery in the NDIS for people with psychosocial disability. We believe that successful implementation of these opportunities will improve the Scheme for participants in the future, as illustrated in Figure 14, and will also support a sustainable Scheme which delivers more outcomes-driven, evidence-based and recovery-oriented services. The intended outcome is for people living with a psychosocial disability to feel supported in their recovery journey, receive supports in a flexible and responsive way, grow their capability to navigate the system more independently and be supported by lived experience and expertise.

> In this submission, we've focused on the "what" – i.e. the opportunities – for improving the Scheme and acknowledge that there are increments of change that are needed to implement these opportunities. The next step is the "how", and we invite an ongoing conversation with the NDIA to determine how to implement opportunities to improve the Scheme for people with psychosocial disability.

Figure 14 | Current and future state for a NDIS participant with psychosocial disability



Appendix A Stakeholders consulted

The Australian Psychosocial Alliance extends its thanks and appreciation to the following organisations and their representatives for their guidance and contribution to the development of this submission.

Australian Psychosocial Alliance members:	Sector representatives from the following organisations:
Flourish Australia	360 Health + Community
Mind Australia	cohealth
Neami National	Community Mental Health Australia
One Door Mental Health	Healing Conversations
Stride Mental Health	La Trobe University
Open Minds	Mental Health Australia
Wellways Australia	Mental Health Carers Australia
Lived experience representatives	Mental Health Community Coalition ACT
	Mental Health Coordinating Council (NSW)
	Mental Illness Fellowship Australia
	National Disability Services
	National Mental Health Consumer Alliance
	National Mental Health Consumer and Carer Forum
	Northern Territory Mental Health Coalition
	Queensland Alliance for Mental Health
	Tandem Carers
	Western Australian Association for Mental Health