MIFA Supplementary Submission to the NDIS Review Panel

25 August 2023

Acknowledgment

We acknowledge our six MIFA Member organisations for their ongoing support, feedback and collaboration in developing this submission to the NDIS Review Panel. We also acknowledge people with lived experience from Finding North Network, who generously provided feedback on their experiences with the NDIS as either a participant, potential participant or as a carer of someone receiving supports under the NDIS.

Disclaimer

This submission represents the position of MIFA. The views of MIFA Member organisations may vary.

MENTAL ILLNESS FELLOWSHIP AUSTRALIA

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Executive Summary

In December 2022, MIFA, Mental Health Australia and Community Mental Health Australia provided a joint initial submission to the National Disability Insurance Scheme (NDIS) Review Panel to highlight our key areas of concern that need to be addressed.[1] MIFA takes this opportunity now to provide additional advice to the NDIS Review Panel about the provision of psychosocial supports both within and outside of the NDIS.

It is important that we support the growth and development of psychosocial supports both within and outside of the NDIS. Participants with a primary psychosocial disability make up over 10% of scheme participants and in the September 2022 quarter, $961 million of paid supports were provided to participants with a psychosocial disability, compared to $714 million in the September 2021 quarter.[2] Substantial growth is projected over the next ten years, with estimates exceeding $4 billion per year for psychosocial disability supports in the NDIS.[3] It is critical that we work together to ensure the system infrastructure supports sustainable, quality outcomes for people with psychosocial disability and quality, sustainable service provision for psychosocial disability providers.

The purpose of this submission is to provide two papers to outline solutions for improving services for people living with psychosocial disabilities.

Paper 1: Addressing the gap in psychosocial supports through the development of a National Psychosocial Support Program (Tier 2)

The primary objective of this paper is to address the existing gap in psychosocial supports for individuals with severe and complex mental health conditions through the establishment of a National Psychosocial Support Program as part of Tier 2. The paper defines psychosocial supports, identifies the cohort of people affected, and underscores the critical nature of bridging this gap. Economic case studies from New South Wales and South Australia illustrate the benefits of community-based psychosocial support programs and the costs of neglecting psychosocial supports.

The paper proposes a tiered system of psychosocial supports and outlines the framework for implementing the National Psychosocial Support Program. It emphasises collaboration between the NDIS and the National Psychosocial Support Program to better support all individuals who require psychosocial supports to live well. Principles guiding the program, its value proposition, barriers to implementation, and processes for conducting the psychosocial support needs assessment are also covered. The paper also outlines processes to commence investment in a new National Psychosocial Support Program, with commitments from all governments in 2024-2025 budget cycles, and potential alternative investment opportunities.

The paper concludes with a call for continued funding for the Information, Linkages and Capacity Building program as another important component of Tier 2 supports.

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[1] MIFA, MHA and CMHA, 2022. *Submission to the National Disability Insurance Scheme Review: 14 December 2022.* Available at: MIFA, Mental Health Australia and Community Mental Health Australia have made a joint preliminary submission to the National Disability Insurance Scheme (NDIS) Review - Mental Illness Fellowship of Australia Inc.

[2] National Disability Insurance Scheme, 2022. *Psychosocial Disability Summary September 2022*. Available at: Psychosocial | NDIS.

[3] National Disability Insurance Scheme. *Annual Financial Sustainability Report 2021-22.* Available at: Annual Financial Sustainability Reports | NDIS.

Paper 2: Improving Supports in the NDIS for People with Psychosocial Disability

This paper focuses on enhancing the NDIS to better support individuals with psychosocial disabilities. It points to the need to implement the Psychosocial Disability Recovery-Oriented Framework, emphasising the importance of capacity-building for mental health recovery. The paper advocates for a national outcomes database, appropriate pricing for psychosocial disability supports, flexible funding packages, and core competency development for the psychosocial disability workforce.

Specific NDIS service provision areas requiring improvement are highlighted, including High Intensity Supports, Support Coordination, Psychosocial Recovery Coaching, Supported Independent Living, Group Support Models and Plan Management.

These two papers collectively advocate for a comprehensive approach to addressing the gap in psychosocial supports for individuals with severe and complex mental health conditions. The proposed National Psychosocial Support Program as part of Tier 2 and the improvements within the NDIS underscore the importance of robust psychosocial support systems. By implementing these solutions, we can create a more inclusive, sustainable and effective service system for people with psychosocial disability while promoting mental health recovery and wellbeing.

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Paper 1: Addressing the gap in psychosocial supports through the development of a National Psychosocial Support Program (Tier 2)

For those of us working to improve mental health services, we have a shared ambition to address the gap in psychosocial supports to ensure that people with psychosocial disability experience better outcomes and can live their best life. Currently, there are people living with psychosocial disability who are either missing out on services, unable to access appropriate services or using services in a way that does not support their ongoing mental health recovery. This applies both to services offered through the NDIS and through non-NDIS mental health and community services.

Through this NDIS Review, there is an opportunity for us to rethink the way we provide services for the cohort of people living with the most severe and complex mental health conditions. This involves looking at how we offer psychosocial supports (a) within the NDIS and (b) outside of the NDIS for people who are not eligible and require psychosocial supports to live well as a valued member of the community.

Defining psychosocial supports

Firstly, we need to understand what we mean by psychosocial supports, as this term is not always well-understood. In the 2020 Mental Health in Australia Report, the Productivity Commission defined psychosocial supports in the following way:

> "Psychosocial supports — which include a range of services to help people manage daily activities, rebuild and maintain connections, build social skills and participate in education and employment — can facilitate recovery in the community for people experiencing mental ill-health."[4]

> "Psychosocial supports are a key facilitator of recovery, can help alleviate some risks of illness relapse and support people as they develop skills to self-manage the effects of variations in their mental health. Services typically provided under this label include respite services, building social skills and relationships in a culturally supportive way, assistance with transport, tenancy or household management and finances, and coordination and support in complying with clinical treatment needs."[5]

Psychosocial supports play a vital role in enabling those living with severe and complex mental health conditions to live well, recover in their communities and experience better quality of life.[6] They enable people to build independence and regain practical living skills during periods where they are not acutely unwell.[7] They also support people to counter stigma and discrimination, promote self-determination, increase control over daily life and promote recovery.[8] Psychosocial supports help people to manage their daily activities and build a meaningful life, helping people to overcome barriers and obstacles in various areas of life and to build resilience and strength. Psychosocial supports are the handrail or scaffolding that support people to step up or step down between services in the community safely.

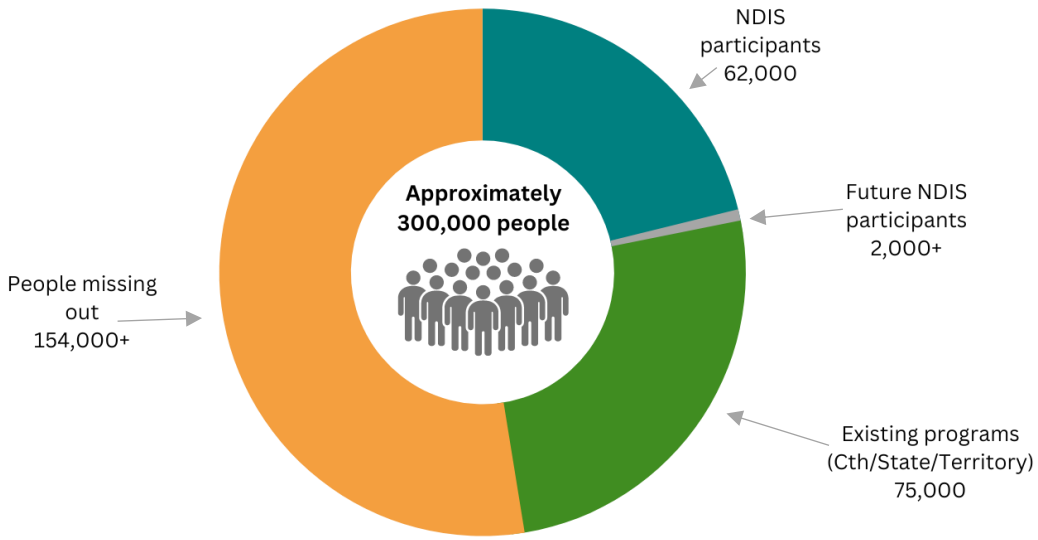
[4] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra, p. 825.
[5] *Ibid*, p. 42.
[6] *Ibid*.
[7] *Ibid*.
[8] *Ibid*.

NDIS participants with psychosocial disability depend on the existence of a strong and robust system of psychosocial supports providing wraparound services outside of the NDIS. This involves individuals utilising the psychosocial supports they want based on their needs and their goals and aspirations in life. To encourage the best outcomes, we need to understand how the NDIS and supports in the community can operate as complementary systems to support people with the most severe and complex mental health conditions. We also need to understand the important role that mental health recovery plays in people's lives and what this means for people with psychosocial disability and their engagement with the NDIS.

The cohort of people experiencing severe and complex mental health conditions

For some time now, MIFA has been urging governments to look at the group of people living with severe and complex mental health conditions as a single cohort of people to ensure we have systems in place that can support the best outcomes. Each year, there are about 300,000 people in Australia living with severe and complex mental health conditions who require psychosocial supports to live well[9] (see Diagram 1).

Diagram 1. The cohort of people with severe and complex mental health conditions who require psychosocial supports



Of this group, there are just over 62,000 people with primary psychosocial disability (more than 10% of all NDIS participants) receiving supports under the NDIS.[10] The NDIA has been steadily working towards a target of 64,000 participants with primary psychosocial disability and, based on the latest projections, the scheme will substantially exceed these original estimates over the next decade.[11] That leaves about 240,000 people who are not receiving NDIS supports. Of these people, about 75,000 people receive supports under existing Commonwealth and State and Territory Programs and at least 154,000 are missing out on mental health supports in the community.[12]

[9] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra.
[10] National Disability Insurance Scheme. *NDIS Quarterly report to disability ministers 30 June 2023.* Available at: Quarterly Reports | NDIS.
[11] National Disability Insurance Scheme. *Annual Financial Sustainability Report 2021-22.* Available at: Annual Financial Sustainability Reports | NDIS.
[12] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra.

If we look at these groups of people as a single cohort, we can consider the type of system architecture we need to provide a comprehensive and integrated approach to mental health care for people living with severe and complex mental health conditions. Before we delve into system design, it is important to understand the status quo and why we need to address the gap the psychosocial supports as a matter of urgency.

The gap in psychosocial supports

The gap in psychosocial supports was first identified by the Productivity Commission in 2020 by applying the Mental Health Services Planning Framework (MHSPF). Since then, South Australia has conducted its own gap analysis using the MHSPF to identify the level of unmet need for psychosocial supports.

What has been found:

1. The Productivity Commission confirmed that at least 154,000 people in Australia with severe and complex mental illness are missing out on the psychosocial supports in the community they need to enable them to live well and independently.[13]
2. South Australia identified an even bigger gap than first calculated by the Productivity Commission, with 19,000 people (as opposed to 11,000 people) in South Australia currently not receiving supports.[14]

Other States and Territories are now considering how to conduct similar assessments in their own jurisdictions. It is expected that other States and Territories may identify similarly greater levels of need than first thought. To provide a federal approach, Health Policy Analysis has been engaged by the Department of Health and Ageing to support the analysis of psychosocial supports outside of the NDIS under the National Mental Health and Suicide Prevention Agreement.

The Productivity Commission analysis identified a significant level of unmet need. This need exists in every jurisdiction. It is important that we move beyond acknowledging this gap in psychosocial supports and take action to address it. There is enough data available to initiate further investment in services now.

There are compelling reasons for addressing this gap that speak to the human cost of inadequate service provision. Without adequate psychosocial supports, people with severe and complex mental health conditions will continue to experience:

- **Shorter lives** – on average, people with severe mental illness die up to 23 years earlier than the general population.[15]
- **Attempts to take their own lives** – approximately 50% of people with the most severe mental illness attempt suicide, compared to 3.7% of the general population.[16]

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[13] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra.

[14] David McGrath Consulting, February 2023. *Unmet mental health service need in South Australia that could be met by the NGO sector: An analysis on behalf of the South Australian Government.* Available at: Unmet-Mental-Health-Service-need-in-South-Australia-that-could-be-met-by-the-NGO-sector.pdf.

[15] Morgan, V. A., Waterreus, A., Jablensky, A., Mackinnon A., McGrath, J. J., Carr, V., Bush, R., Castle, D., Cohen, M., Harvey, C., Galletly, C., Stain, H. J., Neil, A. L., McGorry, P., Hocking, B., Shah, S. and Saw, S. 2011. *People living with psychotic illness 2010. Report on the second Australian national survey.* Australian Government, Department of Health and Ageing.

[16] Morgan, V. A. et al. 2011. *People living with psychotic illness 2010. Report on the second Australian national survey.* Australian Government, Department of Health and Ageing.

- **Poorer outcomes** – people report experiencing relationship breakdowns, loss of employment, homelessness, marginalisation and stigma, long stays in hospital, increased dependence on income support, loss of educational opportunities, and intersections with police and the justice system.[17]

The business case for addressing the gap in psychosocial supports

There is a strong economic case for addressing the gap in psychosocial supports that is pertinent in the current NDIS Review context. By investing in psychosocial supports to provide support early on, we can promote better outcomes for people with psychosocial disability and relieve long-term pressure on the NDIS.

If people do not receive the psychosocial support they need early in illness, there is an increased likelihood of prolonged distress and lifelong disability.[18] This can lead to greater long-term costs to the health system, increased dependence on social services, increased risk of unemployment and homelessness, and increased interactions with police, justice and corrections. Conversely, when support is provided early and consistently, there is a greater likelihood that people will experience mental health recovery, costs will be reduced over time, and there is a reduced risk of enduring illness and disability.[19] With the right psychosocial support, people with serious and complex mental illness can recover their place in their community and live contributing lives. Simply put, access to psychosocial supports promotes recovery and capacity-building. This supports the vision of the NDIS as an insurance scheme that enables participants to develop greater capacity over time and increase economic and social participation.

Research has shown that psychosocial supports enable people living with mental illness to participate in the labour market. Based on previous research, psychosocial supports have an aggregate effect of increasing labour market income by between $79 million to $177 million, which equates to an increase in Quality of Life Years of between 4,912 and 8,903 years.[20]

Case Study – the economic benefit of community-based programs in New South Wales

The Mental Health Coordinating Council recently provided a brief for the incoming New South Wales State Government that outlined the value of community supports in fostering improved outcomes for people with lived experience of mental health conditions, their families and carers.[21] The University of New South Wales evaluated two community-based programs funded by NSW Health that provide psychosocial supports, Community Living Supports (CLS) and the Housing and Accommodation Initiative (HASI). The evaluation found that:[22]

- For people supported by these programs, hospital admissions due to mental health challenges decreased by 74% and the average length of hospital stay decreased by 74.8% over a two-year period. These improvements were sustained after consumers exited the programs.

[17] Morgan, V. A. et al. 2011. *People living with psychotic illness 2010. Report on the second Australian national survey.* Australian Government, Department of Health and Ageing.
[18] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra.
[19] McGorry PD, Killackey E and Yung A, 2008. Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry* 7, pp. 148-156.
[20] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra.
[21] Mental Health Coordinating Council, May 2023. *Community Managed Mental Health: Incoming Government Brief.* Available at Code of Conduct Members Oct 2021 (mhcc.org.au).
[22] *Ibid*, p. 2.

- These programs generated more in cost offsets than the cost of delivering the programs, with a net cost saving per person of approximately $86,000 over five years, with 90% of the cost offsets due to reduced hospital admissions and reduced lengths of hospital stays.
- New charges in the criminal justice system and community corrections orders dropped to almost zero after consumers entered the program.
- Overall, consumers experienced improvements in their wellbeing, their mental health management, and they experienced improved physical health and increased opportunities for social inclusion.

Case Study – the cost of not providing psychosocial supports in South Australia

In October 2021, the Mental Health Coalition of South Australia released a comprehensive case for investing in psychosocial supports. This case identifies the need to:

- reduce demand at the crisis end of health care by addressing the unmet psychosocial support needs, which will help people to stay well more of the time
- reduce unnecessary demand on emergency departments and other hospital-based services by diverting people to alternative care settings and improving discharge pathways to connect people to psychosocial supports.[23]

The South Australian hospital system is under strain. Each year, there are approximately 20,700 mental health presentations to emergency departments and 9,200 acute admissions to hospital beds.[24] In South Australia, the average cost per inpatient bed day in a psychiatric hospital (non-acute wards) is $1,554.25, compared to the national average cost of $953.78.[25] Of the patients that presented to emergency departments, only 57.3% were seen on time based on their triage status on arrival.[26] Once discharged from hospital, 15% of patients are readmitted within 28 days. Only 69.1% of people are followed up within 7 days of leaving hospital after a psychiatric presentation.[27] The current investment in psychosocial supports in South Australia has reduced to 6.4% of the total health budget, a 30% reduction in funding from 2014-2015.[28] There is an urgent need to reduce the number of inappropriate hospital presentations and to eliminate avoidable readmissions through investment in community psychosocial supports.[29]

Psychosocial supports are effective in reducing reliance on emergency department care and other hospital-based care, with evaluations showing a 39% reduction in hospitalisation rates for mental ill-health and a 16% reduction in the average length of hospital stay.[30] In metropolitan Adelaide, 51.4% of people receiving a psychosocial support program said it helped them avoid hospital admission.[31] This was even higher in regional South Australia, with 60.7% of people reporting that psychosocial supports helped them to avoid hospital readmission.[32] A decrease in admission and readmission rates

[23] Mental Health Coalition of South Australia, 2021. *The case for investing in Psychosocial Supports to improve the lives of South Australians.* Available at MHCSA - Psychosocial Support Case.
[24] SA Health, *Mental Health Services Plan 2020-2025*.
[25] Report on Government Services, 2021. *Services for mental health*.
[26] Australian Institute of Health and Welfare, 2021. *Mental health services in Australia*.
[27] Report on Government Services, 2021. *Services for mental health*.
[28] Australian Institute for Health and Welfare, 2021. *Mental Health Services in Australia. Expenditure on Mental Health Tables.*
[29] Mental Health Coalition of South Australia, 2021. *The case for investing in Psychosocial Supports to improve the lives of South Australians.* Available at MHCSA - Psychosocial Support Case.
[30] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra.
[31] *Evaluation of Intensive Home Based Support Services*, UNSW Social Policy Research Centre, March 2015.
[32] *Ibid.*

to hospital and emergency care, resulting in a subsequent reduction in the demand for more expensive hospital interventions, will result in cost savings to the government.[33]

These two case studies clearly demonstrate the economic benefit of investing in psychosocial supports. They also demonstrate the benefits experienced by consumers, with people experiencing overall improvements in wellbeing and mental health management, reductions in readmissions to costly acute care settings, decreased lengths of hospital stays, and less interactions with the criminal justice system and corrections. There is an opportunity to relieve the burden on the health system, and by extension the burden further downstream on the NDIS, by investing in community psychosocial support programs.

Examples of life domains where psychosocial supports play a vital role

Psychosocial supports can help people to manage their physical health and mental health needs together by seeing the person as a whole. Psychosocial support services can work alongside people to help them prioritise and support mental health and physical health at the same time. Nearly 80% of people with severe and complex mental health conditions die prematurely of chronic physical health conditions that could be effectively managed and often prevented.[34] People with severe and complex mental illness are six times more likely to die of cardiovascular disease, five times more likely to smoke and die of a smoking-related illness and four times more likely to die from respiratory disease.[35] People with severe and complex mental illness die up to 23 years earlier than the rest of Australians.[36]

Psychosocial supports help people to overcome the effects of stigma and discrimination.[37] People living with severe and complex mental health conditions experience high levels of stigma and discrimination in many important areas of life, including in relationships, at work, on social media and within healthcare services.[38] The experiences of negative treatment are accompanied by high rates of withdrawal from opportunities, such as avoiding social situations, not applying for employment opportunities, and not getting help for their physical and mental health conditions when they need it. Stigma and discrimination cause many people living with severe and complex mental health conditions to miss out on the important life opportunities, activities and social connections that are known to contribute to recovery, so support is needed to build resilience and overcome this.[39]

Participation in employment is an important milestone in the recovery process for many people living with severe and complex mental health conditions,[40] but the employment rates amongst this group

[33] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra.
[34] Morgan, M., Peters, D., Hopwood, M., Castle, D., Moy, C., Fehily, C., Sharma, A., Rocks, T., Mc Namara K., Cobb, L., Duggan, M., Dunbar, J. A., and Calder, R. V., 2021. *Better physical health care and longer lives for people living with serious mental illness*. Mitchell Institute, Victoria University, Melbourne.
[35] *Ibid.*
[36] *Ibid.*
[37] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra.
[38] Groot, C., Rehm, I., Andrews, C., Hobern, B., Morgan, R., Green, H., Sweeney, L., and Blanchard, M., 2020. *Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues*. Anne Deveson Research Centre, SANE Australia. Melbourne.
[39] *Ibid.*
[40] Saavedra, J., Lopez, M., Gonzales, S., and Cubero, R., 2016. Does employment Promote Recovery? Meanings from Work Experience in People Diagnosed with Serious Mental Illness. *Culture, Medicine and Psychiatry.* 40(3), pp. 507-532; Nagesh, P., Dark, F., and Castle, D. 2021. The importance of employment for recovery, in people with severe mental illness. *Journal of Psychosocial Rehabilitation and Mental Health,* 8: 217-219.

are unacceptably low.[41] Experiences of stigma and discrimination in accessing and participating in employment are common for people with severe and complex mental illness. In the Our Turn to Speak Survey, 78.1% of all participants reported experiencing stigma and discrimination in employment in a 12-month period.[42] Psychosocial supports can help people to overcome the barriers to employment that they experience and build resilience and capacity to thrive in the workplace. This is further enhanced when people are welcomed into mentally healthy workplaces – those that are equipped to offer a sensitive and nurturing environment to support individuals' wellbeing and recovery – and people are supported to bring their whole selves to work.[43]

Psychosocial supports are important for families and carers too

There are significant impacts on families and carers when people do not have access to the psychosocial supports in the community they need. The COVID-19 pandemic has exacerbated these impacts. In 2020, 60% of carers lost supports for the person they cared for, 47% of carers lost supports for themselves, 44% of carers increased time spent on unpaid care, 81% of carers reported that their own mental health deteriorated, 37% of carers lost some or all of their regular income, and 10% of carers lost their job.[44] Unpaid or informal carers constitute a hidden workforce in Australia, saving governments over $13.2 billion (2015 dollars) per year.[45] In 2015, there were over 240,000 mental health carers supporting loved ones around Australia.

The above case studies demonstrate there is much to be gained through greater investment in psychosocial supports. We have an opportunity now to improve the delivery of psychosocial supports in the NDIS and outside the NDIS. This requires a new and innovative approach.

Rethinking the system architecture – two complementary national programs

As part of this NDIS Review, we are proposing that policy makers and governments rethink the system architecture of the NDIS and non-NDIS supports for psychosocial disability and adopt a whole of system approach to supporting people who require psychosocial supports. MIFA is advocating that we need to improve the delivery of supports for people with psychosocial disability within the NDIS (Tier 3) AND implement a National Psychosocial Support Program that sits alongside the NDIS as part of Tier 2 to support people who are not eligible for the NDIS. We propose that these two complementary national programs work alongside each other to support the needs of people who require psychosocial supports to live well, experience better outcomes and improve quality of life.

The need for a National Psychosocial Support Program that sits alongside the NDIS is growing. MIFA has long argued that a national program for people with severe and complex mental health conditions could relieve pressure on the NDIS and provide a more accessible, less traumatic and cost-effective alternative for people to receive supports in their local community. The media and the Hon Minister Bill Shorten MP have highlighted the increasing numbers of future NDIS participants and the enormous associated costs that threaten the sustainability of the NDIS. With these concerns fresh and current,

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[41] Groot, C., Rehm, I., Andrews, C., Hobern, B., Morgan, R., Green, H., Sweeney, L. and Blanchard, M., 2020. *Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues*. Anne Deveson Research Centre, SANE Australia. Melbourne.

[42] *Ibid.*

[43] *Ibid.*

[44] Muir, G., Beasley, A., Shackleton, F., Davis, E., Armstrong, K. and Hayes, L., 2020. *Caring during Coronavirus: Results of the COVID-19 Carer Survey*, Caring Fairly, Melbourne.

[45] Diminic, S., Hielscher, E., Lee, Y. Y., Harris, M., Schess, J., Kealton, J. and Whiteford, H., 2016. *The economic value of informal mental health caring in Australia: technical report*. The University of Queensland, Brisbane.

the time is now to consider how a National Psychosocial Support Program can be the solution that provides cost-effective and easy access to the supports that people need outside of the NDIS.

MIFA has developed the model for a National Psychosocial Support Program, and with the support of our sector partners, has refined this model through various Psychosocial Support Roundtables (held in June 2022, November 2022 and July 2023). We provide detailed information below about how a National Psychosocial Support Program can be rolled out, either in stages in selected regions or in one stage through a national rollout.

At MIFA's recent Psychosocial Support Roundtable in Townsville on 20 July 2023, members of the MIFA Network, lived experience representatives, government and agency colleagues, mental health sector representatives and Dr Stephen King from the NDIS Review Panel, came together to workshop solutions to addressing the gap in psychosocial supports as part of Tier 2 of the NDIS. One of the solutions developed at the Roundtable – a Tiered System of Psychosocial Supports – built on this concept of two complementary national programs. We provide this solution below in detail for consideration by the NDIS Review Panel.

Solution: A Tiered System of Psychosocial Supports

This solution was devised as part of the MIFA Psychosocial Support Roundtable held on 20 July 2023 and provides a solution to addressing the gap in psychosocial supports through investment in services within Tier 2 of the NDIS. This solution builds on the current tiered system of the NDIS that, despite the best intentions, has not yet been fully realised.

What does the solution for a tiered system of psychosocial supports look like?

This solution is based on the premise that each person can access the services they need when they need them. The proposed hierarchy or tiered system of supports encompasses:

1. **Tier 3** – the highest tier where individuals can access services under Tier 3 if they are experiencing the highest levels of psychosocial disability and functional impairment, as per the eligibility criteria.
2. **Tier 2** – this is the next tier down in the hierarchy and comprises the National Psychosocial Support Program and other community services for people with disability who are not eligible for the NDIS and their primary carers.
3. **Tier 1** – this is the lowest tier in the hierarchy that provides guaranteed support to all Australians who acquire a significant disability, as well as community awareness raising of the issues affecting people with disability and the promotion of opportunities for people with disability.[46]

We propose a tiered system of psychosocial supports based on the following **principles**:

- each person is able to **seamlessly access** the services they need, when they need them
- people can move between the service level hierarchy based on their level of need
- the individualised **package will follow the person** through the service level/service type they are utilising
- the focus is on accessing support, rather than focusing on where a person's funding comes from
- people can combine resources from different sectors and experience **integrated and coordinated care**

[46] Buckmaster, L. and Clark, S., 2018. *The National Disability Insurance Scheme: a chronology.* Available at The National Disability Insurance Scheme: a chronology – Parliament of Australia (aph.gov.au).

- there are **streamlined processes** for stepping up or stepping down the levels of support based on the person's needs
- the tiered system includes greater investment in community services for people with psychosocial disability through investment in a National Psychosocial Support Program as part of Tier 2 of the NDIS (discussed in detail below).

This approach sees NDIS and non-NDIS psychosocial supports as one community service sector, where the focus is on providing flexible and person-led services to improve mental health recovery, long-term outcomes and quality of life.

We recommend investment in **three trial sites** to implement a tiered system of psychosocial supports, where there are integrated NDIS and non-NDIS mental health services. Three different geographic regions can be identified where good local data, solid local engagement and community buy in already exist. This will involve Commonwealth and State and Territory coordination, with commitments to continue funding beyond the trial period. It is important that these trial sites are seen as long-term programs in their initial stages of development, as opposed to pilot programs that can be discontinued after a short funding period (for example, one to two years).

We recommend that the three trial sites include additional investment in psychosocial supports, as part of a commitment to enhancing community supports under Tier 2, to commence the development and implementation of a National Psychosocial Support Program.

Solution: Implementing a National Psychosocial Support Program

The solution to addressing the gap in psychosocial supports is the development and implementation of a National Psychosocial Support Program as part of Tier 2 of the NDIS to support people with psychosocial disability.

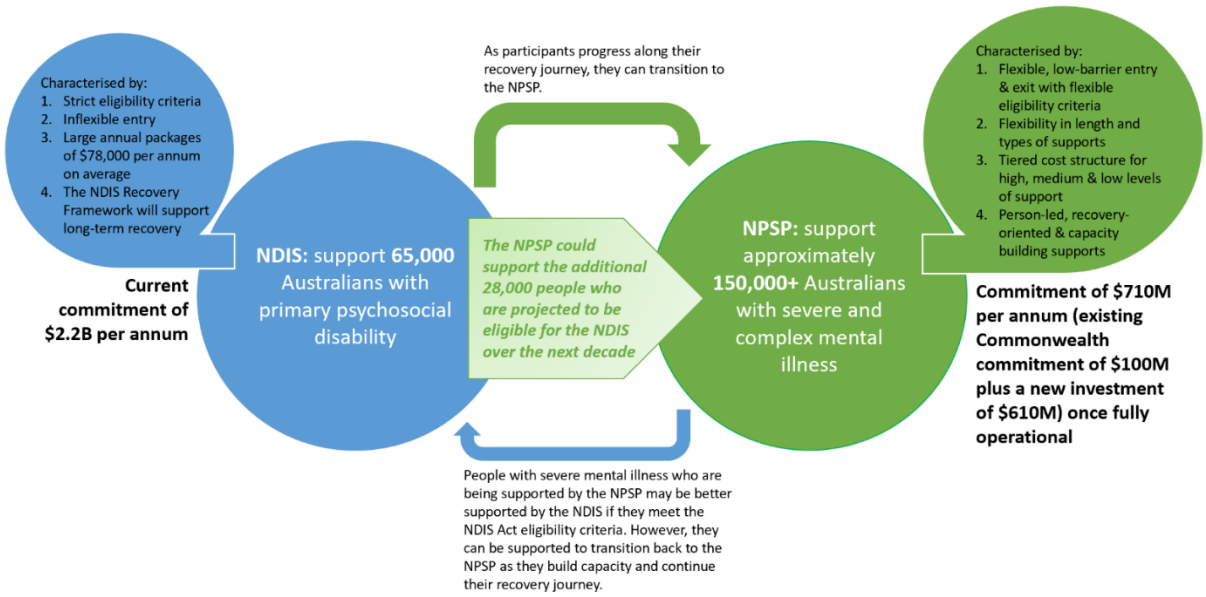
We propose that a National Psychosocial Support Program is:

- designed for purpose
- stands alone (it is not an adjunct to the NDIS or 'state clients')
- community-based
- evidence-based
- person-led, recovery-oriented, trauma-informed and culturally responsive
- inclusive of family and carer support
- well-remunerated and supports the peer and complementary workforce
- co-designed with people with lived experience, their families and carers, and the sector in partnership with governments
- incorporates holistic and coordinated support, where NDIS and non-NDIS services work together to ensure the best outcomes for people.

In MIFA's 2022 Pre-Budget Submission to the Commonwealth Government,[47] we advocated for the model depicted in Diagram 2.

[47] Mental Illness Fellowship Australia, 2022. *MIFA Budget Submission October 2022: Investing in a National Psychosocial Support Program.* Available at: Submissions - Mental Illness Fellowship of Australia Inc (mifa.org.au).

Diagram 2. The NDIS and the National Psychosocial Support Program as complementary programs



To implement this new national program, certain key elements must be addressed between the Commonwealth and the States and Territories. These are:

1. The National Agreement is amended to include:
    a. funding for psychosocial supports (noting current commitments) and the details of agreed cost-sharing arrangements
    b. financial commitments for the Commonwealth and the States and Territories commencing 1 July 2024, as will be noted in 2024-25 budgets across all jurisdictions
    c. clarity of roles, responsibilities and accountabilities for each jurisdiction
    d. how national equity will be achieved using a national planning tool
2. All State and Territory bilateral agreements must be amended to include targets and accountabilities for psychosocial supports
3. Integrated regional planning and commissioning are adopted within the first year to enhance local mapping, which also captures local innovations and responsiveness, to produce local solutions that are balanced with national equity.
4. Three trial sites are identified to commence the roll out of this program as soon as possible.

How the NDIS and the National Psychosocial Support Program can work together

A collaborative and integrated approach is needed to ensure a smooth transition between the NDIS and the National Psychosocial Support Program that minimises the likelihood of people 'falling through the cracks' if they are not eligible (or no longer eligible) for the NDIS. It is important that people maintain their existing connections to services and informal supports without experiencing high levels of distress and/or anxiety. We also need to have confidence that if some people develop their capacity over time, and no longer experience functional impairment to the extent that makes them eligible for the NDIS, there is a pathway for them to transition out of the NDIS seamlessly to access the non-NDIS community supports they need for ongoing recovery and maintenance.

We envisage streamlined transitions between the two national programs to ensure people get help fast. In the September 2022 quarter, 51% of access decisions for applicants with a psychosocial

disability were refused[48] and there is no coordinated approach to supporting individuals beyond the access decision. People with psychosocial disability who are found ineligible under the NDIS can be warmly referred to the National Psychosocial Support Program to access services in their local community without all the barriers. If found ineligible, the information provided as part of their NDIS application can be utilised to support accessible entry into the National Psychosocial Support Program.

It is important that the experience of being referred to the National Psychosocial Support Program is easy and welcoming. Many people with psychosocial disability report that the NDIS application process is stressful and traumatic, asking people to relive some of the most distressing and difficult times of their life. There is no need to repeat this experience to gain access to a National Psychosocial Support Program. The transition needs to be smooth, clear and streamlined when someone is deemed ineligible for NDIS supports. Accessibility requirements for a National Psychosocial Support Program can be mirrored on previously funded programs, like Partners in Recovery or the Personal Helpers and Mentors Program, where formal mental health diagnoses were not perquisites for support and intake was simple and accessible. Above all, it is imperative that these processes are co-designed with people with lived experience to gain wisdom and insights from their experience of navigating service systems.

Principles of a National Psychosocial Support Program

We have learnt from our engagement with people with lived experience and the sector that there are fundamental principles that a National Psychosocial Support Program must be based on to ensure the program's success. These principles stem from a foundational principle that providing best practice models of psychosocial support for people living with severe mental illness is a human right and these supports will help people to achieve better outcomes, and more inclusive and diverse communities.

There is existing research and practice we can draw from to develop a set of key principles for psychosocial support models to support best practice. Previous evaluations of psychosocial support programs[49] have been reviewed to identify key themes for priority outcomes and desirable components of psychosocial support programs, as determined by people receiving those programs. We have also reviewed research on optimal models of care and aspirations for recovery-oriented practice, that focused on embedding quality features to build a strong foundation, build capacity and then promote recovery. This work was undertaken collaboratively with our sector partners and representatives of lived experience networks at Psychosocial Support Roundtables hosted by MIFA.

We recommend that the development of a National Psychosocial Support Program is based on 11 principles that support best practice. These are that services:

1. are accessible and inclusive to those who need them, enabling improved accessibility and wide enough eligibility so that those who need the programs can access them
2. are available for as long as people need them, recognising that time limited programs are inappropriate for many people who have ongoing or fluctuating needs
3. are flexible and responsive to enable anticipated and well-managed transitions – this includes transitions between organisations, between support workers and out of the programs
4. support the development of therapeutic relationships between consumers and workers, where the focus is on establishing rapport, developing trust and building on strengths
5. deliver person-led services where family involvement is offered

[48] National Disability Insurance Scheme, 2022. *Psychosocial Disability Summary September 2022*. Available at: Psychosocial | NDIS.

[49] Including evaluations of Partners in Recovery, the National Psychosocial Support Measure and Continuity of Support, H2Help and Peer Supported Transfer of Care (Peer-STOC).

6. support the development of a stable and well-qualified workforce and a reduction in staff turnover – this includes providing support workers with fair pay, job stability, training and support, supervision and adequate time for planning and debriefing
7. support collaboration and integration across sectors to address the social determinants of health based on individual needs
8. support a capacity building approach for both individuals and communities
9. embed lived experienced voices in program design, delivery and evaluation so that co-design and co-production with people with lived experienced is the benchmark
10. have agreed minimum datasets to support the establishment of a national dataset for psychosocial support services – this will assist in quantifying the need and identifying service gaps
11. are well-funded to enable the delivery of recovery-oriented, trauma-informed, culturally responsive and inclusive services that promote safety and quality. Appropriate funding involves a broader recognition of the important role that psychosocial support services play within the mental health ecosystem.

The value proposition of a National Psychosocial Support Program

Cost savings to the NDIS

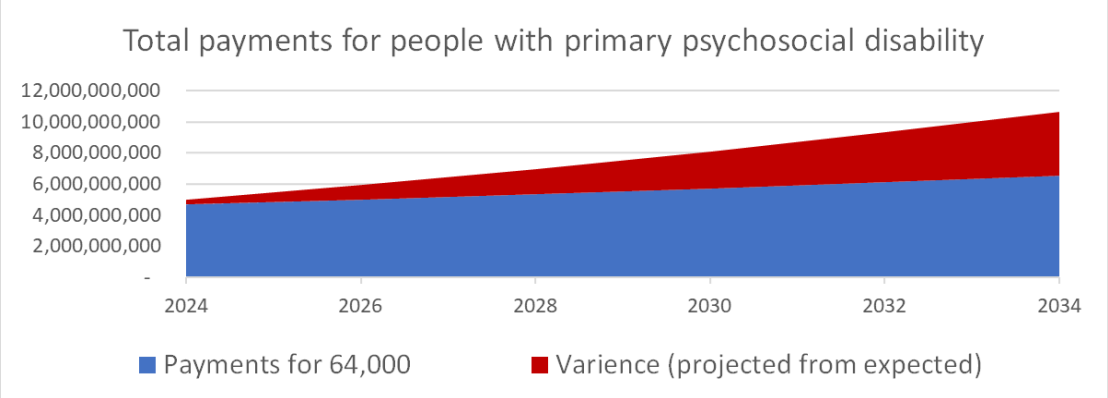
The Productivity Commission estimates that expanding the provision of psychosocial supports to the 154,000 people who are currently missing out on these services would **cost an additional $610 million per year on average** (2019 dollars). Existing funding allocations for the Commonwealth Psychosocial Support Program through Primary Health Networks are approximately $100 million per year. This equates to a total initial investment of approximately $710 million per year.

The National Psychosocial Support Program can relieve pressure on the NDIS, which is expected to support more than 90,000 people with primary psychosocial disability by the end of 2030.[50] The NDIA has projected that the average annual payment will be $89,160 per person. The total payment variance between the original projection of 64,000 people and the revised projection for the 10-year period 2024 to 2034 are set out in Table 1 and the graph below.

Table 1. Total payments and projected total payments for NDIS participants with psychosocial disability from 2024-2034.

	2024	2026	2028	2030	2032	2034	Totals
Average annual payments	$72,954	$77,999	$83,393	$89,160	$95,326	$101,919	
Expected maximum participants	64,000	64,000	64,000	64,000	64,000	64,000	
Projected number of participants	68,382	76,091	83,521	90,674	97,549	104,147	
Total payments (for 64,000 people)	$4.669B	$4.991B	$5.337B	$5.706B	$6.100B	$6.522B	$61.044B
Projected total payments	$4.988B	$5.935B	$6.965B	$8.084B	$9.299B	$10.614B	$83.914B
Variance	**$319M**	**$943M**	**$1.627B**	**$2.378B**	**$3.198B**	**$4.091B**	**$22.869B**

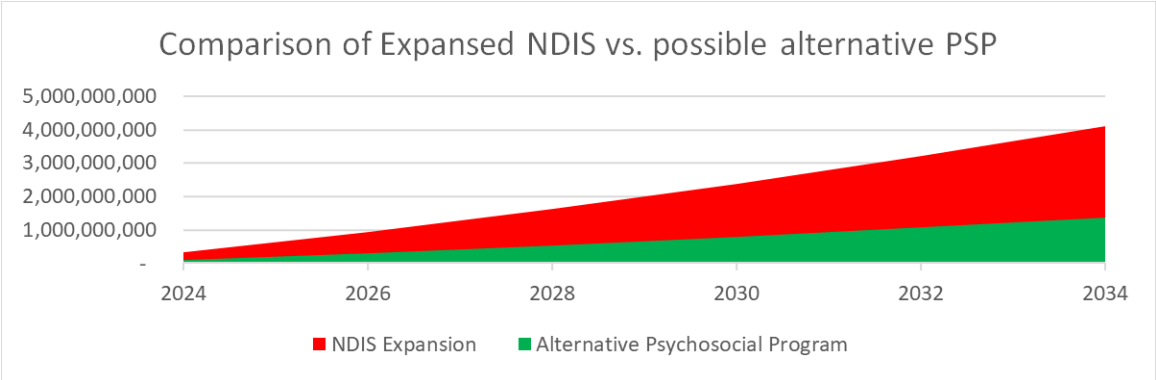
[50] National Disability Insurance Scheme. *Annual Financial Sustainability Report 2021-22.* Available at: Annual Financial Sustainability Reports | NDIS.



For comparison, the following table and graph compare the financial differences between continuing to expand the number of people in the NDIS with psychosocial disability with an alternative program outside the NDIS. There are two working assumptions: (a) that the annual cost per person per annum is one third that of the NDIS (more likely to be considerably less) and (b) it would take two years to establish the program, so the 10-year comparison period is for 2024 to 2034 (analysis provided by Community Mental Health Australia, 2022).

Table 2. 10-year comparison for the total cost of NDIS services for participants with psychosocial disability versus the total cost of an alternative program outside of the NDIS.

COMPARISON	2024	2026	2028	2030	2032	2034	Totals
NDIS Expansion	$319M	$943M	$1.627B	$2.378B	$3.198B	$4.091B	**$22.869B**
Alternative	$106M	$314M	$542	$792	$1.066	$1.363.	**$7.623B**
Difference	$213M	629M	1.085B	1.586B	2.132B	2.728B	**15.246B**



As projected annual costs climb for the NDIS, it is timely to consider the delivery of a complementary program of community psychosocial supports that is cost-effective, sustainable, flexible, recovery-oriented and easy to access.

With a National Psychosocial Support Program in place, more expensive interventions such as hospital and primary care, police, prisons, housing and ambulance services will reduce, leading to cost savings in these areas.

The positive impacts of a National Psychosocial Support Program for governments

We have explored some of the positive impacts for governments, namely the value that would be created by implementing a National Psychosocial Support Program. The value proposition includes:

- medium- to long-term cost savings to governments through an investment approach to support early intervention
- reduced pressures on emergency departments and ambulance services by keeping people out of hospital
- less reliance on primary health care with savings to Medicare, which would alleviate some of the pressures currently being felt by GPs
- people living contributing lives, which includes:
    - increasing quality of life
    - increasing participation in the workforce and productivity
    - increasing wellbeing for families and carers
    - increasing employment opportunities for carers
    - increasing people sustaining their job readiness skills
    - reducing the risk of further deterioration and/or longer-term disability
    - choice and control over health care and supports
    - less reliance on welfare
    - preventing homelessness
    - reducing incarceration rates
- building stronger communities to support community responses
- upholding basic human rights
- supporting families and children to keep families together and strongly connected, which may positively impact child safety issues.

Barriers and solutions to implementing a National Psychosocial Support Program

In our previous work, we have also considered the barriers that currently exist and possible solutions to these barriers (see Table 3). This provides the context for how to make psychosocial supports realisable and viable.

Table 3. Barriers and solutions identified to support the development of a National Psychosocial Support Model

Barriers	Solutions
Legitimacy • Psychosocial supports for people with severe and complex mental illness are not seen as politically popular • The political appetite is low, and the focus is on hospital beds, not on supports in the community to keep people out of hospital • The social determinants of health are not included in system design – we have a narrowly constructed system where the NDIS is an island	• Inclusion of lived experience to amplify the voices of people with lived experience to change the narrative around complex mental health • Inclusion of recovery into NDIS and psychosocial supports, that encompasses the social determinants of mental health in an individualised context • The National Psychosocial Support Program will support this approach
Workforce capacity and workforce development Barriers include: • Casualisation of the workforce • Lack of training and upskilling of the workforce • Lack of current pathways for specific lived experience training	**Workforce development and infrastructure** • Training platforms • Tertiary programs and training pathways • Incentivising traineeships • Appropriate remuneration • Adequately funded supervision programs to support upskilling and quality service delivery

• Lack of planning for the workforce that is needed now and into the future • Community mental health workers are an invisible part of the workforce – exacerbated by lack of data • Workforce attraction needs work • Appropriate remuneration lacking – remuneration must include the cost of training, professional development and supervision, like what is included in psychology and psychiatry models of supervision • Lack of clarity in accountability and who is responsible for what • We get stuck on clinical and non-clinical distinctions, rather than embracing what can be provided in a community setting to support the whole person	• Greater certainty beyond casualisation, career pathways, and ongoing training and professional development to support workforce attraction • Workforce planning to support the growth that is needed in the Lived Experience workforce and in the complementary workforce
Housing affordability and lack of housing stock • Having safe, secure and affordable housing is a fundamental pillar of supporting mental health and wellbeing • The number of people affected by housing affordability is increasing as economic pressures increase	• Implement a systems approach that includes the social determinants of mental health, where housing security is addressed
Lack of regional planning to determine local needs • Programs are being designed in isolation of community • The impact is that programs will not meet community needs or have currency in the community • This can lead to further fragmentation of the system	• Revised National Mental Health Services Planning Framework to ensure national consistency applied across regional areas • Strong regional planning which includes community and other parts of the system contributing to the planning to ensure programs will be current, meet community needs and contribute to connection and integration • Flexible funding to provide services that meet local needs • Funding must support the ability to immediately assist someone based on their needs • Programs must have low barriers to entry
Fundamental lack of services in the community • It is difficult to see a GP in many communities • Available services often do not meet people's needs	**Fund a National Psychosocial Support Program** • Enhance investment in community mental health supports according to local needs
Competing views about what can be done and **viability** between government, non-government organisations and other stakeholders	• Co-design is the solution to creating understanding about what is viable between governments and the NGO sector • This must include an adequately funded co-design process to design a program or response that meets multiple stakeholder needs, and

	provides enough time to undertake genuine engagement activities • Lived experience voices must be at the centre of this co-design work • Engagement must occur throughout the life of the program to support improvements
Issues of scalability for new programs	• Implement five-year funding contracts for service providers to support ongoing sustainability, as recommended by the Productivity Commission • Support innovative programs and move beyond a pilot program approach (where programs may only be funded for one year and then discontinued)

Recognising the inherent value proposition of a National Psychosocial Support Program, particularly how this program can relieve pressure on the NDIS whilst supporting better outcomes for people with severe and complex mental illness, makes this investment an easier sell to governments and constituents alike.

Mapping the need for psychosocial supports

One of the barriers that currently exists is the slow speed at which governments are mapping the demand and unmet need for psychosocial supports, as required under the National Mental Health and Suicide Prevention Agreement. As this process drags out, people who are missing out on services continue to experience hardship and mental distress. Despite this, governments have been unwilling to look at either early investment or staged investment through a National Psychosocial Support Program whilst this work is being undertaken. We expect an analysis to be completed and released by March 2024. However, there has been no advice provided on the timeframe beyond March 2024 for acting on the analysis and initiating new funding commitments for psychosocial supports. This process could take many years yet and, in the meantime, nothing is being done to provide support to people missing out on psychosocial supports.

The current process for completing the unmet needs analysis does not need to be a barrier. There are useful existing tools and data that can be utilised immediately to provide sufficient confidence about the demand for psychosocial supports. **By integrating and analysing existing data, it is viable to commence additional investment while continuing to refine the needs analysis.**

Existing data that is available now includes:

- National Mental Health Services Planning Framework data
- Primary Health Network regional plans
- State/Territory planning tools and reports
- Head to Health preliminary community engagement data
- Specific regional analyses conducted by the Mental Health Policy Unit at the University of Canberra and other bodies.

We recommend that governments establish baseline data that identifies the current investments in psychosocial supports in all jurisdictions.

We recommend that this data is used to commence new investment in psychosocial supports immediately and gradually increase investment in psychosocial supports in each jurisdiction. As a start,

governments can collaborate with Primary Health Networks and Local Health Districts in each of the areas where Head to Health centres are currently being rolled out. In each of these local areas, regional stakeholders have been collaborating to understand the available resources and services, existing stakeholder networks and current service gaps. Additional funding can be provided by the Commonwealth and the relevant jurisdiction to these local areas via their existing commissioning agencies, cost-shared on a 50/50 basis. This will enable selected regions to commence service delivery now, based on existing regional community data and relationships. Each region's population data can be used to extrapolate the appropriate share of the 154,000 people who are missing out on services. Additional investment can be incrementally increased over time as the unmet needs assessment is refined in each jurisdiction.

We recommend that the following principles are adopted in conducting the ongoing needs analysis:

- Regional and sub-regional focus to ensure that regional differences in service gaps and current resources are understood
- All relevant stakeholders are engaged
- Models that respond to regional diversity are considered
- Regional responsiveness is moderated by national equity.

We recommend that the process outlined in Diagram 3 is undertaken for the needs analysis.

Diagram 3. The process for mapping the demand and unmet net for psychosocial support services.

Joint agreement of existing data and tools

Identify existing data and tools to be considered. Parties to this process to include governments and lived experience and sector representatives:

- at a regional level, this includes regional stakeholder networks (such as local mental health networks and Primary Health Networks)
- at a Commonwealth level, this includes the Commonwealth Psychosocial Advisory Group.

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Joint analysis and assessment of the 'technical' application

Governments and stakeholders collaborate to analyse and make sense of the technical assessment. Parties to this process to include governments and lived experience and sector representatives:

- at a regional level, this includes regional stakeholder networks (such as local mental health networks and Primary Health Networks)
- at a Commonwealth level, this includes the Commonwealth Psychosocial Advisory Group.

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"Technical" application of data and tools

Undertake a technical assessment using qualitative and quantitative data, tools and processes identified.

↓

Joint prioritisation of the joint analysis and assessment

Governments and stakeholders collaborate to recommend investment priorities. Parties to this process to include governments and lived experience and sector representatives:

- at a regional level, this includes regional stakeholder networks (such as local mental health networks and Primary Health Networks)
- at a Commonwealth level, this includes the Commonwealth Psychosocial Advisory Group.

↓

Resource allocation by governments

Governments allocate resources and announce funding commitments, budget processes, commissioning processes and formalise these in the bilateral agreements.

We recommend that this process is implemented immediately in selected regions or communities where existing plans, data and tools already exist. Extrapolation of these results nationally will enable additional funding to flow gradually as this planning is refined and rolled out in all regions across Australia. There are opportunities in South Australia, Queensland and New South Wales (all of these jurisdictions have either completed or are contemplating how to undertake a needs analysis and assessment) to select initial trial sites to negotiate bilateral agreements with the Commonwealth and commence investment in the 2024-2025 financial year.

We recommend that the Mental Health Policy Unit at the University of Canberra be engaged to commence deep dives into existing data and plans in regions where this exists, using existing networks, relationships and stakeholder reference groups. This work can support the identification and adoption of initial trial sites across different jurisdictions. Practically, the Mental Health Policy Unit can assist

with identifying three trial sites for which adequate data and community mapping information has already been collected.

Other investment opportunities

The Federal Government has made clear and unequivocal statements about the need for fiscal restraint in the current economic climate, whilst still acknowledging the importance of implementing a wellbeing budget that supports the health and wellbeing of the nation. MIFA's assessment of the economic situation surrounding investment in psychosocial support programs is that there is little political appetite to action larger scale investment in a national program, despite the desperate need for action now and the expected economic gains. The Productivity Commission has identified the need to substantially increase funding to services, especially to community-based psychosocial support services. We have recommended that the Commonwealth and State and Territory Governments cost-share the investment in a National Psychosocial Support Program on a 50/50 basis, and that investment is rolled out in stages in selected regions or trial sites to work towards funding allocations in Commonwealth and State and Territory budgets for 2024-2025.

There are other revenue raising opportunities open to States and Territories that have been pursued in some States. On 1 January 2022, Victoria commenced the Mental Health and Wellbeing Payroll Tax Surcharge, a levy recommended by the Royal Commission into Victoria's Mental Health System. This levy imposes a surcharge of 0.5% on employers whose taxable wages are more than $10 million, and 1% on employers whose taxable wages are more than $100 million. Money generated from this levy is pledged to mental health programs and cannot be spent on other measures. Queensland rolled out a similar initiative on 1 January 2023. The Mental Health Coordinating Council has urged the New South Wales Government to consider introducing a similar payroll levy in New South Wales.[51]

The benefits of payroll levies would far outweigh the costs. The Productivity Commission estimated that a payroll levy would generate $50 billion in savings if a 25% improvement in mental health was reached.[52] With mental illness costing Australia approximately $200 billion per year, there are significant savings to be made through investment in psychosocial support services, funded through alternative funding programs of State and Territory governments.

Solution: continued funding for the Information, Linkages and Capacity Building program

In July 2017, the NDIA established the Information, Linkages and Capacity Building Program (ILC) to support the NDIS. The ILC consists of two components: the ILC grants program, and referral, information and capacity building services undertaken by Local Area Coordinators (LACs) as part of their broader role.

In line with the original concept, ILC grant activities are available to support all 4.4 million people living with disability in Australia, including those who are not NDIS participants. The original concept focused on providing supports to people with disability outside the NDIS to improve their outcomes, in turn reducing the likelihood they would require support from the NDIS.

The Strengthening Information, Linkages and Capacity Building (ILC) – A national strategy towards 2022 (the 'ILC strategy') released in December 2018, provides program funding priorities and parameters

[51] See the priority actions in Mental Health Coordinating Council, May 2023. *Community Managed Mental Health: Incoming Government Brief*, p. 4. Available at Code of Conduct Members Oct 2021 (mhcc.org.au).
[52] Productivity Commission, 2020. *Mental Health*, Report no. 95, Canberra.

for current activities. There are four grant streams in the ILC strategy to be progressively implemented from 2019-2020 for people with disability, their families and carers. These are:

1. National Information Program – to provide access to up-to-date, relevant information linking people to supports and services in the community.
2. Mainstream Capacity Building – to improve the capacity of mainstream services to respond to and include people with disability, increase accessibility and use of mainstream services.
3. Economic and Community Participation – to connect people with disability to activities, employment, community supports and opportunities and help communities and employers to be inclusive and responsive to people's needs locally and nationally.
4. Individual Capacity Building – to establish and support organisations run by people with disability, for people with disability, assisting people with disability to improve their skills and confidence to achieve their goals.

Between June and November 2021, the Centre for Social Impact (CSI), Swinburne University of Technology, undertook a research project to assist the Department of Social Services (DSS) to build an evidence base for the ILC Program and inform the future investment strategy. MIFA supports the following conclusions from this research project:[53]

> The Tier 2 landscape of the NDIS has changed since the commencement of the ILC grants investment. After the initial focus on the roll out of individualised funding via the NDIS, the focus is increasingly shifting to the supports available in Tier 2 via mainstream services and community activities that must, therefore, adequately understand and cater to the needs of people with disability. ILC grants have been valuable in enabling them to undertake worthwhile programs that have delivered positive outcomes for people with disability. However, while the ILC program has also done some good work to build mainstream and community capacity, it has been limited and much more needs to be done, attending not only to building knowledge of disability and inclusion practice but also to the systemic drivers of exclusion. Of particular concern are those people with disability whose experiences of exclusion and disempowerment are constructed by multiple factors including complex, invisible or rare disability, socio-economic, cultural, language and other elements that together increase experiences of marginalisation.

In this context, MIFA calls for continued investment in particular areas of entrenched marginalisation experienced by people with psychosocial disability, and the development of planned and inter-connected suites of activity across the levels of systems that hold such marginalisation in place.

The research project also concluded the following:[54]

> The advent of the NDIS has heightened the delineation between activities and supports that are offered on a commercial basis (fee for service) and those offered on a non-commercial basis (generally available to all people with disability regardless of whether the person has an individualised funding package). Informants to this study highlight the necessary role in this marketized environment for organisations, here called 'demand sector', that are independent of commercial service provision and are peer-led, to provide information and develop the skills and knowledge of people with disability and their family members. These activities are

[53] Wilson, E., Qian-Khoo, J., Campain, R., Brown, C., Kelly, J. and Kamstra, P., 2021. *Overview of results: Informing investment design, ILC Research Activity.* Hawthorn: Centre for Social Impact, Swinburne University of Technology, p. 51.
[54] *Ibid*, p. 51.

> considered 'core' and must continue to be funded as they are fundamental elements that support and inform people with disability and families.

MIFA agrees that 'demand sector' activities underpin other areas of the system (across community services and the social determinants of health) and the NDIS. In these roles, the 'demand sector' is considered a necessary infrastructure of Tier 2. However, since the advent of the NDIS, the MIFA membership has experienced funding reductions and is increasingly insecure with diminished capacity to provide adequate geographic and content coverage.

Finally, it was concluded that:[55]

> The ILC grants have provided a level of funding to this sector though in a largely ad hoc and short term fashion given the nature of a grants scheme. This results in the real risk of program and organisation closure, loss of staff and expertise to the sector and, most importantly, a precarity in the provision of supports to people with disability and their families. In the absence of other investment for 'core' 'demand sector' activities, the ILC needs to determine the best mechanism and level of investment to secure this infrastructure, and to enable it to expand its reach and impact, including through new initiatives.

MIFA recommends that the ad hoc grants approach is not suited to this purpose.

MIFA agrees with the assessment that:[56]

> Despite existing project activities of the ILC being fragmented and disconnected, a level of change infrastructure and practice has been established. Without further ILC funding, and in the absence of other funding sources, this will 'eventually…fall away'. The ILC is a highly valued and unique investment pool, and there is now potential to maximise its apparent and latent capital, and to drive change through coordinated activity and strategic investment.

We recommend that the ILC Program be continued, to support new initiatives for marginalised groups, in particular people with psychosocial disability.

We recommend that the further investment in targeted ILC projects is funded on a sustainable funding cycle of 3 to 5 years.

We recommend that existing ILC projects assessed as effective and successful are moved to an extended, sustainable funding cycle of 3 to 5 years.

[55] Wilson, E., Qian-Khoo, J., Campain, R., Brown, C., Kelly, J. and Kamstra, P., 2021. *Overview of results: Informing investment design, ILC Research Activity.* Hawthorn: Centre for Social Impact, Swinburne University of Technology, p. 51.
[56] *Ibid*, p. 52.

Paper 2: Improving supports in the NDIS for people with psychosocial disability

We recognise that significant improvements have been implemented within the NDIS, whilst others are underway, to enhance the NDIS experience for participants with psychosocial disability. We commend the Federal Government and the NDIA for recognising that improvements needed to be made to promote better experiences and outcomes for participants with psychosocial disability. In this paper, we provide several solutions for consideration by the NDIS Review Panel to improve the delivery of supports, enhance participant experiences, support service provider viability and enhance the overall sustainability of the NDIS.

These solutions are:

1. implementing the Psychosocial Disability Recovery-Oriented Framework
2. greater focus on capacity-building to promote mental health recovery
3. implementing a national outcomes database for people with psychosocial disability
4. appropriate pricing for psychosocial disability supports
5. embracing flexible funding packages
6. developing core competencies for the psychosocial disability workforce
7. addressing specific areas of concern for psychosocial disability service delivery.

Solution: implementing the Psychosocial Disability Recovery-Oriented Framework

The development of the NDIA's Psychosocial Disability Recovery-Oriented Framework ('the recovery framework') has been a positive step that MIFA supports. We were pleased to contribute to the consultation process for the development of the recovery framework.

Since the review commenced, the NDIS Review Panel has undertaken extensive community engagement with people with lived experience and representatives of the mental health sector, so we are confident that Panel members understand the concept of recovery and its importance for people with psychosocial disability. We are also confident that Panel members understand the unique nature of living with psychosocial disabilities, which are often invisible and may fluctuate over time. The recovery framework acknowledges these differences and now we need to ensure a successful implementation and rollout of the recovery framework to support the best outcomes for NDIS participants with psychosocial disability.

The framework sets out six principles, which are:[57]

1. Supporting personal recovery
2. Valuing lived experience
3. NDIS and mental health services working together
4. Supporting informed decision making
5. Being responsive to the episodic and fluctuating nature of psychosocial disability
6. A stronger NDIS recovery-oriented and trauma-informed workforce.

[57] National Disability Insurance Agency, 2021. *National Disability Insurance Scheme Psychosocial Disability Recovery-Oriented Framework*. Available at Mental health and the NDIS | NDIS, p. 7.

The Australian Psychosocial Alliance (APA) has provided a submission to the NDIS Review Panel about how to implement a recovery-shaped NDIS,[58] which MIFA supports. In this submission, the APA suggests a series of outcomes to be achieved to operationalise the recovery framework. We support these intended outcomes and agree that working towards the implementation of the recovery framework is the next step in ensuring better outcomes for NDIS participants with psychosocial disability.

The intended outcomes are:[59]

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.

We recommend that the NDIA considers what good recovery-oriented practice looks like, in consultation with people with lived experience and the mental health sector, to ensure the successful implementation of the recovery framework and the achievement of these principles. We asked our MIFA Member organisations about what it is like to deliver recovery-oriented services in the NDIS. We offer feedback from one MIFA Member organisation about this:

[58] Australian Psychosocial Alliance, 2023. *A Recovery-Shaped NDIS: Australian Psychosocial Alliance (APA) submission to the NDIA review panel*. Available at: Submissions (psychosocialalliance.org.au).
[59] *Ibid*, p. 9.

> "The NDIS has some very helpful sounding rhetoric about their recovery-oriented framework, but this is not translating into the processes that impact participants' lives. Our significant experience in complex mental health support has shown us what the episodic nature of mental illness and psychosocial disability means: yearly hospital admissions, high support needs following an unexpected traumatic event, periods of low-engagement or isolation, and periods of high motivation and active work towards goals. Current NDIS systems are not agile enough to respond to the episodic nature of mental illness – despite claims that this episodic nature is understood by the NDIA. Goals are not aligned with modern understandings of behaviour change and assume that each participant is ready and engaged with their goals at all times. A greater appreciation for the time investment of rapport-building, goal setting, fostering change-talk and supporting a participant with psychosocial disability to make steps towards their goals is needed. A small example of this is the assumptions built into current plans: that Psychosocial Recovery Coach funding for year 1 will be 100 hours, year 2 will be 50 hours, and in year 3 they will return to LAC-support. This does not appear to be a decision based in response to assessments, functional evidence, or that cites literature."

We are committed to the successful implementation of the recovery framework in the NDIS and we note that the experience of delivering recovery-oriented supports in the NDIS to date, as reflected in the comments above, has been challenging. There is a way forward to support the successful implementation of the recovery framework and it requires exploration of key issues and challenges that are undermining recovery-oriented practice in the NDIS.

We recommend that the NDIA take the following issues into consideration:

Exploring what good recovery-oriented practice looks like during the first six to 12 months of service delivery. Additional support may be required in the first six to 12 months of a participant's package as they build rapport and develop therapeutic relationships with their support team. Additional support is needed in that first year, and potentially within the first three years, to develop trust, confidence and a level of comfort with NDIS processes. Support team members will need to work alongside participants to develop a mutual understanding of the concept of recovery, recovery goals and outcomes, and what these mean for the participant. Support team members can also work with participants to assist them with building confidence in exercising choice and control. There is an opportunity at this stage to connect participants with evidence-based early intervention programs that support mental health recovery to promote a decrease in levels of long-term disability.

Peer support workers can work alongside participants with psychosocial disability to enhance supported decision-making. There is an opportunity for peer workers to educate new participants about how the scheme works, what supports are available to them and what choices they can make. Peer workers are uniquely placed to assist participants to enhance supported decision-making and warmly orient participants to the planning, budgeting and review processes by sharing their real-life experiences of the NDIS. Peer-led programs work incredibly well in other areas of mental health and the NDIA could work with providers to fund a peer-led program to support people with psychosocial disability when they first enter the scheme.

Additional hours of Support Coordination and Psychosocial Recovery Coaching may be required within the first three years. Participants may require additional support to navigate the system when their access application is successful. How to navigate supports, the concept of recovery and the benefits of a recovery approach may be new to participants. More time

is needed to work alongside participants so they can build capacity to flexibly apply their supports over time, responding to their mental health needs. **We recommend** providing, as a minimum, the recommended 100 to 120 hours of Support Coordination and Psychosocial Recovery Coaching for each participant **every year**. Some individuals may require more support than this, especially during the first 12 to 36 months. Our MIFA Member organisations tell us that the annual hours for Support Coordination and Psychosocial Recovery Coaching are well below these recommended hours and are inadequate.

Highly skilled workers are needed to support participants to reduce levels of disability over time. Addressing the quality and sustainability of the psychosocial disability workforce is key to providing capacity-building, recovery-oriented and trauma-informed supports. The NDIS National Workforce Plan and the Psychosocial Disability Recovery-Oriented Framework need to work in tandem to support the upskilling of workers providing psychosocial supports to NDIS participants. There is a need to support additional training, professional development, debriefing and supervision to develop a qualified and capable psychosocial disability workforce that can support better recovery outcomes. This includes a greater focus on developing the lived experience or peer workforce. **We recommend** that the NDIS National Workforce Plan is updated to reflect the training and professional development needs of the psychosocial disability workforce and consider the development of designated career pathways for psychosocial disability peer workers.

Promoting quality psychosocial supports comes at a cost to service providers that is not adequately reflected in the NDIS pricing. We have been advised by the NDIA that there is a small portion of accredited NDIS service providers providing recovery-oriented psychosocial supports to participants. The cost of accreditation is substantial and not covered by the NDIS pricing. Many providers choose to remain accredited because this supports their vision and values for quality and safe mental health service provision. We encourage the NDIA to support psychosocial disability providers to remain accredited so they can continue to provide specialised and high-quality services through a recovery-oriented and trauma-informed lens. **We recommend** that the NDIA implement an **annual payment system to accredited psychosocial support providers** to assist with the cost of accreditation. An ongoing annual payment would assist accredited providers to continue to invest in quality psychosocial disability supports.

Promoting greater education and understanding of psychosocial disability, psychosocial supports and recovery-oriented practice within the NDIA. MIFA and our sector colleagues have previously written about the importance of improving psychosocial disability specific skills, knowledge and experience amongst NDIA staff and partner staff.[60] The NDIA has committed to "develop and implement learning and development strategies to deliver psychosocial disability competencies and skills required for NDIA and partner staff"[61] and to

[60] Mental Health Australia, Community Mental Health Australia and Mental Illness Fellowship Australia, 2022. *Submission to the Joint Standing Committee on the National Disability Insurance Scheme: Inquiry into Capability and Culture of the National Disability Insurance Agency.* Available at: Submissions - Mental Illness Fellowship of Australia Inc (mifa.org.au).

[61] National Disability Insurance Agency, 2021. *National Disability Insurance Scheme: Psychosocial Disability Recovery-Oriented Framework*, p. 13. Available at: https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis.

> "embed lived experience positions in both policy and operational areas of the NDIA".[62] The lack of psychosocial disability specific skills, knowledge and experience has led to a range of challenges for participants, including difficulty navigating the NDIS process, plans that do not meet participants' needs, inappropriate decision-making at plan reviews, distress and deterioration of participant's mental health from poorly managed interactions, and poor outcomes for participants.[63] **We recommend** these commitments are expedited as part of the implementation of the recovery framework, and that the NDIA expedite the delivery of psychosocial disability competencies and skills for NDIA and partner staff.

We know that further work needs to be done in consultation with people with lived experience and the mental health sector to successfully implement the six principles of the Psychosocial Disability Recovery-Oriented Framework. MIFA fully supports the continued work being undertaken by the NDIA and recommends that these processes be expedited.

Solution: greater focus on capacity-building to promote mental health recovery

Earlier in this submission, we established the crucial role that psychosocial supports play in promoting mental health recovery to support people to live happy and contributing lives. When we look at the current provision of supports through the NDIS for people with psychosocial disability, we see that funding is primarily directed towards core supports, rather than capacity-building supports. We suggest that this is one of the reasons why the NDIA is not seeing the recovery outcomes or levels of growth for participants with psychosocial disability that were originally anticipated.

The current service mix has been summed up nicely by the Australian Psychosocial Alliance (APA):[64]

> 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.

According to the NDIA, core supports currently make up over 75% of the average payments for NDIS participants with psychosocial disability.[65]

For NDIS participants with psychosocial disability to experience better outcomes and improve their mental health and wellbeing long-term, there needs to be a greater focus on capacity building supports in plans. This will support the transition to a more recovery-focused NDIS, where participants with psychosocial disability can spend more time working with their support team to build capacity, focus on mental health recovery and work towards their goals when they are experiencing periods of wellness.

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[62] National Disability Insurance Agency, 2021. *National Disability Insurance Scheme: Psychosocial Disability Recovery-Oriented Framework*, p. 9.
[63] Mental Health Australia, Community Mental Health Australia and MIFA, 2022. *Submission to the Joint Standing Committee on the National Disability Insurance Scheme: Inquiry into Capability and Culture of the National Disability Insurance Agency*, p. 2. Available at: Submissions - Mental Illness Fellowship of Australia Inc (mifa.org.au).
[64] Australian Psychosocial Alliance, 2023. *A Recovery-Shaped NDIS: Australian Psychosocial Alliance (APA) submission to the NDIA review panel*. Available at: Submissions (psychosocialalliance.org.au).
[64] *Ibid*, p. 15.
[65] National Disability Insurance Agency, 2023. *Explore data.* Available at: Explore data | NDIS.

To successfully do this, participants need to have their own support team, with different professionals who are aware of their needs, their recovery goals and how they need support to connect to various psychosocial disability services. The APA have suggested building coordination teams to support participants in their recovery, where the focus is on building therapeutic alliances between the participant, their Psychosocial Recovery Coach, their Support Coordinator, other allied health and health professionals, and their formal and informal support networks.[66] We support this approach to successfully implement individual recovery plans for each NDIS participant with psychosocial disability.

We recommend that the NDIA reconsider the current service mix for participants with psychosocial disability and provide greater investment in capacity-building supports. This will assist participants to work with their support team to build resilience and capacity to better manage their psychosocial disability.

We recommend that NDIA staff and partner staff receive education on the importance of capacity-building supports in promoting ongoing mental health recovery.

Solution: implementing a national outcomes database for people with psychosocial disability

There is consistent and ongoing feedback from MIFA Member organisations and other service providers that implementing an outcomes measurement framework and a national outcomes database for people with psychosocial disability will support ongoing service improvement and better outcomes for NDIS participants with psychosocial disability.

Developing a national outcomes database for people living with psychosocial disabilities is important for many reasons:

1. **Evidence-Based Decision Making:** A national outcomes database provides a centralised and standardised way to collect, store and analyse data related to the outcomes of participants with psychosocial disabilities. This data can help inform evidence-based decision-making processes, ensuring that policies, programs and services are grounded in reliable information and tailored to the actual needs of the population.
2. **Accountability and Transparency:** Having a national outcomes database increases accountability among various stakeholders, including government agencies, service providers and advocacy organisations. It allows for transparent reporting of outcomes achieved, demonstrating the effectiveness of interventions and services provided to people with psychosocial disabilities. This is important for establishing the return on investment for various programs and services.
3. **Continuous Improvement:** A robust outcomes database enables ongoing evaluation and monitoring of the quality and effectiveness of services. This data-driven approach helps identify areas of improvement and facilitates the refinement of strategies and interventions over time.
4. **Resource Allocation:** With accurate and comprehensive outcomes data, policymakers can make informed decisions about resource allocation. They can identify areas of high impact and allocate resources where they are most needed, optimising the use of limited resources.
5. **Research and Innovation:** A national outcomes database can serve as a valuable resource for researchers, academics and experts in the field of mental health. It can support the development of new research studies, the exploration of trends and patterns, and the identification of innovative approaches to supporting individuals with psychosocial disabilities.

[66] Australian Psychosocial Alliance, 2023. *A Recovery-Shaped NDIS: Australian Psychosocial Alliance (APA) submission to the NDIA review panel*. Available at: Submissions (psychosocialalliance.org.au), p. 21.

6. **Standardisation and Consistency:** Developing national outcomes measures ensures a consistent and standardised way of assessing and measuring outcomes across different regions and service providers. This uniformity helps in comparing results and identifying best practices that can be replicated in different settings.
7. **Person-Led Care:** By tracking outcomes on a national level, the focus can shift towards providing person-led care based on what individuals say is important to them. Outcomes measurement can help tailor interventions to individual needs, preferences and goals, enhancing the overall quality of care and support.
8. **Advocacy and Policy Development:** Outcomes data can be powerful for advocacy efforts aimed at improving the lives of people with psychosocial disabilities. Strong data can influence policy development, legislation and funding allocation by highlighting the real-world impact of various initiatives.
9. **Reducing Stigma:** A national outcomes database can contribute to reducing the stigma associated with psychosocial disabilities. By demonstrating the positive changes and improvements in the lives of individuals who receive appropriate support, it can help challenge misconceptions and promote a more inclusive and understanding society. This can also encourage people with psychosocial disability to move towards recovery and focus on their personal growth and development to build capacity over time.
10. **Long-Term Monitoring:** A national outcomes database can track the long-term effects of interventions and services, providing insights into the sustained impact of support over time. This is crucial for understanding the trajectory of recovery and adjusting services as needed.

Developing a national outcomes database for people with psychosocial disabilities is essential for creating a comprehensive and integrated approach to care and support.

We recommend that the NDIA work with the sector and people with lived experience to develop a national outcomes database for people with psychosocial disabilities to monitor and report on outcomes over time.

We recommend that this approach will be most effective when applied to NDIS and non-NDIS services to provide a national dataset for understanding the needs and outcomes of people with psychosocial disability who are utilising psychosocial support services. A simple, clear and consistent approach is needed so we can all understand the impacts of psychosocial support services and how they support people to experience better outcomes.

Needs and outcomes identified by people with lived experience

It is important to ask people with lived experience about their needs and what outcomes are important to them. We acknowledge that the NDIA collects participant outcomes and satisfaction data for social and community participation, participant employment, family and carer employment, choice and control and education outcomes.[67] This is a start and further work is required to understand how participants experience the NDIS, the services they receive under their plans and the impact of these supports. Developing an outcomes measures framework and a national outcomes database that collects data from each service, for each participant, will enable the NDIA to aggregate data at the national level.

Research has already been done in this space, so we have a foundation for understanding what outcomes to measure. Associate Professor Nicola Hancock from The University of Sydney has advised

[67] National Disability Insurance Agency, 2022. *Psychosocial disability summary: September 2022.* Available at: Psychosocial | NDIS.

MIFA and our colleagues on the repeating themes that are evident across all evaluations for Partners in Recovery (PIR), the National Psychosocial Support Measure (NPS-M) and Continuity of Support (COS), H2Help and Peer Supported Transfer of Care (Peer-STOC). Across all programs, participants identified the same key themes for their unmet needs, priority outcomes and the components of programs that were most valued by them.

The needs and outcomes that were prioritised by participants were:

- connection and community inclusion – beyond the provider relationship
- meaningful activity
- physical health
- goal oriented and hopeful future
- stability and security (especially housing).

The program components that were prioritised by participants were:

- addressing the needs above
- consistency and quality of service provider relationships
- accessible support that was not time-limited
- family inclusive support.

The needs, outcomes and program components that were valued in different programs are outlined in Table 4.

Table 4. Summary of evaluations on PIR, NPS-M and COS, H2Help and Peer-STOC

PIR	
Needs	• having meaningful daytime activity • support with psychological distress • company (to help with social isolation) • support with physical health • support with accommodation
Outcomes	• feeling supported and less alone • having a better social life • getting out of the house and engaging in positive activity • improved physical health • feeling more hopeful and positive about the future • improved focus and order in life
Program components	• rapport with service providers • service providers listen • an individualised approach • collaboration and partnership • reliability • genuine care and respect
MPS-M and COS (NOUS Evaluation)[68]	
Outcomes	• connection and a sense of not being alone • increased engagement in daily activities, relationships and the community • regular positive experiences and something to look forward to

[68] Nous Group, 2021. *Evaluation of National Psychosocial Support Programs: Final Report.* Available at Evaluation of National Psychosocial Support Programs: Final Report (health.gov.au).

	• increased knowledge and skills • new ways of thinking and looking at the world • improved or stabilised mental health and wellbeing • improved self-confidence and self-concept • hope and reassurance for the future • moving forward with specific issues and goals
H2Help	
Program Components	• immediate availability, without long wait times, cost free and conveniently located • not time-limited • open-door contact – being able to call directly with no referral or mental health plan and being able to recontact the service if needed again • personalised and 'warm' referral processes • staff continuity meant people did not have to build trust and rapport with new therapists and retell their story • staff competence and personal qualities such as professionalism, empathy, kindness and respect • person-centred services, such as having choice of therapist or mode of contact (e.g. phone, in person, zoom) • family friendly • responsive to diversity, and respectful of service users from culturally, linguistically, sexuality or gender diverse groups
Peer-STOC	
Outcomes	• better and less traumatic inpatient experience • feeling understood, cared about and less alone • easier to leave hospital • easier to get back into life and daily routines • built and re-established community connections • gained new strategies, knowledge, understanding and skills • felt more hopeful about personal recovery

This work provides important information about the outcomes that can be included in the development of a national outcomes database.

Solution: appropriate pricing for psychosocial disability supports

Since the introduction of the NDIS, MIFA has been advocating to revise the underlying assumptions and methodologies for pricing psychosocial supports in the NDIS market. We need NDIS pricing to reflect the true cost of delivering safe and quality psychosocial disability supports in the NDIS market. The current NDIS Review provides the perfect opportunity to address the inadequate pricing for psychosocial disability and recovery-oriented supports.

The impacts of inadequate pricing

Before the NDIS was introduced, the sector worked diligently over decades to develop responsive recovery-oriented models of support and a workforce that was appropriately qualified and skilled to deliver this support. The previous block funding arrangements supported this approach at the time. However, the pricing constrictions of the current NDIS market have long threatened the sustainability of this workforce. Currently there is a mismatch between the pricing of NDIS psychosocial disability supports and the true cost of service delivery. To remain viable in the NDIS market, providers have

altered their business models to employ less qualified staff, incorporate more client-facing time and less time to provide professional development opportunities, debriefing, supervision and ongoing training. This all comes at a cost and many providers have chosen to take on substantial losses to maintain their workforce and support participants to the best of their abilities according to recovery-oriented practice principles.

Psychosocial disability workers support individuals with complex needs, often integrating their supports across multiple sectors and systems. This work requires a high level of skill and competency, compassion and resilience that is developed and strengthened over time. Better outcomes for participants, including enhanced social and economic participation, require significant investment in the workforce, especially the peer workforce, to enable the transformative change that supports lifelong recovery. Current NDIS pricing does not allow for investment in workforce development and growth.

The Reasonable Cost Model for NDIS Disability Support Workers[69] fails to acknowledge the true cost of providing recovery-oriented supports to individuals with psychosocial disability. The pricing structure raises several challenges, including:

- The potential exclusion of participants with higher needs that require higher levels of staff support from services.
- The loss of existing skilled and qualified staff and a de-skilling of the workforce.
- Service providers may choose to only provide low-priced supports if the NDIS participant also purchases higher-priced supports from them, essentially offsetting losses on one support with profits from another. This limits choice and control and undermines the objectives of the NDIS.
- Without changes to either funding style or the pricing model to adequately fund centre-based group service provision, some organisations report the need to close centre-based group services for people with psychosocial disability, leaving a large gap in the market. Many centre-based services have already closed, including those being operated by some MIFA Member organisations.
- Withdrawal of service providers altogether from the market. Some service providers, particularly in rural and remote areas, are at the point of imminent withdrawal from the market due to unacceptable losses and others have already succumbed to significant financial losses and have withdrawn entirely (including service providers in metropolitan areas).

Lack of access to suitable services continues to be an ongoing concern for many participants and providers alike. As the Productivity Commission notes, "participants sometimes find it difficult to purchase needed supports as they may not exist in their community or may be ill-suited to their needs".[70] The Productivity Commission states that lack of access to psychosocial supports may result from NDIA pricing for services being set too low and markets being too thin in certain regions.[71] The NDIS Review Panel has noted the impacts of thinning markets and asked for solutions on this issue. **One solution is implementing appropriate pricing to support service viability and growth.**

The pricing that is needed

The Disability Support Worker Cost Model requires revision for safe and quality recovery-oriented psychosocial support services to thrive in the NDIS. The sector wants to work with the NDIA to enhance the NDIA's understanding of the relationship between the approved support package and the cost

[69] NDIA and NDS, 2014. *Final Report of Pricing Joint Working Group*.
[70] Productivity Commission, 2020, Mental Health, Report no. 95, Canberra, p. 857.
[71] *Ibid*, pp. 857-858.

drivers, resulting in an appropriate hourly pricing rate. There are many hidden costs not accounted for in the Reasonable Cost Model for psychosocial supports. These cost-drivers are primarily:[72]

- providing an hourly rate that supports the attraction, recruitment and retention of competent, qualified and skilled staff who can provide recovery-oriented, trauma-informed, culturally sensitive and family inclusive supports
- providing an hourly rate that supports ongoing training, supervision, debriefing, planning and professional development, including extensive initial training for staff entering the sector at entry levels, potentially for the first time (this is particularly important given the level of workforce growth that is required)
- revising assumptions around appropriate 'billable' hours for face-to-face service delivery, where high billable hour percentages are leading to staff burnout
- revising overhead allocations to support organisations to invest in quality improvement, accreditation, innovation and systems that support service delivery in a post-pandemic market.

Base hourly rate

The knowledge, skills and experience of employees working with people with psychosocial disability is central to participants receiving services that are relevant to their needs. The Reasonable Cost Model assumes that workers with no or low (certificate-level) tertiary education will be employed.[73] The delivery of recovery-oriented and capacity building supports to a person with psychosocial disability requires a skill set that enables the worker to target the underlying barriers to functional engagement.

The workforce that delivers psychosocial supports is highly skilled and these skills must be reflected in the pricing. The NDIA has stated that it sees capacity building-style work as integral to all kinds of support, including those described as 'core'. However, a pricing model based on SCHADS Level 2.3[74] for core supports does not enable service providers to employ enough staff with the skills to manage complexity, respond to challenging behaviours, maintain engagement and build recovery, whilst receiving appropriate supervision, support and ongoing training and professional development. It is also problematic that the NDIS cost adjustments do not currently align with the timing of the Fair Work Commission Award (SCHADS) minimum wage review, which involves wage review increases in July each year.[75]

Non-client facing time

The requirement for there to be 85% to 95% client-facing time under the Reasonable Cost Model requires an increasingly mobile staff, with very little in-office time. This reduces opportunities for incidental supervision. The current non-client-facing time assumptions fail to account for the following:

- Assertive outreach activities, which may be classified as time not spent directly with a client. Many clients with psychosocial disability require an assertive outreach approach to support engagement.

[72] Cortis, N., Macdonald, F., Davidson, B. and Bentham, E., 2017. *Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs*, pp. 28-29. Available at: http://apo.org.au/system/files/98111/apo-nid98111-354151.pdf.
[73] *Ibid.*
[74] NDIA and NDS, 2014. *Final Report of Pricing Joint Working Group*, p. 12.
[75] Evidence is provided at Social & community services industry pay rates - Fair Work Ombudsman.

- Liaison between Support Coordinators, Psychosocial Recovery Coaches and other support workers working with the person. To ensure the best outcomes for participants with psychosocial disability, supports need to be delivered in a coordinated and integrated way to enable providers to effectively respond to the changing needs of participants and their families and carers. It is imperative that core support workers can meet with Support Coordinators and Psychosocial Recovery Coaches to ensure they are aware of the current issues that are impacting the participant, any emerging risks or any warning signs for the individual. For example, a meeting of one hour per month would assist in facilitating this coordination of support for all individuals.
- Training and development. This is a significant part of furthering the skills of the workforce, but it is not adequately accounted for. MIFA is aware that many organisations are not able to provide paid training to their staff. Training and professional development must be undertaken in the worker's own time, outside of regular working hours, at their own cost. This approach does not support long-term quality service provision.
- Staff travel time and transport costs, particularly for outreach and services in regional, rural and remote areas, is not adequately considered in the hourly cost model.

We recommend that the NDIA work with the mental health sector to reach mutually agreed and appropriate pricing for the NDIS Disability Support Worker Cost Model for the provision of psychosocial supports. This would include a review of the assumptions relating to the delivery of psychosocial supports, particularly those relating to base hourly rate and non-client facing time.

Solution: embracing flexible funding packages

Flexibility is a core tenet of recovery-oriented service provision due to the fluctuating needs of people as their mental health state and function varies over time. It is critical that pricing structures for the psychosocial disability cohort embraces flexibility so that plans can be responsive to the needs of individuals through appropriate funding packages. Access and support must be timely and crisis responsive. Support systems and processes must be flexible enough to fluctuate with the changing support needs of the individual and respond to increased vulnerability and need (for example, in times of crisis, during periods of significant mental health decline, or during enforced isolation or self-isolation).

We recommend the following broad changes to enable flexibility for NDIS participants with psychosocial disability:

- Packages contain adequate hours of support, including Support Coordination and Psychosocial Recovery Coaching, to allow for flexible service delivery.
- Packages allow for a rapid increase in support during a crisis and for the rollover of any unspent funds to be used flexibly during the next year.
- Packages provide for continuity of care when people are in a hospital/acute setting, which is essential for maintaining support worker contact and involvement in the discharge process for better participant outcomes.
- Flexibility could be provided through alternative funding arrangements for certain activities, such as group centre-based programs. These could include subscriptions, memberships, full course fees, bulk buying of support incidences in advance and/or much more lenient cancellation policies.

Solution: developing core competencies for the psychosocial disability workforce

The NDIA has sought advice from the sector about the development of core competencies for the psychosocial disability workforce. There is merit in developing core competencies and scopes of practice for different roles.

We can draw on existing work from the New Zealand Mental Health Commission, led by Mary O'Hagan, to develop recovery competencies for New Zealand mental health workers.[76] Ten recovery competencies were identified. These were developed following a review of the international mental health recovery literature. In the Aotearoa/New Zealand context, a competent mental health worker:[77]

1. understands recovery principles and experiences in the Aotearoa/NZ and international contexts
2. recognises and supports the personal resourcefulness of people with mental illness
3. understands and accommodates the diverse views on mental illness, treatments, services and recovery
4. has the self-awareness and skills to communicate respectfully and develop good relationships with service users
5. understands and actively protects service users' rights
6. understands discrimination and social exclusion, its impact on service users and how to reduce it
7. acknowledges the different cultures of Aotearoa/NZ and knows how to provide a service in partnership with them
8. has comprehensive knowledge of community services and resources and actively supports service users to use them
9. has knowledge of the service user movement and is able to support their participation in services
10. has knowledge of family/whanau perspectives and can support their participation in services.

We recommend that the NDIA work with leading researchers in the field of recovery competencies, in Australia and abroad, to develop core competencies for the NDIS psychosocial disability workforce.

Specific areas of NDIS service provision that require improvement

MIFA has sought feedback from our MIFA Member organisations about the specific areas of NDIS service provision for people with psychosocial disability that require improvement. These areas are:

1. High Intensity Supports
2. Support Coordination
3. Psychosocial Recovery Coaching
4. Supported Independent Living
5. Group Support models
6. Plan Management

We address each of these issues below in detail.

Reintroduction of High Intensity Supports

Our MIFA Member organisations have told us that when the NDIS was first introduced, most people had high intensity supports in their plans. Organisations developed business models in good faith, relying on the inclusion of high intensity supports to provide quality, recovery-oriented services.

[76] Mental Health Commission, 2001. *Mental Health Commission Recovery Competencies, 2001.* Wellington. Available at: Microsoft Word - Recovery Competencies - grain.doc (maryohagan.com).
[77] *Ibid*, p. 7.

Recently, we have seen changes in the high intensity support structure and pricing. Our MIFA Member organisations have advised that when these changes were introduced, there was no engagement with service providers and no transition process to enable providers to respond effectively to the changes.

> "There has been a lot of confusion around when we can and cannot charge for high intensity supports. The 'goal posts' and rules around it keep changing. It has been difficult to keep up with these rule changes." (MIFA Member organisation representative)

Many organisations are experiencing financial bleed from the changes in high intensity supports. They are calling for the reintroduction of high intensity supports to enable organisations to safely support participants with the greatest levels of complexity. Some are also calling for a higher level of supports beyond this to enable the most highly skilled support workers, including senior peer workers, to work with participants to reduce the level of disability over time.

We recommend that high intensity supports are reintroduced to enable highly skilled support workers and peer workers to support participants with psychosocial disability, particularly those participants who experience higher levels of complexity.

We recommend that NDIA staff and partner staff receive training about the importance of high intensity supports for people with complex psychosocial support needs to ensure there is equitable access to high intensity supports in every jurisdiction.

Support Coordination

Our MIFA Member organisations report three main concerns with Support Coordination for participants with psychosocial disability.

Increases in Support Coordination pricing are required

> "Support Coordination is a necessary, valuable and needed service. It is however underfunded. Most NDIS line items have increased in price in line with increased costs such as wages. Support Coordination however lags behind and has not had a price increase in years. This makes the service hard to make sustainable." (MIFA Member organisation representative)

The current pricing for Support Coordination does not adequately account for some operational costs. These include:

- **Increases in SCHADS Award wages, Portable Long Service Leave and increases in superannuation.** The NDIS Support Coordination pricing has failed to increase in parallel with these changes. This is resulting in a margin squeeze for service providers who are working within ever diminishing margins that impact on the financial sustainability of NDIS business models. Many businesses are now running their NDIS Support Coordination services at a loss. Those who are making a profit are reporting the slimmest of margins (often around 1% or 2%).
- **Transport/travel and non-labour costs.** If Support Coordinators fully bill the non-labour cost as per the NDIS Price Guide, then there may be insufficient funds remaining in a participant's plan.

More Support Coordination hours are needed in plans

Secondly, our MIFA Member organisations report that there are generally not enough hours of Support Coordination allocated in plans. There is continued concern that plans simply do not accurately reflect participants' needs. For example, one of our Member organisations has reported that the current hours allocated for Support Coordination are insufficient for most of the participants they are supporting. Many participants are receiving 14 hours of Support Coordination per annum. MIFA has

previously advised the NDIA that it would be ideal to see a minimum of 100 hours of Support Coordination allocated to each NDIS participant with psychosocial disability annually. This would support capacity building, enhanced social and economic participation, and integration between different community sector and health professionals who are providing supports.

The lack of adequate Support Coordination hours in participants' plans points to the need to further educate and resource NDIA planners and LACs to understand the nature of psychosocial disability and the need for meaningful and responsive support. It is critical that participants' plans include sufficient support coordination funds to support recovery.

Greater use of Level 3 Support Coordination

Our MIFA Member organisations have advised that there needs to be more provision for Level 3 Support Coordination for NDIS participants with psychosocial disability who have a high level of complexity. It is appropriate to include Level 3 Support Coordination where supports need to be provided by highly qualified and competent support workers.

Level 3 Support Coordination plays a critical role:

- in regional areas, where it is more challenging to deliver supports to participants
- when participants are in a crisis – experienced staff, especially experienced peer workers, who are highly competent in providing recovery-oriented and trauma-informed supports are needed at these times
- in supporting people after they are discharged from hospital settings – in many jurisdictions, participants do not have access to clinical supports after discharge from hospital and Support Coordination is important for people post-discharge.

Being able to flexibly use funds during times of crisis or greater need is essential. Participants need to be able to flex up and flex down with their Level 3 Support Coordination needs.

We recommend that the NDIA revise the current pricing arrangements for Support Coordination to ensure regular pricing updates in line with organisational costs (such as annual increases in Award wage rates and increases in Portable Long Service Leave and superannuation contributions).

We recommend that Level 3 Support Coordination is used to support participants with more complex support needs, and that funds can be pooled and used flexibly to flex up and flex down supports depending on a participant's needs.

We recommend that the NDIA review its practices for allocating Support Coordination hours in participants' plans and ensure there is education and resourcing for NDIA planners and LACs to accurately allocate Support Coordination funds in the plans of participants with psychosocial disability.

Psychosocial Recovery Coaching

MIFA supports the introduction of Psychosocial Recovery Coaching to the scheme. We have suggestions to improve the role and how it is utilised to ensure both its long-term sustainability and its effectiveness in supporting the best outcomes for NDIS participants with psychosocial disability.

We have received the following feedback from some of our MIFA Member organisations:

> "The demand for Psychosocial Recovery Coaching has increased and is a much-needed service provision within the NDIS."

> "It's barely funded in regional and remote areas, which means services can't invest in establishing [Psychosocial Recovery Coaching] in these communities."

There are certain improvements that can be made to ensure we are making the most of Psychosocial Recovery Coaching in the NDIS. These include:

- including Psychosocial Recovery Coaching in **every plan** where a participant has psychosocial disability to promote recovery and decrease long-term disability
- considering putting Psychosocial Recovery Coaching into core supports
- revising the current cost modelling.

Revising the current cost modelling for Psychosocial Recovery Coaching is critical to ensuring long-term sustainability and success. The current pricing does not reflect the cost modelling that was initially set to employ Psychosocial Recovery Coaches at SCHADS Level 4.4. Our MIFA Member organisations have advised that this pricing does not allow for the level of supervision, professional development and debriefing that is required of this role to ensure employees are appropriately supported.

In practice, the work of Psychosocial Recovery Coaches is often identical in complexity to Specialist Support Cordination work, but it is costed at half the price. Many of our MIFA Member organisations are struggling to successfully develop programs for Psychosocial Recovery Coaches, normally running at a loss. One of our MIFA Member organisations has advised:

> "We have had to make business decisions to not take on more Psychosocial Recovery Coaches due to the cost we incur, despite it being a specialisation and strength of our service. This means more participants are driven to independent Psychosocial Recovery Coaching providers who can operate a leaner service – but may not have supervision structures in place to safeguard staff wellbeing and support high quality mental health practice."

We recommend including Psychosocial Recovery Coaching in every plan where the participant has psychosocial disability and that an appropriate allocation of annual hours is included to reflect each participant's needs.

We recommend revising the pricing for Psychosocial Recovery Coaches to ensure the pricing reflects the true cost of service delivery.

Supported Independent Living

There are challenges associated with operating Supported Independent Living (SIL) services for participants with psychosocial disability. MIFA has received the following feedback about the operation of SIL services from several of our MIFA Member organisations:

> "In South Australia there remains a high number of SIL providers who own/manage the property that the participant would live in – maintaining the problematic relationship of the SIL provider also being the participant's landlord. We have seen this become extremely concerning when Behaviours of Concern are not well managed, and instead the participant is told they cannot return to their own home until certain requirements are met – often requirements that are not achievable or realistic. We have also recently seen SIL providers attempting to charge participants for a higher rate (e.g. 1:1 SIL) to cover the costs incurred from a vacancy – both when they have struggled to replace a housemate, or when they have struggled to find a housemate to join the participant in the first instance."

> "Housing and staffing are the biggest challenges to delivering SIL in regional and remote areas. There are many participants across regional Queensland who are living in situations that do not meet their needs because SIL is not able to be created due to lack of housing and staff. Also, it's a challenge to get the NDIS to fund SIL in these areas, which again leads to services being unwilling to invest in establishing new services in these communities."

> "There is increased demand for SIL in the Cairns region. The main concern is the huge increase in rental costs to the consumer which is not covered by NDIS. Increasingly as a not-for-profit charity we are expected to cover the overspend on the rental costs to enable the consumer to live in acceptable housing in the Cairns region."

> "If we have a group of participants living in the one property in a SIL type arrangement and some of the residents spend time away from the property overnight or end up in hospital at short notice, it is difficult to fund and staff that as we are no longer able to spread the cost across all residents but we still have to pay for staff and overheads that have been costed based on the property having all residents there all the time."

Based on this feedback, we see the need for SIL services to be administered flexibly. We suggest the following solutions to ensure SIL services are better suited to the needs of participants with psychosocial disability and sustainable for service providers:

Revise the current staff to participant ratios of 1:3 to 1:2. The current 1:3 ratio is very difficult to work with for participants with psychosocial disability. Our MIFA Member organisations have advised that it is challenging to find three participants with psychosocial disability who can live well together. It is also challenging to find appropriate houses that can support this number of people, particularly in regional areas. It is much easier to find suitable houses to support two participants at a time.

Ensuring the pricing reflects median accommodation costs in different regions. In some areas the cost of housing is prohibitive and rental costs have been increasing at very high rates. It is important for SIL pricing to reflect median rental costs in different regions around the country to ensure that providers are not left to pay for the variance between high rental costs and what is provided for in the SIL pricing. This could include considering a loading for different regions.

We recommend changing the staff to participant ratio to 1:2 for SIL services that are supporting participants with psychosocial disability.

We recommend revising the SIL pricing to ensure that the pricing is reflective of median rental costs in different regions around the country.

Group Support Models

MIFA has received feedback from some of our MIFA Member organisations that the pricing arrangements for group-based community participation supports introduced on 1 July 2020 are not adequate and will negatively impact financial sustainability. Extensive modelling was undertaken by one of our MIFA Member organisations using the new pricing arrangements and this projected a significant deficit for the organisation. These calculations included the complicated and onerous administrative tasks that would be required to implement the new pricing arrangements. Due to the ongoing costs and administrative burdens associated with providing group supports, this organisation (along with others) has closed many of its centre-based group support services. This is a huge loss to those community members who attended these services on a regular basis.

Some MIFA Member organisations have told us that the pricing arrangements for group-based community participation supports do not support service providers to charge for administrative group service activities. These include billing, planning, preparation and set up for activities, and writing up group risk assessments. The pricing does not include contributions to organisational overheads – organisations do not receive adequate funds to pay for utilities, items for group activities, IT costs, stationery, or the cost of staff participating in community activities and collaboration.

The inadequacy of the pricing became even more apparent during the onset of the pandemic, when service providers were forced to physically close many group centres due to public health orders. Changes to service delivery, including changing service arrangements, planning for business continuity, adapting programs to provide phone and virtual supports, and planning for site closures and the reopening of sites were organisational costs that were not billable.

Overall, the current pricing arrangements place great strain on service providers' ability to provide and maintain group centre-based activities. MIFA stresses that group centre-based programs provide an important offering to many NDIS participants with psychosocial disability. Some participants strongly benefit from centre-based, drop-in style supports that provide an accessible, safe and welcoming environment – a place where people feel like they can belong. We know from experience that participants of group centre-based models commonly cite increased confidence, acceptance, empowerment and hope through the opportunity to engage in supportive relationships with others who share their experience.[78] There is great power in the ability to connect with peers and share stories, experiences and advice about what has been helpful to people's recovery and how people have overcome barriers and adversity.

Without increased flexibility and an injection of further funding, many recovery-oriented, centre-based services are facing closure. Flexibility in funding would allow for use of facilities, brief interactions with support workers or general administration staff, and informal interactions with other participants. Flexible funding would also support people to drop in at short notice and to stay for shorter amounts of time. This would support a recovery-oriented approach of providing support to participants based on a safety and wellness assessment or risk assessment approach, where there may be unpredictable support needs from day to day, rather than requiring a fixed ratio of staff to participants.

The NDIA can support flexible funding of group-based community participation supports by:

- returning to one standard rate for group-based activities in the centre and one rate for group-based activities in the community – with both rates supporting the true costs of service delivery
- adding an NDIS Pricing Guide line item under centre and group-based supports to allow for planning activities and participant engagement
- introducing billing under a Programs of Support Model so that participants can commit to a period of attending centre-based activities to enable service providers to recover costs where there are recurring cancellations.

We recommend that the NDIA support flexible funding arrangements for group-based community participation supports that reflect the true costs of delivering group services in centre-based settings. This includes reviewing the pricing for group-based community participation supports to include organisational costs that are currently not included in the pricing assumptions and modelling.

[78] Raeburn, T., Halcomb, E., Walter, G. and Cleary, M., 2013. An overview of the clubhouse model of psychiatric rehabilitation. *Australasian Psychiatry*, 21(4), pp. 376-378.

Addressing significant losses from Plan Management

Plan Management is challenging for many of our MIFA Member organisations. We have received the following feedback about how Plan Management is currently working:

- many Plan Managers are not paying their invoices
- organisations are writing off debts each year that result from unpaid Plan Management invoices
- one organisation has advised that they have one full-time employee that monitors Plan Management payments and follows up directly with Plan Managers when invoices are not paid – this cost is born fully by the organisation
- organisations are making decisions not to work with certain Plan Managers and are having to advise clients that if they want to stay with their chosen Plan Manager then they will need to find an alternative provider
- organisations are finding that Plan Managers are not educating their clients about how to build capacity to be able to self-manage their plans long-term.

We recommend that Plan Management services are reviewed to understand how Plan Managers and service providers can work more collaboratively and effectively to support participants.

We recommend that the true cost to service providers of successfully working with Plan Managers is reflected in the NDIS pricing.

We thank the NDIS Review Panel for the opportunity to provide this feedback as part of the review process. We look forward to working with the NDIS Review Panel further to provide additional feedback as needed.

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