Australian Psychosocial Alliance

Submission to the Independent Review of the National Disability Insurance Scheme

December 2022

About the Australian Psychosocial Alliance

The Australian Psychosocial Alliance (APA) includes Flourish Australia, Mind Australia, Neami National, One Door Mental Health, Stride Mental Health, Open Minds and Wellways Australia. We are specialist providers of community managed mental health and wellbeing services in Australia, with the majority of us being registered 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.

Contents

A note on recovery:

In this submission, when we refer to the term recovery, we are referring to mental health recovery. Consistent with the *NDIS Psychosocial Recovery Oriented Framework* and World Health Organisation, we define recovery as a unique and personal experience in which an individual gains control of their identity and life, has hope for their life, and is living a life which is meaningful to them.[1] Recovery is personal to the person experiencing mental ill health and psychosocial disability.

[1] NDIA. (2021). *National Disability Insurance Scheme: Psychosocial Disability Recovery-Oriented Framework.* Accessed by: https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis#psychosocial-recovery-oriented-framework
AND
World Health Organisation. "Guidance on community mental health services: promoting person-centred and rights-based approaches." In guidance on community mental health services: promoting person-centred and rights-based approaches, 2021.

Executive Summary

When the National Disability Insurance Scheme (NDIS) was introduced, it was welcomed as a much needed system of support for those experiencing disability in Australia. Inclusion of people living with disabilities relating to their mental health was celebrated within the sector and by people living with psychosocial disability and their families and support networks, although it was understood that psychosocial disability would present some unique challenges for the Scheme.

We strongly support the inclusion of people with psychosocial disability within the scheme. We are deeply concerned by public rhetoric suggesting removing psychosocial support from the NDIS to cut costs or shift responsibility for psychosocial disability to state mental health systems. Psychosocial disability should remain in the NDIS, as many people with mental ill-health require long-term support in-line with their own personal recovery journey to live a life similar to their peers in the community. However, significant reform to the Scheme is needed to ensure this specialist support is recovery-oriented and delivers the appropriate support required to enable participants to live a meaningful life, as envisaged by the NDIS at establishment. We strongly encourage the redesign of the Scheme to better meet the needs of people with psychosocial disability.

As the largest providers of community-managed mental health and wellbeing, and psychosocial supports in Australia, we would welcome a meeting with Independent Panel members to ensure the scheme works for people with psychosocial disability.

In response to the review's preliminary questions, we have provided below **three critical areas of concern with the NDIS**, described how this affects participants with psychosocial disabilities, and outlined some proposed solutions.

1. Make the NDIS recovery-oriented
2. Improve access to housing and support for people with psychosocial disability
3. Fund a program of psychosocial supports outside the NDIS (Tier 2).

The Australian Psychosocial Alliance proposes the following **initial actions** to progress the reforms necessary for supporting people with a psychosocial disability (further detail below):

1. Have a specialist focus on the psychosocial disability cohort in the NDIS and make the NDIS recovery-oriented, including by addressing financial incentives for providers to seek and maintain large packages for participants which run counter to recovery goals.
2. Trial and fund a cohort-specific approach for people with psychosocial disability which sees coordination and delivery of recovery-focused care within the NDIS, such as a new approach with a 'lead provider' to work with a participant to develop a recovery plan and help manage supports to ensure the plan is implemented.
3. Elevate the voice of people with lived experience of psychosocial disability in the redesign of the scheme.
4. Reform Supported Independent Living and Specialist Disability Accommodation settings to increase access to specialised housing and support for people with psychosocial disability to enhance opportunities for mental health recovery.
5. Given the integral role of housing for mental health recovery, and particularly its relationship to timely discharge from hospital, the NDIS should work with Commonwealth, State and Territory Governments to improve housing policy.

6. A suite of Tier 2 supports should be agreed and funded with appropriate implementation and monitoring arrangements.

We anticipate being able to provide more detailed commentary and robust recommendations during 2023, as part of the Review process.

Priority 1: Make the NDIS recovery-oriented

Whilst the NDIS supports many people with psychosocial disability to pursue their goals and lead a meaningful life, there is room for the Scheme to improve so that it adequately meets the needs of participants with psychosocial disability. The APA view the NDIS Review as a significant opportunity to redesign the Scheme for people with psychosocial disability.

There is a gap between Federally-funded NDIS psychosocial supports and rehabilitation supports which are determined to be the responsibility of state/territory governments.[2] The lack of integration between these supports and the ineligibility of some people with psychosocial disability to access the NDIS, along with a shortage of long-term recovery-oriented supports for people with psychosocial disability – otherwise known as psychosocial rehabilitation – is a cause for significant concern.

Psychosocial disability does not fit neatly into the permanent disability paradigm of the NDIS, given the particular nature of mental health concerns which, for some people, includes fluctuating support needs, such as during episodes of acute illness. The NDIS is typically focused on maintenance-oriented supports and therapeutic interventions. This is contrary to the recovery-oriented approaches which are intended to improve the individual's life and functioning to the best possible extent. Current Scheme settings do not support delivery of a model of care which promotes personal and functional recovery.

As registered providers who specialise in mental health and psychosocial disability, we are accountable to ensuring safe and high-quality services are delivered. Financial incentives for providers conflict with recovery goals in that there is an impetus to seek and maintain large packages, emphasising deficits rather than capability. This does not encourage and support recovery which may lead to a participant relying less on their NDIS package. It is concerning to the APA that specialist mental health and psychosocial support providers are reducing their involvement with the NDIS or ceasing delivering NDIS supports entirely. Amongst other things, this is due to unsustainable pricing and inflexible policies which create financial insecurity and risk low-quality provision of support. Whilst unregistered providers deliver benefits in choice and control for participants, they lack the same accountability for ensuring outcomes are actually being delivered.

As providers, it is also our experience that essential components of service delivery for people with psychosocial disability are not adequately funded by the NDIS, or funded at all in some cases. For example, pricing is not adequate to allow for training staff in areas required to deliver evidence-based support to people experiencing mental ill health and psychosocial disability, such as trauma-informed practice, recovery-oriented support, and motivational interviewing. This contributes to high staff turnover and a workforce that cannot afford to value continuous improvement.

The structured and itemised nature of the costing model also lends itself to inflexible plans and does not encourage a flexible, person-centred approach to planning. This inflexibility, alongside a lack of expertise in mental health and psychosocial disability in the NDIS planning process, has led to participants being unable to access the support needed to improve their functional capacity and

[2] Australian Government. (2015). *The Applied Principles and Tables of Support to Determine Responsibilities NDIS and other service*. Accessed at: https://www.dss.gov.au/the-applied-principles-and-tables-of-support-to-determine-responsibilities-ndis-and-other-service

achieve their goals. It also prevents participants being able to increase or decrease levels of support in response to fluctuating need. Participants tell us interactions with the Scheme can be frustrating to the point of undermining mental health, with planning experienced as traumatising, repetitive and frustrating. There is a fear participants who show improvement and have their supports reduced will be unable to flex up and regain additional support should they become unwell. We have heard accounts from participants of plans being reduced, often without adequate explanation or forewarning to enable alternative and safe care arrangements to be designed. Reports in the media and from APA members suggest this is widespread for those accessing the NDIS for a primary psychosocial disability and intellectual disability, with cuts to Supported Independent Living (SIL) particularly prevalent.

The NDIA's recent development and release of the Psychosocial Recovery-Oriented Framework is a step towards a more tailored, and required, specialist approach for psychosocial disability in the NDIS, and recognises the Agency's commitment to supporting participants living with psychosocial disability in their personal recovery. However, whilst we recognise there have been steps to acknowledge psychosocial disability can be episodic in nature, such as through amendments to the Act, funding and policy settings must be amended to enable a recovery-oriented approach for people with psychosocial disability to be implemented in the Scheme. Over the longer term, an evidence-based and recovery-oriented approach has great potential to improve outcomes and reduce costs, as participants recover and become less reliant on the Scheme.

We acknowledge that reform is underway, with the introduction of the NDIS Recovery-Oriented Framework for Psychosocial Disability and Recovery Coach, which are both very welcome. However, these developments only go a small way towards achieving a recovery-oriented NDIS. A redesign of the Scheme is needed for the NDIS to make a practical difference for people with psychosocial disability. This redesign should be co-designed with people with lived experience of psychosocial disability to ensure their voices are elevated.

Solutions

1. **Have a specialist focus on the psychosocial disability cohort in the NDIS and make the NDIS recovery-oriented, through:**
    - addressing financial incentives for providers to seek and maintain large packages for participants, which run counter to recovery goals
    - tailoring specialist and specific responses to psychosocial disability within the NDIS
    - enhancing the regulation of providers within the NDIS to ensure the safety and quality of services for people experiencing mental ill health and psychosocial disability
    - reviewing pricing for items to improve recruitment, retention and ongoing development of a specialist psychosocial support workforce
    - review pricing structure for group-based support so participants have access to group programs which support recovery
    - reducing waiting times for NDIS packages and share transparent data to reflect this
    - ensuring people with psychosocial disability can access Supported Independent Living and Specialist Disability Accommodation with appropriate funding to ensure high-quality supports which build capacity

- setting targets to more rapidly assess and provide NDIS packages for people leaving hospital
- ensuring that the roles of State and Territory governments around housing and psychosocial rehabilitation and health are more clearly defined and that people with psychosocial disability are not falling through the cracks
- adopt standardised outcome measures across psychosocial disability within the NDIS to enable better evaluation of individual and collective outcomes to inform ongoing improvements to the NDIS, such as pricing policy, review processes, and benchmarks for quality care.

2. Trial and fund a cohort-specific approach for people with psychosocial disability which sees coordination and delivery of recovery-focused care within the NDIS.

As part of a proposal by the APA, Mind and Wellways are developing a model which demonstrates how a lead provider approach with tailored recovery plans and evidence-based interventions could contribute to better outcomes for participants with psychosocial disability in the NDIS. Collaborative work is currently underway with the NDIA to develop and refine the proposal to address many of the issues detailed in recommendation 1. **We would welcome the opportunity to provide a further briefing to the Panel on the proposal, which builds on the combined expertise of our sector and, we believe, includes a number of principles which could inform the NDIS redesign for people with psychosocial disability.**

Key elements of the proposal:

The project proposes a new model of working with NDIS funding structures to support participants to achieve recovery goals and improve functioning:

A lead provider with expertise in psychosocial disability will:

- Work with the participant to set personal recovery goals
- Complete functional assessments to inform implemented interventions
- Develop a comprehensive Recovery Plan which coordinates all service providers to meet recovery goals
- Implement evidence-based interventions and evaluate outcomes.

This will involve:

- Providing intensive support to build a strong working relationship with and between participants and their care team
- Improving the NDIS plan review process
- Making services goal focused, with mechanisms to review the service and the impact towards supporting the participant to achieve their goals
- Improving collaboration and communication across the different practitioners and services engaged to support the participant
- Upskill the participant's capacity to understand the NDIS plan and market, and to negotiate it on their own behalf, if they so wish

- Dedicated lived experience role/s that are appropriately funded and supported
- Measuring outcomes and impact.

3. **Elevate the voice of people with lived experience of psychosocial disability in the redesign of the scheme, including through:**
   - authentic participation and co-design where people with a lived and living experience of psychosocial disability are engaged to ensure the system is shaped in a way that best meets participants' needs.

The NDIS must and will be informed by the knowledge and expertise of lived experience. The benefits of lived experience leadership include improvements in innovation of services, accountability, and quality of care, and improved knowledge of the health system. Participants accessing services also benefit from the way that lived experience leaders can help to shape services that better meet participants' needs.[3] [4]

Priority 2: Improve access to housing and support for people with psychosocial disability

We are particularly concerned that the needs of people with psychosocial disability are overlooked under current NDIS home and living settings and that this is creating a barrier to their recovery. While some people will be able to access support from their NDIS package, many people with a psychosocial disability are not eligible for home and living funding under the NDIS.

We know the benefits of providing long-term accommodation with support to those experiencing mental ill-health are significant. A wealth of evidence suggests that having a safe, secure, appropriate and affordable place to call home is the foundation for promoting psychosocial recovery and improving function. This is particularly relevant for people experiencing mental ill-health who are more likely to experience financial hardship and forced moves, impacting their housing stability and increasing the risk of homelessness.[5]

As an example of one successful solution, Mind Australia's Haven residents receive housing and recovery-focused support funded through their NDIS packages. Haven residences feature up to 16 private apartments, providing a place for people to live independently whilst receiving support from qualified mental health workers who help them achieve their unique NDIS Plan goals and includes 24/7 psychosocial support. This support greatly reduces visits to hospital and other demands on the mental health system, as immediate support and reassurance can be provided when mental health is deteriorating. An external evaluation from Latrobe University shows residents are gaining independence, learning new skills, and better managing tasks of daily living. They experience reduction in symptoms of mental distress, improving their self-confidence and strengthening their

[3] Happell, B & Scholz, B. (2018) 'Doing what we can, but knowing our place: Being an ally to promote consumer leadership in mental health', International Journal of Mental Health Nursing, vol. 27, no. 1, p. 440.
[4] Mind Australia (2021) Mind's Lived Experience Strategy. Mind Australia, Melbourne.
[5] Brackertz, N., Borrowman, L., Roggenbuck, C. Pollock, S. and Davis, E. (2020) Trajectories: the interplay between mental health and housing pathways. Final research report, Australian Housing and Urban Research Institute Limited and Mind Australia, Melbourne, https://www.ahuri.edu.au/research/trajectories

skills for independent living.[6] Pre and post data for two sites (Frankston and Geelong) show a marked reduction in hospitalisations before and after entering Haven. A matched analysis[7] shows hospitalisations reduced from total days of 321 to 179, and the average length of stay across the cohort of residents reduced from 10 days per year to 5.6 days per year in 2021-2022.

Another successful model has been Supported Independent living (SIL). However, since 2020, SIL funding has been reduced (often erroneously assessing supports required at standard, rather than complex levels) and is now more insecure, with eligibility requirements also changing in a way which effectively excludes many people with psychosocial disabilities. Participants who were previously eligible, are no longer eligible. For example, participants with psychosocial disability do not always require active disability support for more than eight hours a day, as per the SIL operational guidelines. Rather, access to shared 24/7 support provides psychosocial participants with immediate support and reassurance when mental health may be deteriorating. Those receiving SIL funding now have more complex needs, often with physical and/or intellectual disabilities and other comorbidities requiring personal care. We are witnessing funding being shifted from SIL to Flexible Core which poses a risk to continuity of support in a shared living environment due to Core funding not being dedicated to housing support. The reductions in funding have also meant changes to the workforce profile, limiting the availability of staff and capacity to provide recovery-oriented care to participants.

Residents using core funding for NDIS housing with support are not explicitly funded for a range of other services they require, such as support for alcohol and drug use, de-escalation intervention when their mental health is deteriorating, peer learning activities, and peer support (where capacity building is not funded). Another aspect of home and living that is not funded is the development of community (or therapeutic milieu) within the residence. This creates a positive social environment which supports connection and hope – key elements of recovery. Evidence suggests these supports can assist people to live in the community and can help avoid hospitalisation, yet they are not explicitly funded through the NDIS. Further, staff training in areas such as trauma-informed practice, recovery-oriented support and motivational interviewing, are evidence-based but beyond what the NDIA considers necessary to fund – yet they are important elements of supporting people with psychosocial disability.

Another issue in the area of accommodation is that people with psychosocial disability are also underrepresented in Specialist Disability Accommodation (SDA) funding within the NDIS, due to access and eligibility requirements which do not reflect the needs of people with psychosocial disability. The access process to SDA is convoluted, and there is often difficulty finding funding for assessments and practitioners with the expertise to undertake the required assessments. People with a primary psychosocial disability make up only a small proportion (4%) of Scheme participants with SDA, despite making up around 11% of all Scheme participants. Further, only around 1.4% of participants with a psychosocial disability had SDA funding compared to over 3.4% of non-psychosocial participants.[8] This means some people with a psychosocial disability are missing out on specialist supported accommodation which could contribute to their recovery.

[6] Ratnaike, D., V. Lewis, V. White and G. Marsh (2022). Progress Report 2 - Evaluation of the Haven Homes Accommodation Program: Report for Mind Australia., Australian institute for primary care & ageing, Latrobe University.
[7] Data from matched clients where hospitalisation data is available pre and post Haven admission.
[8] NDIS. (2022). *SDA 2021-22 Q4 report.* Specialist Disability Accommodation (SDA) Quarterly Report. Accessed by: https://data.ndis.gov.au/reports-and-analyses/market-monitoring#specialist-disability-accommodation-sda-quarterly-report

The issue of supply of suitable accommodation and the need for innovative responses was identified by the Productivity Commission a decade ago.[9] More recently, the Victorian Royal Commission (2021) and Productivity Commission Mental Health inquiry (2020) highlighted the need for housing reform, including attributing limited availability of SDA to slow growth in supply and access barriers relating to NDIS settings being focused on physical disability and not reflecting the needs of people with a psychosocial disability.[10] [11]

Further, the time it takes the NDIA to make decisions about home and living applications has grown, with some participants taking almost a year to receive a decision. This leaves some stuck in inappropriate accommodation, including hospitals or institutional care. In this time, many have found themselves in unsuitable accommodation or given up entirely, missing an opportunity for recovery.

Solutions

4. **Update SIL and SDA settings to increase access to specialised housing and support for people with psychosocial disability to enhance opportunities for mental health recovery, including:**
    - amend eligibility criteria to better reflect the needs of people with psychosocial disability
    - amend funding settings to ensure recovery-oriented support can be delivered by qualified and experienced practitioners
    - reform settings to ensure SDA is seen as an option for people with psychosocial disability, including:
        - improving transparency around outcomes and timelines
        - streamline SDA and concurrent home and living application processes
    - ensure participants with a psychosocial disability have a range of home and living options available to them
    - allow flexibility of funding to enable innovation of service models in the home and living context
    - given the benefit of 24/7 support and sense of community, SIL group accommodation settings with shared supports should remain available for participants where appropriate and not be replaced by Core Supports
    - improve information sharing and guidance to empower participants and ensure planners, support coordinators and Local Area Coordinators can appropriately advise and support participants to understand the home and living options available to them.

5. **Given the integral role of housing for mental health recovery, and particularly its relationship to timely discharge from hospital, the NDIS should work with Commonwealth, State and Territory Governments to improve housing policy, including:**
    - ensure the role and responsibilities of governments around housing and psychosocial rehabilitation is clearly defined, and adequately funded
    - set targets for new housing which sees a proportion set aside for people with a lived or living experience of severe and complex mental ill-health and psychosocial disability
    - advocate for funded support for people to maintain their tenancies

[9] Productivity Commission. (2011). Disability Care and Support, Report no. 54, Canberra
[10] State of Victoria. (2021). Royal Commission into Victoria's Mental Health System, Final Report, Volume 2: Collaboration to support good mental health and wellbeing, Parl Paper No. 202, Session 2018–21 (document 3 of 6)
[11] Productivity Commission. (2020). Mental Health, Report no. 95, Canberra

- increase the rates of social security payments so that more people are able to obtain housing in the private rental market.

Priority 3: Fund a program of psychosocial supports outside the NDIS (Tier 2)

The Productivity Commission identified more than 150,000 Australians who need support in the community to manage their psychosocial disabilities and are currently missing out.[12] These supports are vital to recovery.[13] The APA believes there is a need for greater supports in the community to prevent, where possible, mental ill-health becoming permanently disabling, and to provide rehabilitative services for those who are not eligible for the NDIS but may benefit from psychosocial support to pursue their mental health recovery.

One of the original intentions of the NDIS was to service all people with disability and their carers by having a tiered set of supports, including options which the NDIS was not directly responsible for.[14] This was an acknowledgment that there are people with disability who are not NDIS participants but who need support to maintain their wellbeing.[15]

We know that since the introduction of the NDIS funding for supports, including psychosocial supports, outside of the Scheme has decreased significantly and what remains is a fragmented, inadequate and inequitable system.[16] With adequate Tier 2 services in place, more expensive interventions such as hospital and primary care, police, housing and ambulance services will reduce, leading to cost savings and more appropriate and accessible care. In turn, the economy benefits from improved levels of productivity, for example, via people maintaining employment or education.

Support outside of the NDIS is essential given the financial sustainability of the NDIS hinges on people with disability being able to access mainstream services and activities.[17] However, there is little detailed work about what these services should do or what they look like.[18]

Solutions

We acknowledge all levels of governments have committed to improving the availability of psychosocial support services for people who are not supported through the NDIS as part of the *National Mental Health and Suicide Prevention Agreement*.[19] The timeframes for the development of support arrangements should be expedited as a matter of urgency with the psychosocial support sector and people with lived experience co-designing the program. This work should include reviewing programs Primary Health Networks (PHNs) implemented as part of the National Psychosocial Support

[12] Productivity Commission. (2020). Mental Health, Report no. 95, Canberra
[13] Mental Illness Fellowship Australia (MIFA). (2022). National Psychosocial Support Advocacy Alliance Campaign.
[14] Public Interest Advocacy Centre. (2022). *What were the original intentions of the National Disability Insurance Scheme?* Accessed by: https://piac.asn.au/2022/05/17/what-were-the-original-intentions-of-the-national-disability-insurance-scheme/
[15] Olney, S., Mills, A., & Fallon, L. (2022). Finding support outside the NDIS. *The Power to Persuade*. 13 August 2022. Accessed by: https://www.powertopersuade.org.au/blog/theres-much-more-to-disability-support-than-the-ndis
[16] Hewett, R. (2022). Where are the other lifeboats? Services for people with disability outside the NDIS. Parliament of Australia. https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/FlagPost/2022/August/Disability_support_outside_the_NDIS
[17] Olney, S., Mills, A., & Fallon, L. (2022). Finding support outside the NDIS. *The Power to Persuade*. 13 August 2022. Accessed by: https://www.powertopersuade.org.au/blog/theres-much-more-to-disability-support-than-the-ndis
[18] Gibbs, E. (2022). What the hell is Tier 2? *DSC*. 30 August 2022. Accessed by: https://teamdsc.com.au/resources/what-the-hell-is-tier-2?_kx=tl_5-ce0vVXgd-a64MRvCzil7TRRsEOXbmQDplOGl0_ArPLcRRl3YDLGV_TpORpE.X8eRsJ
[19] Federal Financial Relations, Department of Treasury. (2022). *The National Mental Health and Suicide Prevention Agreement.* Australian Government. Accessed by: https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement

Measure and Continuity of Support programs[20], as well as learnings from other programs such as Partners in Recovery, and consolidating best practice into the future suite of Tier 2 services. **We would be happy to work with the Panel as part of the Review to develop recommendations for psychosocial support programs outside of the NDIS.**

6. **Ensure a suite of Tier 2 supports is agreed and funded with appropriate implementation and monitoring arrangements. These services need to have a strong focus on recovery and aim to ensure that people can regain function and do not need to enter the NDIS.**

What parts of the NDIS are working well?

Despite the barriers and concerns with the NDIS for people with psychosocial disability, it is essential we remind ourselves and the community, of how important access to the NDIS is, along with the positive benefits the Scheme is having for Australians living with disability.

As mentioned above, housing with support models such as Haven are also working quite well within the NDIS and have positive outcomes for residents. However, we need continued support from the NDIA, and policy and funding settings which support recovery-oriented models of care for people with psychosocial disability.

Having access to funding gives people choice and control over the supports they receive, and provides opportunities to lead a life of their choosing.

Shaun's story

Shaun was hospitalised 122 times in one year before he moved into safe, supported housing at Haven Geelong – funded by his NDIS package. Prior to moving into Haven Geelong, Shaun was homeless, battling alcoholism, had fractured relationships with his family and his mental health supports were unstable. Shaun has an acquired brain injury and has been diagnosed with bipolar disorder and schizophrenia.

At Haven Geelong Shaun lives in secure long-term housing and has access to 24/7 onsite support. Since moving in, Shaun no longer drinks alcohol or takes drugs, and is relying less on his NDIS support worker, who he previously called up to three times per day.

Most notably, Shaun has had just one hospital admission since moving into the Haven residence. Shaun, a proud Wathaurong man, loves sharing his Indigenous heritage with other Haven Geelong residents. He organises NAIDOC Week events at the service and often shares his own artwork to help others learn about Aboriginal culture. Read Shaun's story.

[20] Department of Health and Aged Care. (2022). *Evaluation of National Psychosocial Support Programs: Appendix A.* Australian Government. Accessed by at: https://www.health.gov.au/resources/publications/evaluation-of-national-psychosocial-support-programs-appendix-a?language=en

Garry's story

Garry has been happily living at Haven Frankston since it opened in 2018. Prior to moving into his own unit, Garry bounced around from place to place and he had no consistency with his living arrangements. During this time, he was diagnosed with schizophrenia.

Having secure housing and a safe environment to call home, funded by his NDIS package, has been a crucial part of Garry's recovery journey.

"Moving around was tough. I've got my own independence now – I'm living my life. Living at Haven keeps me busy and it's better than being by myself. There's always something happening here and it's good for me, socially, to meet some new people. I can have a cup of tea, talk with others and make new friends." Read Garry's story.

Conclusion

To be able to receive funded support to recover in the community is paramount. We must resolve the disjuncture between a recovery-oriented approach for people with psychosocial disability and the tenets of the Scheme which rest on permanent disability. Recent changes to the Scheme have made progress towards this goal, but there is more work to be done.

We look forward to engaging further with the Independent Panel in 2023 to ensure the Scheme works well for people with psychosocial disability.