Australian Psychosocial Alliance

Submission to the Commonwealth (DOHDA) Disability Safeguards Consultation Paper:

- **Disability Support Quality and Safeguarding Framework (the Framework)**
- **Disability Support Ecosystem Safeguarding Strategy (the Strategy)**

20 December, 2025

About the Australian Psychosocial Alliance

The Australian Psychosocial Alliance (APA) is Flourish Australia, Mind Australia (incorporating One Door Mental Health and The Haven Foundation), Neami National, Ruah Community Support, Stride Mental Health, Open Minds and Wellways Australia. We are seven of the largest and longest service specialist providers of community managed mental health and wellbeing services in Australia. We provide support to over 110,000 people with mental health challenges and psychosocial disability every year. This includes expert support to around 5,800 NDIS participants with a psychosocial disability. We come together around a shared policy agenda to improve outcomes for people with mental ill-health and psychosocial disability, and a shared understanding of quality service delivery.

Our members deliver Medicare Mental Health Centres, headspace programs, carer connect centres, step-up step-down services (sub-acute, short-term residential care), residential rehabilitation, supported housing, employment, suicide prevention and postvention programs, individual mental health recovery support and NDIS supports. We respond across the spectrum of need and to people in priority populations, such as LGBTIQA+ individuals, culturally and linguistically diverse (CALD) communities, Aboriginal and Torres Strait Islander people, young people and people experiencing or at risk of homelessness.

We combine evidence-based practice with service delivery wisdom to provide recovery-oriented services that support people to build their capacity to participate in society and manage their lives. We focus on personal goals, participation and living a meaningful life. This can include support to sustain a tenancy, build the skills to live independently, find fulfilling work and build social connections.

Our organisations embed lived experience across our governance and service delivery. We employ a specialist cross disciplinary workforce with expertise in mental health and psychosocial disability, and with the technical skills to deliver recovery-focused, trauma-informed and person-centred support.

Collectively, this experience and expertise provide the APA with deep insight into the systemic safeguarding gaps affecting people with psychosocial disability.

Executive Summary

This submission strongly supports the development of a Disability Support Quality and Safeguarding Framework and the Disability Support Ecosystem Safeguarding Strategy. People with psychosocial disability continue to experience the highest rates of violence, neglect, exploitation, homelessness, and early mortality across the disability community. Safeguarding systems have historically failed this cohort due to lack of visibility, siloed funding systems, and low provider viability. The Framework and Strategy represent a critical opportunity to correct these system failures.

To deliver effective safeguarding for people with a disability, particularly people with a psychosocial disability, the Australian Psychosocial Alliance recommends that the Framework and Strategy:

- Explicitly name psychosocial disability and incorporate a dedicated definition,
- Prioritise supported decision-making and lived experience governance as core safeguards,
- Include system-level reforms to ensure psychosocial supports exist both inside and outside the NDIS,
- Recognise provider viability and appropriate NDIS pricing as essential mechanisms to enable safe practice, workforce capability and lived experience leadership,
- Ensure safeguarding obligations extend to mainstream systems including housing, justice, health and homelessness services, and
- Embed outcomes frameworks that reflect participant-directed goals and psychosocial recovery.

Introduction

The Australian Psychosocial Alliance (APA) welcomes the opportunity to respond to the Commonwealth Disability Safeguards Consultation. The APA is supportive of the intent of both the Disability Support Quality and Safeguarding Framework and the Disability Support Ecosystem Safeguarding Strategy, as outlined in the Consultation Paper. We understand that the consultation process is designed to ensure that *"the voices of the disability community and sector are meaningfully incorporated throughout the process, helping to shape a Framework and Strategy that reflect their needs and priorities"*. In this context, the APA advocates strongly for the needs, rights and experiences of people with psychosocial disability.

The APA supports a rights-based approach as defined in the Consultation Paper - while emphasising the importance of ensuring this is clearly extended to people with psychosocial disability. Psychosocial disability must never be used as an excuse to deny or restrict people's rights.

To deliver on the commitments of the proposed Framework and Strategy, the safeguarding architecture must explicitly recognise psychosocial disability. Naming and addressing psychosocial disability is critical for visibility, tailored safeguards, and equitable protection for one of the most marginalised cohorts.

The APA strongly supports a safeguarding approach that:

- recognises and responds to psychosocial disability - one of the most marginalised and vulnerable cohorts

- prioritises supported decision-making as a core safeguard, including investment in capacity building and resourcing families, carers and supporters to actively support informed choice

- adopts an integrated, rights-based and recovery-oriented framework, co-designed with people with lived experience, including within governance structures, to prevent harm and respond effectively when something goes wrong

- positions provider viability as a safeguard in itself - acknowledging that without sustainable organisations and a skilled workforce, safeguards cannot be delivered.

This submission presents several overarching recommendations for consideration in this consultation, followed by detailed responses to selected questions in the Consultation Paper- specifically sections 3.2, 3.4, and 3.5 - and question 21. We have also provided broader recommendations relevant to the Framework design.

We also refer you to our comments to the Productivity Commission in our submission on Delivering Care More efficiently – Interim Report in relation to consistency in service quality standards (September 2025)[1].

Key recommendations

1. Explicitly recognise and name psychosocial disability

Psychosocial disability must be explicitly recognised and named within the Disability Support Quality and Safeguarding Framework and the Disability Support Ecosystem Safeguarding Strategy. The Consultation Paper refers to people with "mental health conditions" but does not define psychosocial disability. Psychosocial disability refers to disability arising from mental health conditions that create barriers to full participation. It is about the impact and experience of disability, not the underlying diagnosis. Not everyone with a mental health condition experiences psychosocial disability, and because psychosocial disability is often invisible there can be a broad lack of understanding about how it affects day-to-day functioning. It frequently requires different safeguarding approaches than those designed for visible disabilities.

When psychosocial disability is not named:

- People become less visible in policy and safeguarding design.

- Their unique risks are overlooked.

- Safeguarding inappropriately defaults to approaches suited for other cohorts.

People with psychosocial disability are among the most marginalised and vulnerable groups, experiencing high levels of disadvantage, exclusion and unmet need. Explicit recognition is essential to ensure that safeguards meaningfully address their rights, risks and support requirements.

We recommend that the Framework include a clear definition within its glossary and preamble. We suggest:

"Psychosocial disability refers to the barriers and impacts a person may experience when mental health challenges affect their ability to participate on an equal basis with others. It describes how a person's thoughts, feelings and behaviours interact with social and environmental factors such as stigma, trauma, relationships, work and service systems to limit opportunities, reduce inclusion and create inequity.

Not everyone with a mental health condition will experience psychosocial disability, and its effects vary from person to person and can fluctuate over time. Psychosocial disability is shaped not only by individual experiences but also by the supports, environments and attitudes that either enable or restrict a person's ability to live well in their community. "

Safeguarding design should also explicitly recognise the intersectional risks that arise when psychosocial disability coexists with homelessness, culturally and linguistically diverse and culturally and racially marginalised identity, justice involvement, substance use, LGBTQIA+ identity, or poverty. These overlapping factors significantly increase vulnerability and safeguarding complexity.

2. Recognise provider viability as a critical safeguarding mechanism

The APA recommends that the Disability Support Quality and Safeguarding Framework and the Disability Support Ecosystem Safeguarding Strategy include mechanisms that prioritise provider viability as a core safeguarding function. Safeguards rely on providers being able to invest in high-quality practice, staff capability, lived experience leadership, and organisational structures that prevent harm before it occurs. Appropriate NDIS pricing is central to this, enabling registered providers to undertake quality improvement, workforce development training and supervision, and to support lived experience representation, including in governance. These activities function as fundamental safeguards.

Current pricing does not fund:

- Clinical and practice supervision,
- Lived experience workforce leadership,
- Mandatory staff training in safeguarding, trauma, and behaviour support,
- Governance, audit and reporting obligations under the NDIS practice standards, and
- Quality assurance systems and complaint handling.

These activities are core safeguarding protections; they are not optional. Currently, registered providers who engage in such activities do so at their own expense.

Registration, while not a guarantee of quality, is the strongest intervention available and is essential for ensuring safe service options, particularly for people who cannot or do not wish to self-manage their supports. Registration should be seen as a means to ensure all participants can exercise greater

choice and control in a safe way, within a quality provider market. Current pricing settings undermine these safeguarding functions and place registered providers' viability at risk. Differential NDIS pricing, which supports quality, trauma informed, evidence-informed practices, recognises the cost of registration. It is therefore required to maintain a safe, sustainable provider market.

Section 3.2 Effective safeguarding includes people with disability in planning, co-designing, implementing and improving their support systems

- *Q 9: What are ways we can support people with disability to shape their own support system?*

Supported Decision-Making (SDM) as the foundation of effective safeguarding

Section 3.1 of the Consultation Paper, *"Effective safeguarding builds people's capability to understand and exercise their rights,"* recognises that a central way of upholding this commitment is by supporting people with disability to build their decision-making and self-advocacy skills. While this section of our paper responds to Question 9 in Section 3.2, we note Sections 3.1, 3.2 and 3.3 collectively address the importance of including people with disability in planning, co-designing, implementing and improving their support systems, and ensuring services have the capacity to deliver person-centred support. The APA maintains that achieving these outcomes comes down to the following key priorities:

- prioritising Supported Decision-Making (SDM) as the foundation for effective safeguarding,
- recognising that people have the right to make decisions about their own lives and that enabling informed decision making and building self-advocacy leads to safeguarding,
- embedding lived experience in governance, and
- understanding that providing effective SDM often requires knowledge, skill, and significant time.

Effective safeguarding for people with psychosocial disability requires a system-wide approach that upholds the rights-based principles described in the Consultation Paper. These rights are realised in practice through SDM, which should be centred in any safeguarding approach.

Fluctuating decision-making ability can be a feature of psychosocial disability. People may require variable levels of support across time, including during periods of crisis or hospitalisation. Safeguarding design must therefore accommodate episodic change rather than assuming linear, static capacity. This principle is not identified in the Consultation Paper and should be incorporated into the Framework.

The National Disability Services guide, *People with Disability and Supported Decision-Making and the NDIS* (National SDM Guide)[2], identifies SDM as best practice for enhancing people's ability to make their own decisions. As the guide states, this is reinforced in Part 2(6) of the NDIS (Provider Registration and Practice Standards) Rules 2018, which requires that each participant is supported to make informed choices, exercise control and maximise their independence. NDIS Practice Standards

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[2] National Disability Services (2019). The National Disability Services guide, *People with Disability and Supported Decision-Making and the NDIS*, p. 7

embed these rights and require registered providers to uphold participants' decision-making rights and eliminate risks of those rights being disrespected or breached.

The NDS Guide[3] identifies the systems and practices that providers need to uphold these rights as being:

- policies and procedures that describe participants' rights,
- recruitment, training and supervision systems that focus on respecting those rights,
- staff trained in SDM skills with access to tools and resources,
- clarity about decision-making supports when participants cannot make certain decisions, and
- systems ensuring that any decisions made on a participant's behalf occur lawfully.

These underscore the need for pricing and structures that enable registered providers to invest in the workforce, systems and capability required for effective SDM.

We recognise participants who claim their full citizenship rights, including the right to make decisions about their own lives are the strongest safeguard. When people are supported to make informed choices and navigate disability supports and the NDIS, risk is significantly reduced. However, SDM frameworks require time, resources and the appropriate system conditions to succeed[4].

Advocacy networks and strong Support Coordination are essential for people with psychosocial disability, yet current Support Coordination funding is insufficient for genuine oversight and guidance. The APA has long supported people with psychosocial disability to advocate for themselves, but due to functional impairments such as difficulty managing administrative processes or disillusionment due to system failures, many rely on ethical, specialist not-for-profit providers to outreach to them and build their decision-making ability effectively. The NDIS Review[5] recognised the importance of this capability (Recommendation 7).

Guaranteed access to advocacy, outside funding eligibility and administrative constraints, is important to enable people with psychosocial disability to claim rights and challenge unsafe decisions. So, in parallel, addressing significant funding shortfalls for advocacy services and networks is critical to enable both individual and systemic advocacy, and to ensure diverse forms of formal advocacy support complement informal networks rather than leaving them overstretched and unsustainable.

Supporting families and carers

The APA acknowledges the critical role of informal safeguards. Families (of choice and origin), supporters and carers play an essential role as informal safeguard networks through which SDM may be achieved but cannot fulfil this role effectively without adequate resourcing and support of their own. Strengthening systems around families, supporters and carers is critical for equipping them with the tools and knowledge needed to raise awareness of potential system failures and assist in contributing to decision making ability, particularly for people with psychosocial disability.

This further reinforces SDM as a key safeguarding priority if we are to ensure people with psychosocial disability can exercise their rights and genuinely shape their supports, consistent with

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[3] Ibid, p. 8
[4] Peterson, A., Karlawish, J., & Largent, E. (2021). Supported decision making with people at the margins of autonomy. *The American journal of bioethics: AJOB*, *21*(11), 4–18.
[5] See: Recommendations and actions | NDIS Review

the commitments outlined in Sections 3.1–3.3 and the system coordination expectations in Section 3.5 of the Consultation Paper.

Participant-directed outcome measurement as a safeguard

Building on the central role of SDM in safeguarding, it is equally important that the ways we define, monitor and measure outcomes also reflect what people with psychosocial disability value. To achieve this, safeguarding frameworks should incorporate participant-directed measures that reflect people's personal goals, quality-of-life improvements, and self-defined progress markers.

While this submission focuses on outcome measurement in the context of the Framework and the Strategy, it is important to note that there has been no investment in participant-directed outcomes across the sector more broadly. The absence of a nationally consistent approach to outcomes measurement erodes system-level monitoring and limits safeguarding capacity. The APA advocates for an AIHW-led minimum data set and outcome measurement approach, co-designed with the lived experience community.

The disability and mental health systems have traditionally been guided by academic and clinical perspectives to define success, with funding models and performance frameworks built around evidence-based indicators, symptom-reduction scales, and service-utilisation metrics. As the sector evolves, there is growing recognition that these established measures can be enriched by incorporating what matters most to participants and families[6].

This shift aims to capture the lived reality and priorities of people with psychosocial disability. By integrating participant-directed measures into the Framework and the Strategy, there is opportunity to reshape how safeguards are developed, implemented and embedded in systems and cultures, ensuring they align with what people value and need.

In addition, we recommend that the process of monitoring and evaluation be co-produced - not only the design of measures themselves - to ensure meaningful involvement and ownership. Findings should also be openly disseminated in the interests of transparency, accountability, and sector-wide learning and improvement.

Evidence shows that when participants and their families, supporters and carers help shape how actions are co-developed and measured, they naturally become more responsive and person-centred[7]. Such alignment leads to higher quality outcomes for everyone involved.

Engagement and co-design with people with lived experience

The APA does not speak for people with lived experience of psychosocial disability, but we note that the specific priorities expressed by the thousands of people with psychosocial disability we support - and the means by which they could be addressed - are not clearly evident in this Consultation Paper.

Section 3.1 of the Consultation Paper acknowledges that effective safeguarding builds people's capability to understand and exercise their rights, while Sections 3.2 and 3.3 emphasise inclusion in planning, co-designing, implementing, and improving support systems. These commitments can only

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[6] Roe, D., Slade, M., & Jones, N. (2022). The utility of patient-reported outcome measures in mental health. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, *21*(1), 56–57.

[7] Yang, C., & Northcott, D. (2019). Together we measure: Improving public service outcomes via the co-production of performance measurement. *Public Money & Management*, *39*(4), 253–261.

be realised if people with lived experience of psychosocial disability are explicitly included in the next stages of development.

We draw attention to the phased four-step approach to developing the Framework and Strategy and recommend that, in subsequent steps (testing and refining the draft Framework and developing the Strategy), the voices of people with lived experience of psychosocial disability are central to this process. Each APA organisation employs people with lived experience and lived expertise who are well placed to facilitate input and involvement from users of our services.

While co-design is essential, embedding lived experience in governance structures is also a critical but underdeveloped pathway to ensuring services are both responsive and held accountable for delivering quality and safe services[8]. This is a significant opportunity to ensure the Framework and Strategy are shaped and governed by the very people they aim to protect. Emerging practices can be leveraged, and existing models - such as the LELAN Lived Experience Governance Framework[9] - offer valuable guidance for addressing gaps and embedding lived experience in governance.

We maintain it is essential to shift the focus of traditional governance models. Lived experience evidence points to the need for governance systems to rebalance relational and transactional approaches, rethink or expand approaches to risk, focus more on engagement with participants and families, and be more accountable for participant experiences and outcomes. This shift directly aligns with safeguarding principles.

Section 3.4 Effective safeguarding ensures services are accountable for actively preventing and addressing harm

- *Q15. Are there other forms of accountability you think would increase quality and safety?*
- *Q16. What could be changed to keep services accountable?*

Prioritise prevention and dignity of risk over reactive responses to harm.

In addition to the key accountabilities already outlined to ensure services actively prevent and address harm - including through embedding lived experience in governance - the APA also supports enhanced powers for the NDIS Quality and Safeguards Commission under the *NDIS Amendment (Integrity and Safeguarding) Bill 2025*. While we welcome stronger monitoring, compliance, enforcement, and penalties for serious breaches, we note these measures are largely reactive, addressing harm after it occurs rather than preventing it. Enforcement-focused safeguarding alone cannot deliver the outcomes people with disability need. It should serve as a last resort within a comprehensive safeguarding framework, not as the primary strategy.

Safeguarding is not only about rules and penalties. Success will rely on the Commission having sufficient resources and capability to build a safeguarding culture that moves beyond compliance and genuinely respects the choice, control, and dignity of risk of people with disability, as well as

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[8] Loughhead, M, McIntyre, H, Hodges, E & Procter NG (2020). Lived experience leadership for organisational and systems change: a scoping review of concepts and evidence, University of South Australia and Lived Experience Leadership and Advocacy Network SA, Adelaide.
[9] See Lived-Experience-Governance-Framework.pdf

delivering effectively on both enforcement and prevention responsibilities. This means recognising people's right to make decisions others might consider risky while distinguishing between dignity of risk and dangerous neglect. It requires building trust so that people feel safe to report concerns without fear of losing support or autonomy. Prevention is achieved not only by responding to harm, but by equipping the people, families, carers and supporters, and systems supporting people with disability with what they need to reduce the likelihood of harm occurring in the first place.

Registration and appropriate pricing strengthen accountability

We welcome the Consultation Paper's focus on developing a unified Framework and Strategy that supports all people with disability - both within and outside the NDIS - in line with recommendations from the NDIS Review and the Disability Royal Commission for stronger, more consistent safeguards that uphold people's rights, safety and wellbeing while still supporting choice and control.

The APA maintains that provider viability is critical for effective safeguarding cultures and systems. Appropriate pricing is one of the key tools available to government to support this. As our response to Section 3.2 Question 9 highlighted, pricing uplifts for registered disability service providers would enable investment in the essential elements of safe and ethical practice. These activities should be understood as fundamental safeguards.

We recognise that registration is not a guarantee of quality, but it remains the strongest indicator currently available. A strong registered provider market is integral to providing choice and control in the market and ensuring that there are suitable options at scale for people who do not have the capacity, capability, or interest to self-manage their supports; or who are vulnerable and otherwise marginalised. The Disability Royal Commission highlighted that unregulated providers disproportionately exploit people without the skills or informal supports needed to self-manage, demonstrating that a well-funded registered market is a safeguard in itself.

The APA has consistently raised concerns - most recently in submissions to IHACPA on NDIS pricing (November 2024)[10] and on SIL and Support Coordination mandatory registration reforms (March 2025)[11] - about the low rate of provider registration, estimated by the NDIS Review to be around 10 per cent of all providers. Current pricing does not reflect the real costs of registration, including investment in standards implementation, quality improvement, staff training, supervision and development. Larger registered providers, including within APA agencies, demonstrate the system-wide benefits of a regulated sector: there are structures to build and develop the lived experience workforce, we offer practice pathways for graduates, and we provide safe environments for skill development across the mental health and disability sectors.

These commitments strengthen the entire disability ecosystem but are not sustainable without appropriate pricing; the current NDIS pricing and regulatory framework place these activities at risk. This is especially evident in Support Coordination, where pricing requires operation with minimal overheads, undermining important safeguarding functions. The current pricing strategy has supported growth in small, unregistered providers whilst driving larger providers out of the market due to financial sustainability issues. This reduces the availability of safe, registered options for people with psychosocial disability.

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[10] See: APA_Submission on NDIS pricing (IHACPA) Final.pdf
[11] See: NDIS SIL and Support Coordination Mandatory Re.pdf

For safeguarding to operate as intended, differential NDIS pricing is required to reflect and compensate for the true costs of delivering high-quality registered services and the broader system benefits they provide.

Section 3.5 Effective safeguarding requires systems to work together in a coordinated way

- *Q 18. Do you have any examples of when services have worked well together?*
- *Q 19. Are there things that stop services working well together in your experience?*

A system-wide approach to prevent harm

As this submission has outlined, people with psychosocial disability frequently experience marginalisation and often have multiple and complex needs. They encounter significant barriers that limit opportunities for full social and economic participation. These barriers contribute to poorer physical health and lower life expectancy, make it harder to maintain stable housing, and can lead to overrepresentation in homelessness statistics and interactions with the justice system. These realities highlight why effective safeguarding in this context cannot be confined to disability-specific systems but instead must address the broader systemic barriers impacting people.

The APA welcomes the stated intention of the Framework and the Strategy to support people both within and outside the NDIS given the vast majority of people with psychosocial disability will never be NDIS participants. Safeguards must therefore be implemented across systems and explicitly recognise the role of community mental health services, housing and homelessness services, health care (including acute and tertiary mental health), carer and family supports, peer-led services, and the justice system.

The Framework should also consider a single point-of-coordination model for people with psychosocial disability who engage across multiple sectors (clinical mental health, housing, justice, income support). This role would reduce fragmentation, minimise information loss, and prevent escalation to crisis pathways.

Safeguarding for people with psychosocial disability must address the broader social determinants of safety - such as housing stability, social connection, access to services, and evidence-informed, inclusive practices. The formal and informal safeguards required for this cohort may look different from those designed for other disability groups and must be tailored accordingly.

National coordination and an integrated ecosystem of safeguarding

Aligned with our position on the Australian Disability Strategy consultation[12], the APA supports a nationally coordinated approach to implementation of key safeguarding instruments. We support a unified and integrated ecosystem of safeguarding supports - not only a 'disability ecosystem of safeguarding' - which recognises the essential role of mainstream health and community services.

We welcome the Consultation Paper's statement that "formal safeguards… may be specific to disability services or include broader services and contexts, such as health care, education and workplaces." An integrated approach to safeguarding requires coordination across levels of

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[12] See: APA Submission Australia's Disability Strategy.pdf, p. 4

government and across portfolios, including at a state and territory level. This is essential to ensure that systems can work together in a coordinated way to achieve effective safeguarding in practice.

Examples of when services have worked well together (Q18)

In our experience, services work well together when there is clear recognition that safeguarding extends beyond disability systems and when mainstream agencies - such as community mental health, homelessness services, and acute mental health care - can partner effectively to collaborate around shared goals for the person. For example, effective collaboration occurs when:

- housing providers, psychosocial support services and clinical mental health services jointly plan support for people with complex needs

- peer-led services and family/carer supports are included alongside formal providers

- Support Coordination is adequately funded to ensure clear communication across sectors.

These examples demonstrate that when systems are able to effectively collaborate, they can collectively prevent harm by supporting stabilisation and recovery and maintaining people's connection with services and community. To achieve this consistently, the Framework should be designed to support coordinated models of support for people with psychosocial disability who engage across multiple systems. This approach requires sustainable funding to reduce fragmentation, improve information sharing, and help prevent escalation into crisis pathways.

Barriers that stop services working well together (Q19)

There are a range of factors that prevent systems working effectively together. Inconsistent eligibility requirements, fragmented funding arrangements, and a lack of information sharing capacity across systems frequently create gaps in support. Many mainstream services are also not designed with psychosocial disability in mind, resulting in decisions that inadvertently increase risk.

Additionally, when safeguards rely heavily on the NDIS, people who are not NDIS participants - particularly those with psychosocial disability - are left without support, coordination or monitoring. This fragmentation contributes directly to avoidable harm and deterioration in people's circumstances.

Fragmented commissioning undermines safeguarding – Primary Health Networks (PHNs)

In January, the APA's submission to the Review of the PHN Business and Primary Care and Mental Health Flexible Funding Pool Model highlighted barriers to collaboration and their safeguarding implications.[13] While PHNs can be highly connected, the shift to commissioning and contract management often limits providers' ability to build strong partnerships, This undermines efforts to create the sort of integrated system that is essential for safeguarding.

PHNs rely on goodwill and the capacity of providers to form meaningful partnerships -with limited authority outside those in which they have a funding relationship. This leaves APA agencies to pursue partnerships independently – sometimes required by tenders - rather than PHNs leveraging their networks to support this activity. When providers change after tenders, partnerships must be rebuilt.

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[13] See: APA Submission to the PHN Business and Primary.pdf

Frequent commissioning creates unnecessary competition and contributes to market thinning, while overlap in state and federal-commissioned services also impedes integration and creates complexity for clients, referrers and providers. Effective safeguarding depends on systems working in partnership, not in isolation. When integration is compromised, the risk of harm increases.

Section 3.6 Additional information

Q:21 How else can we make safeguarding better? You can share a suggestion or anything else you think is important.

Naming and recognising psychosocial disability is critical to safeguarding

Without explicit recognition and tailored safeguards, people with psychosocial disability risk being invisible within the Framework and Strategy, despite being among the most marginalised and vulnerable groups. As a cohort, they experience high levels of social disadvantage and isolation, poorer physical health, and significantly lower life expectancy. They also face considerable housing instability and are overrepresented in both homelessness services and the justice system.

Extensive evidence demonstrates the depth of this marginalisation. For example, the *2011 Productivity Commission Report into Disability Care and Support,*[14] which informed the design of the NDIS, identified that around 35% of people with a primary psychosocial disability and the highest support needs were likely to have experienced long periods of hospitalisation, were at risk of homelessness if unsupported, and often lacked strong family or social networks. More recent data reinforces this picture. The 2023–24 Specialist Homelessness Services (SHS) national dataset recorded 3,952 people who had both a diagnosed mental health condition and a disability requiring assistance with at least one core activity. Almost half of this group were homeless at the time they requested assistance.[15]

Research for the 2019-2023 Disability Royal Commission also found that people with psychosocial disability experience higher rates of violence, abuse, neglect and exploitation than other disability groups[16], highlighting the heightened safeguarding risks for this cohort.

Marginalisation for people with psychosocial disability can also occur within disability systems. Because psychosocial disability may not be visible or obvious there can be a broad lack of understanding of how mental ill health impacts day-to-day functioning. Mainstream disability services are often not designed to meet the needs of people with psychosocial disability. This is reflected in low rates of NDIS access. The Health Policy Analysis (2024) report, *Unmet Need for Psychosocial Supports Outside the NDIS* found that almost 500,000 Australians require psychosocial support but are not receiving it. Since 2020, access to the NDIS for people with psychosocial disability has decreased by 62%, a far greater reduction than for any other disability type.[17]

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[14] Productivity Commission. (2011). Disability Care and Support, vol.2, p.761 See: Inquiry report - Disability Care and Support | Productivity Commission

[15] AIHW. (2024). Specialist Homelessness Services Collection data cubes 2011–12 to 2023-24

[16] Fry, T. (2023). Economic Cost of Violence, Abuse, Neglect and Exploitation of People with Disability. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

[17] Health Policy Analysis (2024). Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme: Final report. Final Report - Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme

The Grattan Institute's 2025 report, *Bridging the Gap: Meeting the Needs of Australians with Psychosocial Disability* provides further evidence of systemic gaps in support. It identifies that while around 66,000 Australians with psychosocial disability receive NDIS support, more than 130,000 adults with the highest needs receive no support at all - from the NDIS or the mental health system - despite strong evidence that recovery-oriented psychosocial services improve functioning and wellbeing.[18]

Drawing on 2022 ABS data, the Grattan report shows that people with psychosocial disability are less likely to be in the workforce and have significantly lower incomes. Educational disadvantage is also evident. Around two in five people with psychosocial disability have not completed Year 12 or higher qualifications, compared with one in five people without disability. These disadvantages create barriers to accessing safe housing, transport and healthcare and impact community participation.

The same dataset shows that over four in five people with psychosocial disability report barriers to participating in social or community activities, and one in four report discrimination in the past year due to their disability. These intersecting forms of marginalisation co-exist with the increased risks of violence, abuse, neglect and exploitation, creating a compelling case for safeguards that explicitly name and address psychosocial disability.

Safeguarding must also address service continuity. People with psychosocial disability are disproportionately harmed by service withdrawal, waitlists, and sudden provider exits. Embedding requirements for warm handovers, continuity planning, and crisis-escalation pathways would significantly reduce safeguarding risk.

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[18] Grattan Institute (2025). Bridging the gap: Meeting the needs of Australians with psychosocial disability. p.6. See: Bridging the gap: Meeting the needs of Australians with psychosocial disability.