Targeted foundational supports for people with psychosocial disability outside of the NDIS:

Model background and rationale

Authors: Jennifer Smith-Merry, Bernie Mullin, Joel Hollier, Firew Bobo and Jade Chang

Centre for Disability Research and Policy, University of Sydney

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To provide feedback/ receive further information on the project please email: **mh-ndis.project@sydney.edu.au** and please indicate if you wish to be added to the mailing list.

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Purpose of this paper

This paper provides further background and rationale for a proposed model for delivering targeted foundational supports for people with psychosocial disability who are outside the National Disability Insurance Scheme (NDIS). This paper supplements the summary paper[1] by outlining key elements of available research and data that informed the development of this model. The model is described in brief in Appendix A, but this document should ideally be read in conjunction with the summary document which provides more detail.

The aim of our work on foundational supports was to offer a targeted foundational supports model derived from a research perspective, to inform government policy making and the wider mental health and disability sector's approach to foundational supports. Importantly, it was not designed to be *the only answer* to foundational supports but should be considered as one of a range of perspectives from across the sector. This model is only co-designed to the extent that there are members of the research team with lived experience. It has not been co-designed more broadly than this.

The model is primarily derived from research undertaken at the Centre for Disability Research and Policy (CDRP) at the University of Sydney though the Australian Research Council-funded Industry Laureate Fellowship (IL230100154) held by Professor Jen Smith-Merry. Overall, the research program aims to address serious deficits in the operation of the NDIS for one of its largest participant groups: people with psychosocial disability. It also aims to improve the provision of supports for people with serious mental illness outside of the NDIS, building on findings from primary and secondary research.

The full program of work is available on the project website: *Fixing the NDIS for People with Psychosocial Disability*. The foundational supports model has been informed by the following

- Equity analysis of National Disability Insurance Scheme (NDIS) access and characteristics of people with PSD outside of the NDIS
- Large survey (1600+) of NDIS participants, others with serious mental illness and community members on proposed NDIS changes
- A scoping review of Partners in Recovery literature
- A review of literature relating to support coordination and recovery coaching in the NDIS context
- 85 interviews with NDIS participants, family members and 'stakeholders'
- Consultation with First Nations communities conducted by our community-based First Nations researcher
- A scoping review of community-based psychosocial supports

Please note that our background data here is limited by some full data used to support the foundational support model being currently under review for peer-reviewed publication. We will release the peer reviewed publications via the above link and our newsletter as they become available. The email address to be placed on our newsletter mailing list is: mh-ndis.project@sydney.edu.au

The development process has also involved reviewing past programs for the target group, a workshop on early intervention with sector experts, visits to mental health psychosocial services, meetings with NGOs and sector stakeholder groups and discussion and feedback on earlier versions of the model by critical friends.

[1] Smith-Merry, J., Mullin, B., Hollier, J., & Bobo, F. (2025). *Targeted foundational supports for people with psychosocial disability outside of the NDIS: model proposal v5*. https://www.sydney.edu.au/medicine-health/our-research/research-centres/centre-for-disability-research-and-policy/research/fixing-the-ndis-for-people-with-psychosocial-disability.html

We aim for feedback on the model which we will use to consider the future directions of research to support the development of foundational supports. Appendix B contains comments received from earlier versions of the model or are considered outside of scope.

Why do we need ‘foundational supports’ which target psychosocial disability?

There has been long-standing concern about a lack of coordinated supports for people who experience significant impairments related to mental health conditions. This group has been referred to as people with ‘serious mental illness’ or ‘psychosocial disability’. Following the introduction of the NDIS, the term ‘psychosocial disability’ has been increasingly used. It is the term that mental health consumers and carers use to describe the disability experience of people with impairments and participation restrictions related to mental health conditions.[2] It is distinct from ‘severe mental illness’ as not all people with a mental illness will experience functional impacts or barriers to participation. We also use this term here because it combines an understanding of the disabling impact of mental health conditions for some people who need a high-level of supports in the community to support their inclusion, but we acknowledge the deficits in this and other terminology we use. For this group support has been “fragmented and chaotic” (Rosenberg and Harvey, 2021)[3] and this has been of significant concern for successive governments for a long time (e.g. Department of Health and Ageing, 2012 in Smith-Merry et al, 2015)[4] despite the introduction of major reforms such as the NDIS.

Current government-funded nationally available programs outside the NDIS, such as Better Access, do not effectively target this group and previous programs that worked were defunded to pay for the NDIS (e.g. Partners in Recovery) (Rosenberg and Hickie 2019; Smith-Merry et al, 2018)[5]. However, many of the people who received support from those programs didn’t make it into the NDIS (Hancock et al, 2019)[6] as they were not able to meet permanency criteria or other elements of eligibility requirements. It is also important to note that the NDIS was never meant to meet the needs of everyone (Olney et al 2022)[7]. However, with the defunding of existing programs to fund the scheme many people were left without necessary supports. The NDIS did not address fragmentation and gaps but added to them for a significant group of people. When Foundational Supports were introduced into the NDIS Review it was in part an attempt to address these gaps outside of the NDIS for this group.

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[2] National Mental Health Consumer & Carer Forum. (2022). *Position Statement on Psychosocial Disability Associated with Mental Health Conditions*. https://nmhccf.org.au/our-work/nmhccf-library/position-statements?layout=default

[3] Rosenberg, S., & Harvey, C. (2021). Mental Health in Australia and the Challenge of Community Mental Health Reform. *Consortium Psychiatricum*, *2*(1), 40–46. https://doi.org/10.17816/CP44

[4] Smith-Merry, J., Gillespie, J., Hancock, N., & Yen, I. (2015). Doing mental health care integration: a qualitative study of a new work role. *International Journal of Mental Health Systems*, *9*(1), 32.

[5] Rosenberg, S. P., & Hickie, I. B. (2019). The runaway giant: ten years of the Better Access program. *The Medical Journal of Australia*, *210*(7), 299-301; Smith-Merry, J., Hancock, N., Gilroy, J., Llewellyn, G., & Yen, I. (2018). Mind the gap: the national disability insurance scheme and psychosocial disability. Centre for Disability Research and Policy: The University of Sydney.

[6] Hancock, N., Gye, B., Digolis, C., Smith-Merry, J., Borilovic, J. & De Vries, J. (2019). Commonwealth Mental Health Programs Monitoring Project: Tracking transitions of people from PIR, PHaMs and D2DL into the NDIS. Final report. The University of Sydney & Community Mental Health Australia, Sydney.

[7] Olney, S., Mills, A., & Fallon, L. (2022). The Tier 2 tipping point: access to support for working-age Australians with disability without individual NDIS funding. *Melbourne Disability Institute, University of Melbourne ISBN*, *978*(0), 7340.

What are targeted foundational supports for psychosocial disability?

'Psychosocial supports' are defined by the Commonwealth Government[8] as "non-clinical community-based supports that aim to facilitate recovery in the community for people living with mental health challenges – through a range of services to help people manage daily activities, rebuild and maintain connections, build social skills and participate in education and employment." Appendix D contains a list of types of psychosocial supports based on our scoping review of evidence-based, community-based psychosocial supports and Appendix E contains the list of example activities under the Commonwealth Psychosocial Support program guidance.

'Foundational supports' was a phrase introduced by the NDIS Review (2023)[9] to highlight the need to create a unified ecosystem of supports for every Australian with disability, adapting the previous terminology. The NDIS Review report describes the 'foundation' in the following ways:

> "We believe the term foundational supports best describes what they are — the supports that offer people with disability a foundation to live a good life, included in the community, regardless of whether they are in the NDIS or not. Foundational supports are essential to a joined-up disability support ecosystem that ensures people with disability inside and outside the NDIS can access the right support at the right time and place". (p54)
>
> "This should be made up of inclusive and accessible mainstream services, a thriving foundational support system for all people with disability, and a reformed participant pathway in the NDIS for those needing individualised budgets." (pii)

Originally, in 2011 the Productivity Commission identified 3 tiers of support in relation to the NDIS, of which foundational supports most closely aligned with 'Tier 2 supports'. Tier 1 was for all Australians (who would be insured against the costs of a permanent and significant disability); Tier 2 was for people with disability who did not need a NDIS plan and encompassed general information, community awareness building and referrals to mainstream non-NDIS services; and Tier 3 was for eligible individuals to receive a funded, individualized support package. In 2015 all governments agreed to rename Tier 2 as Information, Linkages and Capacity Building (ILC) [10]. However it has been widely felt that the ILC as implemented was not living up to these aims.

Appendix C contains Figure 1 from the NDIS Review (2023) and the glossary with the definitions of general and targeted foundational supports. General foundational supports were envisioned to assist all people with disability and targeted foundational supports aimed at people outside the NDIS who are in most need of additional support. The NDIS Review specifically referred to the need to develop targeted Foundational Supports for psychosocial disability. It also implies the existence of targeted supports as people need to step down into targeted supports when potentially 'stepping down' from a reconceptualized 'early

[8] Australian Government Department of Health and Ageing (2025). Commonwealth Psychosocial Support Program guidance. https://www.health.gov.au/resources/publications/commonwealth-psychosocial-support-program-guidance?language=en

[9] Commonwealth of Australia Department of the Prime Minister and Cabinet. (2023). *Working together to deliver the NDIS, Independent Review into the National Disability Insurance Scheme, Final Report*. https://www.ndisreview.gov.au/sites/default/files/resource/download/working-together-ndis-review-final-report.pdf

[10] Ibid. Glossary, p. 293

intervention' stream for psychosocial disability within the NDIS. What is not clear in existing government advice or documentation is whether general foundational supports are also envisioned to be psychosocial disability specific (at least in part), or whether most supports are best considered as part of targeted psychosocial supports to create more seamless and person-centred experiences. This needs to be further clarified by government in order to ensure that the range of needs are met across system offerings and gaps don't continue.

The 'Target Group'

It is important that the group to which targeted foundational supports is aimed is broadly defined to include anyone living with mental health challenges, experiencing severe functional impairments and barriers to participation, and likely to benefit from support services. This paper does not attempt to further quantify the population with psychosocial disability who would be considered eligible for targeted foundational supports but summarises data currently available.

Accurately describing the target population is challenging given the source data and assumptions required, including the use of 'expert opinion' to inform service needs. To do so we considered: 1) the data from the Analysis of Unmet Need (2024)[11], 2) people receiving a Disability Support Pension for a mental health condition and 3) people who are currently receiving individualised funding through the NDIS for a psychosocial disability. These groups either specifically or implicitly define a population that has both mental health challenges and is experiencing severe functional impairments and barriers to participation.

We did not specifically review the current national surveys of health and disability that collect population level estimates of mental health conditions and functional impairment but that is the subject of ongoing work via a separate aspect of our research and we will release data from that report in the future. What we can say from that work is that inconsistent definitions and data on mental health and psychosocial disability across national health and disability surveys contribute to the difficulty of estimating 'need' and identifying the target group. In addition, these datasets do not align with the goal of achieving equal participation and inclusion for people with psychosocial disability. This needs to be considered when describing the population, given Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities.

Moving forward, understanding the target group and ensuring that we can accurately estimate the demographic dimensions of the target population is important for ensuring that there is equity of access to foundational supports.

National Mental Health Service Planning Framework and Planning Support Tool

The Analysis of Unmet Need (2024) estimated need based on the National Mental Health Service Planning Framework (NMHSPF) and Planning Support Tool (PST). [12] This is a high-level planning tool that considers population prevalence by severity of mental illness, estimated need and demand, support intensity and duration, staffing, and caseloads to calculate service capacity. Using this tool, a mental illness is considered severe where it is associated with significant disability and severe and ongoing functional impairment. The prevalence of mental disorders for adults was based on the Global Burden of Disease prevalence estimates, with various adjusters based on survey data. Impairment levels were categorized

[11] Health Policy Analysis. (2024). Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme Final Report. https://www.health.gov.au/resources/publications/analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme-final-report
[12] Diminic, S., Gossip, K., Page, I., & Comben, C. (2023). *Introduction to the NMHSPF June 2023-V4.3*. https://www.aihw.gov.au/nmhspf/support-material/general-documentation

using survey data and the World Health Organization's Disability Assessment Schedule (WHODAS) with low (>10-15) and high impairment (>15) scores. Relevant diagnoses for severe mental illness typically include psychotic disorders such as schizophrenia, bipolar and related disorders, severe and persistent anxiety or mood disorders and borderline personality disorder.

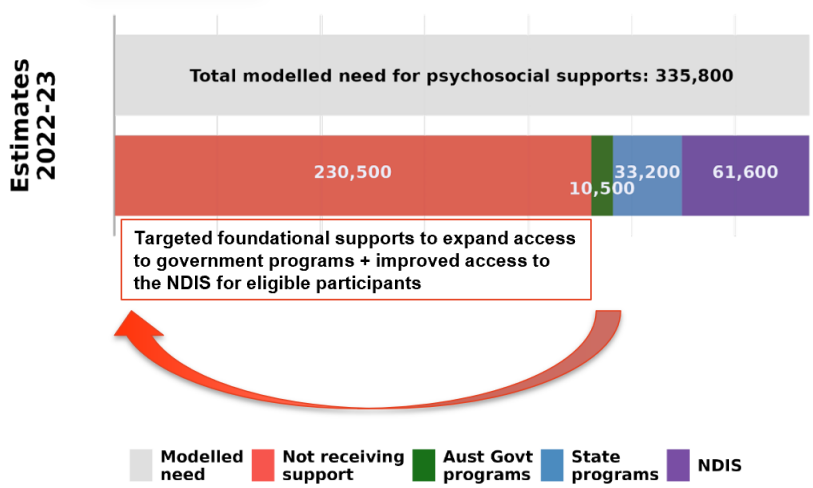
As a tool, the NMHSPF was originally designed for mental health service planning and with a health sector lens rather than an approach aligned with the United Nations Convention on the Rights of Persons with Disabilities. The service elements contained within the NMHSPF classify specialised mental health community support services at an aggregate level across four support categories (Group Support and Rehabilitation Services, Individual Support and Rehabilitation Services, Other Residential Services and Family and Carer Support). As academic research teams are not permitted users of the NMHSPF we could not use it in our own estimations of need, so have relied on the Analysis of Unmet Need report.

The analysis estimated there were 335,800 people, aged 12-64 years, living with severe mental illness and 311,500 living with a moderate mental illness in Australia in 2022-23. Only a very small proportion were having any support needs met through existing government funded programs, with 61,600 people on the NDIS for psychosocial disability, 33,200 people receiving services through state and territory programs and 24,000 though Commonwealth programs such as the Commonwealth Psychosocial Support Program (CPSP).

We consider that the highest demand for foundational supports would come from people with severe mental illness and significant, ongoing functional impairment—approximately 230,500 people, accounting for 83% of support hours (average of 61.0 hours each per annum). The 263,100 people with moderate mental illness requiring fewer hours of support (average 10.5 hours per person). The report did not describe the specific characteristics of the cohort requiring support (e.g. what their support needs were likely to be beyond having needs that were unmet).

Figure 1 below shows the estimates psychosocial need, service provision and unmet need for people with severe mental illness aged 12-64 years from the Analysis of Unmet Need (2024). This demonstrates the large cohort of people who are missing out and the challenge of extending psychosocial supports through providing foundational supports or improving access to the NDIS. In this report the target groups are only further described at the state and territory level and whether the population had severe or moderate mental illness.

Figure 1: Estimates of psychosocial need, service provision and unmet need for people with severe mental illness aged 12-64 years[13]



[13] Health Policy Analysis. (2024). Analysis of Unmet Need, p. 10

The Analysis of Unmet Need (2024) and the Australian Health Ministers response[14] also acknowledge limitations in this method of identifying the need for psychosocial support:

- The estimates are derived from a health sector perspective instead of a rights-based approach that considers lived experiences.
- It presumes that individuals who receive services have their needs met.
- There are recognised limitations in the data collection given the reliance on a multitude of different administrative data source. The tool was derived using historical survey data and expert opinion.
- It does not include important programs operating in some jurisdictions, for example Social and Emotional Wellbeing Programs, which are one of the main ways that psychosocial supports are provided to First Nations communities.

The reported level of unmet need varies over two-fold across states and territories, reflecting both variation in funding levels as well as these challenges of classifying psychosocial support services which are not consistently offered in each state and territory.

Disability Support Pension for a mental health related condition

Given the limited population level data available from the Analysis of Unmet Need (2024) and the recognized overlap between people on the Disability Support Pension (DSP) for a permanent psychological/psychiatric condition and those who require further psychosocial disability supports, we also explored the Disability Support Pension data.

DSP is an income support payment for people who are unable to work for 15 hours or more per week at or above the relevant minimum wage, due to permanent physical, intellectual or psychiatric impairment[15]. A DSP claimant must be aged 16 years or over and under Age Pension age, however once in receipt of DSP, a person can continue to receive DSP beyond Age Pension age. Data on the medical conditions of DSP recipients is recorded by the primary medical condition, and the condition with the highest impairment rating determines which primary medical condition a recipient is recorded under.

The general eligibility definition for DSP is:

> "For the purposes of DSP… a disability is a physical, intellectual or psychiatric impairment." AND
> "For the purposes of DSP, a recipient is severely disabled if the recipient:
> − has a physical, psychiatric or intellectual impairment, or 2 or all of these impairments, which make the recipient:
> a. totally unable to work for at least the next 2 years, and
> b. unable to benefit within the next 2 years from participation in a program of assistance or a rehabilitation program, or
> c. is permanently blind.
> A recipient is accepted as being severely disabled if their impairment prevents them from:
> − doing any work for 8 hours a week or more for the next 2 years, and
> − benefiting from training, education or rehabilitation to the extent of being able to work at least 8 hours a week.
> Note: Recipients who have been accepted as having a manifest inability to work are not necessarily severely disabled. The critical matter is the severity of the condition."[16]

[14] Australian Health Ministers. (2024). Statement from Australian Health Ministers: Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme. https://www.health.gov.au/resources/publications/statement-from-australian-health-ministers-analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme?language=en

[15] Department of Social Services (2025) Disability Support Pension https://www.dss.gov.au/income-support-payments/disability-support-pension

[16] Australian Government. (2014). Guides to Social Policy Law: Social Security Guide Canberra: Australian Government. Retrieved from DSS website: **https://guides.dss.gov.au/guide-social-security-law/3/6/1/40**

To qualify for DSP for a mental health related condition an individual must have a diagnosed mental health condition, including recurring episodes of mental health impairment that cause significant and ongoing impairment in daily functioning, behaviour, and participation in social or work activities. The condition must be medically diagnosed, treated and stabilized, the condition and the resulting impairment is more likely than not to persist for more than 2 years and result in severe or extreme limitations (20 points or more). For example:

> **20 points:** An individual has a **severe functional impact** on their ability to work. Their symptoms are present most of the time and severely limit their ability to perform basic work tasks, maintain social interactions, or manage daily activities without support. They are unable to work more than 15 hours per week in a regular workplace.
> **30 points:** An individual has an **extreme functional impact** on their ability to work. They are unable to function independently in a work environment and require a high level of support in most aspects of daily life.

As at June 2025, those with a primary medical condition classified as psychological/psychiatric were the largest group on the DSP (39% of participants).[17] Appendix F includes the summary data on the number of people on DSP for a mental health condition. There were 283,915 individuals aged 16-64, and a further 96,640 'carer payments' were made linked to care receivers aged under 16 with a psychological/psychiatric condition. DSP payments increase with age, and currently for those aged 16-20 year, 50% are on the DSP for a psychological or psychiatric condition.

NDIS participants with psychosocial disability

People with psychosocial disability who are eligible for the NDIS will not be the primary target group for foundational supports because they can have their needs met through the NDIS. This should not stop them from receiving supports through foundational supports if they choose this as the best way for their needs to be met of if the NDIS is not meeting their psychosocial support needs. Even though they are not the target group in order to understand the boundaries of foundational supports it is important to understand when a person would be eligible for the NDIS and therefore be more likely to have their needs met through that system, rather than receiving foundational support services.

To be eligible for the NDIS, an applicant must provide evidence that they have a permanent disability linked to a psychosocial impairment, the impairment substantially reduces functional capacity to do one or more daily life activities, including moving around, communicating, socialising, learning, undertaking self-care, or self-management tasks, and the permanent impairment affects ability to work, study or take part in social life, and it is likely that NDIS supports will be required for a lifetime. It is also possible to be eligible under separate early intervention criteria if a person has an impairment that is likely to be permanent. [18]

Appendix G has a summary of the NDIS psychosocial participant data from 30 June 2025. [19] There were 65,272 psychosocial participants (9% of all participants). They received an average payment of $88,700 ($383,100 for those in Supported Independent Living (SIL) and $68,100 for participants not in SIL). In addition

- 52% of new psychosocial participants in the previous 12 months were aged 45+ and this age group represented the majority of psychosocial participants (63%) compared to 22% of all participants

[17] Data.gov.au (2025) DSS Benefit and Payment Recipient Demographics. Quarterly data. Expanded DSS Benefit and Payment Recipient Demographics June 2025 https://data.gov.au/data/dataset/dss-payment-demographic-data/resource/c3adb418-d2f9-48a8-bca6-66fa448628e5 Accessed 28 October 2025
[18] National Disability Insurance Agency (2025) Our Guidelines. **https://www.ndis.gov.au/our-guidelines**. Accessed 20 October 2025.
[19] National Disability Insurance Agency (2025) Participant Dashboards: Psychosocial Disability **https://dataresearch.ndis.gov.au/reports-and-analyses/participant-dashboards/psychosocial** Accessed 21 October 2025

- psychosocial participants were more likely to have a lower functional capacity than all participants (92% had medium or low functioning compared to 65% of all participants)
- 72% live in major cities, 9% were first nations and 13% culturally and linguistically diverse
- 49% of current NDIS payments to this group are for daily activities and 34% supporting community access
- 25% of applicants (2,825) met access criteria in the year ending 30 June 2025 compared to 80% for all participants (95,454)

In the latest data available from June 2023, AIHW reported that half of NDIS participants with a psychosocial primary disability (50%) had a primary mental health condition of schizophrenia, followed by bipolar affective disorder (9.7%) and major depressive illness (8.6%) with the remaining record as 'Other'.[20]

Summary
It is clear that across Australia there are many people living with psychosocial disability, and most are not receiving government funded psychosocial support services. It is difficult to provide an accurate estimate of the target group at a population level. but it is likely that there are at least 200,000 people who might benefit from increasing the availability of targeted foundational supports.

In summary:

- For 2022-23, the Analysis of unmet need (2024) identified that there were 547,300 people in Australia living with a severe or moderate mental illness
    - only approximately 118,800 people were receiving services including NDIS supports
    - since then, only 3,672 people have become eligible for the NDIS under a psychosocial disability
    - there are no updated national data on the number of people receiving services through other government programs and little progress with implementing foundational supports
- Currently there are 283,000 people on the Disability Support Pension with a mental health condition, which is likely to underestimate the group of people who might benefit from psychosocial support services, given the additional non-health criteria.
- There is widespread consensus that the NDIS is not accepting people with psychosocial disability commensurate with need, given the majority of new and current participants are aged over 45, despite mental illness commonly presenting at a younger age and the level of functional impairment is more severe than for any other disability type.

Cost, Funding and Commissioning arrangements

Cost

The only estimation of cost of we have for foundational supports comes from an analysis of the implementation of Partners in Recovery (2014-2015) which found that the "The total cost of providing the service for a consumer per year (set-up and ongoing) was estimated to be AUD$15,755 and the ongoing cost per year was estimated to be AUD$13,434…". [21]. This is a per-participant amount averaged out from a cost (in 2014) of $1,328,419 per Medicare Local (later PHN) site. The PIR model bears a strong resemblance to the model developed through this work so is the closest estimate of an actual retrospective

[20] Australian Institute of Health and Welfare (2025) Psychosocial Disability Support **https://www.aihw.gov.au/mental-health/topic-areas/community-based-services/psychosocial-disability-support** Accessed 27 Aug 2025
[21] Isaacs AN, Dalziel K, Sutton K, Maybery D. Referral patterns and implementation costs of the Partners in Recovery initiative in Gippsland: learnings for the National Disability Insurance Scheme. Australasian Psychiatry. 2018;26(6): p.587

review of cost for an existing program in Australia. Other costing of more limited national programs provided a lower cost estimates: Day2Day Living ($2,421); PHaMs ($7,208). [22]

Funding

Detailed funding mechanisms are expected to rely on ongoing Commonwealth and State/Territory agreements. We do not have enough existing public information about these agreements available to be able to provide a full consideration of funding mechanisms. The recent Productivity Commission review of the Mental Health and Suicide Prevention Agreement recommended in an Interim Report that governments should immediately work to resolve the commissioning and funding responsibilities for psychosocial supports outside the National Disability Insurance Scheme. [23] Specifically, the next agreement should:

- confirm the roles and responsibilities for psychosocial supports and the funding split between the Australian, state and territory governments
- include Australian Government funding to the state and territory governments to help cover the shortfall in support
- include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030. (Draft Rec 4.4, p22)

The report also stated that:

> *'…the analysis of psychosocial support services outside the National Disability Insurance Scheme (NDIS) was done at a high level and does not provide guidance on the regional gaps that need to be addressed' (p7).*
>
> *'PHNs currently commission some psychosocial supports and have experience and existing relationships; they are well placed to work with state and territory governments and providers to support this expansion and transition' (p10).*

We agree with this latter statement because it is important to utilise an existing national infrastructure as the common vehicle for a standardised approach to regional commissioning. This does not mean that each PHN area should be funded equally. To avoid this and a 'post code lottery' regional population-based funding allocations should be based on:

- The level of current investment and unmet need
- The existing supply and coverage of services (including those already funded by Commonwealth and State/Territory governments, or delivered through NGOs and private providers)
- Socio-demographic characteristics of the population (e.g., culturally diverse communities, Aboriginal and Torres Strait Islander peoples, rurality, and other social determinants of health)

Allocating funding across services and programs should occur on the basis of local needs assessment including consideration of the services required by individuals with a psychosocial disability to support equal participation and inclusion. A sustainable approach to funding must be needs-based, flexible, and locally tailored, recognising diverse demographics and mental health needs. Recommendations for this, based on the Nous evaluation include[24]:

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[22] Nous Group 2021, Evaluation of National Psychosocial Support Programs: Final Report https://www.health.gov.au/sites/default/files/documents/2022/04/evaluation-of-national-psychosocial-support-programs-final-report-evaluation-of-national-psychosocial-support-programs-report.pdf p106-107.

[23] Productivity Commission 2025, Mental Health and Suicide Prevention Agreement Review, Interim report, Canberra, June

[24] Nous Group 2021, Evaluation of National Psychosocial Support Programs: Final Report https://www.health.gov.au/sites/default/files/documents/2022/04/evaluation-of-national-psychosocial-support-programs-final-report-evaluation-of-national-psychosocial-support-programs-report.pdf

- Longer-term (five-year) program funding for stability and certainty
- Access to innovation funding and communities of practice
- Program funding tailored to the higher costs of service delivery in regional, rural, and remote areas.

Relational Contracting and Commissioning

A recent report on 'Collaborative Commissioning and Formal Relational Contracting from the Melbourne Disability Institute[25] recommended that the Productivity Commission Final Report on Delivering quality care more efficiently include two additional recommendations: (1) strengthening collaborative commissioning practices, and (2) embedding formal relational contracts into public service procurement frameworks. Relational commissioning is an approach to public service design and delivery that emphasizes long-term, trust-based partnerships between commissioners and providers to collaboratively achieve shared outcomes.

Relational commissioning, in the context of the Considine et al (2025) recommendations, is relevant and important for foundational supports given the challenges of commissioning foundational supports exemplifies the scenarios where service commissioning is problematic, namely where:

- there is no abundance of high quality service providers;
- the outcomes being sought are not easily specified;
- the purchaser will have very limited means to improve system-wide quality given that they are not familiar with the details of service delivery and therefore become more focused on milestones and payments and transaction based reporting; and
- the assessment of public value is very limited without consideration of factors such as unintended consequences or cost-shifting.

They recommended that

1. Formal Relational Contracts should be trialled with a view to being adopted widely as the default position in the care economy where the services are complex and the outcomes are difficult to measure.
2. Collaborative Commissioning is most likely to deliver the expected benefits if these arrangements embrace Formal Relational Contracts and so Formal Relational Contracts should be a first step towards Collaborative Commissioning.

In the context of targeted psychosocial foundational supports commissioning of services should also be informed by:

- Existing data such as the Analysis of Unmet Needs report and additional analyses as needed (e.g. social and emotional wellbeing programs in the Northern Territory, existing programs run through individual local health districts)
- Mapping of existing service providers (including public, NGO, and private entities) and assessment of their capacity to deliver psychosocial supports
- Gap analysis for specific services or population subgroups
- Potential for service integration and partnerships in each locality, including place-based commissioning.

[25] Considine, M. B., B. Olney, S. Deane, K. (2025). *Formal Relational Contracts and the Commissioning of Complex Public Services Position Paper*.

Foundational support interfaces

Interface with the NDIS

The NDIS Review[26] recommended that all Australian governments should prioritise foundational supports for people with psychosocial disability, recognising that the NDIS was not designed to meet the needs of most people with psychosocial disability. People with permanent ongoing needs that are best met through an individualised funding package would be supported to apply to the NDIS. Once foundational supports are more available it is expected there will be a reduction in unsuccessful applications to the NDIS and the opportunity for people to access more effective locally coordinated services. Without foundational supports the NDIS growth targets are not likely to be achieved and the NDIS will remain 'the only port in the storm'.

The NDIS will continue to be available for some people with psychosocial disability where this is the best funding mechanism, however packages may be scaled down where services are best provided through local foundational support organisations, as determined by individuals themselves. Choice and control for selecting providers should remain with NDIS participants as part of individual planning.

People eligible for the NDIS, with evidence of permanent psychosocial disability, may also choose to access foundational supports without affecting their NDIS eligibility (e.g., by having a zero-dollar NDIS plan, by having a reduction in their NDIS plan using a process similar to that already occurring where NDIS participants are also receiving compensation arrangements for personal injury.[27]

Interface with clinical services

Mental health recovery requires both optimal clinical management of mental health challenges and access to high quality psychosocial support services.

As stated in the NDIS Review (2023), all Australian governments should improve access to mental health services for people with severe mental illness and strengthen the interface between mental health systems and NDIS. Foundational supports require a combined person-centred approach, that intentionally combines clinical and psychosocial supports to provide wrap-around services that facilitate clinical and functional recovery[28].

Our review of Commonwealth commissioned reports found there was a great deal of consistency around the theme of strengthening interfaces and reducing silos through improved intra and intersectoral working. Particularly, the requirement to improve the interoperability of the health and disability systems for people with psychosocial disability is evident. Although reviews have been commissioned by different sectors, they include findings and recommendations across sectors and at times only include data from one funding stream when both are relevant. The Analysis of Unmet Need (2024) does not measure psychosocial supports delivered in the health sector through community mental health settings.

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[26] Commonwealth of Australia Department of the Prime Minister and Cabinet. (2023). *Working together to deliver the NDIS, Independent Review into the National Disability Insurance Scheme, Final Report*. https://www.ndisreview.gov.au/sites/default/files/resource/download/working-together-ndis-review-final-report.pdf

[27] National Disability Insurance Agency (2025) Recovery compensation reduction amounts and special circumstances. https://www.ndis.gov.au/participants/compensation-and-your-plan/recovery-compensation-reduction-amounts-and-special-circumstances

[28] Hancock, N., Smith-Merry, J., Gillespie, A., Islam, M. R., Yen, I., & Wells, K. (2023). Community-based models of care facilitating the recovery of people living with persistent and complex mental health needs: a systematic review and narrative synthesis. *Frontiers in Psychiatry*, *14*, 1259944.

The Nous Evaluation (2021) provides a psychosocial support integration framework (section 6.5) that outlines the 'multiple dimensions of integration that can support the delivery of consumer-focused psychosocial support services'. This covers integration of services (e.g. NDIS and state-based psychosocial supports programs); stakeholders driving integration (e.g. PHNs and State/Territory governments); integrating aspects of care and support (e.g. assessments and care pathways); and using levers to support integration (e.g. aligned funding, commissioning and governance).

Implementation and evaluation of foundational support programs

An incremental implementation strategy should be adopted on a trial site basis. This process should encompass PHNs that are both well-established and those requiring additional support, as well as including various population sub-groups and diverse geographical locations. Such an approach will facilitate a comprehensive understanding of the support necessary for successful establishment.
Delivering value and achieving outcomes will require ongoing evaluation, including local data collection, comparative national data analysis and data linkage, with transparent reporting.

Our review of Commonwealth commissioned reports shows that these reports have provided many recommendations for improving the implementation of areas relevant to foundational supports: most importantly the need for a clear program logic outlining how supports should work and the links between inputs, activities, outputs and expected outcomes. The suggested enablers include

- Funding cycle for psychosocial supports should be a minimum of 5 years (Mental Health Report, 2020; Nous Evaluation, 2021).
- Longer lead-times for implementation to increase effectiveness (Nous Evaluation, 2021).
- Increasing transparency and effectiveness of governance arrangements including lived experience and provider input (Mental Health and Suicide Prevention Agreement Review Interim Report, 2025; Nous Evaluation 2021).
- Updating the taxonomy used to describe psychosocial support services with improved classification (Analysis of Unmet Needs, 2024).
- Improving source data, service activity reporting and supplementing data with consumer surveys (Mental Health Report, 2020; Nous Evaluation, 2021; Analysis of Unmet Needs, 2024; Mental Health and Suicide Prevention Agreement Interim Report, 2025).
- Build on the evaluation framework and guidelines (Mental Health Report, 2020; Nous Evaluation 2021;, Mental Health and Suicide Prevention Agreement Interim Report, 2025).
- Dedicated funding for collaborative initiatives and enablers of collaboration (Mental Health and Suicide Prevention Agreement Interim Report, 2025).
- Providing PHNs with access to a funding pool to support innovative commissioning and communities of practice (Nous Evaluation, 2021).
- Program funding to consider the increased costs of service delivery in regional and remote areas and in Aboriginal and Torres Strait Islander communities (Nous Evaluation, 2021).
- Clarifying funding for carer and family supports (Mental Health and Suicide Prevention Agreement Interim Report, 2025).
- A standardised intake and assessment tool measuring psychosocial function, to support step-up or down, recovery and encourage independence (Nous Evaluation, 2021).
- A fit for purpose outcomes assessment tool (Nous Evaluation, 2021).
- Streamlining funding streams into one single-recovery oriented program with wide promotion, common branding and clear description of services (Nous Evaluation, 2021).
- Workforce incentives to maintain a stable workforce (Nous Evaluation, 2021).

- Funding for NDIS testing (Nous Evaluation, 2021).
- Programs that are consumer-centred and co-designed, recovery-oriented, with flexible tailored support, accessible and stable, smooth transitions (Nous Evaluation, 2021).

Summary of project research reports drawn on for this model

The **'Fixing the NDIS**' research team is using an iterative approach to develop its research program, with the research aims evolving as challenges are identified and the sector seeks evidence to support policy decisions. This section provides a summary of the reports currently available on the project website. Other publications are in the process of peer review and will be shared via the website when available. As described above some results that the foundational supports model relies upon are not yet released, but will be released on our website as peer review is completed.

a) Qualitative interviews with sector stakeholders

Data on foundational supports were collected through semi-structured interviews with stakeholders between Feb and June 2025. Interviews involved 37 participants from across Australia, including NDIS advocates, NDIS service providers including allied health and housing providers, federal government policy makers and representatives from NGOs and mental health peak bodies at national and state/territory levels. The interviews 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. The full results are available on the project website[29].

Key findings were that while there was confusion about what foundational supports would look like in practice, they were seen as a way of addressing many of the problems of the NDIS, including the lack of access by people with severe mental illness. A strong conceptual framework for the design of the model was articulated to include:

- 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

[29] Smith-Merry, J. M., B. Hollier, J. . (2025). *Targeted foundational supports for psychosocial disability: Evidence from qualitative interviews with sector 'stakeholders'*. https://www.sydney.edu.au/medicine-health/our-research/research-centres/centre-for-disability-research-and-policy/research/fixing-the-ndis-for-people-with-psychosocial-disability.html

b) Survey on community views on psychosocial supports

We conducted an online survey of 1625 people in Australia through May and June 2025[30], asking them about their views on recent and proposed reforms to the NDIS and broader psychosocial supports. Around half of respondents had mental health challenges with 18% on the NDIS for psychosocial disability and 29% outside of the NDIS.

For people with mental health challenges outside the NDIS (n = 464) and carers (n = 69), around two thirds identified unmet needs. In open ended questions, respondents had the highest needs for

- accessing healthcare and therapies (38%)
- getting out of the house to do activities (32%)
- improving relationships with family and/or friends (31%).

These were described as

- psychological supports which provided therapies, counselling, and illness self-management programs to improve executive functioning, and emotional regulation
- psychosocial support for personal recovery and independence (such as capacity-building training, recovery coaching, and peer support),
- daily living supports
- financial and employment supports
- involvement in community and social activities.

Participants were then asked which types of foundational supports they would utilise. The most commonly identified supports were:

- access to a key worker to help navigate systems (49%)
- illness self- management program (39%)
- social and community engagement programs (37%)
- skills and capacity-building support (35%)
- daily living assistance (32%)
- peer and family support (27%)
- employment support services (27%)
- housing assistance (24%).[i]

The full report is available on our project website.

c) Psychosocial Navigator Role: key attributes

The 2023 NDIS Review recommended the introduction of a specialist 'Navigator' role with expertise in psychosocial disability to assist people with disability in a complex support system. A short paper has been published outlining the key attributes of a psychosocial navigator, following a scoping review of the peer-reviewed literature on Partners in Recovery (PIR) and interviews with eighty-six participants, including 30 NDIS participants, 19 carers/informal supports, and 37 'stakeholders'. A longer paper focusing on the navigator role will be released when peer reviewed. Findings are summarised here.

Drawing on this research we found that navigators were viewed as essential for a reformed system of supports for people with serious mental illness across Australia because they would address many of the

[30] Chang, KYJ, J. Hollier, J. Smith-Merry, I. Yen, H. Kim (2025) Beyond the NDIS: Unmet needs, Foundational Supports and system reform for psychosocial disability. Sydney: Centre for Disability Research and Policy, The University of Sydney. https://ses.library.usyd.edu.au/handle/2123/34389

operational issues that people commonly criticise: a lack of personalisation, siloing and systems gaps, and a lack of recovery orientation.

The navigator role centres on supporting individuals with serious mental ill-health through personalised, recovery-oriented, and culturally sensitive approaches that foster independence and community connection. Success in the role relies on strong interpersonal skills, mental health knowledge, and local expertise, with lived experience and formal qualifications both valued but not solely sufficient. They need deep alignment and understanding of the core values and practices of recovery and trauma-focused support. Navigators should be embedded within an organisation able to support them in community-based recovery-oriented practice.

The navigator role was viewed as a generic role rather than a system-specific role; equally useful within the National Disability Insurance Scheme (NDIS) as it was outside of it. An example of a previous, similar role, that had been evaluated as effective for this population in an Australian context was that of the 'support facilitator' within Partners in Recovery (PIR). An example that interviewees gave of a role that did not currently work well was the 'support coordinator' role funded through the NDIS. Evaluation of programs such as PIR which are formed around a navigator-role have shown that they are an effective lower-cost or cost-neutral alternative to moving people into high-cost schemes such as the NDIS.

d) A review of Commonwealth commissioned reports: themes and key findings

This paper, available via a link from our website, presents our synthesis of the key common themes that we considered in the design of the research-based model, from relevant Commonwealth government commissioned reviews and reports, published from 2020 through to June 2025. It focuses on the findings and recommendations from the perspective of government policies, rather than the perspectives of the academic literature and research sector or any critiques of these reports from the broader mental health advocacy and lived experience sectors. Our analysis of these reports found the following key themes running across existing reports:

The level of unmet need for psychosocial support is high, and the target group is people with severe mental illness
There is no debate that there are gaps in psychosocial supports, particularly for people with severe mental illness and significant, ongoing functional impairment. Across Australia there is a diversity in current psychosocial support programs and their funding levels. Given the known challenges in accessing supports through the NDIS, current government programs and mainstream services, it is important that inequities in access are not replicated for accessing foundational supports.

There is a need to strengthen interfaces and reduce silos through improved intra- and inter-sectoral working
There are consistent themes recommending strengthened interfaces and reducing silos through creating a cohesive ecosystem across health, disability and mainstream services. These recommendations range from macro level system changes through consistent policies and shared governance to recommendations focusing on the individual, creating a person-centred approach, supporting individuals to navigate and access through complex systems.

Support for navigation is essential
Specific support for navigation and navigators is recommended to empower consumers to effectively connect through a complex service and funding system. This recognises the challenges that people with psychosocial disability may face and is an approach based on empowering the consumer to have choice and control over their care by enabling them to effectively access the services they need and extends beyond information sharing.

A human rights-based approach is required including inclusion and accessibility to mainstream services
Foundational supports need to be designed so that individuals with psychosocial disability can use the same services and participate in the same activities as others in the community. This requires positive action and early consideration of structural changes to create more inclusive approaches and improved outcomes. This commitment is not only for psychosocial support services but extends to improving access to health and other government funded mainstream services.

Funding is required but remains an area of contention
Commonwealth, State and Territory governments will need to fund additional psychosocial support services supports, given the shortfall in support and unmet need.

Support for implementation and evaluation is essential as part of ongoing governance for effective systems of support
A wide range of enablers are suggested from more effective governance, dedicated funding, standardised tools to more rigorous and ongoing evaluation and data. These recommendations sit alongside the requirement for a clear program logic outlining how foundational supports should work and the links between inputs, activities, outputs and expected outcomes.

e) Research currently under peer review

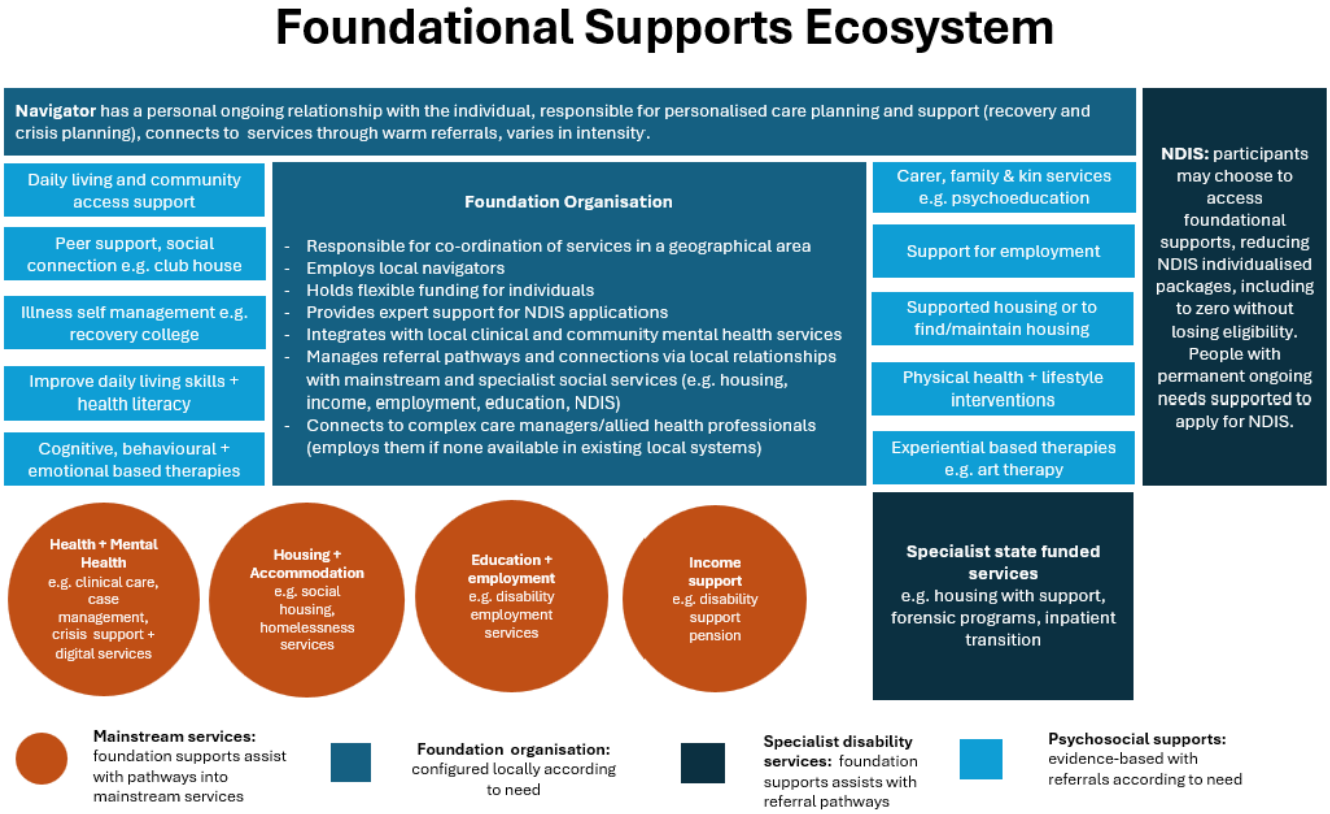
We will release further research underpinning the model as it has been approved for released after peer review. Other reports currently under peer review but where the data were relied upon for our model include:

- A scoping review of evaluations of the Partners in Recovery model of care
- An analysis of NDIS participants' expectations and lived realities of the scheme drawing from interviews with 30 participants and 19 carers/informal supports
- An inequity scoping review
- A scoping review of community-based psychosocial supports (see appendix D for summary of findings)

In addition to these reports we will also be releasing further work currently in preparation for submission for peer review. These focus on releasing quantitative data on NDIS eligibility, forecasts of future mental health population needs and qualitative data relating to support coordination, recovery coaching and navigation. These data have fed into this report and are being finalized for publication so not included here as yet. Research is released here as it becomes available: NDIS Psychosocial Disability ARC Laureate Project

Appendix A: Proposed service model

The model is national in scope and based around a local foundation organisation and a set of core services available in each location.



Core features of the model:

- Foundation organisation with competency in mental health and strong connections to health, disability, community-based supports and communities.
- Navigator role: an intervention in itself to support recovery, as well as a systems connector.
- Access to specialised assessments where needed.
- Flexible funding: for small individual and community-based capacity building where there is not existing facility in the system.
- Referral pathways to mainstream and specialist supports, including specialist referral and application support for NDIS where appropriate.

Key attributes of services:

- A ‘no wrong door’ approach is needed where people are directed to different intensities of support, from information to intensive support.
- Person-centred, recovery-oriented, trauma-informed, human rights-based.
- Equity-oriented in accessing and delivering services, prioritising accessibility for the most disadvantaged.
- Services that are personalised and align with preferences, flexible, and focused on recovery, aligned with a participant’s goals and relevant to their community context.
- Non-health related, based on the Applied Principles and Tables of Support (APTOS) agreed by COAG in 2015. Supports must be most appropriately funded through the foundational supports program and not NDIS or mainstream services.

- The design and configuration of supports should be determined locally, based on evidence of impact (see Appendix D for a list of types of psychosocial supports), participant experience and outcomes, local geography and demographics, and existing services.
- Foundational supports operate separately from, but in collaboration with the NDIS, health services and other mainstream services.
- Once eligible for targeted foundational supports, people should be able to access services at a frequency and intensity that meets their changing needs. Some supports should be available as low-intensity, long-term programs with low barriers to re-entry.

Key elements of model:

(a) *The foundation organisation:* The organisation should have a standard role nationwide, focusing on local service coordination and navigator supervision. It should be well-connected to the local community and health services, possess expertise in psychosocial disability and lived experience, and employ key personnel such as navigators. The organisation would manage flexible individual funding and funds for local community activities where there are gaps. They will provide a 'knowledge network' to assist navigators to source supports.

There are a range of organisations and approaches that could be considered when establishing a 'foundation organisation', each with distinct strengths and limitations depending on the commissioning strategy chosen by governments. PHNs have experience in commissioning psychosocial support services. Their geographical focus and established relationships with local mental health services, providers, and state and territory governments position them well for commissioning and system coordination. Individual providers or consortia of experienced psychosocial support organisations can offer specialised expertise and more hands-on, direct support to participants, but may require additional support from PHNs in their connections to broader system partners. Advocacy organisations bring the advantage of strong lived experience representation, ensuring that the lived experience and perspectives of participants are central to service delivery, though their commissioning experience may vary. Finally, collaborative relational commissioning approaches that combine the reach and local relationships of PHNs with the sector-specific experience of psychosocial support providers and advocates can leverage multiple strengths, potentially facilitating both effective coordination and responsive service delivery. Evaluations of previous programs such as Partners in Recovery have highlighted the potential for PHNs to deliver positive outcomes in diverse community settings when working with locally based consortia[31].

(b) The navigator: Navigators are essential, helping individuals connect with both informal and formal psychosocial, mainstream, and social services (housing, education and employment, financial support) to have psychosocial needs met. They provide basic recovery-oriented interventions, monitor progress, provide regular follow-up, and must be available over time due to the episodic nature of psychosocial disability. The navigator's relationship with individuals, families, carers, and kin is central and at the heart of the role. Navigators need understanding and experience of mental illness and psychosocial disability through training and experience, must receive supervision, and be embedded within a supportive team.

The role is flexible according to need. A navigator may provide basic information or might support a client in developing a personalized crisis plan during a period of instability, or coach someone through the steps to manage their medication regimen after hospital discharge. In other scenarios, a navigator may act as a recovery coach, helping someone set goals for returning to work or facilitating access to community programs tailored to their interests. Navigators should provide information and support in collaboration with

[31] Trankle SA, Reath J. Partners in Recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis. BMC Health Serv Res. 2019;19(1):524; Smith-Merry J, Gillespie J. Embodying policy-making in mental health: the implementation of Partners in Recovery. Health Sociology Review. 2016;25(2):187-201.

NDIA planners and other services where needed. Importantly, this role remains distinct from online and digital navigation initiatives, because of the ongoing personalised recovery-oriented support provided.

(c) Flexible funding: Flexible funding would be held by the foundational organisation.

Flexible funding (individual): This has shown to be useful in past programs (PIR) to meet short term, urgent individual needs that are important for recovery but are not immediately available in existing systems, e.g. emergency support to maintain housing or reports needed for NDIS applications.
Flexible funding (community level): Funding may support short-term activities to promote mental health awareness and inclusion in local communities, especially for cultural groups. Longer-term supports would be commissioned separately.

(d) Standardised assessment: Ongoing assessments of mental health, functional impairment, and social determinants are essential for matching supports and supporting recovery. These can be completed in-house or by community/health specialists and may be funded through flexible funding. Family, carer, and kin needs should also be assessed. A fit-for-purpose tool for intake, outcomes, and stepped care should be developed and aligned with NDIS requirements. [32]

(e) Referral pathways: Depending on individual needs, navigators will be responsible for referring to other psychosocial support programs and mainstream services (e.g. clinical care, housing, employment). These should be provided by organisations with specific expertise and mainstream services should be accessible to people with psychosocial disability.

(f) NDIS application support: If it is identified that someone needs intensive, ongoing support, specialised support should be provided to gather evidence and make a NDIS application to cut down inappropriate or weak applications and reduce cost and administrative burden for services, families and individuals.

(g) Individual coordination: Where more intensive support is necessary (e.g., specialist support for transition from inpatient care or forensic settings, or housing programs such as HASI, NDIS), these should be coordinated to ensure effective step-up and step-down pathways. There should be ongoing coordination with health supports.

(h) Systems coordination: Current Commonwealth guidance includes service navigation as an output, such as providing information and facilitating access for participants, families, and carers, as well as supporting GPs, service providers, and local hospitals. System-level navigation improvements should be the responsibility of commissioning bodies, while foundational organisations provide direct participant information.

(i) Digital supports: Evidence-based digital supports should be available nationwide, for example by utilising SANE's digital navigation tool[33] and navigators should be knowledgeable about these options.

(j) Closing the gaps: A community-based approach for Aboriginal and Torres Strait Islander people should be adopted, including connections to social and emotional wellbeing programs, housing, employment, income, and Closing the Gap initiatives.

k) Reducing inequities: Given the link between social determinants and mental health, particularly for groups exposed to a multitude of intersecting social risk factors, specific interventions need to be in place to ensure that there is equity of outcome and this is considered when designing access and service provision.

Interface with NDIS

The NDIS Review recommended that all Australian governments should prioritise foundational supports for people with psychosocial disability, recognising that the NDIS was not designed to meet the needs of most

[32] Nous Group 2021, Evaluation of National Psychosocial Support Programs: Final Report https://www.health.gov.au/sites/default/files/documents/2022/04/evaluation-of-national-psychosocial-support-programs-final-report-evaluation-of-national-psychosocial-support-programs-report.pdf p124
[33] SANE (2025) Digital Navigation Project. https://www.sane.org/digitalnav

people with psychosocial disability. People with permanent ongoing needs that are best met through an individualised funding package would be supported to apply to the NDIS. Once foundational supports are more available it would be expected there would be a reduction in unsuccessful applications to the NDIS and the opportunity for people to access more effective locally co-ordinated services. Without foundational supports the NDIS growth target of 6% is not likely to be achieved and the NDIS will remain 'the only port in the storm'.

The NDIS will continue to be available for some people with psychosocial disability where this is the best funding mechanism, however packages may be scaled down where services are best provided through local foundational support organisations, as determined by individuals themselves. Choice and control for selecting providers should remain with NDIS participants.

Interface with clinical services

As also noted in the NDIS Review, all Australian governments should improve access to mental health services for people with severe mental illness and strengthen the interface between mental health systems and NDIS. Foundational supports require a combined person-centred approach, that intentionally combines clinical and psychosocial supports to provide wrap-around services that facilitate clinical and functional recovery.

Implementation and evaluation of foundational support programs

An incremental implementation strategy should be adopted on a trial site basis. This process should encompass a range of PHNs including those requiring additional support for commissioning services, as well as including various population sub-groups and diverse geographical locations. Such an approach will facilitate a comprehensive understanding of the support necessary for successful establishment.

Delivering value and achieving outcomes will require ongoing evaluation, including local data collection, comparative national data analysis and data linkage, with transparent reporting.

Appendix B: Summary of feedback

This feedback has been collected from individuals and organisations through the sharing of draft versions of the foundational supports model. We collect the feedback in order to embed our research-based model in the critiques of those working in the mental health sector and those with lived experience who receive services, or have unmet needs and those that support them. We use this feedback to frame further research. We encourage ongoing critique via email: **mh-ndis.project@sydney.edu.au**

Rationale

- Could strengthen rationale to include consideration of risks such as introducing more bureaucracy, administration, management costs and rationing.
- General foundational supports are unlikely to be developed with psychosocial disability in mind and therefore there needs to be targeted foundational supports.

PHNs

- Are well positioned to commission foundational supports such as navigators but are not suitable in terms of service delivery or individual fund holding in terms of participants - this should sit with navigators.
- Vary in terms of their capacity and understanding of psychosocial supports and complex mental health issue.
- A risk with PHNs is their health focus to the exclusion of other meaningful support areas, so the description should explain how the risk would be addressed/avoided.

Suggestions for the foundation organisation

- Medicare mental health care centres - depending on who is operating them and how they are configured.
- Advocacy organisations - that operate locally and with a strong connection to lived experience and orientation towards participant experience. They may lack service provision experience and lack of connection to health and social care services.
- Individual psychosocial support-focused non-governmental organisations (NGOs) - with experience of psychosocial service delivery. Benefit would be expertise in working with people with psychosocial disability as a primary group. Drawback may be lack of formal connection to health system. The tendering process would need to ensure that there were existing local connections.
- Consortia of psychosocial support-focused NGOs and local community groups Tender to operate in a particular area. Benefit would be broad expertise in working with people with psychosocial disability as primary group and local community connections. Drawback may be lack of formal connection to health system.
- Consortia of PHNs and any of the above.

Service models

- A model should be based around ‘functional focused interventions’ with the following principles:
    - Active citizenship as the underpinning approach; consider choice and control and agency within any approach; Low- to no-cost; diversity of workforces and skillsets; flexible and personalised approaches.
    - Trial and pilot new models particularly given the absence of evidence-based interventions to build capacity.

Navigator role

- There are many examples of ‘navigator’ roles across the sector and these need to be considered. Also whether there will be any overlap/synergies with the NDIS funded roles such as local area coordinators, support coordinators and recovery coaches and NDIS planners.

Incentivise for recovery outcomes

- The NDIA Recovery Framework needs to be implemented across the disability eco-system – we need to consider and develop a lever for this to be incentivised. Currently providers are financially incentivised only to provide services, not to obtain recovery outcomes.

Family, carer and kin supports

- There is not enough focus given to the really important role of family, carer and kin - and building up the informal supports and community in people's lives.

Need for low intensity long term supports and appropriate assessment periods

- the existing system of mental health supports does not provide much in the way of low intensity long term supports that could be a basic building block for many people with psychosocial disability. While there are some good programs, they are all time limited (6 -12 months). If there was capacity for people to dip in and out of these supports as they needed with providers that they trusted, this would avoid the need for more intensive supports in many cases and would also avoid hospitalisations.
- Explore the possibility of longer assessment periods – offer a level of support provision to a person to enhance the assessment process (e.g. maybe support provision could be provided for 6 months whilst ongoing assessment occurs).

Interface with mainstream services

- Mainstream services need to be able to identify need so there is not extra administration and rationing.

Early intervention pathway

- This needs to consider the broader psychosocial ecosystem including consideration of how the early intervention pathway is integrated.

Workforce

- People with psychosocial disability typically require fewer hours of support with a more qualified workforce (peer workforce and community mental health professionals) and this needs to be included in the cost modelling.
- Competencies for assessors'/planners, service providers are essential –the NDIS review agreed that providing specialist support to people with psychosocial disability requires specialist skills and knowledge.

Governance

- Foundational Supports should be 'Health managed' with clear governance arrangements to ensure that the services are truly integrated with health.

Challenges

- What is the nature of the 'unmet need' that will then determine the services required.
- How do foundational supports embed 'choice and control' for the individual, family, carer and kin to enable the curation of unique support teams responding to specific needs.
- How does commissioning and block funding support individualised approaches, and manage the potential conflict of interest such as providers incentivised to maximise profitable services.

Miscellaneous

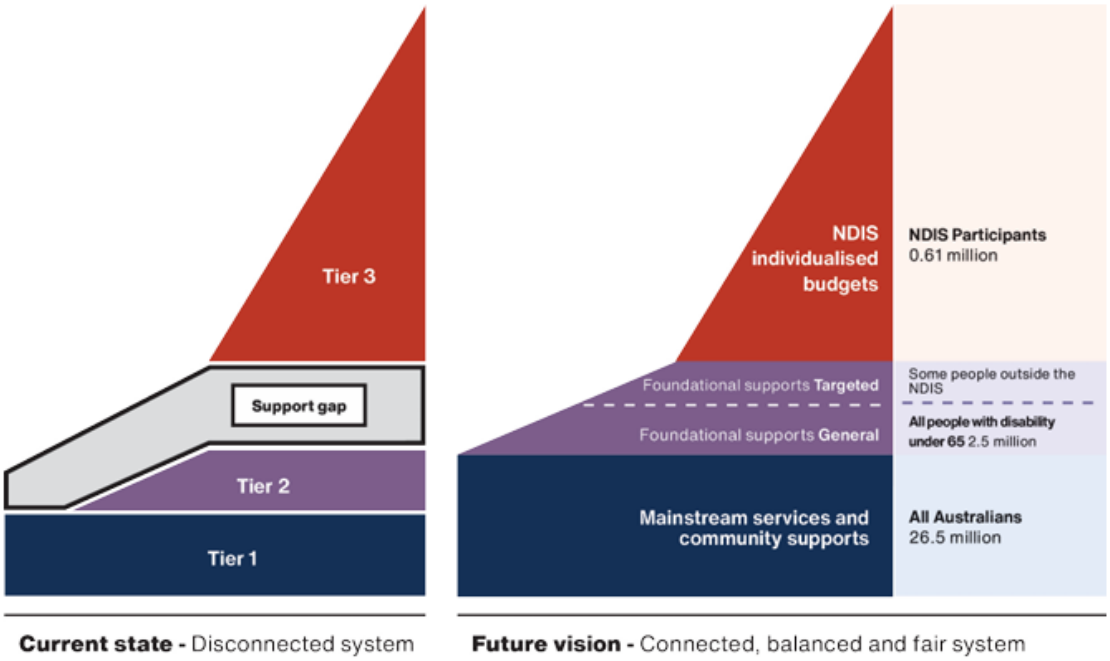
- Given the lack of understanding of foundational supports could this be something that differentiates psychosocial supports and from clinical services such as the Medicare Mental Health Centres e.g. ‘Wellbeing Connect’.

Appendix C: Defining general and targeted foundational supports

Figure 1 in the NDIS Review (2023)[34] and the glossary outlined the position of foundational supports outside of NDIS individualised budgets and mainstream services and community supports.

Figure 1

Vision for an integrated, graduated model of supports for all people with disability



From the glossary:

General foundational supports: Disability-specific supports that are available to benefit all people with disability, and where appropriate, their families and carers and people aged over 65. This includes information and advice and peer support. [35]

Targeted foundational supports: Early intervention and low intensity care supports that are primarily for specific groups of people with disability outside the NDIS who are in most need of additional support. Some NDIS participants may prefer targeted foundational supports from supports available as part of their individualised budget. This includes things like home and community care supports (such as shopping and property maintenance) for people with chronic-health related conditions and other disabilities, aids and equipment, early supports for children with development concerns and psychosocial support services.[36]

[34] NDIS Review (2023) p. 35
[35] NDIS Review (2023) p. 288
[36] NDIS Review (2023) p. 293

Appendix D: List of evidence-based psychosocial interventions

This is based on our scoping review of community-based psychosocial supports.

1. Case Management and Support Coordination: e.g., service navigation and personalised care planning to ensure continuity of care and better access to resources.
2. Peer Support Programs: e.g., one-on-one or group-based support delivered by individuals with lived experience to provide support, and mutual understanding.
3. Occupational therapies and Daily Living Skills Training: e.g., interventions teaching personal care and household tasks to improve independent living and daily functioning.
4. Illness (Self) Management: e.g., psychiatric crisis planning and self-monitoring programs to enhance individuals' ability to manage symptoms and prevent relapse.
5. Psychoeducation or Recovery College: e.g., structured educational course and workshops to increase mental health literacy, self-efficacy, and recovery-oriented skills.
6. Cognitive Therapies: e.g., cognitive remediation therapy and metacognitive therapy to improve cognitive functioning, such as memory, attention, and problem-solving.
7. Behavioural and Emotion-Focused Therapies: e.g., CBT, mindfulness-based interventions, and positive psychotherapy to address emotional regulation.
8. Social Skill Training: e.g., structured group sessions to build interpersonal communication and relationship management skills.
9. Clubhouse or Day Centre Programs: e.g., psychosocial rehabilitation communities offering work-ordered day structure, social opportunities, and skill development to promote community participation.
10. Physical Health Promotion and Lifestyle Interventions: e.g., exercise programs, sports activities, and dietary education to improve physical well-being and reduce comorbid health risks.
11. Experiential/Nature-Based Therapies: e.g., art therapy, music therapy, writing workshop, or equine-assisted therapy to enhance emotional well-being, self-expression, and social engagement.
12. Family Psychoeducation: e.g., educational workshops for relatives and carers to improve their understanding of mental illness, reduce stress, and strengthen family support systems.
13. Supported Housing: e.g., Housing First programs to provided stable and secure living environments that foster independence and recovery.
14. Assertive Community Treatment: e.g., multidisciplinary team-based outreach to provide intensive, ongoing support aimed at reducing hospitalisation and promoting community integration.
15. Supported Employment and Vocational Rehabilitation: e.g., Individual Placement and Support (IPS) to reintegrate individuals into the workforce.

Appendix E: Psychosocial program activities from Commonwealth Psychosocial Support Program Guidance

Commonwealth Psychosocial Support Program Guidance:

Individual supports

- Support to work towards individual recovery goals. For example, confidence to catch public transport, developing a meal plan, and accessing education and training
- Making decisions to support with problem solving and skill building
- Assistance to plan, face challenges and develop resilience and management/coping strategies • Providing emotional support and opportunities for social connections
- Providing practical assistance. For example, accessing housing assistance or government support payments
- Support to re-connect and improve relationships with family and friends to increase support networks
- Assistance with navigating the mental health system and accessing other appropriate services, including Alcohol and Other Drugs services, transport, advocacy and housing
- Support to test NDIS eligibility
- Building knowledge and capacity to improve physical and mental health
- Participating in the program participant's care team and providing advocacy support, noting the important role carers and family will often play in supporting a loved one
- Providing opportunities to practice life skills (e.g. grocery shopping).

Group supports

- Psycho-educational groups covering emotional wellbeing promotion activities, such as mindfulness and self-care
- Information sessions/workshops aimed at enhancing daily living skills (e.g. budgeting, nutrition)
- Visits from other service providers and organisations to provide information on services, eligibility and referral pathways
- Visits to continuing education centres to explore study options
- Opportunities for social connection and skill building, including participation by families, carers and friends in activities, such as:
    - o Art/craft activities
    - o Cooking classes
    - o Gardening groups
    - o Drop-in spaces.
- Opportunities to contribute and engage in meaningful activities, such as volunteering
- Exercise/physical activity groups (e.g. dance, walking, yoga)
- Excursions to community events and cultural experiences.

Appendix F: Disability Support Pension Recipient Demographics - June 2025 Quarter

Expanded Department of Social Services Benefit and Payment Recipient Demographics extracted at 27 June 2025

		Top 5 Medical Conditions							
Gender	**Age**	**Psychological/ Psychiatric**	**Musculo-Skeletal & Connective Tissue**	**Intellectual/ Learning**	**Nervous System**	**Circulatory System**	**Other Conditions**	**Total**	**Proportion of all participants with psychological or psychiatric condition**
Male	**16-20**	9,290	60	5,995	635	35	2,120	**18,140**	51.2%
	21-24	10,060	110	7,460	735	65	2,240	**20,670**	48.7%
	25-34	25,965	810	18,915	2,520	250	5,915	**54,375**	47.8%
	35-44	28,340	2,755	15,715	2,850	630	8,725	**59,020**	48.0%
	45-54	39,975	10,735	10,715	4,205	2,055	16,570	**84,255**	47.4%
	55-64	43,040	29,740	9,335	7,255	6,920	31,955	**128,245**	33.6%
	65 +	16,710	23,485	4,070	5,085	6,090	19,905	**75,350**	22.2%
	Total	**173,380**	**67,700**	**72,210**	**23,280**	**16,045**	**87,435**	**440,050**	**39.4%**
Female	**16-20**	5,255	90	3,685	560	55	1,560	**11,205**	46.9%
	21-24	6,270	185	4,630	685	115	1,805	**13,685**	45.8%
	25-34	16,110	945	12,900	2,255	375	5,675	**38,260**	42.1%
	35-44	20,050	2,495	11,100	3,110	720	8,685	**46,160**	43.4%
	45-54	32,975	9,090	7,915	4,960	1,640	17,275	**73,850**	44.7%
	55-64	46,585	27,790	7,025	8,200	4,050	33,185	**126,835**	36.7%
	65 +	21,230	26,020	3,510	5,655	3,315	21,080	**80,810**	26.3%
	Total	**148,475**	**66,610**	**50,760**	**25,425**	**10,270**	**89,265**	**390,805**	**38.0%**
Total	**16-20**	14,550	150	9,680	1,195	90	3,680	**29,345**	49.6%
	21-24	16,330	295	12,090	1,415	180	4,050	**34,355**	47.5%
	25-34	42,070	1,755	31,820	4,775	625	11,590	**92,635**	45.4%
	35-44	48,390	5,250	26,815	5,960	1,350	17,410	**105,180**	46.0%
	45-54	72,950	19,825	18,630	9,165	3,690	33,845	**158,105**	46.1%
	55-64	89,625	57,530	16,355	15,455	10,970	65,140	**255,080**	35.1%
	65 +	37,940	49,510	7,580	10,745	9,405	40,985	**156,160**	24.3%
	Total	**321,855**	**134,310**	**122,965**	**48,710**	**26,315**	**176,700**	**830,855**	**38.7%**

[DSS Benefit and Payment Recipient Demographics - quarterly data - Expanded DSS Benefit and Payment Recipient Demographics - June 2025 - Data.gov.au]

Appendix G: NDIS psychosocial disability participants

Quarterly dataset for psychosocial disability to 30 June 2025 [37]

	Active participants with psychosocial disability	All active participants	Percentage of all participants with psychosocial disability	Percentage of all participants
Reported level of function				
High	4,247	236,724	7%	32%
Medium	39,882	324,396	61%	44%
Low	20,180	157,984	31%	21%
Missing	963	20,310	1%	3%
Age group				
0 to 8	18	173,466	0%	23%
9 to 14	109	144,351	0%	20%
15 to 18	227	73,303	0%	10%
19 to 24	1,323	64,248	2%	9%
25 to 34	8,516	64,457	13%	9%
35 to 44	13,634	52,933	21%	7%
45 to 54	17,674	58,090	27%	8%
55 to 64	16,880	69,458	26%	9%
65+	6,891	39,108	11%	5%
Remoteness				
Major cities	47,112	507,128	72%	69%
Population > 50,000	6,137	80,197	9%	11%
Population between 15,000 - 50,000	5,020	60,500	8%	8%
Population between 5,000 - 15,000	2,690	32,770	4%	4%
Population < 5,000	3,278	47,237	5%	6%
Remote	508	6,784	1%	1%
Very Remote	480	4,436	1%	1%
First nations	5,746	60,529	9%	8%
Culturally and linguistically diverse	8,318	64,697	13%	9%
Total	**65,272**	**739,414**		

Total payments by support category for year ending 30 June 2025 (Table 14)

Category	Million $	Proportion of payments
Core - Daily Activities	$2,797	49%
Core - Community	$1,962	34%
Core - Consumables & Transport	$102	2%

[37] National Disability Insurance Agency (2025) Participant Dashboards: Psychosocial https://dataresearch.ndis.gov.au/reports-and-analyses/participant-dashboards/psychosocial Accessed 21 October 2025

Capacity Building - Daily Activities	$319	6%
Capacity Building - Other	$509	9%
Capital	$26	0%
Total	**$5,723**	**100%**

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