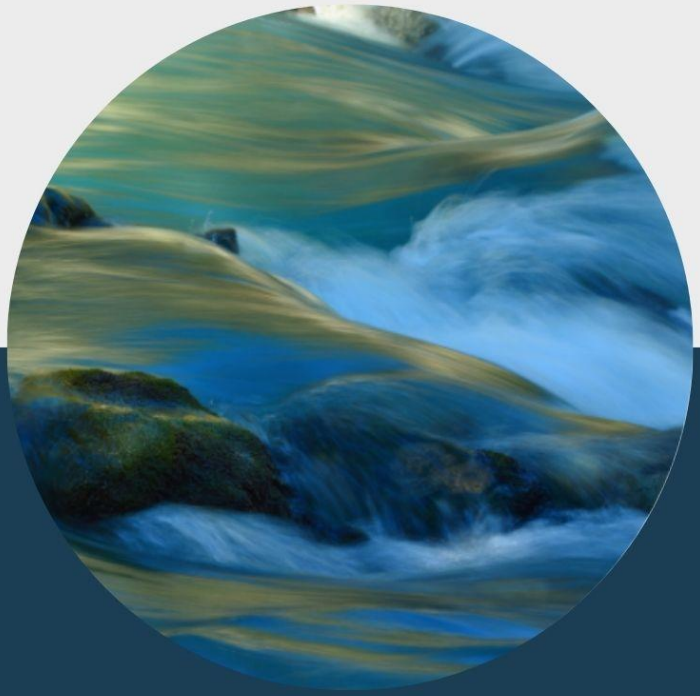
CONSULTATION ON THE FINAL REVIEW OF THE MENTAL HEALTH & SUICIDE PREVENTION AGREEMENT



OTSi

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ABOUT OTSI

OT Society Incorporated for Invisible Disabilities (OTSI) is a national society whose purpose is to enable Occupational Therapists who work alongside people with hidden and invisible disabilities, to reduce barriers to full participation in our world as active citizens of Australia. Our focus is on ensuring access to resources, opportunities, and supports for people of all ages with invisible disabilities, including access to Occupational Therapy. OTSI has a strong voice in systemic advocacy and policy direction, as well as enabling individuals to build better lives.

Invisible & Hidden Disabilities

The term ' hidden and invisible disability' is an umbrella term and acknowledges that the impacts of hidden and invisible disability are often poorly misunderstood or overlooked. We commit to shining a light on the impact of invisible and hidden disabilities alongside people who experience them, and to work to address barriers to active participation, and barriers to societal recognition and understanding. OTSI approach underscores the importance of empathy and awareness in interactions and accommodations, to build a more inclusive world.

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Final Review of the Mental Health and Suicide Prevention Agreement

EXECUTIVE SUMMARY

The Occupational Therapy Society for Invisible and Hidden Disabilities (OTSi) welcomes the opportunity to provide a submission to the *Productivity Commission Final Review of the Mental Health and Suicide Prevention Agreement* consultation.

The need for effective mental health services for people with mental health challenges and psychosocial disability has never been greater. With youth mental health issues rising significantly over the past decade and nearly 500,000 Australians lacking access to psychosocial support, there is a need to innovate and seek new solutions. Existing services are under immense strain, with gaps in service provision and access to skilled providers, particularly for young people and individuals with complex needs.

This submission, in line with the Productivity Commission's inquiry into the NMHSP Agreement, focuses on two key priorities:

1. Resourcing tailored supports and interventions that enable the achievement of active citizenship and meaningful participation for people with mental ill-health and psychosocial disability (Section 1).
2. Building a service structure and workforce that delivers these supports effectively and cost-efficiently (Section 2).

OTSi urges greater investment to address the rising demand for mental health and psychosocial disability services. A fully integrated system is essential, ensuring people can seamlessly transition between primary care, foundational supports, targeted supports, and the NDIS, achieving a safer and more responsive step-up, step-down model.

KEY RECOMMENDATIONS

1. Co-design a new model of service encompassing allied health and peer-worker roles that prioritizes function-focused interventions delivered in an individualised, citizenship focused model. This could be PHN-commissioned to harness the existing workforce, as described in Section 2 below.

2. Establish a new Medicare item for people aged under 25, targeting Focused Functional Interventions (FFI), a distinct service offering to support functional outcomes and address barriers to social and economic participation, and to prevent longer term psychosocial disability.

3. Embed function-focused interventions delivered by occupational therapists to all existing service models under the NMHSP model to target functional outcomes and enhance social and economic participation outcomes

1. THE CASE FOR PARTICIPATION-ORIENTED FOCUSED FUNCTIONAL INTERVENTIONS WITHIN AN ACTIVE CITIZENSHIP MODEL

1.1. An Active Citizenship Model promoting social and economic participation

Robust consideration of the fundamental principles underpinning models of care and participation is necessary, at this monumental junction for people living with mental health challenges and psychosocial disability in Australia. Clear and considered overarching principles are pivotal to the development of models, services and interventions, and to allocating resources and ensuring outcomes under the NMHSP Agreement.

This submission aligns with a citizenship-focused framework. A key feature of this is a tailored approach to addressing barriers to participation. Services and interventions must focus on tailored approaches to building active citizenship, including enhancing meaningful social and economic participation, and functional capacity. This approach aligns with a social model of disability, important as we consider the definition of psychosocial disability as distinct from mental health challenges; and as we consider the interface between mental health services and the NDIS.

International best practice, learnings from the NDIS over the past ten years and recommendations from the recent *Disability Royal Commission into violence, abuse, neglect, exploitation of people with disabilities Final Report* [1] highlight the shift to a social model of disability as critical to identifying and overcoming barriers to participation, including the stigma and segregation frequently experienced by people living with mental health challenges and psychosocial disability.

There is a need for service provision to make a conceptual 'leap' from models of 'care' to models of 'participation'. This conceptual shift moves from viewing the person as the passively 'helped' by a provider 'helper' and moves closer to a model of active citizenship [2]. This model is the antithesis of the segregated and institutional models that previously dominated service provision.

This submission utilizes the definition of psychosocial disability provided by the Australian Psychosocial Disability Collective (See Appendix 1).

1.2 The risks of neglecting to address social and economic participation through the NMHSP Agreement

There is limited evidence for current models and approaches to substantially improve the social and economic participation for people living with severe mental health challenges and psychosocial disability. These groups continue to experience poor outcomes and face major barriers to active citizenship within our communities. The human cost, alongside the productivity impacts, are significant [3]. They include:

- Reduced social and economic participation
- Social and economic exclusion
- Barriers to community access, engagement and to living an independent life.
- Increased risk of requiring more intensive disability supports, sooner e.g. NDIS access
- Increased need for medical intervention and acute services.

1.3. The Initial Assessment and Referral Decision Support Tool (IAR-DST) identifies functional needs

The Initial Assessment and Referral Decision Support Tool (IAR-DST) is a structured tool used in Australia's mental health system to guide GP's and clinicians in determining the appropriate level of care for individuals seeking support. It ensures consistent, evidence-based referrals by assessing needs across eight key domains, including symptom severity, risk of harm, functioning, co-existing conditions, treatment history, social stressors, support networks, and engagement in treatment [4].

While the IAR-DST includes a functional domain, there remains a risk that resource allocation focuses more strongly on a medical response, and on short-term symptom management rather than the broader factors that contribute to mental health decline and suicide risk, such as **functioning, social stressors, support networks, substance use, and physical health**. Addressing these factors is essential for comprehensive mental health intervention and reducing the barriers that lead to psychosocial disability.

Further, even where the IAR-DST captures a need for function-focused interventions across the range of function-focused domains, there is a marked absence of targeted, evidence-based service models that meaningfully enhance functional abilities, and associated social and economic participation. Without targeted service responses, this gap risks widening under ongoing reforms, potentially leaving individuals without services that support daily around functioning, relationships, and community participation. Addressing participation barriers is essential for better life outcomes, and we propose an overarching active citizenship model that both creates and embeds targeted and function-focused interventions as a primary strategy to reduce the barriers that can create psychosocial disability.

1.4 Do existing models adequately address function, and barriers to social and economic participation?

A recent systematic review of models of care in psychosocial disability included a review of a number of the previous models (Partners In Recovery; Intensive case management), and concluded that these models would need to evolve to meet current and contemporary needs. The evidence examination highlighted that none of the models reviewed met best-practice standards. The authors called for 'inevitable evolution and adaption' [5]. New models must evolve from the assumption of homogenous need, and a position that one-size-fits all.

New models must also evolve from a simplistic understanding of, and assumptions around, participation-focused capacity building. Support is not equivalent to capacity building to overcome participation barriers. A carer involved in our co-design group commented [6]:

> *" We can't always assume a single service offering of a supportive relationship will lead to capacity-building, in fact, it can further segregate the person, limit agency, and even create dependency, moving the person further from their goals".*

1.5 The need for new service models and structures through the MNHSP Agreement

The unmet needs analysis revealed nearly 500,000 Australians lacking access to psychosocial support [7]. However, it did not identify the nature of the unmet needs. The cohort of people with psychosocial disability identified in the Unmet Needs Analysis is a highly diverse group with a very broad range of needs facing a range of barriers to participation. Further analysis is required to determine the nature of the unmet needs so that new models can optimally address these. Contemporary models must be goal-focused and will need to reflect the diversity of needs that fall under the umbrella of psychosocial disability, which can include cognitive, sensory, neurodiverse, and physical barriers to participation.

There are very significant and under-recognised complexities experienced by those who live with substantial psychosocial disability, that contribute to reduced lifespan of 20 years compared to the average Australian [8]. For example, current research highlights the high rates of persistent disability experienced by the cohort identifying with an impairment of schizophrenia, which includes two-thirds with a cognitive impairment [9]; 24% experience hearing impairment [10]; 26-70% of people experiencing vision, or visual processing, difficulties with functional impact, impacting literacy and social engagement[11]; motor skills and gait difficulties [12] [13]; and a 2.5 fold increase in lifetime risk of developing early-onset dementia [14]. An individual experiencing one or a combination of these issues could be inappropriately placed within an existing NMHSP-funded program, without prior recognition and accommodation of the whole-of-person functional capacity; barriers to participation; and goals and aspirations. The absence of tailored responses will not lead to positive, sustainable outcomes, and may result in the person receiving services that at best do not understand individual needs, and at worst are experienced as inappropriate, harmful or ablest. New models are required that can address current gaps.

The development of new, contemporary models of participation for people living with psychosocial disability will optimally include exploration of the benefits of flexibility and personalised approaches to addressing barriers to participation. A process to trial and pilot new models of care would ensure a comprehensive, fiscally responsible approach to establishing fit-for-purpose models that can meet diverse care needs and address barriers to participation at both individual and societal levels.

1.6 The need for targeted participation and function-focused interventions

Access to evidence-based and effective supports is critical to meeting the unmet needs of people with both mental health challenges and psychosocial disability living in our community. Major proportions of this cohort cannot currently access evidence-based interventions to enhance functional capacity. This can lead to a range of impacts and barriers to living full, meaningful lives as active citizens. Creating access pathways to focused functional interventions is an opportunity to adopt a best practice approach under the NMHSP Agreement. These access pathways must exist at all tiers of mental health service provision, and particularly for those who IAR-DST indicates a need in the functional domain. There is significant identified need for tailored support to enable people with mental health challenges, and those living with psychosocial disability, to live full lives and to participate in our communities, through building functional skills, and addressing disability-related participation barriers in a strengths-based manner.

Current access to tailored, focused functional interventions is limited by:

- The absence of function-focused targeted foundational supports in the community
- The limited nature of existing Medicare items to address functional capacity for these cohorts, and the cost-prohibitive nature of co-payment systems.
- A high threshold to access NDIS for psychosocial disability, and likely increased rates of revocation of NDIS access in future.

1.7 What are tailored, function-focused interventions?

Evidence-based function-focused capacity-building interventions are optimally planned in conversation with the person and with an understanding of their goals and evaluation of barriers to participation, offering a clear understanding of the purpose, intent, delivery methods, and expected outcomes. This enables the person to be an active partner in planning interventions. Models of participation for people with psychosocial disability, must recognise the person as expert in their own disability and enable capacity-building interventions to be tailored to individual needs.

Ensuring the 'just right' right mix of capacity-building, including allied-health delivered capacity building, and day-to-day supports is available at the right time, is fundamental to addressing social and economic exclusion for people with psychosocial disability. A significant and growing evidence base exists for the following function-focused interventions*, which can be adapted in an age and disability appropriate manner. Occupational therapists lead the implementation of these interventions**:

1. Executive functioning and cognitive strategies/approaches
2. Lifestyle re-design/time-use/occupational balance
3. Social functioning and social prescribing
4. Routine development and life-skill development for self-care.
5. Vocational – work and study engagement
6. Creativity-based strategies
7. Sensory based strategies

***See Appendix 3**

****A detailed program of work is underway to review the evidence base for these interventions, in the context of both mental health and NDIS reform. We seek the opportunity to provide this work to the Productivity Commission Inquiry on the NMHSP Agreement once it is available in late April.**

1.8 How could access to function-focused interventions be improved through the NMHSP

1.8A New models and approaches:

1. Co-design a new model of service that places function-focused interventions delivered in an individualised, citizenship focused model. Occupational therapists would play a lead role in this model, and can work effectively with allied health assistants and/or with peer-led and recovery-focused workers to ensure service responses are tailored and targeted to individual needs. This could be PHN-commissioned to harness the existing workforce, as described in Section 2 below.

2. Establish a new Medicare item for people aged under 25, as per the current recommendation form mental Health Australia. This Medicare item should target Focused Functional Interventions (FFI), and be offered alongside current Medicare Better access to Mental Health items- as the focus, intention and evidence-base for Focused Functional Interventions (FFI) is distinct form those focused psychological interventions delivered under BAMH.

1.8B Embed function-focused interventions and active citizenship approaches into existing and emerging service models.

New and existing models funded under the NMHSPP, including Medicare Mental Health Local Commonwealth MHFFS, must prioritise access to occupational-therapy delivered contemporary interventions that can provide access to tailored responses to individual needs. Flexibility and personalization of capacity building interventions are required in tune with life transitions, fluctuating capacity and changes of circumstance. Many people with psychosocial disability require frequent or extended programs of intervention to ensure carryover of learning to daily life and functional tasks to overcome barriers to participation. Occupational therapists utilize a ‘top-down’ approach to evaluation of barriers to participation, meaning evidence-based capacity-building interventions are personalised to the persons goals and lived experience of barriers to participation. Occupational therapy needs to be firmly embedded in future service models to facilitate opportunities and evidence-based capacity building to enable people with psychosocial disability to live full lives and work towards active citizenship.

The core business of occupational therapy is to enable opportunities for full participation in everyday life in the community, where people live, learn, work and play. Since the dawn of the profession, occupational therapy has been committed to building participation for people living with psychosocial disability. Occupational therapists work in partnership with people living with psychosocial disability considering the unique barriers each individual faces; their individual needs and goals; the influence of their environment; and the interplay of these factors and their impact on function. Occupational therapists support principles of co-production and co-design. Occupational Therapy is regulated, evidence-based, client centred and cost-effective [15].

Historical models of psychosocial support were established in Australia approximately 20-50 years old, some are older, and would require critical analysis for fitness-of-purpose in current policy and practice context (e.g. the Clubhouse model, which was traditionally established as a post-institution era stepping-stone and became itself a model segregated from mainstream community). A potential systemic bias towards historical, albeit dated, models, must be acknowledged to ensure new models are reflective of

current consumer, carer and community expectations, and contemporary research. This bias may be reinforced by perceived administrative ease of reverting to historical models, though these remain unproven in terms of government return on investment, at the scale currently required. Conceptual considerations cannot be short-cut in the development of contemporary models.

1.9 A note on NDIS 'Psychosocial Early in Scheme' Intervention (PEIS)

OTSi supports the funding of National disability Insurance scheme **Psychosocial Early in Scheme' Intervention (PEIS)** to remain the responsibility of the NDIS, to avoid policy segregation for this cohort and ensure disability rights are upheld. In Appendix 2 below, we include a past submission detailing our rationale.

2. A STRONG PRIMARY HEALTH NETWORK (PHN) IS KEY TO BUILDING A MENTAL HEALTH AND SUICIDE PREVENTION SERVICE WORKFORCE TO RESPOND TO CURRENT AND EMERGING PRIORITIES

Over the past decade, the introduction of the NDIS has led to a growing psychosocial disability workforce employed in community-based, localised practices of all sizes. This includes occupational therapists, allied health professionals, peer workers, and others, who have developed innovative, tailored services to meet participant needs while working within their unique scopes of practice. The sector has also benefited from the re-entry of highly experienced allied health professionals, including occupational therapists, who had previously left the workforce or shifted to other fields, contributing to increased workforce supply.

This workforce is predominantly female and carries significant caring responsibilities, making flexible, community-based employment essential. It is also likely to include a large proportion of workers with disability and lived experience. Despite being the backbone of local service provision, this workforce lacks a strong advocacy or union voice and have been largely excluded from national consultations that have primarily engaged large mental health organisations. Workforce planning must account for gender dynamics, inclusivity, workforce well-being, and changing employment preferences, as these factors are crucial to building a sustainable mental health workforce. 22% of the entire NDIS workforce were not employed prior to the NDIS, and this statistic must be unpacked to understand the drivers for enhanced employment through this model, which can then be employed to broader mental health workforce supply models.

As of June 30, 2023, data shows that the 10 largest psychosocial disability providers held just 5% of the NDIS market, with their share declining annually. This reflects a clear preference among people with psychosocial disability for local, tailored supports rather than homogenous service offerings from large providers.

PHNs have a critical role in ensuring that local mental health needs are met through local solutions by leveraging existing public, NGO, and private providers. We strongly recommend PHNs undertake an inclusive mapping exercise examining local provider composition to inform workforce and service planning.

Expanding PHN infrastructure to implement aspects of the NMHSP Agreement, such as funding new and existing psychosocial support programs, would help achieve equitable access to services, particularly in Western Australia, the Northern Territory, and Tasmania.

OTSi recommends that a range of NMHSP services be commissioned through PHNs, including the mental health flexible funding stream (MHFFS), to integrate a broad, diverse workforce, including NDIS-funded allied health, peer, and community-based providers. This locally responsive approach would ensure funding reaches communities

directly, supporting innovative, tailored service models under independent PHN oversight to monitor local needs, trends, and service gaps.

2.1. Recognising and Supporting Local Service Providers

- **Current Issue:** Federal mental health and psychosocial disability reforms prioritize large, national providers by consulting only through a single peak body for national providers, potentially **displacing small and medium-sized local providers** who have built **highly responsive and flexible services** over the past decade.
- **Best Practice:**
  - PHNs should **map local networks of small providers** (allied health, peer support, niche services) to harness their **expertise and innovation**.
  - PHNs should **prioritize these providers** in service commissioning to **preserve community-based solutions**.
  - This would ensure inclusive commissioning and maintain workforce engagement, particularly for **female-led practices; and carers** and providers with disabilities who rely on flexible work arrangements.

2.2 Strengthening Mental Health Workforce Through Targeted Investment

- **Current Issue:** There is a **retention issue** for occupational therapists and other skilled allied health professionals in mental health, particularly in community-based services, largely due to the uncertainty of mental health and disability reforms.
- **Best Practice:**
  - Increase the **use of Allied Health Assistants (AHAs) operating within a tailored delegation framework** to extend service reach while maintaining clinical oversight.
  - Commit to invest in **mental health occupational therapy** through PHN funding models, consolidating the current workforce and ensuring a skilled workforce can deliver functional interventions.
  - Recognize that **occupational therapists are a key workforce** in stepped-care models and should be included in future service planning.

2.3. Embedding Stepped-Care Models and Psychosocial Early Intervention

- **Current Issue:** NDIS reforms will likely **raise eligibility thresholds**, leaving many with **severe mental illness and psychosocial disability without adequate support**.
- **Best Practice:**
  - PHNs should **lead the commissioning of targeted foundational support** services, ensuring that individuals who do not meet NDIS criteria still receive targeted foundational support.
  - Ensure stepped-care models include **a broad workforce of public, private, and NGO providers**, rather than relying solely on large service providers.
  - Implement **Focused Functional Intervention (FFI) models**, delivered by **occupational therapists**, to provide tailored support for daily function, social participation, and active citizenship.

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2.4. Improving Productivity Through Effective Commissioning

- **Current Issue:** The mental health and disability system risks **becoming more fragmented**, with multiple funding streams across Federal and State programs creating **barriers to access and inefficiencies**.
- **Best Practice:**
  - PHNs should **integrate local service commissioning** to ensure seamless pathways between **NDIS, stepped-care mental health, and foundational supports**.
  - Use PHNs to **distribute funding more effectively**, allowing for **place-based responses** tailored to community needs.
  - Enable **NDIS providers to transition into other service areas**, ensuring the workforce is not lost due to funding changes.

2.5 Potential Productivity Improvements for the Mental Health and Disability Workforce through PHN-commissioned models

Issue	Proposed Solution	Impact on Productivity
Loss of local, small and medium-sized providers due to large provider preference in funding	PHNs to map and engage these providers in service commissioning.	Retains **highly skilled, community-based workforce** and prevents service disruption.
Shortage of skilled mental health professionals	Expand **Allied Health Assistant roles within a delegation framework** and increase investment in **occupational therapists**.	Increases **service reach and cost-effectiveness**, allowing professionals to work to full scope of practice
Gaps in care for people with psychosocial disability who don't qualify for NDIS	PHNs to commission targeted foundational support services.	Ensures targeted foundational supports are **tailored to local service gaps and needs**
Fragmentation of mental health and disability services across multiple funding streams	PHNs to integrate **NDIS, foundational supports, and stepped-care pathways**.	Improves **service navigation, reduces duplication, and enhances efficiency**.
Underutilization of occupational therapists in stepped-care models	Implement **Focused Functional Intervention (FFI) models** through PHN funding.	Ensures **tailored, evidence-based interventions** to improve function and social participation.

NOTE:

New and existing programs must be further co-designed by neurodiverse individuals and representatives, if the intention is to include these groups under the NMHSP Agreement. This group experiences elevated rates and risks for negative mental health impacts and suicidality, and their needs must be addressed through reform agenda's.

ACKNOWLEDGEMENTS: OTSi is grateful to all the therapists, advocates and people with lived experience who provided input to this submission.

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APPENDIX 1: Australian Psychosocial Disability Collection Definition of Psychosocial Disability

Reference: https://www.apdcollective.net/

Psychosocial disability can be defined as the often severe and enduring consequences of mental ill health, combined with other social, economic, cultural, and environmental factors, together with cooccurring disabilities and health conditions, the effects of trauma and stigma, and other complex issues.

It is important that psychosocial disability not be conflated with mental ill health in the NDIS context because mental ill health is only one part of a much broader picture - both in terms of lived experience and the combined severity and pervasiveness of the impairments.

Psychosocial disability is complex, multi-factorial, and affects people in varied ways. It impacts virtually every aspect of life; including employment, education, relationships, social interaction, community participation, cognition, communication, self-care, mental and emotional wellbeing, and maintaining energy and motivation. Psychosocial disability tends to be linked to co-occurring serious physical health conditions and earlier mortality. Such problems, exacerbated by stigma and discrimination, contribute to high levels of disadvantage, including poverty, housing stress and homelessness, social isolation, food insecurity, disenfranchisement, substance issues and, sadly, a high incidence of suicide compared to the population averages.

APPENDIX 2:

Attn. NDIS Joint Standing Committee- General Issues Inquiry

March 7th, 2024

1. PURPOSE

This paper has been prepared for the NDIS Joint Standing Committee by the NDIS mental health occupational therapy community of practice, and responds to the NDIS Review Final report with a focus on psychosocial disability. This paper is intended to inform policy makers and decision-makers regarding potential risks, gaps and solutions pertaining to the NDIS Review Final Report, for people living with psychosocial disability.

Occupational Therapy Australia, the professional association and peak representative body for occupational therapists in Australia, supports this submission.

2. INTRODUCTION

The NDIS Review Final report is a landmark report sign-posting the road ahead for the NDIS and the broader disability ecosystem. We welcome the report and acknowledge the effort that has led to it. In particular, we commend the recommendations to build an Australia-wide ecosystem for psychosocial disability, including the commitment to building foundational supports. We welcome a strong focus on the reduction and elimination of restrictive practice for all groups, including psychosocial disability. We welcome the introduction of the *International Classification of Functioning (ICF)* as a best practice, internationally recognised, framework with high compatibility with the NDIS.

While the Review report brings some recommendations that have potential to improve both NDIS outcomes for participants alongside Scheme sustainability, we highlight that Recommendation 7, without careful and deliberate design aligned to disability insurance principles, is at high risk of manifesting and exacerbating existing issues, for both people living with psychosocial disability, and for Scheme sustainability. We are also concerned that the expected cost savings, and participant outcomes, anticipated in the proposed new operating model for psychosocial disability through Actions 7.1 and 7.2, will not in fact eventuate as anticipated.

We appreciate the reinvigorated NDIS must reduce the rate of cost growth (targeting 8% p.a) and understand the importance of the outcomes of this Review to save money, improve outcomes for people with psychosocial disability and ensure Scheme sustainability over the long term. We are contributing this paper to help ensure the recommendations from this Review have the best chance to deliver on these aims. This response paper focuses on NDIS Review Supporting Analysis Chapter 2, Part 6, p.507- 536. Specifically, Recommendation 7, Actions 7.1 and 7.2 (p.508).

Recommendation 7: Introduce a new approach to NDIS supports for psychosocial disability, focused on personal recovery, and develop mental health reforms to better support people with severe mental illness

Legislative change required

- Action 7.1: The National Disability Insurance Agency should introduce a new approach to psychosocial disability in the NDIS based on personal recovery and optimising independence.
- Action 7.2: The National Disability Insurance Agency should establish an early intervention pathway for the majority of new participants with psychosocial disability under section 25 of the *National Disability Insurance Scheme Act 2013*.

3. PSYCHOSOCIAL DISABILITY

We highlight the need for the NDIS Review implementation to recognise the profound impact psychosocial disability has on daily lives. The profound impact persists between acute episodes and is not adequately addressed by systems outside the NDIS. We call for ongoing commitment to choice and control and the right to an 'ordinary' life for this group.

Further, potential risks due to the development of the ecosystem and introduction of the NDIS early intervention pathway, must be explored to mitigate the risk of creating further barriers to accessing disability support. These risks include: The step-up step down approach creating a revolving door for the NDIS; the limited and prescribed nature of early intervention supports and the proposed frequency of assessment creating barriers to effective support; and the potential complexity and gate-keeping a multi-tiered system with multiple funding streams across Federal and State funding systems, will bring.

4. Response to Action 7.1: The NDIA should introduce a new approach to psychosocial disability based on personal recovery and optimising independence.

The risks and benefits of introducing this new approach, which departs from existing NDIS concepts and constructs, require further examination, particularly from the perspectives of conceptual clarity, expanding Scheme scope, and the creation of new, separate constructs and pathways for the psychosocial disability cohort. We highlight that the National Mental Health Consumer and Carer Forum has published a position statement focused on the NDIS Review, highlighting that the Review report has misunderstood the concept of personal recovery [13], and we concur with this position.

4.1. CONCEPTUAL CLARITY & SCHEME SCOPE

The core construct utilised within the NDIS Act is functional capacity, and eligibility for the NDIS is determined by evidence demonstrating substantially reduced functional capacity. The focus on functional capacity as core construct is a key point of difference that demonstrates the role of the NDIS, beyond other service systems. The Review report introduces the construct of 'personal recovery' and

'independence' and recommends a legislation change to formally incorporate these concepts to the NDIS (Action 7.1).

The issues with this direction, are evidenced throughout Chapter 2, Section 6, where there is blurring, overlap and inappropriate interchange of each of these constructs, and also between recovery from symptoms, and the recovery of function. Each of these constructs are discrete, with specific theories of change, intervention targets, and role in the lives of people with disability. 'Personal recovery', the highly personal and internal recovery of hope and self-identity, is an entirely separate construct to both clinical, and functional, recovery, and these appear conflated in the Review report, which goes so far as to suggest a personal recovery approach can remediate impairment or reduce disability [1].

An understanding of personal recovery as a basic principle, holds significant value in the same way that underpinning principles such as a trauma-informed approach, or culturally safe practice, hold value within the NDIS. The psychosocial recovery-oriented framework may retain value as an *accommodation* within the NDIS, as per the original design of this framework. Beyond these, formalising the introduction of a personal recovery approach risks expanding Scheme scope at a time when greater focus is required to achieve outcomes for people with the most significant disability; and further entrenching conceptual confusion.

Conceptual clarity is paramount, and it is recommended the NDIS maintain construct integrity with the focus on functional capacity, and construct validity in the design of both functional and support needs assessment processes, and intervention. The focus on functional capacity is compatible with the broader introduction of the ICF to the NDIS, and psychosocial disability policy should progress in alignment, for example, by drawing upon the international best practice such as the World Health Organisation core sets to frame functional impairment and address restriction in participation [2].

4.2. EQUITY ACROSS DISABILITY GROUPS

The proposed introduction of a 'personal recovery and independence' approach, alongside a recommended early intervention pathway, initiates a new psychosocial-disability specific construct and pathway. This raises potential questions around fair and equal access to support for all groups, and, is this segregation by policy targeting a particular group of disabled people? While the Review broadly recommends moving away from a diagnostic to a functional capacity focus for people with disabilities, the psychosocial disability cohort are not afforded that right. They are in fact defined by and segregated according to the diagnostic origins of the disability. The early intervention pathway proposed within the Review report for the majority of this group, including detailed and prescribed intervention plans, clearly singles out this adult group only.

5. ***Response to Action 7.2: The NDIA should establish an early intervention pathway for the majority of new participants under Section 25 of the NDIS Act 2013***

We recognise an early intervention approach may be effective for some people with psychosocial disability if the service delivery model is well designed and includes models that encompass evidencebased capacity building by trained mental health professionals. A robust *Theory of Change* would need to be developed and the pathway piloted, prior to changing the legislation. Streamlined access to the NDIS under Section 24 of the NDIS must be upheld, for those who meet the criteria for inclusion. We express concern that the proposed pathway as it is described in the Review departs from disability insurance principles, and the evidence base and case for the select early interventions proposed is not sound and will not deliver on the outcomes expected from it.

5.1. PROPOSED EARLY INTERVENTION PATHWAY & DISABILITY INSURANCE PRINCIPLES

Currently, the NDIS lacks tailored assessment processes to determine when remedial approaches (capacity building) are required, and when accommodations (compensatory/core) approaches are required. It has largely lacked the capacity to fund and implement interventions in tune with these principles. This has resulted in the much-highlighted over-reliance on core support, essentially an accommodation, when allocating resources to the psychosocial disability cohort. This has had significant and ongoing cost-implications, in both the short and longer term. Concerningly, this issue has not been addressed through the NDIS Review, despite being fundamental to the success of an early (in-scheme) intervention pathway which aims to 'front-load' capacity building to reduce future need for compensatory strategies. In fact, the proposed early intervention pathway under Section 25 of the NDIS Act, for psychosocial disability, appears to depart from these disability insurance principles.

5.1 PROPOSED EARLY INTERVENTION PATHWAY & DISABILITY INSURANCE PRINCIPLES (cont)

This glaring gap is highlighted in Case Study 17 provided in the NDIS Review, 'Brett', (p. 508, NDIS Review Supporting Analysis) Brett is allocated to the early intervention pathway, apparently without consideration or assessment by a professional of his functioning. The navigator offers him a limited range of options devoid of *Theory of Change*, apparently not tailored to need, capacity or consideration of remediation or potential accommodation factors, or goals. When these interventions are proven to be ineffective - 2 years later -the navigator supports him to access the NDIS under Section 24 of the Act.

An early intervention pathway that does not focus on disability insurance principles to allocate resources, funding and support, risks perpetuating and worsening the already problematic issue of inappropriate supports being delivered to people with psychosocial disability. The trend of poor outcomes and high cost, at both human and fiscal levels will only continue to worsen under the proposed early intervention model described in the Review.

We recommend the re-establishment of disability insurance principles to determine remediation and accommodation requirements in both NDIS early intervention (Section 25) and the NDIS (Section 24), as an urgent priority, before progressing policy and model design and legislation change. This nuance is critical to achieving both improved participant outcomes and cost savings. The workforce would then need to be structured to meet these Scheme requirements, so that these principals can be implemented with competence through targeted, personalised approaches.

The recent Australia National Audit Office audit-report to the Australian Auditor General Effectiveness of the *NDIA's management of assistance with daily life supports (June 2023) [3],* indicates the completion of a (non-WHODAS) functional capacity and assessment, generally completed by mental health occupational therapists, led to a core-support budget reduction of an average of $8000 per psychosocial participant during 2021-2022. If we assumed each of the 63,000 participants with psychosocial disability undertook a plan review that year utilising this assessment approach, this would create a core-support cost-reduction of $540,000,000, based on this assessment approach alone, for the year – possibly significantly more, if personalised capacity building intervention were implemented based on tailored assessment recommendations. The existing NDIS policy and system of allocating core budgets

based on Typical Support Packages, and the absence of a comprehensive assessment of support needs for people who do not access occupational therapy, have been primary drivers of over-reliance on high core-budget allocation and compensatory funding for people with psychosocial disability.

This NDIS Review provides the opportunity to rebalance the provision of individualised supports and save money through an increased focus on remediation (capacity building funding) and a consequent reduction in the accommodative/compensation approach (core support funding). This rebalancing will save costs overall, improve outcomes for the participant, reduce workforce risk for the Scheme, and increase the likelihood of an early intervention pathway delivering on its aims.

5.2. A CONTEMPORARY EVIDENCE-BASE FOR EARLY INTERVENTION?

The Review report recommends a timeframe of 3 years for the early intervention pathway, with assessments to occur frequently. Following this, the Review report indicates that some people will no longer need the NDIS can be exited back to foundational supports, as part of a step-up, step-down approach. There is no rationale or justification provided in the Review report for the specific 3-year timeframe or the frequency of assessment.

Such a significant policy recommendation requires broad and deep justification, including evidence of effectiveness for this group. We have significant concerns from our decades of experience working with this cohort experiencing substantial psychosocial disability, that there is a high likelihood that the limited range of early intervention supports proposed in the NDIS Review report, will not lead to substantial functional outcomes for the cohort, and may result in delays to accessing effective support and intervention. We recommend early intervention supports are tailored to individual need.

Tailored functional and support needs assessment built on the ICF core sets could assist with identification of the vast and unrecognised range of factors that persist between acute episodes and lead to poor social and economic participation outcomes for people living with psychosocial disability. Use of evidence-based assessments, identifying impairment-related participation restrictions, would result in identification of supports that could then be structured in accordance to actual need.

There are very significant and under-recognised complexities experienced by those who live with substantial psychosocial disability, that contribute to reduced lifespan of 20 years compared to the average Australian [4]. For example, current research highlights the high rates of persistent disability experienced by the cohort identifying with an impairment of schizophrenia, which includes two-thirds with a cognitive impairment [5]; 24% experience hearing impairment [6]; 26-70% of people experiencing vision, or visual processing, difficulties with functional impact, impacting literacy and social engagement[7]; motor skills and gait difficulties [8] [9]; and a 2.5 fold increase in lifetime risk of developing early-onset dementia [10]. An individual experiencing one or a combination of these issues will be inappropriately placed within a social skills group, or a recovery college, for example, without prior recognition and accommodation of functional capacity; and addressing a range of disability support needs. It is critical to note a skilled professional workforce is required to make these support needs assessments.

Early intervention approaches that do no not recognise and address complex layers of disability faced by individuals, will not fulfil the aims of early intervention for the disabled person or for the NDIS. Nor will it save the NDIS money.

The proposed interventions do not reflect practice learnings or the factors associated with positive experience and outcomes, from the NDIS over the past 10 years. They do not substantially reflect developments in international research and practice during that period. For example, social skills

training for people with psychosocial disability is currently not an intervention commonly used in practice due to the inconclusive evidence supporting efficacy [11]. Further, while the Review report recommends cognitive remediation as an intervention, a 2023 NDIA evidence snapshot reviewed 16 cognitive remediation studies and stated "results were mixed and not statistically significant, meaning we still do not know whether we should expect meaningful improvements on functional capacity and recovery. Finally, compensatory cognitive training…may be effective as well" [12]. A practicing occupational therapist has shared some of her concerns with the evidence-base for the listed early interventions, in Appendix 1 below.

We recommend that early interventions delivered under Section 25 undergo detailed literature review and review of fitness for purpose, particularly if they are intended to be prescribed in a blanket manner. Consultation with the sector and the pursuit of co-designed models and market interventions may yield more effective and innovative approaches.

A potential systemic bias towards historical, and dated interventions, must be acknowledged. We must ensure any new models being proposed are reflective of current consumer, carer and community expectations, and contemporary research. This bias may be understandable if there is a prevailing perception of administrative ease through reverting to historical models, though these remain unproven in terms of government return on investment. While there may be cost-drivers and administrative convenience in reverting to previous models, or a temptation to conflate the development of NDIS models with concurrent model development through the Department of Health psychosocial support programs, solid process, genuine co-design, and rigor in model development is imperative to ensure fitness for purpose and for the NDIS to meet its stated aims. Conceptual considerations cannot be short-cut in the development of contemporary models. We do not want the NDIS Review to take the Scheme backwards for people with psychosocial disability.

5.3. WORKFORCE CONSIDERATIONS

The Review report indicates a particular 'non-clinical' workforce providing the prescribed early interventions proposed. This would not only restrict participant choice and control, but also restrict access to available skilled and effective interventions and practitioners. It will also introduce new layers of risk into the scheme, which clearly add their own significant cost to the Scheme.

The conceptual separation of "clinical" and "non-clinical" elements of the workforce is a false dichotomy and has no place in a contemporary disability system focused on optimising outcomes. This false dichotomy hails back to a bygone era where service options were either: a heavily biomedical and patriarchal public mental health system ('clinical') OR community-based assistance, welfare and help ('non-clinical'). The separation of 'clinical' and 'non-clinical' supports appears to be applied by the NDIS Review to psychosocial disability only (See NDIS Factsheet on Psychosocial Disability), and there is no evidence that this is based on the perspectives of lived-experience or evidence-informed practice. Instead, the workforce planning and design must focus on fit-for-purpose, regulated and professional skillsets, and cost-effective practice governance for the NDIS, as the primary system addressing functional and support needs for people with substantial psychosocial disability

An integrated system recognising the whole-of-workforce will be needed to ensure the broader ecosystem can realise the vision of a safe step-up, step-down approach. This will be required if people are shifting between support levels, including foundational supports, targeted foundational supports, early intervention, and the NDIS (See Fig 76, p. 508).

We refer you to Attachment 1, the document titled Discussion Paper: *Towards active citizenship for people living with psychosocial disability (October 2023)* written by the NDIS Mental Health Community of Practice and supported by peak body Occupational Therapy Australia, where we explore contemporary models and interventions for a psychosocial disability ecosystem; governance and safeguarding considerations; evidence-based occupational therapy-led interventions aligned to the NDIS functional domains and a participation-focused social model of disability; and a detailed description of psychosocial disability workforce elements and their role in achieving functional-domain focused interventions and outcomes.

We highlight that the Allied Health Assistance role is an underutilised and cost-effective resource, that could be developed to ensure the implementation of evidence-based interventions while maximising the reach of the allied health workforce. The role of an Allied Health Assistant is a growing, but at present significantly underutilised, skilled resource. We believe that the increased use of allied health assistants presents a significant opportunity for the NDIS that can be developed to ensure the implementation of evidence-based interventions while maximising the reach of the allied health workforce. The Allied Health Assistant workforce represent an opportunity due to their sharp focus on capacity building and the in-built clinical governance and delegation framework provided by the supervising Allied health professional. Important to note here the extensive benefits to individualised capacity building, risk reduction and access to workforce supply – this all for a similar hourly rate to support workers. It makes sense that AHAs should be used extensively across the Scheme.

6. CONCLUSION

We call for ongoing commitment to equitable access to the NDIS, and individualised supports, for people with substantial psychosocial disability. We propose that the NDIS early intervention pathway requires further conceptual clarity, explicit theory of change, access to a skilled workforce, and evidence-based interventions grounded in disability insurance principles, prior to implementation. We believe there has been insufficient consultation and co-design of the early intervention pathway for psychosocial disability, and recommend detailed review of the evidence-base and a clear consultation and co-design strategy be implemented.

Written by Muriel Cummins, Sally Davison, Carolyn Fitzgibbon and Bianca Parsons, on behalf of the Occupational Therapy Community of Practice.

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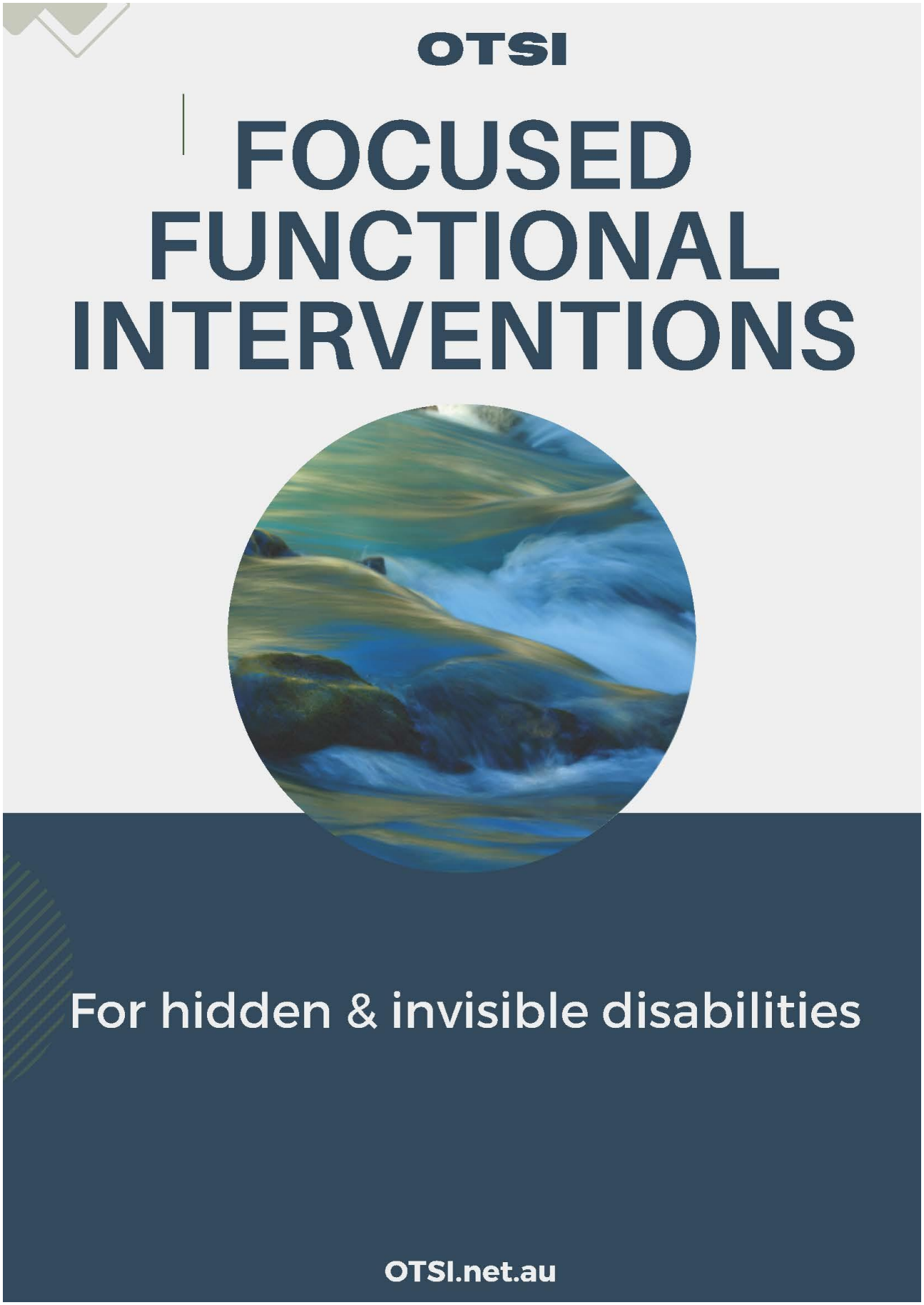
APPENDIX 3: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POLICY DRIVERS

There is an URGENT need to build foundational supports in the community for, the groups identified above.

• NDIS reform highlights an intention to focus on people with the most severe disabilities and a consequence may be a higher threshold for NDIS access, meaning that cohorts who experience significant functional impact from a range of disabilities cannot access the NDIS. Currently there are unprecedented rates on NDIS eligibility reassessment meaning significant numbers of people are losing access at 28 days-notice.

• The Australian government is yet to respond to the Senate ADHD Inquiry, which was completed over 1 year ago.

• The recently published Unmet needs analysis identifies extensive unmet psychosocial need within Australian communities, this is likely to be an underestimation of the scale of unmet need and likely to expand following changes to NDIS plans and access.

Existing Medicare items such as Better Access to Mental Health, target mental -health specific interventions or 'focused psychological strategies', and do not focus on building functional capacity.

• The Australian government is planning to support the mental health of people with long covid.

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WORKFORCE READY: OCCUPATIONAL THERAPY

Occupational therapy is a person-centred, outcomes-based and participation-focused, profession with current national reach, including to people with disability through NDIS.
Occupational Therapists are degree qualified (Bachelor and/or Masters and Doctorates) and regulated by the AHPRA.
There is a large national network of Occupational Therapists already established in communities to deliver support to this cohort.
Occupational Therapy is by far the leading Allied health discipline already providing services to these groups (eg autism, psychosocial and intellectual disabilities) under the NDIS.

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FOCUSED FUNCTIONAL STRATEGIES:

Executive functioning and cognitive strategies/approaches

Routine development and life-skill development

Social functioning and social prescribing

Vocational - work and study engagement

Creativity/Occupation/Activity -based strategies

Sensory based strategies

Activity grading and energy conservation

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The Impacts

Reduced social and economic participation

Barriers to: community access, engagement and to living an independent life

Higher risk of hospitalisation

The Issue

Significant proportions of people with disabilities cannot currently access evidence-based interventions to enhance functional capacity, delivered by Occupational Therapists. There is a large identified and unmet need to enable these cohorts to live full lives and to participate in our communities, through building functional skills, and addressing disability-related participation barriers.

This issue is compounded by:

The absence of function-focused foundational supports in the community

A high threshold to access NDIS, and increased rates of revocation of NDIS access

The limited nature of existing Medicare items to address functional capacity for these cohorts, and the cost-prohibitive nature of co-payment systems.

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