Australian Psychosocial Alliance

Future Psychosocial Support Arrangements – Response to the Consultation Paper

February 2025

About the Australian Psychosocial Alliance

The Australian Psychosocial Alliance (APA) includes Flourish Australia, Mind Australia, Neami National, One Door Mental Health, Ruah, Stride Mental Health, Open Minds and Wellways Australia. We are specialist providers of community managed mental health and wellbeing services in Australia, with most registered as NDIS providers with a particular focus on psychosocial disability.

Members of the APA have extensive experience providing recovery-oriented care and support which focuses on personal goals, participation and living a meaningful life. We have evidence of what works, and combine this with service delivery wisdom, to provide recovery-oriented services that support people to manage their symptoms and build their capacity to participate in society and manage their lives. This includes support to sustain a tenancy, build the skills to live independently, find fulfilling work, and build social connections.

The people who access our supports come from diverse communities across Australia, with each of our organisations having a clear commitment to promoting community inclusion and participation. We have experience providing services to at risk groups, such as LGBTIQ+ individuals, culturally and linguistically diverse communities, and Aboriginal and Torres Strait Islander people, as well as young people. We recognise the value of lived experience and seek to co-design services and approaches wherever possible.

Plan on a Page

Part of a mental health "eco-system"	• Psychosocial supports as the primary focus of the mental health system, with clinical support provided as needed. • Expanded psychosocial support offering which fits within the existing system (eg: medicare mental health, head to health/NEIS/digital, clinical mental health services, existing psychosocial). • National vision and consistency – with local responsiveness • Clear pathways to the NDIS • Clear entry points and service navigation (remove duplication of story telling)

Individualised Recovery Based Service Models	• Privileges lived experience
	• Supports individuals in their context and community (as social citizens)
	• Client directed planning tools/ individualised "support pathways" across all life areas:
	  ○ job/study
	  ○ relationships/social
	  ▪ family/carers
	  ○ home/housing
	  ○ health (physical and mental health) management
	  ○ financial inclusion and literacy
	• Service navigation (finding and linking)
	• Access to discreet/time-limited tailored programs to provide choice and options:
	  • individual, group, mainstream
	  • for example: psycho-education (Recovery Colleges), recreation, mutual support and self help.
	• Housing (links, access, living and tenancy support) must be factored in.
	• 2 – 2.5 year time frame/ flexibility to re-enter
	• Pathway to NDIS for those that have long term ongoing support needs.

Outcome measures	• Need to measure what is important to service users.
	• Agency outcome measurement supports quality service delivery; a suite of tools can/may be necessary for this (can and should change; be different for different services).
	• Government focus should be system measures for psychosocial outcomes:
	  ○ Housing gained/maintained
	  ○ Improvement in relationships/community participation
	  ○ Gained/maintained employment/education
	  ○ Improved physical health
	  ○ Positive changes in use of health services
	  ○ Financial stability.

Enablers	• Common national community mental health data set which supports monitoring of psychosocial outcomes at system level. • Market stewardship across portfolios – consistent pricing, longer contracts/funding cycles, pay and stability for workforce. • Reflect real costs of developing and supporting lived experience within service structures and delivery.

1. Our vision

The plan for meeting psychosocial unmet need should be ambitious. It needs to recognize that psychosocial support is not discretionary but a fundamental part of a contemporary, comprehensive mental health support system. It is about maximizing outcomes for individuals and their friends, family and supporters, the community and the service system.

Addressing this significant service gap provides an opportunity to ensure that we invest in a service system which is integrated, builds on what already exists and ensure a response across the spectrum of need. This means:

- Defining the new "eco-system" of care, taking the leadership to coordinate across portfolios and programs, and addressing the fragmentation in the system which has been exacerbated by the introduction of the NDIS, and piecemeal funding of the community mental health sector.
- Making psychosocial supports the primary focus of the mental health system, with clinical support (treatment) provided as needed. This better reflects the reality that people want and do get most of their supports in the community and from family, friends and other supporters.
- Designing for access for those who are most at risk of missing out (eg: assertive where necessary, local, welcoming, culturally appropriate).
- Privileging lived experience in service delivery, and ensuring that people's voices, expertise and participation is appropriately funded.
- Placing services in the community and elevating the right of individuals to take up or reclaim full citizenship.
- Scaling and adapting what is already working.
- Taking responsibility for market stewardship and ensuring that there is a thriving, quality community managed mental health sector.
- Building a common National data set and shared understanding of system outcomes (including the reduction of health expenditure).
- Planning for and having mechanisms to adapt to changing population and groups.

2. Brief responses to the consultation paper:

2.1 Current state and case for change

The plan must acknowledge that the gap and level of unmet need is widening. This is occurring because:

- Access rates to the NDIS for people is now less than 30% and is declining[1].
- The NDIS Review (2023) identifies that the NDIS was not fit for purpose for people with psychosocial disability but as yet there is no commitment from Government to implement the Review recommendations. We understand that any action from the NDIA regarding the new early intervention pathway is two to four years away; and in the mean-time a reassessment may lead to people being moved off the scheme. In any case, we are noticing a pattern of decreasing package sizes (even though needs have not changed) for both existing and new participants.
- Declining capacity (and therefore activity) in the CPSP due to lack of indexation and increasing costs. Agencies are responding by renegotiating targets, or increasing throughput by discharging earlier than is optimal.
- Worsening of mental health in the community[2].

[1] NDIS Quarterly Report, Q1 2024-2025, Supplement E, https://dataresearch.ndis.gov.au/media/4109/download?attachment
[2] National Mental Health Commission Report Card 2023, https://www.mentalhealthcommission.gov.au/publications/national-report-card-2023

Additionally, the specialist community managed mental health sector continues to shrink with providers exiting regional areas and/or merging to be of sufficient size to remain viable. The effects of short and unpredictable funding cycles, lack of indexation, managing multiple and different funding mechanisms, reporting and data requirements, and changing registration/regulatory environments are affecting the sustainability of the sector, with flow on effects to workforce and ultimately the choice and quality of services for the community.

This plan cannot exist in isolation of other Government programs and commitments. At a minimum it must address its interface with the NDIS, but ultimately should also identify interface points with housing, employment, health and education/training.

2.2 Principles to support delivery of psychosocial supports

The APA supports the principles for effective service delivery as outlined in the MHA/MHCCF Advice to governments: evidence information and good practice psychosocial services (2024). The APA emphasises the following elements as essential:

- Human Rights
- Privilege of lived experience
- Social citizenship
- Accessibility and inclusivity

We recognize that the response for Aboriginal and Torres Strait Islander people may need to be different, however, it is important that the significant disadvantage and poorer health outcomes of this group are also emphasised within the development of this plan, including for mainstream services.

The Plan itself must be underpinned by the following principles:

- Reducing and eliminating the unmet psychosocial needs
- Funding quality service provision
- Service and workforce sustainability
- Commitment to responding and adapting to changing populations and groups.
- National consistency

Finally, this plan needs to be integrated with other national agreements, including disability, housing and health.

2.3 Characteristics of good and emerging practice service models

Individualised recovery based service models

The MHA/MHCCF Advice to governments (2024) provides a solid guide to what is working and what people want. What is also shows is that there is no one size fits all for people in their recovery, and it is important that there is a variety of options and/or a menu of supports for people to draw from. This includes a mix of individual, group and mainstream programs.

However, as a starting point for many people with significant mental health issues and psychosocial disability, it is an individualised recovery support program which provides a way to build hope for recovery and plan for future wellbeing, set goals and receive practical assistance to access the services, supports, opportunities and programs that will work for them. These programs can respond in crisis, where there is

trauma and where people may not yet have knowledge or understanding of their options; and they offer options for how to access support. Examples of such programs include the Commonwealth Psychosocial Support Program, the NSW Housing and Accommodation Support Initiative (HASI)/ Community Living Support (CLS) or the Victorian Early Intervention Psychosocial Support Response.[3]

Similarly, the Victorian mental health locals, and some Medicare mental health centres, are clearly demonstrating how the integrated hub model with clear entry points and access to support and service navigation, is providing a platform which assists people to identify, and then access, the support they need.

All these programs are suitable for scaling to meet the psychosocial unmet need. The APA also notes that there are many program guidelines/service delivery frameworks (past and present) which define these types of service offering and which could be adapted to develop guidelines for a nationally consistent approach.

The APA notes that psychosocial support is also provided within clinical (ie: public mental health) services and by people with clinical qualifications. The APA supports psychosocial support being provided within clinical settings as part of comprehensive mental health care. However, public clinical services generally provide short term care, and often only after people experience a significant mental health crisis. The specialist community managed sector can deliver psychosocial support in the community where people want and need this type of support. It can deliver more cost effective and early interventions, supporting people to access clinical care (including within the community managed sector) as needed and before they reach crisis point and preventing the need for more intensive health service/ hospital funded care.[4]

Filling the gap – key factors for a new response

The psychosocial unmet needs project measured the service gap for people with moderate to severe mental illness and associated psychosocial disability. It is important that the plan retains a focus on meeting the needs of this group of people and that service design fully consider what this means for access and choice. For example, it necessarily needs to consider more assertive approaches as well as initial support and service navigation that can respond in crisis and where people may also be experiencing trauma.

The new response also needs to:

- Embrace lived experience as an essential part of service delivery.
- Support individuals in their own community, place of living and "context" (as social citizens).
- Use client directed planning tools (across all life areas) which lead to, and support access to, individualised "support pathways".
- Provide for the development of "programs" which provide evidence based discrete or time limited interventions which give choice in how and where support is received. For example, psychoeducation programs (eg: Recovery colleges), mutual support and self help, social or recreational groups and employment assistance.
- Factors in housing (eg: links, access, living and tenancy support)

[3] In addition to the MHA/MHCFF advice to Governments (and the research used to develop this document), reviews such as those undertaken by Nous of the Evaluation of National Psychosocial Support Programs (2021) provide important pointers to what is required to deliver quality services. (eg: funding timeframes, data etc)

[4] The Productivity Commission Inquiry Report into Mental Health (2020) reports data showing psychosocial support reduces hospital admissions and length of stay. Vol 3,p28.

- Extend time periods that people can access support to 2 - 2.5 years; and flexibility to re-enter and/or use the program as required. The expectation should be that people requiring consistent support for more than two years would meet the criteria for long term support though the NDIS and should be assisted to test their eligibility).
- Pathway to the NDIS for those that have long term ongoing support needs (ie: after 2-2.5 years).

2.4 System enablers and broader system improvements

Improving system access, coordination and navigation

Key factors for consideration are:

- Strengthen and building on the existing system. This includes to build on and ensure a more consistent service offering of Medicare mental health centers (in Victoria, mental health locals), carer connect centres, and the NEIS as increasingly acceptable and known entry points.
- Commitment to (promoting) funding integrated hubs.
- More consistency across PHN/Commonwealth funded "core" mental health offerings – eg: clear pathways and roles around support and service navigation (same outcomes but allowing for flexibility in response to local needs).
- Peer navigational supports: our experience is that in our Medicare mental healths/Victorian mental health locals (and previously through programs such as PIR and PHAMS) that peer support to assist with navigation is effective.
- Peer support: our experience is that peers providing practical support and advocacy to assist and accompany people to access the supports they need, or participate in activities that they want, is also very effective and evidence-based.
- Digital/hybrid approaches to ensure maximum reach and accessibility.
- Quality client directed planning tools, and a skilled and experienced workforce who understand the broader service system and service/support options.

Building and retaining a skilled workforce

Addressing this requires providing a workplace which offers competitive pay and job security. Governments need to commit to market stewardship of the community managed mental health sector. This includes a commitment to:

- Appropriate pricing consistent across sectors – disability, aged and health care.
- Less frequent tendering. Frequent tendering ultimately results in providers exiting the market (including regional area where if a tender is lost the provider exits permanently), reduces choice and workforce sustainability.
- Program funding for Certificate IV level workers, including lived experience (peer) workers, ongoing learning development and supervision.
- Contracting practices which prioritise quality and outcomes over cost.

There also needs to be a more significant commitment to workforce panning. There needs to be a greater consistency between national and state workforce strategies, and to expand the National Mental Health Workforce Strategy (2022-2032) so that it also considers the psychosocial or community workforce development needs.

Information and advocacy

Quality information and advocacy support is a fundamental right and should exist across the service system. However, how and when it is accessed will be different depending on people's needs and which services they are using. It is important that it is seen in a broader context than just mental health/psychosocial support delivery but that the need for advocacy support exists across a range of life areas.

For this target group and the psychosocial support response, the focus needs to be on how the service model identifies, and then navigates people to the right advocacy support. For example, to receive legal advice on a non mental health related matter.

Changing attitudes and culture

As community managed mental health services we are committed to addressing stigma and discrimination, and we do so through engaging with local communities, the media and supporting our service users to embrace their social citizenship.

However, this plan should reference and build on existing frameworks in this space – for example Australia's Disability Strategy 2021 - 2031, and the National Mental Health Stigma and Discrimination Framework rather than provide a separate response.

Coordinated and consistent frameworks for evaluation and monitoring

It is timely to consider a more national approach to data collection and implementation of a common data set across the range of community managed mental health programs, including those funded through the PHNs. This should be managed and overseen by the AIHW and data should be publicly available to aid research and monitoring across community and academia.

Governments should focus on measures which reflect psychosocial outcomes. For example, a suite measures could encompass:

- Housing gained/maintained
- Improvement in relationships/community participation
- Gained/maintained employment/education
- Improved physical health
- Positive changes in use of health services
- Financial stability.

Governments should expect that a quality service will invest in a suite of tools for individual and service outcome measurement. It is reasonable to expect that agencies will choose these tools, and change and adapt these measures to suit different service types and information needs. It is unclear that it is necessary that this information be compiled at an aggregated level and/or whether it can or could provide useful information. However, agencies should and could share this information when it assists in providing insights about what is working (or not).

All evaluation and monitoring should also measure what is important to the service user. Some of this will need to sit at the service level, while others should be sitting at the system level.