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Towards a responsive psychosocial support system: An occupational therapy perspective

Advice and actions for government

October 2025



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Introduction

Australian Governments have indicated their intention to design and deliver a new system of supports outside of the National Disability Insurance System (NDIS) for people with psychosocial disability. This system is intended to result in a connected-up system of mental health and psychosocial supports that incorporates and builds on mainstream services, and existing psychosocial support programs, to meet the high volume of unmet need. This plan builds on the recommendations for psychosocial foundational supports outlined in the final report of the NDIS Review.

The new system of supports is intended to align closely with the NDIS, with a range of potentially shared services including assessment and navigation. However, almost two years after the release of the NDIS Review, no plan has yet been provided to people with psychosocial disability or the people that support them and it is likely that significant work will still be needed to design and implementation a new system of supports. This provides an important opportunity for governments to design an accessible and inclusive system that better supports people with psychosocial disability and the workforces that will deliver those supports.

Occupational therapy is a key profession that delivers vital and unique services to people with psychosocial disability. The functional, vocational focus of occupational therapy practice focuses directly on psychosocial outcomes and has a long and proven history of supporting recovery. Yet this area of occupational therapy practice is often less recognised. To address this, Occupational Therapy Australia (OTA) has invested significantly in a program of work to provide practical policy guidance to all governments as they respond to the challenge of building a new and expanded system of psychosocial supports and the workforce structures that will support those.

OTA's vision is that the new and expanded system of psychosocial supports will harness the full potential of the occupational therapy workforce, which is uniquely skilled and qualified to support the recovery and independence of people with psychosocial disabilities. Below, we describe the unique role and value of occupational therapy in working with people with psychosocial disability, including an explanation of the skills and capabilities of mental health occupational therapists, to better equip policymakers in future system design. Fully utilised, with a focus on functional capacity building and restoring independence, occupational therapy has the potential to provide efficiencies within psychosocial support systems and to attain positive outcomes for people with psychosocial disabilities.

This document outlines that vision and seeks to show how governments can build:

1. A new system of psychosocial foundational supports based on a multi-tiered system of general and targeted supports, with clearly defined roles for occupational therapists working to use their unique skills and approaches across all tiers of supports.
2. Improved access to all supports with a focus on better connecting mental health and health supports. This necessitates a multidisciplinary workforce, including mental health occupational therapists, who draw on psychotherapeutic approaches as well as core occupational therapy practice to support the health and mental health needs of people with psychosocial disability.
3. A strong and equitable National Disability Insurance Scheme (NDIS) that continues to fund the highly individualised occupational therapy and other psychosocial support services needed by people with more complex psychosocial disability and ongoing support needs.
4. Improved system integration between mainstream, foundation supports, and NDIS systems.

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To support the enactment of these four conditions, this paper outlines key considerations across three domains – service models, workforce conditions, and funding models – to support policy makers to design and implement an efficient, effective and well-integrated psychosocial support system. The actions proposed in this document are also intended to support a safe and effective transition to a new support system for those who require its support, with continued access to high quality occupational therapy.

Process for developing this paper

To develop this paper, OTA established an Expert Advisory Group for Psychosocial Foundational Supports (EAG), comprising twenty highly experienced occupational therapists working across a range of public, non-government and private psychosocial services. OTA also worked in close collaboration with the occupational therapy community to develop this paper and to guide our advocacy work. We are grateful for the significant contributions of the EAG during the development of this paper, as well as the contributions of individual members who also provided advice and input.

Additional note on the importance of multidisciplinary teams

While the scope of this document is to provide expert advice on the role of occupational therapists in psychosocial supports and how occupational therapists can support the establishment of a new and expanded system of supports for psychosocial disability, this does not diminish the importance of the other professions who work in multidisciplinary teams. Best practice involves a multidisciplinary team of allied health professionals, mental health nurses, certificate trained mental health or support workers, assistant workforces, and peer or lived experience workers. Recommendations about the inclusion of occupational therapists across mainstream and foundational support programs should not be seen as excluding or diminishing the important role of other professions working in mental health and psychosocial disability.

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Recommended actions for Australian governments

A clear plan for change must be a key priority for all governments. The recommended immediate, short and medium term actions below are intended to support governments to take the requisite steps to design and deliver a new and expanded supports system that meets their articulated goals, and determine appropriate funding to ensure smooth implementation.

OTA calls on governments to commit to the following actions:

Immediate actions:

1. **Release a government response to the NDIS Review and Analysis of Unmet Psychosocial Support Needs outlining a timeline for the design, funding, and implementation of foundational and other psychosocial supports.**

   The Commonwealth, in conjunction with the states and territories must agree on what will be funded and by whom, how services to meet psychosocial support needs will be delivered, and how a contemporary model of service will integrate with NDIS and mainstream supports including mental health supports. Governments must urgently develop and communicate a coordinated roadmap for how consistent national models of service delivery will be developed and maintained, how workforce needs will be addressed, and how they will intersect with existing health, mental health, and disability systems. As the Productivity Commission has noted in Draft Recommendation 4.4 in its Interim Report, governments cannot delay progress until the next Mental Health and Suicide Prevention Agreement is negotiated and must develop a plan for fully addressing unmet need.[i]

2. **Fund the development of a dedicated psychosocial workforce strategy to supplement the National Mental Health Workforce Strategy 2022 – 2032 and ensure work on a capability framework includes the capability requirements of the psychosocial support workforce.**

   The current mental health workforce strategy does not account for the workforce needs arising from new and expanded psychosocial supports or the roles of different professions in delivering effective outcomes. The proposal to develop a mental health workforce capability framework by Health and Mental Health Ministers as a deliverable for the Mental Health Strategy 2022-2032[ii] is welcomed but will need to explicitly include the capability needs, and scopes of practice, of the psychosocial workforce. This includes the role of occupational therapists, and how their more specialised training is a key foundation for psychosocial outcomes, particularly where individual needs may be more complex. A supplementary psychosocial workforce strategy and inclusion of psychosocial workforce needs in the capability framework will need to be underpinned by dedicated modelling that seeks to quantify supply and demand, outlines the scope, skills, and training needed by each profession, and identifies the student and early career development pathways needed to support the growth of the workforce and a move away from generic support roles.

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3. **Work with OTA and the provider sector to develop National Guidelines on Regional Planning and Commissioning that support commissioning work by Primary Health Networks (PHNs), State and Territory Governments, and other funding bodies.**

   The Productivity Commission[iii] has noted a range of issues undermining the planning and commissioning roles of PHNs, local hospital networks, and other bodies with a role in supporting or undertaking commissioning work. This includes poor coordination, significant variation in commissioning approaches and levels of quality. Draft recommendation 2.1 calls for government to release detailed National Guidelines, but does not consider the additional work needed to ensure that new guidelines incorporate the findings of the Review of Primary Health Network Business Model & Mental Health Flexible Funding Model, and support improved PHN commissioning capabilities. In the context of a new and expanded system of psychosocial supports, commissioned by PHNs, addressing the lack of innovation in commissioning approaches, and the significant barriers that commissioning approaches may present to the largely private occupational therapy and allied health psychosocial support workforce must be a key priority in the development of updated guidelines. A greater focus is also needed on outcome measures that assess clinical and quality outcomes, not just occasions of service.

Short and medium-term actions:

1. **Finalise work to improve the accessibility of the NDIS for people with psychosocial disability and improved outcomes for participants with psychosocial disability, in conjunction with OTA and the occupational therapy profession.**

   Access rates for people with psychosocial disability seeking NDIS funding remain well below those of other participant cohorts People with psychosocial disability also typically access a smaller proportion of capacity building and recovery-oriented supports than is best practice. The NDIA is currently undertaking work to develop and implement new assessment and planning frameworks as well as to develop new early intervention entry pathways. These will provide an important foundation not only for NDIS access and outcomes for people with psychosocial disability but should also support access to other psychosocial supports outside of the NDIS for those not needing more complex supports. Occupational therapists are well established as experts in establishing functional support needs and capacity and will need to continue to play a key role in the more complex assessments needed to support people with psychosocial disability. OTA and the occupational therapy profession must be involved in work to develop and trial new assessment and planning approaches, as well as early intervention pathways for psychosocial disability.

2. **Fund the development and delivery of a national model of evidence-based psychosocial supports that underpins an integrated and collaborative system of services.**

   Considerable changes have occurred in how and where psychosocial workforces operate and in the broader psychosocial support ecosystem since the introduction of the NDIS. This means that previous models of psychosocial support delivery may no longer meet needs or reflect a contemporary understanding of psychosocial supports and needs. New models are needed that reflect

contemporary evidence about the roles and capabilities needed to deliver effective outcomes, particularly more specialised workforces such as occupational therapists. New models will need to support a diverse provider workforce, including small private providers, whether through commissioning approaches or through other funding mechanisms. Work to consolidate an evidence-base for a new model should be led by a consortium of experts with representation from all key sectors as has been undertaken on behalf of the Commonwealth for the Best Practice Framework for Early Childhood Intervention. Consideration should be given to how the multi-year evaluation of the Commonwealth Psychosocial Support program is included in this work. Funding must be sufficient to provide a viable alternative to the NDIS and to meet the unmet psychosocial needs of the Australian community.

3. **Fund an expanded system of accessible mental health supports for people with psychosocial disability that improves access to mental health occupational therapy.**

   The NDIS Review identified the need for more accessible mental health supports for those with psychosocial disability noting a range of issues in relation to the accessibility of services, and their integration with psychosocial supports. The Commonwealth has since committed to funding a range of initiatives such as expansions of the headspace and Medicare Mental Health programs without a clear strategy for ensuring that services meet consumer needs including those with more complex support needs. A clearly defined strategy is needed that outlines how private services funded through Medicare, private health insurance, and other government programs, alongside public acute and community mental health programs, and user pays services, form a comprehensive and accessible mental health system for all Australians. Occupational therapists are a recognised mental health workforce working across mental health services, often with those experiencing more complex mental health challenges. Due to the occupational and functional focus of the profession, occupational therapy mental health supports not only support symptom reduction and clinical mental health outcomes, but also recovery-focused psychosocial outcomes providing an essential bridge between mental health and psychosocial supports. However, occupational therapists are too often limited by lower rebates, exclusions from programs and scope restrictions and access will need to be prioritised under mental health reforms.

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Policy background

The National Disability Insurance Scheme (NDIS) Review Final Report (NDIS Review) in November 2023 found that significant reforms are required to ensure that people with psychosocial disability are properly supported, both withing and outside of the NDIS. The NDIS Review found that a joined-up system of support is required that enables access to non-clinical mental health and psychosocial capacity building supports.

The NDIS is not currently meeting the needs of people with psychosocial disability. For instance, the review found that participants with psychosocial disability experience lower community participation, as well as lower employment and carer employment than other participants in the NDIS.

Further, people with psychosocial disability are disproportionately experiencing barriers to accessing the NDIS[iv]. The access rate for people with psychosocial disability is 15 percent lower than the overall average of 85 percent across the scheme.[v] This rate that continues to fall over time with rates as low as 23 percent of applications being accepted in Quarter 3 of 2024-25.[vi]

This aligns with feedback that OTA has received from occupational therapists who work as providers of psychosocial supports under the NDIS who have observed increasing challenges for participants seeking NDIS access. Despite evidence that the overwhelming majority of participant funds are being used for core supports rather than those that support recovery, [vii] an increasing number of participants' plans are being reduced, particularly for capacity building therapeutic supports.

The NDIS Review also identified significant gaps in mental health systems, including barriers to accessing mental health services, and a lack of coordination of mental health and psychosocial support policy and services. These gaps "prevent people from being as well as they can be and maximising life outcomes." [viii] The major shortage of psychosocial supports outside the NDIS was identified as one of the most significant issues in the NDIS Review, mirroring findings by the Productivity Commission in 2020.

Insufficient service availability outside of the NDIS was highlighted in the May 2024 *Analysis of unmet need for psychosocial supports outside of the NDIS* report (Unmet Needs Report).[1] This report identified that approximately 230,500 people with severe mental illness aged between 12 and 64 were not receiving psychosocial support and approximately 263,100 people with moderate mental illness aged between 12 and 64 were not receiving psychosocial supports.[ix] These shortfall estimates indicate that almost 70 percent of those with severe mental illness and around 85 percent of those with moderate mental illness are not receiving supports.

Further, the above estimates do not include the needs of older Australians with psychosocial support needs. This means that the true volume of support needs that governments be required to address will be greater than the estimates in the Unmet Needs Report. The report also proposes that those with moderate support needs will need around 10 hours of support, while those with more complex needs may need

[1] This report was commissioned by all Australian governments under section 128 of the National Mental Health and Suicide Prevention Agreement (the National Agreement).

around 65 hours of support, with volume of need based on current service levels. Further work is required to more accurately estimate the support needs, particularly those associated with more intensive supports such as those provided by occupational therapists for psychosocial outcomes in areas such as employment, education and housing.

Despite overwhelming evidence of the need for an expanded system of psychosocial supports, Australian governments have yet to release a plan for the establishment of new psychosocial foundational supports or any expansion of other psychosocial programs to meet unmet need. A formal response to the NDIS Review was to be released by the end of 2024 but no further information is available at this time. While Health and Mental Health Ministers met in mid-June 2025 to discuss unmet demand for psychosocial supports, no commitment was made to any expansion. The minister's communique not only failed to formally reference work on psychosocial foundational supports, but ministers also failed to respond to the volume of unmet psychosocial need in the community, committing only to maintaining supports and to consider psychosocial supports a priority in a new Mental Health and Suicide Prevention Strategy.[x] Work by an all government Psychosocial Project Group to develop a Psychosocial Plan also appears to have stalled.

The increasing delays in designing and establishing psychosocial supports, when combined with a less accessible NDIS, is reducing opportunities for people with psychosocial disability to recover and participate in their communities, and exacerbating the disadvantages they experience. Failing to address psychosocial support needs has a direct impact on the ability to participate in the community, complete education or gain employment, maintain housing, and build and maintain relationships. Australian governments have ethical and human rights obligations to meet support needs, but failing to act on unmet psychosocial need outside the NDIS is also economically unsound, reducing the productivity of people with psychosocial disability and the people that care for them.

Further, the impact of NDIS policy changes and ongoing delays in responding to the need for expanded psychosocial supports are seen first-hand by occupational therapists who too frequently experience how a lack of available supports, resources and funding impacts outcomes for their clients.

Recent progress in relation to foundational supports for children through the new Thriving Kids program provides a blueprint for how the Commonwealth can lead much-needed changes even if full agreement with states and territories has not been reached. This document is intended to support all governments in progressing work to meet the needs of people with psychosocial disability and OTA welcomes the opportunity to support that work.

The work in this document is intended to build on, respond to, and complement current government frameworks, strategies, reviews and policy documents to provide the concrete guidance needed to support the development of new and updated policies and programs for mental health and psychosocial disability.

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These include:

- NDIS Independent Review Final Report and supplementary analysis (2023)
- Analysis of unmet need for psychosocial supports outside of the NDIS (2024)
- Productivity Commission Inquiry into Mental Health (2020)
- Productivity Commission Mental Health and Suicide Prevention Agreement Review (2025)
- National Mental Health and Suicide Prevention Agreement
- National Mental Health Workforce Strategy 2022–2032

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The unique value of OTs in the psychosocial workforce

Occupational therapists play a unique role in mental health, and psychosocial support systems, with their specialised focus on functional outcomes and capacity building to enable everyday occupations of life independently.

Occupational therapists support people of all ages with psychosocial support needs and work across all states and territories, in a diverse range of geographic settings, and across multiple sectors. Occupational therapists are the largest allied health workforce providing NDIS-funded psychosocial supports, and also work in psychosocial support programs, deliver supports funded by traffic and accident compensation schemes, and work across a range of private and public mental health programs.

This means that occupational therapists are an indispensable part of the psychosocial workforce and play a unique role in the psychosocial support system. There are approximately 35,000 occupational therapists across Australia, a significant proportion of whom work exclusively in mental health and psychosocial disability, often as credentialled mental health occupational therapists.

Any new or expanded system of psychosocial support needs to imbed occupational therapy in a way that maximises its value and potential, to those with psychosocial disability, and for the benefit of the system as a whole.

OT scope of practice

"Occupational therapy promotes health and wellbeing by supporting participation in meaningful occupations that people want, need, or are expected to do."[xi] *(WFOT,2025)*

Occupational therapists are rightly recognised as a key support for people with disability, including with mental health and/or psychosocial support needs. Whilst core supports facilitate access to community activities or support self-care activities, occupational therapy interventions focus on building the capacity of the person to reduce their dependence on formal supports so they can undertake those activities independently. These activities include:

- showering
- dressing
- preparing food
- productive activities such as education, work, volunteering and caring for others, and
- leisure/social activities, such as being part of a community group, engaging in a hobby, and being part of a friendship group.

Occupational therapy as a profession emerged in the late 1800s and was focused on recovery and activity-based practice to support people with mental health conditions, often in psychiatric hospitals. Therefore, mental health supports, including psychosocial support is at the very core of occupational therapy. Further, occupational therapists are one of only a small number of clinically trained mental health professions in Australia and one of only three allied health professions currently eligible to provide Medicare-funded mental health supports through the Better Access program.

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In the mental health context, mental health occupational therapists examine the client's emotional, social, and behavioral functioning across their natural environments (e.g. home, workplace, community settings) to assess and identify mental health factors, such as symptoms, diagnosis, or no diagnosis. Mental health occupational therapists manage and navigate clinical and mental health risk, mental health assessment, wellbeing and function, and offer mental health interventions for primary mental health needs (DSM 5-TR /ICD-10).

They also address the individual's mental health condition by integrating this with their understanding of the individual's psychosocial disability. Unlike other mental health or psychosocial professions, occupational therapists don't differentiate between clinical and non-clinical supports. Instead, the profession focuses on what may be considered non-clinical, psychosocial outcomes, with a highly specialised clinical skillset allowing them to achieve outcomes where other professions may not.

Occupational therapists working with a psychosocial focus draw on their mental health and broader occupational therapy skillset to deliver tailored person-centred interventions for individuals who have, or are at risk of having, a psychosocial disability. Occupational therapists collaborate with individuals and their support systems to address their psychosocial disability and enable meaningful occupational engagement. Occupational therapists employ a range of psychosocial strategies (assessments, tools, modalities, and approaches) to support emotional wellbeing and psychosocial functioning for the individual.

Occupational therapists also provide a specialist role in psychosocial supports for clients with more complex needs, and with more complex psychosocial outcome goals such as employment and education. This is because occupational therapists are distinctly qualified to provide occupation-based practice, with expertise in occupational performance, activity analysis and design, environmental analysis, neurophysiology, psychosocial development, and group dynamics.[xii]

For example, an occupational therapist may work with a person with complex mental health challenges transitioning from rehabilitation to independent living, or someone with major depression and anxiety who is struggling to keep up with role demands from work and family life.

Occupational therapy practitioners utilise a combination of approaches, including: [xiii]

- detailed occupational analyses,
- activities graded to meet personal needs
- explicit time use planning to encourage balanced participation
- education about specific occupational situations, which empowers individuals to effect change
- focused efforts to capitalize on strengths and build skills, and
- consultation and environmental modification to secure the best match between the person and the occupation in which she or he is seeking to participate.

The above outlined expertise means that occupational therapists are also uniquely placed to provide support for peer and certificate trained professions through supervision and support, as well as training and guidance in the use of capacity building approaches.

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Underutilisation of occupational therapy workforce

Despite the above, occupational therapy is often under-recognised and under-utilised in mental health and psychosocial support programs. Examples include:

- The Medicare Mental Health Centres centralised tele-psychology and tele-psychiatry service, which excluded occupational therapists from tendering to deliver the service.[xiv]
- The final report from the Productivity Commission's inquiry into mental health, released in November 2020, listed occupational therapy as an allied health profession responsible for 'assist[ing] people with daily living and work skills' (p702, Volume 2) rather than as a mental health profession. This is a misunderstanding of the role and expertise of occupational therapy that has unintended adverse consequences for the profession, those who would benefit from occupational therapy, and the mental health system useful.
- Occupational therapists are not consistently employed across school mental health programs despite their status as a recognised mental health workforce and experience barriers to working under some government mental health programs, including PHN-commissioned services.

Occupational therapists also experience significant barriers to working to their full scope of practice within many psychosocial support programs. This is because of a commonly utilised model where generic mental health worker roles are designed to be filled by a broad range of professions, including occupational therapists and other allied health professionals, nurses, certificate trained mental health workers, or peer workforces.

This model was intended to support increased access to services in environments where there have been significant workforce supply issues. However, there are unintended adverse consequences and risks for people requiring support. These include:

- Barriers to maintaining discipline-specific identities in generic roles for early career practitioners.
- Inconsistent outcomes for service users due to inconsistencies in the training and capabilities of the person providing supports.
- Ambiguity about the scope of individual members of a team.
- Scope creep and the risk of people working outside of where they have professional capabilities.
- Blurred lines between clinical and non-clinical skillsets.

Occupational therapists are experiencing constraints in how they work and the level of intervention that they can provide. This impacts not only outcomes for service users, but also on the occupational therapist's own longer-term professional development. A key consequence of this has been occupational therapists choosing not to work in these services, contributing to workforce shortages.

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Key takeaways:

- *Occupational therapists are experts in psychosocial support and recovery. Occupational therapists focus on helping people regain or develop skills for everyday tasks (like self-care, social interaction, employment, and community participation), which are core goals of psychosocial recovery.*
- *Occupational therapists are trained to analyse the interaction between a person, their environment, and the tasks they want or need to do, allowing them to work collaboratively to develop adaptions and undertake therapeutic interventions focused on supporting outcomes for service users.*
- *Occupational therapists draw on both clinical and non-clinical skillsets, allowing them to achieve outcomes in more complex areas of psychosocial support need.*
- *Occupational therapists are a highly specialised workforce that can be used effectively in psychosocial support programs to provide more focused and individualised interventions for those with higher levels of support need.*
- *While access to occupational therapy should be prioritised for those with higher levels of support need, occupational therapists work with all levels of acuity and support need.*
- *Occupational therapists are ideally placed to support other workforces through supervision and professional support.*
- *While general mental health roles play a role in psychosocial support programs, ensuring that there are an appropriate proportion of discipline specific roles for occupational therapists is crucial.*

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Principles, concepts, and practices underpinning the delivery of best practice psychosocial supports

As noted above, a range of reviews have identified significant barriers impacting the availability of psychosocial supports within and outside of the NDIS. However, governments have yet to commit to the reforms required to create a more inclusive system.

As governments work to develop new, nationally consistent, evidence-based approaches to the delivery of psychosocial supports, and to build the workforce strategies and capability plans that are needed to deliver those, there are three system components that need to be designed, in concert, to ensure that a new and expanded system of psychosocial supports achieves is aims: **psychosocial service model, workforce design, and funding model.** The principles required for these components are expanded on below. We have also identified a recommended structure for the development of a psychosocial model in Appendix 1.

The importance of laying a strong foundation for psychosocial supports

The delay in progress towards the development of a new model of psychosocial supports by Australian governments is causing significant uncertainty amongst the providers currently delivering services. Feedback from the sector suggests that there is significant concern about the future viability of current NDIS-based provider models given slowing NDIS access rates and evidence of reassessment of eligibility and a lack of clarity about the role of providers in new systems outside of the NDIS. This is slowing investment, including in workforce development. While careful consideration is needed to develop the right service models for a future system, there is a need to balance the time required for planning and design with clear communication and timeframes to support current providers.

Undertaking a dedicated program of policy work to lay the foundations for a more effective and consistent psychosocial system is critical. Australia's mental health and psychosocial support system has changed significantly with the introduction of the NDIS, with real benefits for those that have been able to access funding. Attempting to replicate what and how psychosocial services were delivered prior to the NDIS risks stepping back from significant areas of progress.

Given the wide variation in how psychosocial programs are currently delivered, which services are funded, the differences in the skills and scopes of the workforces that are delivering services, and between the types of supports that can be sustainably delivered in different geographic settings, developing a consistent and evidence-based framework and model of service delivery must be a priority.

Regarding approach to the design of a new and expanded psychosocial supports system, there is a sound example in the early childhood space. The Commonwealth funded the development of a best practice framework for early childhood intervention to guide the delivery of supports for children and young people within and outside the NDIS, now known as Thriving Kids.

This approach provides a valuable example of how governments can fund the policy foundation for future psychosocial supports. We note also the funding by the Department of Health and Aged Care (now Health, Disability, and Ageing) of an Orygen-led consortium to deliver sector-led advice on models of care for mental health services for young people aged 12 to 25. While this piece of work is focused on mental health models, early advice from the consortium has identified the need to build an evidence base

regarding the effectiveness of mental health and psychosocial services. [xv] Further work arising from that project may help to support the evidence base for youth services.

A wide range of available evidence from Australia and internationally demonstrates the effectiveness of occupational therapy psychosocial, psychoeducational, cognitive and exercise interventions and their positive impact on daily living skills, social participation, and participation in vocational activities for people with severe mental health issues and psychosocial disability.[xvi] [xvii] [xviii] That evidence should be drawn on as part of work to define the role and value of occupational therapy as key providers of psychosocial interventions and supports.

Principles for a strong psychosocial service model

We have identified four criteria required in the design of a new psychosocial model, for it to meet the objectives of the Australian governments' reform agenda. The model needs to:

- Account for different recovery journeys and needs
- Support early intervention
- Include appropriate intensity and duration of service delivery
- Improve access to mental health services

These are expanded on below.

A model of psychosocial supports that accounts for different recovery journeys and needs

In order to account for different recovery journeys and needs, the model will need to align with different individual needs, life stages, and lived experience, and facilitate local approaches with regional variation as appropriate.

Aligning supports with life stages

It is important to define at the early design stages, how programs will work across age cohorts. The approach taken should align with that of the public mental health system, which has been designed around age cohorts. This typically comprises of child and youth mental health services, including headspace services for those aged up to 25, adult mental health services including Medicare Mental Health or Head to Health Centres, and older persons mental health services for those aged 65 and over (with some flexibility to support younger people with age related mental health support needs).

It is important to note that different groups may be seeking to achieve very different psychosocial outcomes, and be navigating different life transitions. An individual's access to different mainstream and other support programs may will also differ based on their age. The psychosocial needs of older Australians have not been established or discussed in modelling of unmet psychosocial need but must be considered a priority alongside youth and adult services. It is therefore important that programs respond to these variations in desired outcomes and life transitions.

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Despite the well-established nature of the above noted structure within the mental health system, current discussions about psychosocial supports do not focus on the differences between existing and potential support systems for the different age cohorts, including differences in how mental health supports might be integrated with psychosocial supports. This must change.

A focus on age cohorts is also important to ensure system integration. The need for much closer integration between mental health and psychosocial supports has been well-established by a range of reviews. For example, the Sector-led advice on new and/or refined models of youth mental health care paper, developed by Orygen and a consortium of organisations funded by the Commonwealth, noted the evidence for the importance of psychosocial supports and the need for integration of clinical and psychosocial supports.[xix]

In considering how to improve integration between mental health and psychosocial supports, governments need to ensure that the crisis driven nature of many mental health services does not also drive decision-making about access to psychosocial supports. An expanded ecosystem of supports will likely need both public mental health programs with integrated psychosocial support programs or pathways to psychosocial supports delivered collaboratively and psychosocial support programs that are integrated with other mental health supports for less complex mental health needs. This includes those provided through Commonwealth programs such as Medicare and funded through private health insurance.

From an occupational therapy perspective, establishing fit for purpose psychosocial models can only occur with appropriate consideration of the different recovery journeys and the key psychosocial supports needs associated with those age groups, consideration of the environments in which people are living and engaging, and the supports that are available. For example, psychosocial supports for young people should focus on key areas such as educational outcomes, home and family relationships, as well as transitions from school to training, further education, and employment, moving into new housing arrangements, learning how to drive, and more.

The setting for those psychosocial supports will need to include natural settings: environments in which children and young people engage, including schools, training or education services, as well as homes. Psychosocial services for young people must be aligned with the range of supports available to young people, including potential mental health and other school supports, mental health supports outside of school, and the range of non-mental health services that may benefit young people such as programs focusing on social and peer connection. Similarly, the needs of adult and older adult cohorts will also differ, as will the ecosystem of services, the psychosocial needs, and the settings for potential supports. Defining these should be considered a crucial foundation for the development of a model of supports.

Aligning supports with individual needs and lived experience

The psychosocial support model should also allow for targeted approaches based on the individual needs of the person seeking support, their level of prior engagement with psychosocial and mental health supports, and their ability and preference in relation to engagement with services. The needs of these cohorts differ significantly, which likely determines differing appropriate level of intensity of supports, focus of interventions, and capabilities needed by the workforce delivering supports.

OTA suggests that three pathways need consideration within an overall psychosocial support approach: early intervention, coordination and support, and enhanced outreach.

Early intervention has been identified as a priority in the NDIS Review and is discussed in more detail in the section below. The key factors associated with the early intervention pathway are the more intensive but time-limited, more structured approach aimed at rebuilding independence and supporting recovery.

The coordination and support pathway recognises that many people who will need to access psychosocial supports are likely to have longer term support needs and existing experience of mental health and psychosocial supports. This cohort are less likely to achieve outcomes within a time-limited approach and are more likely to benefit from a case management approach that works alongside a range of other supports aimed at addressing ongoing barriers to recovery alongside key psychosocial outcome areas.

The final enhanced outreach pathway recognises that some people with psychosocial support needs will not actively seek support and will require outreach. This approach aims to build their capacity to engage by overcoming the barriers that are limiting their ability and desire to access psychosocial services and supports. This pathway may include elements of the other pathways but draws on a different service model and will require a workforce with experience working in this manner. The current occupational therapy NDIS workforce working in psychosocial supports is skilled at providing this sort of support.

These pathways should be explored in more detail as part of both the development of a model of psychosocial supports, and the development of a capability framework that outlines workforce needs and capability requirements.

Regional variation

New models of psychosocial supports will also need to account for regional differences in the range of available services and service infrastructure, differences in workforce availability, and local factors such as the availability of transport that may impact service design and access. Governments have tried to address this difference previously through flexible commissioning processes, such as via Primary Health Networks (PHNs). However, this has led to inconsistencies in the services that people can access.

For example, there are significant differences between the services available across different Head to Health and Medicare Mental Health services, including in some cases restricted supports available in some regions. Some services provide only phone-based access to advice and appointments, with no access to drop in options or home visits. Similar challenges apply in relation to the range of psychosocial supports available in different regions. Despite government funding to expand the number of centre-based supports such as Medicare Mental Health services available in communities, many communities currently have no services available and may not have access in future.

While digital initiatives can meet the needs of some consumers, governments should prioritise creating alternative service models for rural and remote settings. We speak more to workforce below, but in the rural and remote context, the current workforce is predominantly private practice occupational therapists and practice businesses. This workforce has a wealth of knowledge, experience and expertise in psychosocial disability supports and have been operating within the NDIS. This workforce is highly innovative and can be leveraged in a new and expanded system of supports to drive innovative approaches that draw on local knowledge and networks and create efficiencies in the system.

For example, a local occupational therapist could be commissioned to run family focused psychoeducation groups, support community capacity building, as well as providing other targeted supports. This approach has the benefit of strengthening existing services and allowing local workforces

to build more sustainable service offerings. A range of stakeholders including the Office of the Rural Health Commissioner have also noted the potential role of mixed-use services in rural settings that offer more sustainable incomes for occupational therapists and other allied health professionals by drawing on a range of funding sources across health, aged care and disability. Providing options for local providers to provide access to some general foundational support services could be a valuable component of mixed-use services.

Supporting early intervention and/or early support

The NDIS Review prosed that early intervention, sometimes also referred to as early support approach, provides best chance of reducing longer-term dependence on formal support systems (see Action 7.2). This is achieved by ensuring that participants are supported to put in place the right mix of services when first accessing supports. This is also supported by other evidence of the effectiveness of supported housing, supported employment and social skills-focused interventions as early intervention approaches that support recovery outcomes.[xx] Some caution is needed though as much of the literature focuses on early intervention in mental health[xxi], based on local support and resourcing that may not be scalable[xxii], or on current trials where final outcomes have not yet been evaluated.

Additionally, while the NDIS Review recommended the development of an early intervention pathway through the NDIS, the role of early intervention outside of the NDIS remains a significant policy gap. The Grattan Institute has noted the importance of early intervention outside of the NDIS, as well as the potential inefficiency of having early intervention programs both within and outside of the NDIS. Their recommendation is that Early Intervention pathways would sit outside of the NDIS as part of psychosocial supports,[xxiii] though it is not clear what form this would take or whether this approach is viable.

From an OTA perspective, there is value in recognising the additional needs of those accessing psychosocial supports for the first time. Some stakeholders have suggested that the terminology 'early supports' may be more appropriate and may better align with the needs of this group of services users. Regardless of the term used, the emphasis should be both on recognising that those accessing supports may be new users of psychosocial services, and that they may benefit from more intensive interventions focused on reducing longer-term support needs. The use of early intervention in this document should be seen as including both areas of focus.

OTA agrees that there is a risk of duplication if there are early intervention programs both for NDIS participants, and within a foundational supports system, and that it may be most effective to have a single program for all users. However, given the mature nature of NDIS supports and the NDIS provider market, it is not clear that basing early intervention programs outside of the NDIS is a more effective approach than one within the NDIS.

Addressing questions about where best to situate early intervention approaches will require coordinated policy and program design discussions between the NDIS and other government teams working on psychosocial supports outside of the scheme. It will also be important to ensure system integration between the NDIS and services outside of the NDIS. This will need to occur in conjunction with a clear commitment to:

- fully funding the supports that would be needed to deliver this program within foundational supports,
- development of a nationally consistent model of early intervention that recognises the role of occupational therapy, and
- development of commissioning approaches that supports access to private providers. The Grattan Institute[xxiv] have noted the importance of supporting flexible funding models that allow for contracting and sub-contracting, as well as consortia approaches.

In addition to considering which systems deliver early intervention supports, there are key factors that need to be considered that support an effective early support approach. This includes the development of a more structured and consistent approach to providing guidance and support for participants seeking to understand the range of options available to them. Such support should include intensive occupational therapy supports, that are focused on maximising outcomes and may draw on innovative approaches focused on sensory and other areas of support need.

Further consideration about the duration of a time-limited early intervention approach is also important. The NDIS Review has suggested that early intervention supports may have a duration of up to 3 years.[xxv] This is longer than most current psychosocial programs that are not focused on early intervention. OTA supports the range of focus areas identified by the NDIS Review for foundational supports, including supported employment, supports to find and maintain housing, illness self-management, cognitive remediation, family psychosocial education and social skills training. However, there is also a risk that this list of supports may not meet the individual needs of the person seeking supports.

To mitigate this risk, close integration with the NDIS should allow foundational supports to be part of a step up and down approach that supports access to ongoing NDIS supports for those that need it. Further, there should be mechanisms to enable transition to mainstream supports for those that are able to regain psychosocial function and who can continue their recovery journey with a lower level of support.

The effectiveness of early intervention approaches is heavily dependent on a skilled workforce capable of identifying, assessing, and responding to psychosocial support needs in a timely and developmentally appropriate manner. Clinicians need to be able to effectively weigh a wide range of factors to tailor interventions to individual needs, ensuring engagement in therapeutic programs and activities, and continually assessing if activities are supporting psychosocial outcomes and a reduction in the severity and duration of the person's needs.

Without appropriate training and clinical expertise, opportunities for early identification may be missed, and interventions may lack the precision required to alter developmental trajectories. Evidence from the mental health sector shows that early intervention services staffed by qualified mental health professionals are associated with better clinical and functional outcomes, including improved education and employment participation. Research undertaken to look at psychosocial services also demonstrates the importance of ongoing training, even where those delivering services can draw on a rigorous training foundation and a clearly defined scope and set of capabilities.[xxvi]

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Key takeaways:

- *Early intervention/early support must be recognised not only as a dedicated pathway within the NDIS but also within a broader system of psychosocial supports.*
- *Moving early intervention out of the NDIS and into targeted foundational supports may provide a more streamlined option but only if appropriately resourced, and as part of a step up and down approach that supports transition to the NDIS where ongoing supports are needed, and to mainstream and community supports where a person no longer needs more intensive supports.*
- *Key elements of early intervention include a higher intensity of initial supports and a structured approach.*
- *Early intervention requires a highly qualified workforce with the ability to quickly and accurately determine the person's needs and how to address those.*

Funding appropriate service intensity and duration

It is important to ensure that psychosocial supports are funded at a level that allows the right frequency, intensity and duration of supports. This is particularly important for targeted psychosocial foundational supports that are focused on achieving functional outcomes.

Current psychosocial support programs are often shorter in duration and focus on low to moderate intensity support. This approach can work for some people with lower levels of support need or psychosocial disability but will not be sufficient for many people. Another key need is for supports to be in place for a sufficient period of time to ensure that the person accessing supports can continue to access those in a way that aligns with the episodic and recurrent nature of mental illness and psychosocial disability. At the same time, supports should be time-limited wherever possible to reduce the risk of building long-term dependence.

Evidence relating to effective program length for psychosocial supports in Australia is limited. Therefore, more research is required to build the evidence base that demonstrates outcomes arising from occupational therapy psychosocial supports delivered under the NDIS.

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The IPS model

The strongest local and international evidence is for the Individual Placement and Support (IPS) approach. This is a well-established, evidence-based model for assisting people with mental health conditions into employment. In the Australian context, IPS has demonstrated strong outcomes when delivered as a high-intensity, long-duration support embedded within mental health services such as headspace or community mental health teams. Unlike traditional vocational models, IPS emphasizes rapid job search, integration with mental health care, and client-directed goals, followed by ongoing support that typically lasts 12 months or longer. Evaluations of IPS programs confirm that participants achieve competitive employment placement rates of up to 49.5%, with average job retention spanning approximately 22 weeks—substantially outperforming less intensive services. This aligns with other international IPS research. [xxvii]

The IPS model's effectiveness is closely tied to its intensity and duration. It delivers one-on-one, sustained and time-unlimited coaching, closely integrated with mental health treatment supports including clinical supports, a factor that consistently correlates with improved vocational outcomes. In contrast, moderate-intensity psychosocial supports—such as group-based programs or time-limited interventions—can offer psychosocial and educational benefits but typically fall short in achieving and sustaining employment. These programs may last only 2–4 months and are generally not individualised to the same extent or integrated with mental health care, limiting their ability to respond to complex barriers faced by people seeking psychosocial outcomes.

While IPS was initially developed to improve employment outcomes, the IPS trial in Australia, run through a range of Headspace sites also seeks to support young people re-engaging in education and training. Evidence shows this more intensive approach can support access to vocational training or study; however, outcomes are dependent on the workforce delivering IPS supports and additional or complementary strategies such as learning supports may be needed for ongoing engagement with education and training.

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From an occupational therapy perspective, the key elements of the IPS program that make it more effective than other approaches are:

- the ability to provide more intensive and individualised supports focused on the individual outcomes an individual is seeking,
- the ability to remain connected (to provide follow-along supports) to the person after they have successfully connected with a vocational role in order to be able to support them through challenges that may arise, and,
- the recognition of the specialist nature of this workforce, and the focus on connection with mainstream supports including close collaboration with mental health supports.

These elements are not unique to IPS and reflect an occupational therapy approach that practitioners use in other psychosocial outcomes areas such as building and maintaining social connections and accessing housing. Occupational therapists working in an IPS role bring a range of specific professional capabilities including the ability to help ensure workplace environments suit the mental health, sensory and physical needs of the individual. The profession strongly argues that this more intensive level of support should be built into targeted psychosocial foundational supports and that the role of occupational therapists in delivering these supports must be recognised.

Not all people accessing psychosocial supports need the intensive level of support provided by the IPS model. Whilst some might benefit from a more intensive IPS approach, and the need for more specialist supports provided by occupational therapists and other allied health professionals, some may benefit from low or moderate intensity, shorter duration supports. Determining which approach is required should be based on several factors, such as whether:

- The person is already receiving general psychosocial supports, delivered by a peer worker or general mental health worker, such as developing social skills and friendships, managing money, and building life skills.
- The person requires more intensive support from a specialist workforce associated with education and training, employment, or housing.
- Outcomes are achievable with lower intensity supports for that individual.

It is also important to consider which supports pathway is most appropriate, in line with the required approach. The pathways proposed in this document demonstrate the need to differentiate between those requiring a more structured early intervention approach, those with ongoing support needs that may also include more intensive supports, and those requiring a more assertive outreach approach. Those accessing the outreach pathway are likely to require more intensive supports that do not have an initial vocational focus.

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Practitioners have suggested that a process for assessing and re-assessing the person's needs would enable more accurate and current determinations of whether the approach being taken is best for the individual at that time. For example, whether the person may benefit from more intensive or complementary supports. This should entail an initial assessment and then reassessment at, for example, three months. This reassessment should be undertaken as a multidisciplinary case review. Additional check-ins for lower intensity support should be taken at regular intervals.

Regardless of the intensity of supports being delivered, careful consideration of how to ensure that the duration of supports aligns with the episodic and potentially ongoing nature of psychosocial disability is required. Some supports may need to be time-unlimited, with reductions to very low levels of intervention, except when needed. For others, supports will need to be able to be re-accessed as needed.

Key takeaways:

- *While evidence for the dosage of psychosocial supports is limited, more intensive supports based on an IPS model are well established.*
- *Occupational therapists have a key role in delivering more intensive supports associated with psychosocial outcomes associated with education and training, employment, housing and other areas of more intensive support need.*
- *Decisions about the dosage of supports should also be aligned with the psychosocial outcomes that are being sought.*
- *Decision-making frameworks should be developed that support consistent decision-making by fundholders and those undertaking assessments and referring people for supports to make appropriate decisions in conjunction with the person seeking services.*

Improved access to mental health services

The limitations of Australia's mental health system have been well-documented. Research shows that while around 3.1 percent of Australians experience severe mental health, only 1.8 percent of those with mental health needs are receiving state or territory mental health services.[xxviii] Private Medicare funded services are accessed by a much higher proportion of Australians (around 10 percent of the population), however only around half of that cohort access non-medical (GP and psychiatry) mental health services.[xxix] The impact of this is that many Australians with severe mental health needs are either missing out on services, or presenting in locations that are not set up to meet their needs. Headspace data from 2017-18, showed that of those first presenting to headspace centres, almost half (47.2%) had high or very high psychological distress on the Kessler 10, indicating they were likely to have a severe mental disorder.[xxx]

The close association between psychosocial disability and severe mental health needs means that a high proportion of people needing psychosocial support also require ongoing mental health supports. These include access to medication, case management, and psychotherapeutic support. However, practitioners report that many of those clients experience significant barriers to accessing mental health services. These barriers are due to multiple factors, such as resourcing constraints, the resulting crisis driven nature of current public mental health services, and the lack of alternative mental health services for moderate and severe mental health needs.

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Many Australians are only able to access Medicare Better Access mental health funding. However, low rebates, particularly for occupational therapy, leave the service out of reach for many clients. Practitioners also report that even where someone has an NDIS plan, a high proportion of NDIS participants lack access to appropriate mental health services, particularly coordination and case management supports. The scarcity of mental health and psychosocial support funding outside of the NDIS has resulted in significant fragmentation of services. NDIS funding guidelines largely restrict NDIS providers from providing mental health supports, despite clear evidence of the benefit of an integrated approach to addressing mental health and psychosocial support needs. To achieve better outcomes for people with psychosocial disability, and to improve system efficiency, this must change.

The Commonwealth recently committed to a major increase in investment in mental health services, announcing 21 new Medicare Mental Health Centres, funding to expand Headspace services, and 20 Youth Specialist Care Centres. Occupational therapists have cautiously welcomed the news, welcoming additional funding and the recognition that more services are needed, while noting ongoing issues associated with the dependence on Medicare funding for services provided through these services and significant variability in the service models.

Despite some caution, the investment in new centres, and commitment by all governments to expand resourcing for mental health services, provides an opportunity to revisit the intersection between mental health supports and psychosocial supports. A fit for purpose model can be developed that supports genuine access to mental health supports delivered by occupational therapists and other allied health professionals working to their full scope of practice.

Occupational therapists also note the importance of school-based mental health supports for children and young people. While school-based mental health supports are expanding in many states and territories, providing important additional options for support, access varies. Occupational therapists are ineligible to provide services in many school-based programs. This is a significant gap that means children and young people are less able to access the occupational focused skills of occupational therapists that are highly effective as a means of addressing the interaction between mental health challenges and environmental factors that can result in poor educational psychosocial outcomes.

OTA also notes that older Australians with mental health and psychosocial support needs experience significant barriers to accessing services. A range of reviews including the Royal Commission into Aged Care Quality and Safety[xxxi] noted the need to better address the mental health needs of older Australians and to provide improved supports within the aged care system.

Key takeaways:

- *Mental health and psychosocial supports should be accessible to all Australians.*
- *Mental health and psychosocial supports should be delivered in collaboration with service models and funding structures encouraging teams to work together to support the needs of the individual.*
- *Access to school-based and older persons mental health supports should be prioritised.*
- *Occupational therapists should be recognised as providers of school-based mental health supports.*
- *Aged care programs should be resourced to improve access to occupational therapy and other mental health supports as part of ongoing aged care reforms.*

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Workforce needs

Building a sustainable and effective response to the high volume of unmet psychosocial support needs outside of the NDIS requires more than just an expansion of current services. The current psychosocial and broader mental health landscape is larger than ever but also more fragmented, including a highly skilled and experienced private workforce that provides services within the NDIS. Supporting this workforce is required to safeguard access to high quality supports for people with psychosocial disability.

Planning and timeframes

In August 2024, Australian health and mental health ministers agreed that the Psychosocial Project Group would develop a plan to support the delivery of new and expanded psychosocial supports in conjunction with mental health stakeholders.[xxxii] This all-government group was established under the National Mental Health and Suicide Prevention Agreement to progress work on future arrangements for psychosocial supports outside of the NDIS. The decision to develop a plan was welcomed by the sector but the delay in providing updates about how the plan will be developed or how the group will consult with the sector to develop a fit for purpose plan is causing significant uncertainty.

Progressing discussions around the development of a plan for the delivery of psychosocial supports with all stakeholders is critical. Mental Health Australia led work with sector stakeholders to develop a list of current and previous psychosocial programs that governments should fund to meet psychosocial support needs. These programs include Partners in Recovery, Personal Helpers and Mentors, the Housing and Accommodation Support Initiative, and Individual Placement and Support[xxxiii]. However, that work provides only a high-level description of how those programs function rather than how they intersect to deliver a coordinated set of supports. It also fails to account for changes in the mental health and psychosocial systems, including the introduction of the NDIS. There has been no attempt to develop a coherent and nationally consistent plan for a functioning ecosystem of psychosocial supports that draws on evidence of what is most effective, and how this can be delivered.

Further, a shopping list of potential program options will not result in a cohesive and connected system of supports, nor offer consistent and effective capacity building supports that reduce demand for the NDIS and long-term support. Governments should exercise caution when considering which programs to include in a new and expanded system of supports, as system design and integration are just fundamental to success. If a program isn't accessible, or isn't well connected with other programs, it will not achieve intended outcomes. The same is true of workforce; workforce capacity and capability is crucial.

One of the biggest gaps is engagement of the large private workforce providing psychosocial supports. Prior to the introduction of the NDIS, non-government organisations from the community mental health sector, along with state and territory governments were responsible for services, largely through block-funded programs. However, the NDIS created the opportunity for more individualised and innovative solutions that better met the needs of many people with psychosocial disability. However, consultation activities have largely excluded this provider group. This must change if governments are to avoid the risk of providing funding to programs that are fragmented and poorly aligned, that don't take into

consideration the broader ecosystem of supports that are available, and that don't align with changes occurring in the mental health ecosystem and workforce.

The considerations and proposals outlined below should be read in conjunction with the more detailed model structure outlined later in Appendix 1. We encourage governments to engage with OTA and the sector to explore these proposals in more detail.

Workforce capabilities and training

The agreement by Australia's health and mental health ministers to develop a mental health capability framework by mid-2026 has been welcomed by the occupational therapy workforce.

The psychosocial workforce is highly diverse comprising a wide range of different professions including occupational therapists and other allied health professionals, mental health nurses, vocationally qualified mental health workers, peer workers, and support workers. The diversity of the workforce supports a multidisciplinary team approach, and the range of psychosocial support roles needed to support effective interventions.

Peer worker models and training may differ significantly across different psychosocial programs. For example, the Mind peer work framework notes that peer workers are considered practitioners and work with similar position requirements and focus as other community mental health practitioners, often in the same team. Peer practitioners are required to have formal qualifications in mental health, mental health peer work.[xxxiv] Other organisations may not require formal qualifications or may recognise a broader range of training options.[xxxv]

The impact of this high level of variation is that there can be significant variation within a single workforce in relation to scope, and capabilities. By contrast, all occupational therapists undertake training in mental health prior to being qualified to practice. Occupational therapists are bound by national standards that define the requirements to be registered to practice, have a clearly defined scope of practice, and defined capability requirements. The profession is also supported by the dedicated OTA credentialling pathway for mental health occupational therapy, which recognises additional mental health training and experience, and a mental health capability framework that supports all occupational therapists working with people with mental health and psychosocial disability.

Outcomes from psychosocial models of support can be impacted significantly by the training and background of the person providing supports. This means that variation in training within and across psychosocial workforces directly impacts service delivery and outcomes for consumers, leading to inconsistency.

Orygen noted potentially significant variation in outcomes for clients accessing IPS supports through Headspace, which were linked to the person delivering those supports. They also noted high rates of staff turnover further impacting the consistency and capabilities of workforces.[xxxvi]

This challenge is amplified in settings in which there are generic mental health worker roles. Variation in the capability of different workforces, and the dependence on these general roles in community mental health and psychosocial support programs impacts the extent to which professionals in those roles can draw on their full scopes of practice and skills. Occupational therapists in these roles describe constrained scopes of practice and limits on their ability to draw on their unique skills when working with

clients. This not only impacts outcomes but limits the ongoing professional development of those profession-specific skills for occupational therapists in these settings.

The commitment to the development of a mental health capability framework by health and mental health ministers provides an opportunity to improve consistency across the Australian mental health and psychosocial workforces. However, the working group leading this work on behalf of government will need to ensure that the framework includes a specific focus on the capability needs of the psychosocial workforces, alongside that of mental health workforces.

While there is significant overlap between mental health and psychosocial workforces, there are particular skills and capabilities required in each. A particular focus should be on the role of clinical skills in supporting the delivery of psychosocial supports. The capability framework must also focus on the different roles required to deliver psychosocial supports and the capabilities associated with each, including the false dichotomy between clinical and non-clinical supports which can lead to overlooking the vital role of occupational therapists and other allied health professionals in delivering psychosocial supports. While each member of the multidisciplinary psychosocial team has an important role to play, roles are not interchangeable, and the capabilities required for each will be different. Those different capabilities will also require different scope, skills, and training.

Key takeaways:

- *A capability framework is needed to support psychosocial workforce planning and development.*
- *Capabilities will need to be defined for different roles within a psychosocial support model.*
- *The scopes of practice and capabilities of individual professions should be aligned with these capabilities to support more consistent and high-quality delivery of psychosocial supports.*
- *Occupational therapists should be recognised for their unique and highly focused psychosocial capabilities.*
- *OTA has a well-established capability framework for mental health practice that provides an important foundation for psychosocial practice. Similar frameworks should be developed for and by other psychosocial support professions.*

Workforce development and planning

Meeting the unmet psychosocial needs of the Australian community presents major workforce challenges for Australian governments. All mental health workforces, including occupational therapy, are experiencing workforce shortages. This issue was identified in the Mental Health Workforce Strategy 2022-2032[xxxvii], which led to the Department of Health, Disability and Ageing developing its capacity to undertake supply and demand mapping for occupational therapy. Workforce shortages are impacted by a range of factors including the availability of supported training pathways and the ability to retain workforces. The well-established shortage of mental health workforces is based on current needs and does not consider the current and future workforce needs of the psychosocial support sector and how they will impact access to both mental health and psychosocial supports. Addressing this should be a priority.

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Need for a fit for purpose workforce strategy

A more targeted and fit for purpose workforce strategy is required. This could take the form of an update to the current mental health workforce strategy to include an additional and explicit focus on the psychosocial workforce. However, it would be more effective to develop a separate psychosocial workforce strategy, which is connected to the current mental health workforce strategy. To be effective, this strategy will require a more careful analysis of the factors that impact the growth and development of individual professions than is included in the current mental health workforce strategy. This will enable the strategy to effectively meet the workforce needs of a growing psychosocial support system.

An important starting point will be better defining the role of different mental health and psychosocial support professions in a psychosocial support system. The current mental health strategy has poorly defined professions. It fails to include occupational therapists as a mental health workforce despite occupational therapists being one of only three eligible allied health professions under the Medicare Better Access scheme, and the well-established roles occupational therapists play in mental health and psychosocial support programs across Australia.

A new strategy should also seek to better define mental health and psychosocial supports and the professions that deliver those supports, avoiding the simplistic and inaccurate suggestion that mental health supports are clinical and psychosocial supports are non-clinical approaches. Occupational therapists draw on a highly specialised clinical skillset to achieve functional, occupational outcomes that are the focus of psychosocial supports.

Governments have made a clear commitment to supporting and building the role of peer workforces in psychosocial supports systems. A commitment to developing the peer workforce is strongly supported by occupational therapists. There is a long history of occupational therapists supporting the development of peer workforces and peer-led programs. Occupational therapists often work in close collaboration with peer workforces, providing additional and more specialised supports that complement peer approaches. This makes occupational therapists an asset to a new and expanded system of psychosocial supports, in that they can provide support to one of the key workforces within it, the peer workforce.

There are also risks in overestimating the capacity of the peer workforce and developing models that depend on peer workforces without also considering the current and future size and capacity of that workforce. Data from the current national mental health workforce strategy suggests that peer workers make up only around five percent of the workforce.[xxxviii] This is why it is vital to clearly define the role and scope of each workforce working within a new and expanded system of psychosocial supports.

Evidence also suggests that meeting the mental health needs of the Australian community will require innovative approaches and a dedicated focus on supporting workforce development.[xxxix] Innovative approaches include more careful consideration of the role of occupational therapists and other allied health professions working with paraprofessional and non-clinical workforces. Workforce development requires a focus on better estimating supply and demand, identifying key barriers, and most critically, funding targeted workforce initiatives to address barriers such as clinical placements, early career support and supervision.

A focus on how to build appropriate support and supervisory structures should be a key focus in a psychosocial support workforce strategy. All workforces involved in providing psychosocial supports may experience additional risks to their own mental health and wellbeing. For example, work undertaken in Queensland identified that peer workers have been found to experience additional psychosocial

hazards.[xl] This is supported by the work of the National Mental Health Commission, which identified issues in relation to the available support and supervision for many peer workers.[xli] The Commonwealth government commissioned Mental Health Workforce Labour Market Analysis also noted that lack of supervision is a key issue for some workforces, whether due to a lack of discipline specific supervision for allied health professionals, including occupational therapists, or an overall lack of supervision for mental health workers and peer workers.[xlii]

Key takeaways:

- *Meeting psychosocial support needs will require effective use of the whole current mental health and psychosocial workforce and a dedicated focus on growing the workforce.*
- *Understanding the training and development needs of individual workforces is crucial.*
- *A focus on growing peer workforces is appropriate but should not come at the cost of investment in occupational therapy and other mental health and psychosocial workforces.*
- *Supervision and support structures are critical. Occupational therapists are an important potential source of supervision for other workforces as well as being able to delegate and direct the work of other paraprofessional workforces.*

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Service models and commissioning approaches

The establishment of the NDIS and its associated market-based approach has driven a significant shift from NGO or government to private occupational therapy services. This shift has created important opportunities and flexibility for a workforce that is predominantly female, frequently have caring roles, and who may also have lived experience of disability. A similar trajectory can be observed across a range of mental health and psychosocial workforces, particularly those in the allied health sector. The impact of this shift is that many of the most experienced psychosocial providers, with the strongest connections to local services and supports, are now private providers rather than working within government and non-government services as was the case prior to the NDIS. However, this shift in how and where services are delivered is not being sufficiently considered in proposed reforms.

Current proposals for the establishment of psychosocial supports made by the NDIS Review and Productivity Commission have called for future services to be commissioned, either by governments directly, or by PHNs on behalf of governments. However, there is little detail about how this will be undertaken or how greater consistency will be built into funding programs. The complex nature of psychosocial support funding in Australia has been noted in the NDIS Review, with reviewers raising concerns that providers are often delivering a range of different programs for different funders with different eligibility criteria and approaches, as well as varying program funding periods and funding certainty. These factors add cost and complexity to service delivery, impacting on the ongoing viability of services, and job security for the psychosocial workforce.

There are real risks associated with relying on existing commissioning processes and organisations. Evidence shows that a commissioning approach heavily favours large non-government providers and may exclude occupational therapy and allied health providers. A range of PHN and other government commissioning programs have previously excluded occupational therapists.

Commissioning is also impacted by the level of knowledge and capability of the commissioning organisation, with many PHNs being impacted by more limited knowledge of, and engagement with, allied health providers. The Productivity Commission noted in its interim report on the mental health and suicide prevention agreement that comprehensive national guidelines on regional commissioning and planning are needed, noting inconsistencies and inefficiencies in the way PHNs approach their role in commissioning and the negative effect this has on the availability of mental health and suicide prevention services and consumer experiences of care.[xliii]

Much more careful consideration is needed of how new commissioning approaches will support the involvement of existing providers, particularly private providers. The NDIS Review has noted the importance of alternative commissioning arrangements for both First Nations and Remote communities (Action 14.1), emphasising the importance of local input and needs within the commissioning process. The Review also noted the importance of supporting consortia-based approaches within commissioning models in order to support greater involvement of local services.

The establishment of an expanded ecosystem of psychosocial supports will need dedicated commissioning and planning guidelines as proposed by the Productivity Commission. However, engagement with OTA and the allied health sector is vital to ensure that guidelines and planning processes best utilise the highly skilled and experience private provider workforce through contracting, consortia-based approaches.

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Key takeaways:

- *Many of the most experienced providers are now private providers.*
- *Access to highly qualified, experienced providers must be a priority in the design of commissioning models.*
- *Current commissioning processes often limit the involvement of occupational therapists and other allied health providers and must be updated and standardised through national guidelines.*

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Conclusion

While there are still many questions about how a new and expanded system of psychosocial supports will be structured, funded, and delivered to those that need them, work must commence urgently. Significant time and deep consideration are required to develop the service models, capability frameworks, funding processes, and workforce development programs that will be needed to support a more effective and connected system of supports, which is well integrated with other systems. Given the extent of unmet need in Australia, there is no time to lose.

This document provides constructive suggestions about how to structure services in a way that ensures a new, nationally consistent and effective approach. The paper also provides insight into how best to utilise the unique role and scope of occupational therapy in a way that will contribute to new and expanded system's success. Occupational therapy is a profession that is embedded across our system, with deep expertise and knowledge, and a key driver of innovation. To date, occupational therapy has often been overlooked in policy and program design; this is an opportunity to make a shift.

Further, this paper identifies that there is a role for all workforces within a psychosocial support system. Program and system design will benefit from including the individual strengths and differences of all relevant workforces.

To this aim, while generic mental health roles have played a role in growing the psychosocial support workforce and improving service access, without structured training, clear scopes, and pathways for progression, where and how these roles are utilised must be reconsidered. Generic roles are hindering both professional development and service quality. The work to build an expanded psychosocial support workforce and a capability framework for that sector offers an opportunity to better understand and value individual professions, and reassess which roles are embedded into programs and services.

New funding models will need to recognise the diverse nature of the psychosocial workforce and the shift to private practice. The shift to a market-based model has had many benefits, including enhancing participant choice and supporting the growth of the workforce. A focus on how to include private occupational therapy and other providers of all sizes in commissioning programs, as well as how to support contracting or direct funding arrangements, will be crucial if governments are seeking to provide equitable access to supports for those not based in well-serviced metropolitan and regional areas.

By committing to the actions and principles outlined in this advice, governments can uphold their promise to deliver a more accessible, responsive, and outcome-focused psychosocial support system that that works alongside mental health supports to empower people with psychosocial disability to connect to their community and engage in meaningful roles and activities.

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Appendix 1

Outline for a psychosocial model

This outline is intended to identify the key elements of a psychosocial support model and the role of occupational therapists within that model. If utilised, this will support greater consistency in how services are delivered and the core elements that comprise the program.

It is important to preface this with the understanding that local implementation of psychosocial support programs will need to reflect differences in service structure and availability, differences in available workforces, and in the needs of individual communities.

Key elements

For:	People experiencing, or at risk of, psychosocial disability, which arises from the interaction between a long-term mental health condition (that may be episodic) and attitudinal and environmental barriers that hinder their full and effective participation in society and may result in significant functional impairment and associated support needs.
Dedicated services for key age cohorts:	Psychosocial supports must focus on the stage of life of the person needing support and the key psychosocial outcomes, and life transitions, that are relevant to that life stage. To do so, psychosocial supports should echo mental health service structures that focus on children and young people, adults, and older adults.
Clearly articulated psychosocial outcome areas:	The following psychosocial outcome areas are considered priority areas for the psychosocial support model: • Relationships (family and social network relationship building and maintenance, socialisation both with peers and with members of the broader community, support to manage social interactions and behaviours) • Day-to-day living skills (cooking, shopping, driving skills building as well as supports when the person can't maintain these) • Housing (find and maintain appropriate housing that meets the individual needs of the person) • Education (support to adapt education approaches and environments, participate in education and achieve educational outcomes, connection to community supports such as homework clubs) • Employment (skills associated with being able to seek employment, job readiness, support to access closed and open employment opportunities)

- Technology use (support to access and learn to use technology to enable access to other supports and systems)
- Managing finances and budgeting (support to access services that can help with financial planning, financial literacy, and access to financial supports).
- Addiction (access supports focused on managing addition to alcohol and other drugs, gambling, gaming and other addictions).

Multiple points of entry with no requirement for diagnosis:	Easy access to supports must be a priority for an expanded psychosocial support system. There must be multiple entry points, including access through mental health and health service systems, through updated NDIS access and navigation pathways, and via assertive outreach that seeks to identify those with the greatest needs. Key referral points will be: • General practice and allied health primary care providers. • Primary Health Network (PHN) mental health access and referral services. • Mental health services such as Headspace, Medicare Mental Health, and Head to Health services. • PHN or state and territory commissioned community mental health and psychosocial support services. • Aboriginal Community Controlled Health Organisations and community health services.
Multi-tiered:	The model recognises different levels of complexity and interaction with other systems including acute and community mental health and supports step up and step-down approaches with targeted approaches for the different tiers (see below for more detail). General foundational supports provide an initial entry point and a set of services that are accessible alongside more complex supports. The NDIS must remain the primary means of accessing higher levels of support need as funding needs must be based on individual need and all supports are likely to need to be highly individualised.
Initial triage and assessment:	Those seeking services will require initial triage and assessment by an occupational therapist or appropriately qualified allied health or other mental health professional. Initial assessment should focus on identifying.

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Dedicated pathways based on stage of recovery journey:

Those needing psychosocial supports will vary widely in their individual needs and personal recovery journey. However, despite that variance, those accessing services will benefit from a targeted pathway associated with where they are at in terms of accessing and being connected to supports. Based on broad categories of need, the following pathways are proposed:

- *Early intervention pathway:* early intervention is not based on age of entry but rather is focused on those who are only just commencing their psychosocial recovery journey and may have limited connection to existing mental health or psychosocial support services but are actively seeking support. More intensive initial supports are intended to support longer term psychosocial outcomes and focused on not building dependence.
- *Coordination and support pathway:* this pathway is for those people that are already have a history of service use and connection and who may be accessing some supports but who have not been able to achieve psychosocial support outcomes.
- *Enhanced outreach:* those that are not connected to services and are not seeking support and will need active outreach approaches to ensure they are given the assistance they need to commence a recovery journey and access supports.

While many of the elements of support provided to each of these cohorts may be similar, the intention of defining different pathways is to ensure that each group can access supports at a level of intensity and frequency that meets their needs and incorporates an appropriate mix of skills and capabilities in the multidisciplinary team delivering supports. In the context of the NDIS Review's conception of a psychosocial support system, these supports fall within targeted psychosocial supports.

Workforce:

Delivering psychosocial supports effectively for most people will require an ecosystem of different supports working in collaboration. An effective workforce model recognises the roles and scopes of different professions as well as differences in how those professions can support an individual's recovery journey. Occupational therapy, and other allied health professionals with more specialised skills are recognised as being able to draw on clinical skills and expertise that underpins effective capacity building supports for clients with more complex needs and in particular psychosocial outcome areas such as vocational outcomes. The structure of this is outlined in more detail in the model below but includes:

- Peer and certificate trained mental health workers providing non-clinical supports such as peer supports, aspects of recovery college programs, and general individualised psychosocial supports.

- Occupational therapists and other allied health professionals providing more specialised psychosocial supports for people with more complex support needs, and in specific areas such as employment, education, and housing.
- Mental health clinicians including psychiatrists, mental health occupational therapists and other allied health mental health professionals, and other clinically trained mental health workforces providing mental health-focused interventions in collaboration with psychosocial and other supports to achieve psychosocial outcomes.

Support for multiple funding approaches:	An effective psychosocial support model must prioritise access to appropriately skilled and experienced occupational therapists. While the model recognises the importance of integration with existing mental health and psychosocial programs and services, including physical drop-in and community services, this model does not require occupational therapists to be employed within non-government or government organisations. Instead, the model is intended to support a range of approaches including employment with a commissioned provider, participation by an occupational therapy or allied health provider in a consortium that is commissioned to provide psychosocial supports alongside other providers, contracting or provider panel approaches that allow private occupational therapists to deliver services on behalf of commissioned providers, and direct funding by government.

Psychosocial foundational supports system tiered structure

An improved psychosocial support system should be based on a three-tier system, broadly aligning with the recommendations of the NDIS Review:

- Tier 1: General Psychosocial Foundational Supports
- Tier 2: Targeted Psychosocial Foundational Supports
- Tier 3: NDIS Psychosocial Supports including an early intervention pathway and ongoing psychosocial supports for those with psychosocial disability

Tier 1: General Psychosocial Foundational Supports

Tier 1 supports should be based around existing psychosocial supports and mental health infrastructure already funded by governments associated within the age range of the person seeking supports. Existing programs will need to be expanded, and additional capacity built in areas that don't have current programs, noting that older persons' supports in particular are more limited than those available for children and young people and adults. Tier 1 supports should draw on physical locations that can be accessed on an ad hoc basis in the form of drop-in services, as well as providing access to group programs and services such as peer support groups or recovery college programs, in addition to telephone and digital services.

The functions and characteristics of tier 1 services are:

1. Low barrier to entry (i.e., limited or no requirement to demonstrate eligibility) based on self-referral or referral from family and carers, other government and commissioned mental health services, general practice, and other mental health practitioners including mental health occupational therapists.
2. Appropriate for the age range of the person seeking supports
3. Involve initial triage focus to help establish level and type of support need provided by an appropriately skilled occupational therapist of other mental health professional. Triage may identify the need for immediate access to tier 2 supports as well as assessing use of, or need for, public mental health supports.
4. Include centre-based access options (e.g., for opportunistic drop ins or scheduled appointments at hub services) as well as telephone or online services
5. Offer services including:
    a. Information and advice
    b. Digital mental health program access
    c. Peer group programs focused on social connections, skills development for daily living skills, and mutual peer support
    d. Psychoeducation for consumers through recovery college or similar programs offered in-person or online
    e. Family and carer psychoeducation
    f. Referral and basic coordination of access to other services including short-term mental health services delivered through Headspace, Medicare Mental Health Services or new initiatives such as the Commonwealth National Early Intervention Service
    g. Referral to Tier 2 supports, focusing on need for more individualised support and psychosocial outcomes such as housing, employment and education.
6. Provides a general outreach component focused on increasing awareness of supports for priority cohorts. E.g., providing information to school-aged children and young people or working with other programs such as meals or social programs to engage with people who might benefit from psychosocial supports.

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Occupational therapy role in Tier 1 supports

Occupational therapists have an important role in Tier 1 supports, contributing to broad community initiatives through education and support of individuals, family members, caregivers, and others, through collaborative and consultative partnerships and by fostering social participation and community mobility. Occupational therapists in systems-focused roles can play a key role in supporting broader community capacity-building and population health outcomes. Occupational therapists in Tier 1 also have an important role supporting other workforces providing Tier 1 supports, including the adaptation of programs and approaches to meet the needs of individual consumers, and supporting triage and initial identification of support needs. Occupational therapists should be included in Tier 1 support programs to:

- Deliver triage and assessment services directly or in team lead roles to support earlier career and professions with a lower level of mental health training. The holistic nature of occupational therapy practice and assessment approaches, and high level of expertise in the physical, cognitive, and environmental aspects of participation is an important foundation for ensuring effective triage that ensures service users are directed to the most appropriate services and only those with higher levels of need are referred up to Tier 2 and Tier 3 (NDIS) programs.
- Design programs and program resources in conjunction (co-design) with people with lived experience. For examples, this may include designing group programs that meet the specific needs of a particular group of services users or that reflect the local workforce and ecosystem. It could also include resources for consumers on specific topics such as a resource about panic attacks for autistic people.
- Support peer and certificate trained workforces to deliver group programs, including adapting program approaches to meet the needs of individual group members
- Deliver or support the delivery of consumer psychoeducation programs. While some programs such as recovery colleges may be primarily lived experience led, other programs may be co-designed by people with lived experience and occupational therapists to meet local needs.
- Deliver or support the delivery of family and carer psychoeducation programs (co-facilitating and co-designing services).
- Providing supervision and support for peer, certificate trained, and other workforces in Tier 1 support programs to support understanding of, and guidance for addressing, barriers to engagement, risk assessment and management, and grading up and down to meet the individual's needs.

Tier 2: Targeted Supports

Tier 2 supports represent individualised psychosocial services delivered through a primary psychosocial support worker working with an individual. These types of roles may be filled by a general mental health worker from one of a range of professions where support needs may be less complex, however adequate resourcing of discipline specific occupational therapy and other roles should be a key component of targeted supports.

Decisions about the most appropriate discipline to provide support should be made in consultation with the person accessing support services as well as considerations about their individual needs, the capability needs associated with those needs, and the service pathway being accessed. As outlined in the advice to governments paper, this can look different for different people. Those with lower-level support needs may be able to draw on peer and certificate trained workers. Those with higher level support needs, or specialised support needs associated with more complex psychosocial outcomes such as vocational needs, may work primarily with an occupational therapist, or with a team comprising their general psychosocial support worker, and an occupational therapist working to achieve particular outcomes.

The functions and characteristics of Tier 2 services are:

1. Builds on (and may be parallel to) Tier 1, i.e., includes peer group activities and clients choose to be connected to or continue to be connected to that service.
2. Commences with a comprehensive assessment by an occupational therapist or other qualified allied health mental health professional that builds on the initial triage and assessment process built into entry to Tier 1.
3. Assessment comprises initial and ongoing risk assessment, history (including service access history and barriers), current supports and services, reasons for attending, and discussion about the key psychosocial areas of need and outcomes or goals sought. Assessment also considers health needs with potential referral to health supports and/or additional assessments.
4. Service pathway is decided based on assessment:
    a. Early intervention pathway – The early intervention pathway involves a more intensive and structured approach aimed at rebuilding independence and connection back to community, relationships, education and employment.
    b. Coordination and support pathway – This pathway focuses more heavily on coordination and case management and addressing ongoing barriers to recovery alongside key psychosocial outcome areas. This pathway recognises that someone may need longer term supports.
    c. Enhanced outreach – This pathway recognises that many people with psychosocial supports will not actively seek support and may experience significant barriers to accessing psychosocial services and supports. This pathway may include elements of the other pathway but draws on a different service model and highly experienced professionals with the capabilities needed to achieve outcomes for this cohort.
5. Services include:

a. Support with activities of daily living for those that need support through referral to Home and Community Care services.
b. Individual, family and community psychoeducation focused on the individual support needs and recovery journey of the individual.
c. General psychosocial recovery supports aimed at improving health and emotional stability, connection to community, family and friends.
d. Specialised individualised therapeutic services focused on achieving psychosocial outcomes such as housing, relationships and parenting roles, employment and education outcomes drawing on models such as the IPS model. Supports are aimed at building capacity to address barriers and functional impairments including those associated with executive function.
e. Case management of support programs such as supported housing and supported employment programs.
f. Coordination with mental health supports including private and acute and community mental health services.
g. Referral to (or coordination with) specialised family and sexual violence, addiction and financial support services.
h. Referral to and coordination of access to mainstream services such as health.
i. Systemic capacity building through strengthening of local systems and supports.

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Occupational therapy role in Tier 2 supports

The occupational therapy role in Tier 2 builds on the roles outlined in Tier 1 with a greater focus on providing direct, individualised psychosocial supports. A key strength of occupational therapy practice, and important area of focus for Tier 2 supports is determining the most impactful and appropriate next step for those accessing psychosocial supports. Occupational therapy practice focuses on whether the person needs (or example) housing before they can develop new routines in a natural/predictable context, or whether they can safely wait for new accommodation while getting more focused supports to build skills. A key strength of this approach is that occupational therapists can help drive effective service planning and avoiding of investing in services that may not yet have the necessary impact on outcomes for the person.

Occupational therapists:

- Provide primary, individualised psychosocial supports to people with more complex and ongoing needs, particularly in the more complex support pathways. This role may encompass coordination and case management activities to support access to other programs such as supported housing or employment programs, support connection to mainstream community services and programs, as well as direct therapeutic interventions focused on support psychosocial recovery.
- Providing specialised, complementary psychosocial supports that sit alongside the role of the primary psychosocial support role in areas such as education, training and employment.
- Providing shorter duration individualised psychosocial supports in conjunction with a primary support role when the person is experiencing barriers to ongoing recovery (providers have referred to this as clients getting stuck).
- Providing supervision, support, and training for peer, certificate trained, and other workforces delivering Tier 2 support programs.

Tier 3 Supports: NDIS early intervention and ongoing supports

The NDIS must remain a key source of support for people with ongoing psychosocial support needs. While the NDIS provides highly individualised supports that achieve outcomes for many people with psychosocial disability, access to the NDIS remains difficult. Evidence shows that the vast majority (83 percent) of NDIS funding for participants with psychosocial support needs is spent on core supports rather than investing in therapeutic supports that build independence and overall capacity[xliv]. Investing in increased access to a high-quality occupational therapy workforce across access, navigation, early intervention, and therapeutic support not only improves outcomes for participants, but it is also the primary way in which government can invest in reducing longer term dependence on core supports.

A more effective NDIS will need to include:

1. Supported psychosocial access pathways that reduce the burden of evidence for people seeking supports and streamline access to the most appropriate supports across general and targeted foundational psychosocial supports and the NDIS.
2. A psychosocial support navigation role that provides support to participants in the NDIS and those accessing foundational support programs. Navigator roles for people with psychosocial disability require specific psychosocial capabilities and should generally be delivered by occupational therapists and other allied health professions with appropriate training.
3. An early intervention pathway for psychosocial disability that provides access to a structured, but individualised, set of supports delivered by occupational therapists and other workforces with psychosocial capabilities. Early intervention services should be delivered by occupational therapists and providers with the skills and experience to achieve early intervention psychosocial outcomes. OTA notes the proposal that these services are commissioned. This may be appropriate as long as commissioning models allow consortia and contracting of private providers, but OTA is concerned that commissioning approaches may not support access in all areas due to the volume of need. It may be more appropriate to develop panel approaches whereby providers can register with the NDIA to provide early intervention services based on demonstrating the necessary capabilities and experience.
4. A more outcomes focused model of funding NDIS supports that prioritises investment in achieving capacity building associated with community participation employment and other psychosocial outcomes rather than daily living supports and social and community access. This will require improved navigation supports and better guidance for participants about how and why to access occupational therapy and other psychosocial support providers and consideration of how NDIS funding approaches can better invest in and reward outcomes.[2]
5. Improved coordination of psychosocial and mental health supports and a reduction in artificial barriers between mental health and psychosocial support needs through a redefinition of the interaction between both supports, clearer definition of funding responsibilities, and increased access to case management.

[2] OTA notes that while a re-focusing of funding from primarily core supports to capacity building and occupational therapy is needed, caution must also be applied to ensuring that providers are not disincentivised to work with more complex clients with less capacity to achieve outcomes. Many people with significant psychosocial disability experience ongoing barriers to achieving psychosocial outcomes, including motivational barriers, and risk of relapse. Occupational therapists are highly experienced at building and maintain motivation, overcoming barriers, and outcomes that are relevant and appropriate to the individual participant.

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Occupational therapy role in Tier 3 supports

The occupational therapy role under the NDIS focuses on highly individualised psychosocial support for people with more complex psychosocial disability access, often associated with long-term serious mental illness and post-traumatic stress. Many participants with psychosocial disability experience significant barriers to recovery, may experience relapses or significant changes in their mental health and functioning over time, and may draw on a wide range of supports within and outside of the NDIS.

Occupational therapists:

- Holistically assess the person's needs, environment, and overall capacity, focusing not only on their own therapeutic interventions but also the range of supports and adaptations that the participant may benefit from to support recovery.
- Work collaboratively with participants to help them identify appropriate goals and outcomes they are seeking.
- Work collaboratively with the participant to build hope and the motivation to make changes, to establish routines and structures that can support functioning, and a network of formal and informal supports around them.
- Work with participants to determine how and when to focus on different functional outcome areas, balancing the goal of achieving outcomes with not overwhelming the person with too many changes at once.
- Draw on their expertise in delivering highly focused and evidence-based functionally focused therapeutic interventions to provide individual supports that provide the greatest likelihood of improving the person's ability to participate in their community and in education, training and employment.

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