Targeted foundational supports for psychosocial disability

Evidence from qualitative interviews with sector ‘stakeholders’

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Context

We conducted interviews with 37 people who have high-level knowledge of the operation of the NDIS and supports for people with serious mental illness outside of the NDIS. We specifically asked all interview participants about foundational supports, including general perceptions of the concept and what they would ideally include.

These data are not comprehensive in that they only include the perspectives of the interviewees that self-selected to participate in the study however they do provide a snapshot of the main concerns and interests of people who understand the current situation with regard to NDIS supports and related gaps. Refer to the Methods and Interview Participant Descriptions at the end of the discussion for more information about how these data were put together and their limitations.

Key findings

Interview participants were very much in favour of foundational supports despite confusion about what they would actually look like in practice. Foundational supports were viewed as a way of addressing many of the problems of the NDIS and a lack of access to the NDIS by people with severe mental illness. There were concerns about a lack of progress towards foundational supports caused by poor government prioritisation of the needs of people with serious mental illness, conflict between the Commonwealth and states/territories governments, and in-fighting in the disability and mental health sector.

Interviewees were clearly able to articulate a strong conceptual framework for the design of a model of foundational supports which they felt should underpin all elements of operation. These were:

- Connection – the core is a connection between people and available supports, facilitated by a navigator
- Values-based support – person-centred, recovery-oriented, trauma-informed, human rights-based
- Integration – integrated with mainstream supports, the health system, community mental health and other disability support (including the NDIS).
- Flexibility – supports that are adaptable to fluctuating needs
- Stability – provide a point of connection for individuals even when needs change
- Accessibility – no wrong door approach; high and low intensity needs supported
- Universality – available throughout Australia

- Cultural-relevance – prioritises local community interests; First Nations knowledge
- Community-based – community partnerships; sees the individual in the context of the community they are in (families, communities) and the supports available for this community to support them
- Targeted– supports focus on people with severe mental illness whose needs were not met by other existing systems

Interview participants felt that there should be core support offerings available in each local area including a psychosocial navigator whose role was to understand the individual via the development of a support relationship based on recovery principles, and then to understand their needs and connect them to services. The services should, where possible, be drawn from existing services available in the community.

Other supports discussed included clubhouses, day centres or drop-in centres, capacity-building for day-to-day living, Open Dialogue approaches, access to allied health services, family support, psychoeducation and recovery colleges, 'case' management to support complex needs and NDIS access for suitable applicants, connection with supports to address social determinants of health, and immediate needs for tenancy support, food etc., connection to employment, volunteering and education supports and transition support for step-up and step-down from acute care and other intensive mental-health supports.

A strong 'foundation organisation' was viewed as important for assuring the ability of the program to deliver on the ground. Interviewees favoured a localised, consortium-based model building on examples of what has previously worked including effective examples of Medicare Mental Health locals and Partners in Recovery.

Detailed results

Benefits of foundational supports

The benefits of foundational supports were seen to be that it would address the current problems associated with having the NDIS as the only available support. The NDIS was seen as a costly and rigid alternative that only addressed permanent needs.

Arresting the development of disabling mental illness

Foundational supports were seen to offer support to people to keep them well so that their illness doesn't become debilitating to the extent that they can no longer participate in society.

> "…if I had had the support back then, I'd probably still be doing - I probably wouldn't have got as physically ill and I would be working, or I would be doing more advocacy work and things like that, and volunteer stuff and whatever." (S1 – stakeholder and NDIS participant)
>
> "…it will prevent a lot of people needing to go on the scheme in the first place." (S17)

Addressing NDIS demand and costs

Foundational supports would deal with the 'oasis in the desert' effect which keeps people applying to the NDIS and pushing up demand for the NDIS. It would have the potential to be a cost saving to government and stop reliance on the permanent supports funded by the NDIS. It was also felt that without foundational supports there would be no potential to reform the NDIS as there needed to be something for people to move off into via a step-down approach.

> “I think foundational supports might be something that could bridge that gap. $90,000 NDIS average package compared to, I mean, the Commonwealth Psychosocial Support Program is around $6,000 per person per annum and only designed for three to six, 12 months.” (S13,14,15)
>
> Speaker 1: “Look, I think there is - I think there’s a good case for keeping people out of the NDIS if there were the right supports available to them outside of the NDIS. I think there’s a lot of people that go into the NDIS that probably could be supported outside of it. Once they’re in the NDIS system it seems…” Speaker 2: “They become reliant on the NDIS system.” (S32,S33)

A lack of foundational supports was seen to force people onto the more costly NDIS supports when individuals didn’t need that much funding to meet their needs and may get extra supports that they do not need or may potentially reduce their capacity by providing more support than needed. Relating the situation of one client who was forced into applying for the NDIS to get supports, one interviewee noted this option: “…is going to cost the government potentially a $150,000 NDIS plan, where really all he was originally asking for was the equivalent of maybe $15,000 worth of funding” (S17).

Sustainability of support offerings

Service providers felt that they were currently filling in the gaps surrounding the NDIS but in an unfunded way, through stretching their services to meet the needs outside of the scheme: e.g. “They've got a drop-in centre as well as NDIS supports and other bits and pieces of PHN funding to try and make them sustainable as best they can” (S26). They felt that foundational supports would recognise this and provide more consistent funding for the supports that already target this group and allow programs and services to be sustainable.

Concerns about foundational supports

Concerns were about how the model would be developed, whether it would actually be developed (“I'm not feeling very optimistic” -S20), and what it would look like in practice:

> “…robust enough to be able to meet the need, and that it’s going to be done in a way that is going to travel together, I guess. The reform from the NDIS and the foundational supports being built…I just hope it happens seamlessly, because I’m worried that the NDIS will start reducing plans and funds without the foundational supports being available to access.” (S10)

Interview participants were concerned that supports on the NDIS would be stripped from people with the expectation of a foundational supports model that was either lagging, did not actually fill the gaps, or did not target the right group (people with serious mental illness).

Political and sector interests stopping progress

Interviewees were concerned that the whole foundational supports project would become stuck in an intractable Commonwealth-states/territories battle over funding and nothing would actually happen. A lack of intergovernmental working and intragovernmental working was behind this. Another barrier to progress was seen to come from the disability sector itself, with some groups of participants, advocacy organisations, provider groups, and professional groups being viewed as having vested interests which would stall progress because of a failure to collectively agree around action: “some loud voices who should have a seat at the table have become the sole [voices] being listened to by the NDIA and government to the expense of other participants and their families and carers” (S23). There was seen to be a lack of government commitment to people with serious mental illness and their needs, despite much lobbying and good evidence, which would mean that they would prioritise other issues. Above all there was seen to be a lack of political will to actually do something:

> “So it comes to leadership across the government. So that's got to be the central agencies, not just health, or any of the state agencies. The Productivity Commission original report gave the strong economic argument for reform. What we found is that an economic argument hasn't resulted in

> change. The human rights argument doesn't seem to sway governments either. They still haven't looked at any way in which the gap in psychosocial support can be addressed. There's no commissioning arrangements, co-funding, or anything like that. So it's a lack of leadership, it's a lack of commitment.” (S28,29)

Getting the model right and general confusion

> “There's a huge temptation at the moment, I think, to create, we call them the bums on seats models. They're just models that are there to give people something because something's better than nothing and they're cheap.” (S3)

At a practical level there were concerns about commissioning and whether the right organisations could be commissioned to deliver localised, community-connected supports, and the availability of a workforce in all areas. The potential cost involved in doing it right was a concern but it was felt that using existing infrastructure would mitigate this. There were also concerns about needing to focus on the right participant group (ie people with serious mental illness) for foundational supports and how decisions would be made about what was offered:

> “Like, at what point do you intervene? How do you measure the cost avoidance of intervening at that point compared to something else? How do you know the cost of what the consequences of doing nothing are compared to doing something at that point? I don't know how those decisions are being made.” (S9)

As this shows, while some of the discussion indicated a clear vision for the supports, and what would be included, others were simply confused about what it would involve: “because we don’t know what they’re going to look like, or who’s going to tender for them, or who’s going to provide these foundational supports” (S10). Others were confused about the timelines involved and who, and what, would actually prompt action to make it happen.

The overarching design of foundational supports

> “…it could be that it's [foundational supports] everything that the NDIS is not. It's easy to find and it's accessible to everyone. It provides you with the help you need in the way you need it when you need it.” (S28,29)

Twenty-four interviews discussed key elements of the model design which they felt should underpin all elements of operation. Key elements were:

- Connection – foundational supports should at their core a connection between people and available supports, facilitated by a navigator (discussed below) working within a supportive organisational context.
- Values-based support – person centred: including recovery-oriented, trauma-informed and human rights-based support. Recovery was viewed as the primary orientation for all aspects of support.
- Integration – offer integration with mainstream supports, the health system, community mental health and other disability support (including the NDIS).
- Flexibility – the ability to adapt supports as people go through fluctuating needs
- Stability – provide a constant point of connection or reconnection even where people are receiving acute treatment or choosing to not use services for a time.
- Accessibility – provide a no wrong door approach and provide supports for high and low intensive needs for people with serious mental illness.
- Universality – available throughout Australia, level of support not depending on remoteness or state/territory location
- Cultural-relevance – working with community needs and interests, including prioritising a social and emotional wellbeing approach for First Nations communities and First Nations knowledge.

- Community-based – prioritises community partnerships; sees the individual in the context of the community they are in (families, communities) and the supports available for this community to support them.
- Targeted – supports should be appropriate to people with severe mental illness as a priority population whose needs were not met by other existing systems.

Several interview participants described foundational supports as resembling "hubs" of knowledge and support (e.g. S10, S11, S28,29) whose aim was to link people with the mainstream and mental health specific supports that would meet their needs. Support types available needed to be standard nationally, but offerings also needed to adapt to local need. Interviewees did not want the "Commonwealth and the jurisdictions going in their own ways" because "then it's harder to make sure that that postcode lottery is addressed". Integration with existing federally and state/territory-funded supports, including clinical services was viewed as important in order to address current gaps in coordination.

> "…foundational supports need to be integrated into the existing mental health service system. You can't have two lots of information services or information supports." (S25)

Intensity of supports

Intensity of supports needed to be adaptable to needs which may differ between individuals, but also at different times for the same individual:

> "It might be that they need to be streamed into NDIS quickly, or it might be that they just need some social support groups, or some psychoeducation, and that's all that's required to better understand, or whatever it is, and so they're referred into that." (S12)
>
> "So there is the ones which are about, I suppose, a base level of access and information, and then there are the more specialist [supports]." (S25)
>
> "So they will increase in line with intensity of disability, but they will also increase as life changes. As episodes and crises develop, as people leave hospital after two months and have lost their housing or their family support or whatever. So it has to take account of the need related to the person's mental health condition, has to take account of the changing circumstances in people's lives." (S28,29)

There was a preference against time-limited supports, but this could be addressed in favour of an approach where supports could "ramp up and ramp down" (S6) as needed.

Localisation

Interview participants felt that foundational supports needed to be localised and avoid a "cookie cutter approach everywhere in the country. It's not going to work" (S13,14,15). Localisation was important so that people could be directed to the right services and supports available in their region, and that supports could be provided in culturally relevant ways:

> "…there's service navigator positions in [existing program] in Darwin. Well, that was a service that got the funding, but the Territory is a large place for all those phone calls to be going to Darwin. Someone flicking through a spreadsheet or something to provide that support isn't - that's not changing anything, really." (S26)

Linked to this was a failure of commissioning models to understand local conditions and fund service providers that had existing strong connections to communities and an understanding of communities: "Yep, and they haven't got anything else happening in the NT, but they were funded" (S32,33). Instead, there is a need for localised connections with a group of participants in an Aboriginal community-controlled organisation in the Northern Territory explaining: "it's the relationships, it's the network, it's the ecosystem in the region" that make the difference to success. While there may be a central initial contact line (open to family members, clinicians, and individuals themselves) to provide information and connections to local areas, beyond that local services were preferred.

Organisational structures

Having the right organisation or consortium of organisations as the ‘foundational organisation’ was seen as important. It was felt strongly that there needed to be 1) mental health competency in the foundation organisation 2) connection to community 3) connection to health and community services. For the navigator role the organisation was seen as essential because it could provide recovery-oriented support, supervision and training for the navigators (in lieu of a highly trained professional workforce) and a knowledge-bank for supporting connections to services.

Several interview participants talked about consortium models operating in each region. Consortia were seen to help to cut down competition between providers but also enable greater connectedness:

> “…this environment of - competitive environment of trying to look at silo areas of individual support is - needs to be reframed in a way of being a collective responsibility for a region, and the people in the community of those regions are managed by this consortium approach.” (S22)

A panel of providers would help to link to different types of supports and force collaboration because “…they often focus on their own patch and it doesn’t create the best outcomes for participants” (S26).

Existing infrastructure

Several people spoke about a strong role for PHNs, mainly because of their connections with local areas, and their experiences with collaborative commissioning:

> “I think my thoughts on foundational supports, I really liked the idea of the PHNs having a really strong role and PHNs looking very locally at the needs in their communities so that they're very localised responses.” (S3)

PHNs were viewed as the commissioners of foundational supports. However, they were seen by some as too stretched to provide the supports themselves, but should be integral to the operation in working with the foundational organisation to help facilitate connections. In regional areas and in Western Australia and the Northern Territory the PHNs were viewed as being too geographically large to actually be able to deliver a localised model and did not have existing good connections with existing services in all areas. Other possible organisations working as part of a consortium or singularly included local councils, existing Medicare Mental Health centres, Aboriginal community-controlled organisations and non-government organisations. While foundational supports are non-clinical, it was seen as appropriate that some organisations who provide clinical services would also offer foundational supports. This was viewed as important, for example, in remote communities where such organisations are the only ones realistically available to provide foundational supports.

Existing models to build on

There was a feeling that there were existing elements of foundational supports across Australia, but that these were poorly coordinated around the individual, not consistently available, and only available to certain groups. This was seen as a result of there being a lack of a ‘foundational infrastructure’ to bring this together and provide something more consistent and holistic. Several participants spoke about the Medicare Mental Health services being a good approach to learn from in the development of foundational supports, but only where connected well to health and local communities. Some also used the operation of Medicare Mental Health services as an example of poor practices, where out-of-area organisations had been commissioned. An example of an effective Medicare Mental Health local model given was that operating in Katherine, which had strong connections to local Aboriginal communities and adapted its model to local needs. Several also spoke about the Partners in Recovery (PIR) model being a useful one to base the new model on because of 1) the structure of supports offered, 2) the navigator-like support facilitator role, and 3) the consortium-based regional commissioning model. Other programs relevant to this group mentioned as having elements worth building on were the Remote Community Connectors, the Commonwealth Psychosocial Support Program and the former Partners Helpers and Mentors (PHaMS) program.

Funding approaches

Block funding was preferred to individualised funding such as that provided by the NDIS, as this would allow a more flexible approach. A regional loading was viewed as important for addressing the additional costs of providing supports in rural and remote areas. While most assumed there would be no costs to the participant others suggested a 'low fee model' for some core, community-based participation or drop-in centre-based supports.

Supports to be included

> "…use the existing - like the Medicare Mental Health services and those, build on those as a key foundational support. Then, what you want after that is a pathway into more individualised supports, and that would be - I think probably in a way, the review probably got it right. Things like recovery colleges are good. You probably want some group and individual options, and well, something like the navigational support, which is this idea of having some - a navigator. But you will need some supports to navigate to. But a range of - I've been still toying with how to talk about this or the words, but it's this notion of an individualised recovery support option, and it can be a very small thing, or it can be a very large thing. It might be one hour a week. It might be one hour a fortnight. It might be five hours a week or more, or 10 hours a week." (S25)

As this long quotation shows, interview participants articulated a range of supports available under foundational supports. Key to these were the navigator role, specific psychosocial supports and facilitated access to more general community-based supports.

The navigator role

Navigators were viewed as core to the operation of foundational supports (and indeed any system of psychosocial supports): "The navigator or the planner is the glue" (S28,29). At the heart of the navigator role would be the development of a relationship with the individual to understand their needs and connect them to supports:

> "…first understanding the person's needs and where they - trying to understand, is this someone that would really benefit from real psychosocial supports, capacity building supports, what are their social structures like, their support networks, et cetera, and then being able to provide them with some daily living supports, but not to the same level in the hopes that you can try and divert them from needing permanent NDIS support." (S13,14,15)

Another role for the navigator was to provide basic psychoeducation and recovery supports within a trauma-informed framework in order to have people understand their recovery goals and 'self-agency' as part of directing people to supports that were really going to meet their needs (S30). Intensity of the relationship could depend on an individual's needs. Interview participants from an Aboriginal community-controlled organisation spoke about how the navigator role might work in a remote community context:

> "…supporting people with psychosocial issues, to identify disabilities and helping them in applying for NDIS and also, in helping them not to get into the worst-case scenarios of their disability or their psychosocial issues. Maybe for like therapy or referring them to other providers, doing activities out in the communities just to integrate and keep them from escalating and improving their life supports." (S34,35,36,37)

It was important for interview participants that the navigator be a locally-based role connected to the way other foundational supports for psychosocial disability were operating, thereby avoiding some of the problems with the current operation of support coordinators via the NDIS. Some support coordinators were not based in the same state as participants and did not understand the local contexts in which they were receiving supports and did not have a good understanding of mental illness.

There was a concern that there would not be an existing workforce available to fill the navigator role, depending on what type of competencies were required. This is discussed further in a separate document which details and justifies the navigator role. While some argued that this role should be held by university-trained registered allied health professionals and social workers, most felt that this role did not require a particular qualification but could be filled by people with more general competencies in mental health, including the peer workforce.

Supports that should be included

> “So what's the foundation? Now, the foundation is the glue that enables that person to find their way within living independently in the community. So it's about family connections and strengthening and maintaining those. It's about natural connections, friendships, joining clubs, all of those sorts of things. It's about access to employment. It's about stable housing, having the support that's needed in daily living, shopping, cooking, eating well, exercising, and being included, having friends, being a part of the community. So they're the foundations.” (S28,29)

Supports that were mentioned as important were:

- A psychosocial navigator
- Clubhouses
- Day centres or drop-in centres
- Capacity-building for day-to-day living
- Open Dialogue approaches
- Access to allied health services
- Psychology or trauma counselling
- Family support (capacity-building, connection and psychoeducation)
- Psychoeducation and recovery colleges
- ‘Case’ management to support complex needs
- Connection with supports to address social determinants of health, and immediate needs for tenancy support, food etc.
- Connection to employment, volunteering and education supports
- Connection to community-based nursing and health supports, such as medication management
- Transition support for step-up and step-down from acute care and other intensive mental-health supports
- Supported NDIS access where suitable

Some of these supports, such as navigation, open dialogue, drop-in centres or family-supports were viewed as being directly provided by the foundation organisation or consortium, where others were sourced from existing supports in the community. Connection to relevant community-based supports or working with community-based organisations to increase capacity to support people with mental illness. Several people spoke about the need to connect people with culturally relevant services. For example, one person spoke about the need to connect people with faith-based services where they could receive spiritual support that was also appropriate to their mental health needs. Some of these interviewees felt there might need to be expansion of mainstream services to address demand, such as access to public allied health services.

Digital supports

While digital supports were viewed as an inevitable part of any model, concerns were raised by several interview participants about an over-reliance on digital models for this population in general. As one person commented, “digital can’t be the only thing for this group” (S7), because of low digital literacy and low cognitive functioning, but also for some populations who struggle with access, for example remote communities, such as those in the Northern Territory:

> “If you have a digital element, you have to have your data on your phone and your phone charged for it to work and for you to receive that, which isn't always the case.” (S34,35,36,37)

Step up to the NDIS

Supported access to the NDIS was viewed as important because some people who enter through foundational supports would need the NDIS. It was felt that this should be a service offered under foundational supports because they were best placed to know the individual, understand their psychosocial needs and to support them to gather the information needed to make an NDIS application that had more likelihood of success. This would also address problems where people were paying large amounts of money to get access to documentation to prove eligibility.

Data collection methods and interview participants

This research was funded by the Australian Research Council through an Industry Laureate Fellowship held by Professor Jen Smith-Merry at the University of Sydney. These interviews were part of a broader set of data collection which has included 50 NDIS participants and carers and a national survey of 1600 people across Australia. That data will be published elsewhere. Ethics approval for the interviews was gained from the University of Sydney.

Data on foundational supports were collected through semi-structured interviews which focused on a range of topics related to the support of people with severe mental illness in relation to the NDIS and potential policy responses related to gaps in support. Interview participants were contacted to participate in several ways: 1) via our project advisory group who passed on details of the study; 2) via known contacts in the sector who we felt would have enough understanding to be able to give a view on the topic; 3) public advertising via social media and on our website; 4) via snowballing where existing interview participants passed on details of the study to people they knew. Jen Smith-Merry conducted all interviews and carried out the thematic analysis, which was checked by another member of the team, Joel Hollier.

Interviews were conducted either in person or via zoom and transcripts were professionally transcribed before being sent to all interview participants to make changes if they wished. Data were then thematically analysed using an open coding scheme with data brought together under relevant topics according to the main themes identified.

Interview participants

Table 1 below provides a list of all of the interview participants, the states and territories they were based in and the roles that they have in the sector that they were speaking from in the interviews. As this shows, participants came from all states and territories except Tasmania and included people working in rural, regional and remote areas. The interview participants included First Nations individuals. As with all research interviews will always be limited by the individuals who chose to be interviewed and therefore do not represent the full cross-section of stakeholder groups. The interviews took place between February and June 2025 and stopped when 1) there was limited additional data being generated by the interviews and 2) there was a need to bring together the existing results for publication. All interview participants were happy to be contacted again for further research so we will come back to them as policy changes occur in order to understand perspectives on these changes.

Table 1: Interview participants, roles and locations

Identifier	Role	State - regional/rural/remote
S1	Independent lived experience advocate, NDIS participant	SA
S2	NDIS provider, lived experience	QLD
S3	Allied health NDIS provider, advocate	Vic
S4	Allied health provider and peak body representative	QLD
S5	Independent lived experience advocate, NDIS participant	Vic - rural
S6	Allied health provider and peak body representative	SA
S7	Allied health NDIS provider	QLD
S8	Allied health NDIS provider	QLD - regional
S9	Academic researcher, NDIS expertise	Vic
S10	Allied health NDIS provider	Vic
S11	Allied health NDIS provider	QLD
S12	NDIS service provider	SA
S13	Federal government policy	ACT
S14	Federal government policy	ACT
S15	Federal government policy	ACT
S16	Allied health NDIS provider	NSW - regional
S17	Allied health NDIS provider	QLD
S18	Allied health, behavioural support, NDIS provider	Vic - rural
S19	Lawyer	QLD - regional
S20	NDIS service provider	Vic
S21	Allied health NDIS provider	QLD
S22	NDIS housing service provider	NSW
S23	NDIS service provider	Vic
S24	Allied health NDIS provider	NSW
S25	Mental health peak body representative	Vic
S26	Mental health peak body representative	NT
S27	Mental health peak body representative	ACT
S28	Advocacy organisation	QLD
S29	Advocacy organisation	QLD
S30	Mental health peak body representative, carer representative	WA
S31	Mental health peak body representative	WA
S32	NDIS service provider	NT
S33	NDIS service provider	NT
S34	NDIS service provider	NT - remote
S35	NDIS service provider	NT - remote
S36	NDIS service provider	NT - remote
S37	NDIS service provider	NT - remote

Contact

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For more information on the project in general please visit our website: **Fixing the NDIS for People with Psychosocial Disability**

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