

Australian Psychosocial Alliance

Submission: Supported Independent Living (SIL) Commissioning Consultation

to the Department of Health, Disability and Ageing

September 2026

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, Richmond Fellowship Queensland, Ruah Community Support, Stride Mental Health, Open Minds and Wellways Australia. We are eight of the largest and longest service specialist providers of community managed mental health and wellbeing services in Australia. We provide support to over 120,000 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.

Introduction

This submission draws on the direct service delivery experience of the five APA member organisations that currently deliver Supported Independent Living (SIL) and SIL-like home and living supports to people with psychosocial disability: Mind Australia, Wellways Australia, Flourish Australia, Richmond Fellowship Queensland and Stride Mental Health. Between them, these organisations deliver SIL and SIL-like supports across metropolitan, regional and forensic or long-stay settings, to cohorts ranging from high, complex support needs to lower-intensity independent living support.

Our members support people with psychosocial disability every day in complex and often high-risk NDIS living situations. We see, first-hand, a system built for a different kind of disability. One that consistently fails people who need someone reliably present, not eight hours of scheduled care; people whose needs change from one day to the next in ways a fixed annual plan cannot anticipate; people who are excluded from SIL altogether, and who then go on to pay for the same support informally, with less oversight, and therefore sometimes unsafely.

We understand government has not yet decided whether to commission SIL directly, or how much of the SIL market to commission. Nevertheless, we write with a clear view: people with psychosocial disability should be one of the first groups government considers. The case for a different approach is stronger here than almost anywhere else in the NDIS. Better outcomes and efficiencies for government are both possible.

We are suggesting a tiered, flexible model, where support can adjust to what a person actually needs rather than being fixed at a set level, so that people get the right level of support rather than being pushed into a one size fits all package. This is likely to direct funding to where it makes the most difference to people's lives; it may also reduce overall spend. Ultimately, people would be better supported, and NDIS resources used more effectively.

Our submission presents participant examples in line with this tiered model (p.11), and further examples in the appendix (from p.16). The submission and these examples all seek to:

- Provide insight into the challenges that people with psychosocial disability experience in their daily lives
- Underline the challenges people with psychosocial disability experience with SIL and SIL-like supports
- Demonstrate the importance of specialised psychosocial disability expertise in improving outcomes for people with psychosocial disability. Such expertise is not sufficiently valued by the current funding and regulatory approach to delivery of SIL, SIL-like and general NDIS supports.

Recommendations

Recommendation 1: That government commission psychosocial disability-specific SIL as part of a broader SIL commissioning approach.

Recommendation 2: As an immediate first step, we recommend that psychosocial disability be selected as one of the targeted cohorts for the next stage of the government's consideration of SIL commissioning. The APA is ready to contribute practice evidence and lived experience to that process.

Recommendation 3: That government amend SIL and SIL-like funding for people with psychosocial disability so that support needs, workforce expertise, expenditure and outcomes are directly connected, rather than determined by a generic disability funding model.

Recommendation 4: That government ensure SIL and SIL-like support for people with psychosocial disability is available across a tiered model of support, matched to purpose and outcomes rather than diagnosis or current package size. Responsive, flexible support should be provided within each tier with the ability to step between tiers as changing needs and recovery allow. This model should be anchored to Australia's existing, ministerially-endorsed recovery-oriented framework, and delivered through a panel of approved specialist providers.

Recommendation 5: That government extend mandatory registration for SIL providers to all those providers that provide SIL-like services through other NDIS support items, such as Assistance with Daily Life support funding.

1. The current context: SIL fails people with psychosocial disability

People with psychosocial disability are exploited, excluded, and under-served

People with psychosocial disability already experience some of the poorest outcomes and least safe support arrangements in the NDIS. They face heightened risk of exploitation and abuse in shared and supported living settings[1], and current pricing structures make it uneconomic for providers to employ the specialist, psychosocially-trained workforce that managing this risk demands. This leaves some of the most vulnerable participants in the NDIS supported by staff without the expertise their safety depends on. In addition, the fact that many SIL providers or providers of SIL-like services are not registered or even visible to regulators exacerbates the risks faced by people with a psychosocial disability who are seeking to find housing and support.

This sits alongside the NDIS access process that has failed this cohort more than any other. Approval rates for psychosocial disability applicants fell from 66 per cent in 2020–21 to around 25 per cent across 2024–25, while NDIS-wide approval rates remained steady over the same period[2]. The most recent quarterly data shows some recovery, to around 34 per cent in the April–June 2026 quarter. However, it remains far below the NDIS-wide rate for the same quarter, at around 78 per cent, and far below where this cohort started[3]. The proposed changes to Social Civic and Community Participation, by the Government's own analysis, will also disproportionately negatively impact on people with psychosocial disability. Any SIL commissioning model needs to be considered against this backdrop: a cohort already exploited, already excluded, and already under-served.[4]

SIL's design excludes people with psychosocial disability

SIL was built for people with ongoing, stable and predictable disability support needs around activities for daily living/self care. SIL plans work because they can consistently provide for the same support at the same intensity every day. Capacity building support is an add on, not integrated with, nor expected to impact on, this day-to-day care. However, this is not the scenario for many people with psychosocial disability who require 24-hour support:

- For psychosocial disability, functional support need is frequently episodic rather than static. A person's support needs on a good day and a difficult day can differ enormously, in ways that do not map onto a single assessed intensity level for the life of a plan.
- Psychosocial support by definition includes capacity building and flexibility. It responds to the presenting need, adjusting to what is happening for a person that day, switching between practical and/or hands on, to guidance and teaching to motivational. A SIL support worker employed at SCHADS 2 provides a base level of support, but they are not skilled nor supervised to provide intentional psychosocial support.

[1]Harrison, M., Singh Roy, A., Hultqvist, J., Pan, A.-W., McCartney, D., McGuire, N., Irvine Fitzpatrick, L., & Forsyth, K. (2020). Quality of life outcomes for people with serious mental illness living in supported accommodation: systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 55,* 977–988.

[2]Australian Psychosocial Alliance. (2025). *Access Denied: NDIS access for people with psychosocial disability*. Retrieved from: https://psychosocialalliance.org.au/campaign-1

[3]National Disability Insurance Agency. (2026). Quarterly Report to Disability Ministers, 2025–26 Q4, Supplement E (National), Table E.5: Assessment of access per quarter by primary disability group.

[4] Vincent, J., McCarthy, D., Miller, H., Armstrong, K., Lacey, S., Lian, G., Qi, D., Richards, N., Berry, T. (2022). *Research Report - The economic cost of violence, abuse, neglect and exploitation of people with disability.* Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. Taylor Fry.

- SIL thresholds require that people need eight hours of active daily support. Most people with psychosocial disability do not require this level of sustained, high intensity care every day all day, but they do need someone reliably available and with the skills to recognise and respond to deterioration before it becomes a crisis, including overnight. People who are unable to demonstrate that they meet the SIL threshold of active support, are left without a genuine safety net which delivery the right support at the right time. The evidence base on supported housing models for people with severe mental illness confirms that no single model serves every subgroup well, and that outcomes are strongest where the model of support is matched to the person, rather than the reverse[5].

There are some additional concerns at the level of housing and tenancy. The current SIL model can incentivise practices that do not promote positive outcomes for people with a primary psychosocial disability. These include:

- the group housing model (for example, 1 to 3 support ratios for people with similar levels of support) which is not generally the preference for people with psychosocial disability. In fact, amongst the APA SIL providers, there are few examples of more than two people who would be sharing, and Mind's Haven model comprises up to 16 individual living units.
- lack of tenancy protections for participants, for example in cases where the service provider is also the landlord. It would be preferable to have a situation where people can choose their support provider regardless of who their landlord is. In practice, lack of housing and a tight NDIS pricing model provide barriers to change. We note in considering commissioning that the government is balancing protection of choice and control, against questions of improved outcomes, increasing supply of appropriate housing, sufficient regulation and a thriving market. It is important that participants' tenancy rights are protected independently of their support arrangements, so that changing support provider does not put someone's housing at risk. Future NDIS reforms should explore how to ensure greater protection of the right to stable, affordable housing and an independent tenancy, along with appropriate support.

For most people with psychosocial disability, therefore, the current SIL scenario does not work well. It presents a choice between full, high-intensity SIL, or no structured accommodation support at all. It forces people to define their support needs in a way which matches SIL thresholds, rather than SIL responding to people's support needs. It promotes a poorly-fitted, generic congregate model, for which the evidence points to a real risk of recreating the restrictive, institutional dynamics the NDIS was designed to move people away from[6].

Recommendation 1

That government commission psychosocial disability-specific SIL as part of a broader SIL commissioning approach.

[5]Leff, H.S., Chow, C.M., Pepin, R., Conley, J., Allen, I.E., & Seaman, C.A. (2009). Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness. *Psychiatric Services*, *60*(4), 473–482.

[6]Dearn, E., Ramcharan, P., Weller, P., Brophy, L., & Johnson, K. (2023). Supported residential services as a type of "total institution": Implications for the National Disability Insurance NDIS (NDIS), *Australian Journal of Social Issues*, *58*(2), 279–295.

Recommendation 2

As an immediate first step, we recommend that psychosocial disability be selected as one of the targeted cohorts for the next stage of the government's consideration of SIL commissioning. The APA is ready to contribute practice evidence and lived experience to that process.

2. The financial case for commissioning this cohort

The case for a psychosocial disability-specific approach to SIL is not only about better guidelines or better practice. It is, just as importantly, a direct and significant contribution to the financial sustainability of the NDIS. We set out that case below, across five distinct benefits to government.

It reduces cost pressure for the most expensive part of the NDIS

The NDIS is spending heavily on this cohort without investing in the kind of support that would reduce that spend over time. People with psychosocial disability account for around eight per cent of SIL participants, yet expenditure on SIL for this cohort represents around 28 per cent of total psychosocial disability spend, and 12 per cent of total NDIS-wide SIL spend.[7] The average SIL payment for a participant with psychosocial disability is approximately $494,200 per year[8], with inter-year growth averaging around nine per cent, and inter-plan growth of around 18 per cent over the past three years.

Some of the cost relates to the fact that people with psychosocial disability who require SIL are more likely to be aged 55 and over, more likely to have co-occurring chronic health conditions, and have a shorter average life expectancy than the general population. These are factors that add cost and complexity regardless of how well support is delivered.

However, SIL is also among the most expensive support types in the entire NDIS, which means even a modest improvement in outcomes for this cohort represents a substantial dollar saving. International evidence confirms that appropriately designed, lower-intensity housing and support models can achieve comparable or better outcomes than high-intensity residential care, at meaningfully lower annual cost.[9] These models are based on separate tenancy and support options, housing choices and intentional psychosocial support provided flexibly and in response to changing needs. A properly targeted psychosocial model brings the same logic to the most expensive part of the NDIS.

Our recommendations in section three below explain how a psychosocial-specific model could account for this reality and avoid future cost growth that is often treated as evidence of a failure to contain SIL.

It brings currently invisible SIL-equivalent spend inside proper oversight

Where SIL is inaccessible or reduced, people do not stop needing the support and the NDIS pays for this in other ways. We see people meeting the same underlying need through flexible core funding instead, commonly through funding for assistance with daily life, without the safeguards, oversight, or specialist

[7] 2025-26 Q4 report ('Supplement E National, table e.17'). Quarterly report supplements | NDIS

[8] National Disability Insurance Agency. (2026). *Annual Financial Sustainability Report 2024-25*. Retrieved from: https://www.ndis.gov.au/publications/annual-financial-sustainability-reports Annual financial sustainability report 2024-25, 100.

[9] Killaspy, H., Priebe, S., Bremner, S., McCrone, P., Dowling, S., Harrison, I., Krotofil, J., McPherson, P., Sandhu, S., & Arbuthnott, M. (2016). Quality of life, autonomy, satisfaction, and costs associated with mental health supported accommodation services in England: a national survey. *The Lancet Psychiatry*, *3*(12), 1129–1137.

staffing a properly assessed SIL arrangement would provide. This spend is neither visible to government as SIL expenditure, nor subject to the same scrutiny. It means government cannot currently see, govern, or plan for a meaningful share of the true cost of supporting this cohort.

This also affects people unevenly. We have heard cases where wealthier families top up formal funding to secure the level of support their family member needs, while people without that means go without or receive a lesser, informally assembled version of the same support. This is not an equitable way for the NDIS to meet a genuine, permanent support need.

We are not asking government to fund this spend as new money. We are asking that SIL funding supporting people with psychosocial disability be recognised, brought within a properly designed and overseen commissioning model, and delivered with the safeguards and specialist practice that formal SIL arrangements are meant to provide to enable oversight and management of the true cost of this cohort, rather than a partial and misleading picture of it.

It closes a registration and regulatory blind spot

The same invisibility carries a distinct integrity risk. Because this spend sits outside SIL-specific reporting, a whole category of SIL-like providers currently sits in a regulatory blind spot for mandatory SIL registration.[10] That is a quality and safeguarding gap in its own right, and it is also a cost risk to the NDIS: unregistered, unregulated provision is far harder to monitor for value for money, and far more exposed to the kind of poor practice and exploitation that ultimately costs the NDIS more to remediate. It also carries human risk to participants and their families, carers and kin.

It keeps the specialist workforce the NDIS depends on

Our workforce is our expertise, yet current pricing is making that expertise impossible to sustain. The NDIA's Disability Support Worker cost model effectively sets an hourly price limit for specific types of service delivery, but this does not adequately price in the qualifications, supervision, and specialist training that psychosocial work requires. The result is a low hourly price that makes it uneconomic to employ, train and retain genuinely skilled staff, which reduces quality and expertise across the sector.

A commissioned model would enable organisations like those in the APA to build in a different type of capability into the model:

- A workforce trained in recovery-oriented, trauma-informed practice.
- The ability to recognise early signs of deterioration and respond before crises that exacerbate functional impairment.
- Intentional support which builds skills and confidence for greater independence.

Reductions to complex support pricing, alongside standard disability pricing more broadly, have made it increasingly difficult for specialist providers to sustain this capability while remaining financially viable.

Many people with psychosocial disability are already feeling the effects of this shift. Specialist providers have exited the Scheme, withdrawn capacity, or been pushed toward a more generic model focused on personal care, leaving little room for the recovery oriented, skill building practice that was meant to support them. As specialist expertise disappears, participants are left with a more generic, less effective, and ultimately more costly model of support, one less likely to improve their outcomes or help stabilise costs over time. Without a different funding model, this loss will continue, and more people will be pushed into support that does not

[10]NDIS Quality and Safeguards Commission, SIL provider registration requirements (registration group 0138).

meet their needs. Retaining this capability is not simply a matter of supporting the sector. It is about ensuring people with psychosocial disability get support that actually works for them, while also avoiding unnecessary cost to the Scheme.

It stabilises the fastest-growing cost trend in the NDIS

Of current expenditure on SIL participants, around 76 per cent funds core domestic assistance, while six per cent funds capacity-building support[11]. Investment is concentrated on maintaining people's current level of function, not on building the skills and stability that could reduce support needs over time. This is the reverse of what a recovery-oriented, psychosocial-specific model would prioritise. The NDIS pays repeatedly for the same level of need year on year, rather than investing to reduce it, which is a direct driver of the inter-plan growth rate set out above.

Evidence from comparable Housing First and recovery-oriented models is instructive here: appropriately designed, recovery-focused support has been shown to reduce homelessness and reduce reliance on far more costly downstream services, including hospitalisation and emergency department presentations[12],and to produce more rapid improvement in functioning and quality of life than standard, treatment-as-usual support.[13] Investing in genuine capacity-building, , is key to stabilising this cost trend..

Recommendation 3

That government amend SIL and SIL-like funding for people with psychosocial disability so that support needs, workforce expertise, expenditure and outcomes are directly connected, rather than determined by a generic disability funding model.

3. A model for psychosocial disability SIL, matched to purpose and outcomes, not diagnosis

We set out below the shape of a model we believe merits genuine testing and further development, as part of the targeted consultation process, not as a finished design. We would be pleased to share further, more detailed costing and analysis with the Department/Agency to inform this work. Support intensity should be organised around a continuum: from continuous, high-intensity presence at one end, to on-demand, contingency-based support at the other. We propose three tiers, distinguished by purpose rather than by diagnosis or current package size:

- **Tier 3:** complex support for people whose needs require sustained, high-intensity, near-constant support.

[11] Source: supplement E, Table 108 Quarterly report supplements | NDIS

[12]The experience of Mind Australia, within the service delivery context of The Haven Foundation, is that hospitalisation reduces at least 70% in the first year, as evidenced in both internal and independent external evaluation such as Ratnaike, D., & Lewis, V., White V. and Marsh G. (2024). *Final Report: Evaluation of the Haven Program.* Latrobe University report for Mind Australia. See also Adair, Carol E., Brianna Kopp, Jino Distasio, Stephen W. Hwang, Jennifer Lavoie, Scott Veldhuizen, Jijian Voronka et al. "Housing quality in a randomized controlled trial of Housing First for homeless individuals with mental illness: Correlates and associations with outcomes." *Journal of Urban Health* 93, no. 4 (2016): 682-697.; Peng, Y., Hahn, R.A., Finnie, R.K.C., Cobb, J., Williams, S.P., Fielding, J.E., Johnson, R.L., Montgomery, A.E., Schwartz, A.F., Muntaner, C., Garrison, V.H., Jean-Francois, B., Truman, B.I., & Fullilove, M.T. (2020). Permanent supportive housing with Housing First to reduce homelessness and promote health among homeless populations with disability: a Community Guide systematic review. *Journal of Public Health Management and Practice*, *26*(5), 404–411.

[13]Aubry, T., Nelson, G., & Tsemberis, S. (2015). Housing First for people with severe mental illness who are homeless: a review of the research and findings from the At Home–Chez Soi demonstration project. *Canadian Journal of Psychiatry, 60*(11), 467–474.

- **Tier 2:** for people with genuine potential for functional gain, combining stabilisation support with embedded, dedicated skill-building.
- **Tier 1:** for people who are substantially stabilised and need a guaranteed safety net, not daily hands-on support.

Table 1 sets out how each tier differs in target cohort, support model, workforce, and funding logic.

Table 1: A model for psychosocial disability SIL/SIL-like support.

	Tier 3 (high)	Tier 2 (medium)	Tier 1 (mostly stable)
Target cohort	High, persistent support needs; limited capacity for independent function without near-constant support	Variable need medium to high support needs, with genuine potential for functional gain	Mostly stable support needs; needs a guaranteed safety net, not daily hands-on support
Support model	Broadly consistent with current SIL arrangements 24/7 shared or individual support	High level of coverage retained, with a defined share of hours delivered as embedded capacity-building support	Lower-ratio shared support, contingency/surge hours, and technology-supported monitoring
Workforce (drawn from specialist psychosocial disability and mental health providers)	Standard and high-intensity disability support workers; access to psychosocial support workforce (including peer workers)	Blend of stabilisation/daily life support and dedicated skills development, life transition and self-management support, delivered by the same team (with psychosocial expertise, including peer workers)	Predominantly standard-level support, with periodic specialist input (with psychosocial expertise, including peer workers)
Funding logic	Guaranteed floor; funding rises with assessed complexity and is not capped while complexity persists	Guaranteed floor; funding tapers only as functional gains are independently evidenced	Guaranteed floor, as a permanent safety net reflecting the permanent nature of psychosocial disability

Examples connected to each tier of the model for psychosocial disability SIL/SIL-like support.

Organisations in the APA that deliver SIL, support NDIS participants with psychosocial disability across the continuum of need set out in these three levels. Many of these people have struggled to access SIL when they need it and/or to the degree they needed. Examples of these participants below illustrate how the standard model of SIL is not suitable for this cohort.

Julia - Tier 3 (high)

Julia is in her 30s and lives with schizophrenia, an acquired brain injury, intellectual disability, and significant physical health problems. She has little capacity to independently function without regular prompting, supervision and hands-on support. During the daytime, she needs support to maintain her safety; manage appointments and health needs; and access the community. Staff also need to be available overnight to respond when Julia loses all ability to independently function and her health deteriorates.

Overall, Julia needs a high and relatively stable level of support, however, current SIL funding settings do not always adequately account for the level of individualised, responsive and sometimes unplanned support required across a 24-hour period.

Tony - Tier 2 (medium)

Tony is in his late-40s and lives in rural Victoria. He has schizophrenia and anxiety. He was living with his mother but experienced a significant decline in his mental health and ability to manage his Assistance with Daily Life (ADL) activities when she moved to aged care. These higher support needs could not be met with his low ADL funding but his plan re-assessment requests were denied. He consequently spent an extended period in hospital and then in a Community Care Unit where he demonstrated capacity to build independence. Had SIL been available earlier, the extent of decline in his mental health would have been much lower.

Phillip – Tier 1 (mostly stable)

Philip is in his mid-20s and lives with his parents in rural Victoria. He has Autism, Major Depressive Disorder, Attention Deficit Hyperactive Disorder, and General Anxiety Disorder.
He has tried moving out of home three times, but each time he struggled to keep on top of his activities of daily living and his mental health significantly declined, including to the point of suicidal ideation. This deterioration in health led him to return to live with his parents.

Philip's NDIS package only provides for less than an hour of 1:1 support a day, which is insufficient to meet his needs, however, he does not need eight hours of 1:1 support every day. Consequently, he is ineligible for SIL and unable to access the support to safely live independently of his parents, who are taking on a significant amount of his daily support, leading to significant burn out and difficulty supporting him to build capacity.

Put simply: the model of support, informed by specialist psychosocial expertise, should determine the appropriate ratio of support and not the reverse. Under current settings, a standardised staffing ratio has the effect of determining who can access SIL at all.

Published evidence supports reversing the current ratio-first approach: comparable supported housing and residential care models have achieved similar clinical and psychosocial outcomes for people with severe mental illness[14], and recovery-oriented practice that promotes autonomy and rights is itself a predictor of successful transition to less intensive support over time.[15]

The safeguards built into the proposed model

- A guaranteed funding floor at each tier, so no person's support is reduced below a safe baseline that ensures the sustainability of their supported independent living.
- Fast access to additional support when required through a pre-funded contingency mechanism rather than a full plan reassessment which recognises that episodic need is a feature of psychosocial disability, not a sign that someone's assessed tier should change.
- Step-down to a lower tier of support only following scheduled, evidence-based reassessment, protecting against any incentive to overstate need to retain access to support at all, and maintaining housing arrangements regardless of step-down.
- Assessment and tier placement undertaken independently of the delivering provider, avoiding any conflict between a provider's interest and a participant's assessed level of need.
- No reduction in any current participant's funding on implementation. Anyone already receiving SIL retains their current level of support; movement between tiers occurs prospectively, only as genuine need changes.

This is about safety, not just savings

For many people who would sit in the recovery tier, the primary value of a guaranteed SIL-equivalent funding floor is protection, not cost efficiency. It would remove the risk of relying on flexible core funding that a provider can exhaust and then withdraw from with limited notice and limited recourse, and it would close the current gap between full SIL and no reliable, safeguarded support at all.

Initial modelling and potential savings

We have undertaken preliminary internal modelling of the potential cost implications of a model along these lines, including grandfathering of current participants, prospective step-down rates, and the treatment of currently informal spend. This modelling indicates the potential for savings to the NDIS over time, driven by genuine reduction in support need rather than any reduction imposed on day one. We have not included detailed figures in this submission given the assumptions such modelling necessarily requires, without reliable data. We would welcome the opportunity to share our work, and to test and refine it, as part of a more detailed engagement process.

[14]Dehn, L.B., Beblo, T., Richter, D., Wienberg, G., Kremer, G., Steinhart, I., & Driessen, M. (2022). Effectiveness of supported housing versus residential care in severe mental illness: a multicenter, quasi-experimental study. *Social Psychiatry and Psychiatric Epidemiology, 57*(5), 927–937.

[15]Killaspy, H., Priebe, S., McPherson, P., Zenasni, Z., Greenberg, L., McCrone, P., Dowling, S., Harrison, I., Krotofil, J., & Dalton-Locke, C. (2020). Predictors of moving on from mental health supported accommodation in England: national cohort study. *The British Journal of Psychiatry, 216*(6), 331–337.

How this could be commissioned

We do not propose a separate SIL NDIS or a separate set of guidelines running in parallel to broader SIL commissioning. Psychosocial-specific requirements should sit as a supplementary specification layered onto a single, unified commissioning framework, consistent with the way the NDIS Quality and Safeguards Commission has already added supplementary registration requirements for SIL providers onto general provider registration.[16]

Any psychosocial-specific specification should be anchored in Australia's existing, ministerially-endorsed recovery-oriented mental health framework, rather than requiring an entirely new practice standard to be developed from first principles. This framework is well established, broadly accepted across the mental health sector, and would allow specification development to quickly proceed.

Commissioning should draw on a panel of approved, specialist providers, rather than sole-provider or single-region contracts. This would preserve genuine participant choice and control, avoid the risk of participants becoming, in effect, 'owned' by a single provider, and maintain a competitive, quality-focused market among providers with demonstrated specialist capability.

As specialist community managed mental health and psychosocial support providers, we are clear about the outcomes that can be achieved, and would bring existing quality frameworks and expectations.

Table 2: Outcomes

Participant outcomes	System outcomes
Housing stability and tenancy sustainment Reduced involuntary admissions Reduced emergency department presentations Increased social and community participation Improved self-management and daily living skills Progression to lower-intensity support where appropriate Participant-reported quality of life and recovery measures	Reduced SIL expenditure growth Reduced crisis service utilisation Reduced support coordination complexity Reduced plan review requests linked to housing instability Improved provider retention and workforce stability

Recommendation 4

That government ensure SIL and SIL-like support for people with psychosocial disability is available across a tiered model of support, matched to purpose and outcomes rather than diagnosis or current package size. Responsive, flexible support should be provided within each tier with the ability to step between tiers as changing needs and recovery allow. This model should be anchored to Australia's existing, ministerially-endorsed recovery-oriented framework, and delivered through a panel of approved specialist providers.

[16]NDIS Quality and Safeguards Commission, SIL provider registration requirements (registration group 0138).

Recommendation 5

That government extend mandatory registration for SIL providers to all those providers that provide SIL-like services through other NDIS support items, such as Assistance with Daily Life support funding.

What this submission does not address

We have deliberately focused this submission on the design of support, rather than on the parallel and equally important question of housing supply. Access to appropriate, affordable housing, including Specialist Disability Accommodation stock, community housing and private rental, fundamentally shapes what support model is even possible for a person to access, and is a significant constraint independent of how support is funded and delivered. Under current settings, when funded support ratios change, participants are sometimes met with almost-impossible choices. We would welcome the opportunity to contribute further to this question, including the case for co-commissioning between the Commonwealth and state housing agencies, but consider it separate from, and additional to, the case made in this submission.

We also recognise that delivery in regional and remote areas raises distinct challenges of workforce, housing stock, and provider viability that require dedicated consideration, and that fall outside the scope of this submission.

Conclusion

People with psychosocial disability are among the most vulnerable participants in the NDIS, and are not well served by current funding and regulatory settings within Supported Independent Living. Generic SIL models leave many people without the kind of support that actually helps them, and the money spent often does not translate into better outcomes for them.

However, there is a strong, well evidenced starting point for a different approach to SIL commissioning, one built around what this group needs and what they also express a preference for. There is also a specialist sector with the expertise to help people live well and build the skills that support their recovery. It just needs a funding model that allows this expertise to reach the people who need it.

The type of model benefits described above deliver on the priorities being explored through this submission opportunity:

- **Better outcomes** and reduced cost, through recovery-oriented, specialist practice this cohort is not currently receiving.
- **Better support for people**, by closing the gap between full SIL and no structured support at all, and by bringing informally funded, unsafeguarded support within a properly designed model.
- **Provider viability**, by giving the specialist psychosocial sector a funding model that reflects the real cost and nature of the work, rather than one that is steadily forcing it from the NDIS. For this cohort, doing right by outcomes and doing right by the NDIS's finances are the same course of action.

We ask government to commission psychosocial disability-specific Supported Independent Living, to shift SIL funding for this cohort so that need, expertise, expenditure and outcomes are properly connected, and to build any such model around a tiered, flexible approach to intensity of support. As an immediate first step, we ask that psychosocial disability be selected as one of the targeted cohorts for progression of this work and be directly named in government's advice later this year.

We would welcome the opportunity to discuss this submission further, and to contribute practice experience, further evidence, and detailed modelling to support the next stage of this work.

Appendix 1: Psychosocial disability SIL case studies

The following four personal stories, presented as case studies, demonstrate some of the challenges that people with psychosocial disability experience in undertaking daily living tasks and participating in their community, as they relate to SIL or SIL-like settings. They also underline the benefits of specialised psychosocial disability expertise in delivering NDIS supports.

Case Study #1: Building Capacity Through Relationships

Paul is a person with psychosocial disability living in regional New South Wales who came to an APA member following a period of hospitalisation. At the time, he required two staff members 24 hours a day to support him in managing aggressive behaviours, emotional regulation and communication difficulties.

Over two years, our staff built a strong, trusted relationship with Paul while supporting him to reconnect with family, engage with his community, and participate in meaningful activities such as music and art. As these relationships and supports strengthened, Paul's ability to regulate his emotions and manage challenges associated with his disability improved significantly.

As a result, his support requirements reduced from two staff members 24 hours a day, to one staff member, and more recently from active overnight support to a sleepover arrangement. While Paul continues to require assistance with daily living, personal care and household tasks, the intensity of his support has decreased.

Reflection: Paul's experience demonstrates how sustained relationships, family connection and community participation can build capacity, reduce reliance on intensive supports, and improve long-term outcomes for people with psychosocial disability. These are distinctly psychosocial supports, requiring expertise, judgement and trust building over time, in addition to ongoing support with activities of daily life.

Case Study #2: The Impact of Relationship-Based Support

Ian is a First Nations man living in Melbourne who sustained a brain injury approximately ten years ago. Prior to joining an APA member, he was socially isolated, resistant to support and experiencing significant risks related to daily living, personal care and community participation.

We focused on building a trusted relationship with Ian while supporting him to reconnect with local First Nations community networks. As his connection to community and engagement with support strengthened, his overall stability improved.

When complex family challenges later emerged, we adopted a trauma-informed de-escalation approach that prioritised safety, connection and relationship preservation. This significantly reduced incidents of escalation and supported positive progress in Ian's relationship with his daughter.

Reflection: Ian's experience highlights the importance of culturally responsive, relationship-based support in improving outcomes for people with complex disability and psychosocial needs.

Case study #3: Supporting transition from long stay hospital care to sustainable community living

In 2020, an APA member's Residential Team partnered with a Sydney Local Health District's Pathways to Community Living initiative to support four people to move from long stay mental health inpatient care into supported community accommodation.

The four people had collectively spent five years and eight months in hospital. The LHD had previously experienced barriers to placing them in appropriate community based supports. We worked with the LHD, the participants and their support networks to establish an appropriate home and support a safe transition into the community.

Participants continued to receive support from the local Community Mental Health Team, with arrangements in place for a facilitated return to hospital if they became unwell. We also worked with each participant and their support network to develop an NDIS application.

All four participants were subsequently approved for Supported Independent Living funding and all chose us as their ongoing provider. Twelve months later, all four remained living well in their home, with our Residential Supports.

Reflection: This is direct Australian practice evidence that people with significant and enduring psychosocial disability can transition from prolonged institutional care into community based SIL when specialist psychosocial support, clinical continuity and a reliable safety net are available.

Case study #4: Complex Support Needs in Shared SIL

James* (pseudonym) is a man in his early fifties living in a shared 1:3 Supported Independent Living arrangement. His plan is funded for 24/7 SIL support at a 1:3 ratio with an inactive overnight model. James has treatment-resistant paranoid schizophrenia, severe intellectual disability and multiple physical health conditions, including dysphagia, diabetes, chronic respiratory disease and sleep apnoea. Together, these conditions significantly affect his insight, decision-making, communication, daily living skills and ability to independently recognise and manage risk.

James requires structured support and supervision throughout the day. This includes medication administration four times daily, blood glucose monitoring, supervised meals and modified food and fluids, personal care, continence and hygiene support, CPAP assistance, anxiety management, community participation and the implementation of regulated restrictive practices. Many of these supports are individual, time-critical and cannot safely be delayed or absorbed into general household activities, despite James living within a shared staffing model.

Dysphagia presents a significant and ongoing risk. Staff must prepare meals and fluids in accordance with James' Mealtime Management Plan, supervise his food and fluid intake, monitor for choking and aspiration, and complete incident documentation where concerns arise. Several medications must also be modified or administered using specialised swallowing supports. Safe delivery therefore depends on appropriately trained and competent staff, current clinical plans, suitable equipment and access to specialist advice.

James' support needs continue overnight. He frequently wakes to use the bathroom and requires assistance to reapply his CPAP mask, monitoring of coughing and throat clearing, support with cigarette-seeking behaviours, cleaning, documentation and preparation of prescribed thickened fluids for his morning medication. The frequency and nature of these interventions demonstrate a need for active overnight support that is not reflected in his current inactive overnight funding model.

James also requires consistent routines, familiar staff and clear communication. Changes to routine, unfamiliar environments or too many planned activities can increase his anxiety and reduce his capacity to participate. Staff work with James to structure each day, provide reassurance and support him to engage in activities that are important to him, including listening to music, participating in the community, spending time with co-residents and maintaining family relationships.

There are gaps between James' assessed needs and the supports funded through his NDIS plan. Essential swallowing assessments, Mealtime Management Plan reviews, staff training, specialised equipment and psychological and cognitive assessments have required funding outside his plan. Without these inputs, the provider's ability to safely manage James' health risks and maintain a competent workforce would be significantly reduced.

Reflection: James' experience demonstrates that a standard 1:3 staffing ratio does not necessarily reflect the actual intensity or timing of support required within shared SIL. Commissioning should distinguish between genuinely shareable household support and individual, concurrent or time-critical interventions. It should also recognise the full cost of safe service delivery, including active overnight support where required, allied health input, specialised equipment, workforce training, competency assessment and clinical governance.

For people with similarly complex and intersecting needs, funding should be based on evidence of the person's actual support requirements across the full 24-hour period. This would enable providers to deliver a skilled, flexible and sustainable response that manages risk while supporting choice, dignity, relationships, community participation and quality of life.

Appendix 2: Practice evidence

Recovery oriented residential support can build capacity when delivered with psychosocial disability expertise

This example of an APA member's Adult Step Up Step Down (ASUSD) service is not SIL, however it provides useful supporting evidence for the submission's argument because the model combines 24/7 psychosocial support, recovery planning, daily living and self-management skill development, peer support and planned transition back to community living.

The data below is from an evaluation of consumer outcomes from July 2022 to January 2026. This evaluation showed improvement across all routinely reported measures. The data demonstrates how specialist, recovery oriented psychosocial residential support can produce measurable gains in recovery, quality of life and unmet need. All APA members can present similar outcome measures from programs of relevance to the government and the NDIA as they consider directly commissioning SIL and SIL-like services. Also of interest to government is the implication for adjacent government-funded disability, health and mental health services.

Outcome	Entry to exit	Participants improving
Psychological distress (K10)	35.6 to 27.1	87% reported lower distress
Quality of life (AQoL-4D)	62.7 to 72.3	77% improved
Recovery (RAS-DS)	93.6 to 109.7	85% improved
Unmet needs (CANSAS)	5.8 to 3.4	72% reported fewer unmet needs