Psychosocial Position Statement

November 2025

NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander Peoples as the traditional custodians of the land on which we work and pay our respects to Elders past and present. Sovereignty was never ceded.

This paper outlines the position of the National Mental Health Consumer Alliance (the Alliance) on provision of psychosocial supports in addition to the National Disability Insurance Scheme (NDIS) to address current unmet needs for people in all areas of Australia with psychosocial disability and life altering mental health challenges.

All references to 'Consumer' and 'lived experience' in this submission refer to mental health consumers with lived experience of mental health challenges and/or suicidality. We use the term "mental health consumers" as a catchall term due to its connection with our movement's history, but we acknowledge that different people self-identify with different terms. We do not include family, carers, kin or the bereaved in our definition of lived experience as it appears in this paper.

About us

The Alliance is the national peak body representing mental health consumers. We work together to represent the voice of all mental health consumers on national issues. We are the people experiencing mental health issues/distress, at the table advocating with government and policy makers, and working with a robust network of grassroots communities.

More information is available on the Alliance's website: nmhca.org.au.

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Executive Summary

This paper outlines the position of the National Mental Health Consumer Alliance (the Alliance) on provision of psychosocial supports in addition to the National Disability Insurance Scheme (NDIS) to address current unmet needs for people in all areas of Australia with psychosocial disability and life altering mental health challenges.

The Alliance is the national peak advocacy body for people with mental health challenges including psychosocial disability. The Alliance is a federation of state/territory consumer peak bodies across Australia. It works in allyship with the Indigenous Australian Lived Experience Centre (IALEC). In relation to psychosocial supports, it adopts a consumer/service user lived experience view underpinned by contemporary evidence and human rights frameworks.

At a high level, the Alliance proposes the introduction of a *National Psychosocial Support Scheme* (NPSS), which would be an integrated and consistent national system of psychosocial supports to address unmet need, improve mental health outcomes, and enable every mental health consumer to live their best life.

Under the NPSS, services would be co-produced by mental health consumers alongside governments. Consumers would undertake co-production via their mental health consumer national and state/territory peak bodies and IALEC. The work would be informed by family/carer/kin peak bodies and Community Managed Mental Health Organisations (CMMHOs). Reformed services would retain existing psychosocial supports that consumers have consistently identified as effective or essential.

The NPSS would replace PHNs as commissioning bodies for psychosocial supports. Instead, *State/Territory Psychosocial Support Scheme Committees* in each state/territory would oversee commissioning in their jurisdiction, which would in turn be overseen by a *National Psychosocial Support Committee*. Mental health consumers would be involved in the governance of these Committees to ensure that consumer lived experience principles and values are incorporated and services are held accountable.

The NPSS would recognise the reciprocal nature of inter-personal relationships and provide tailored supports based on individual circumstances, life stage, and living arrangements. This could include support for families or carers of a person or young person living together, support for partners to maintain their relationship, and support to children and young people with a parent living with a mental health challenge. It might also include supports for people to disconnect from those causing harm and establish healthy alternative relationships. Relational approaches support connection, purpose, and participation in community life. Healthy relationships are the building blocks of a good life and should be facilitated and promoted through the program.

Our modelling indicates that psychosocial disability supports for nearly half a million people identified in the *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme (Unmet Needs* report) are less expensive than the NDIS (on a per person basis). If psychosocial supports are provided, it is expected that the need for high-cost clinical supports, such as inpatient services, outpatient services and rehabilitation, will decrease which would in turn reduce hospital and health budgets significantly.

Current State of Play

The Alliance defines psychosocial supports as "the full range of social, relational, cultural, material, and structural conditions that enable a person to live with dignity, agency, connection, and self-determination. High quality psychosocial supports strengthen a person's capacity to have full citizenship rights; experience belonging; determine identity; feel safe; participate in community; sustain relationships; access housing, employment and income; and navigate systems that affect their wellbeing".

The Federal Government defines psychosocial supports as *"non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community". (Psychosocial Project Group, 2023)*

Psychosocial supports are effective across the public health spectrum of prevention, early intervention, response and recovery, with direct evidence-based benefits for individuals, their families/friends/kin, and the broader community. Psychosocial supports need to be flexible enough to involve and support family relationships (including chosen families) when desired by the consumer.

Critically, psychosocial supports enable people with mental health challenges to improve the social and economic determinants of their health, and more effectively exercise their human and consumer rights.

A significant, proven benefit to governments of psychosocial supports is they reduce the use of expensive clinical services.

Psychosocial services may include, but are not limited to:

1. **Life-skills, daily living and housing support**

- Building/maintaining routines for daily activities (self-care, household tasks)
- Financial management/budgeting supports (help with money, bills)
- Assistance finding, securing and maintaining housing (or adjusting to a new living arrangement)
- Provision of specialist housing options
- Help with managing health and wellbeing (physical activity, nutrition, sleep)
- Managing substance use

2. **Social, community and relationship support**

- Peer engagement (people with lived experience supporting each other)
- Social skills development (making and keeping friendships, communication)
- Support to join, participate and lead in community groups, clubs, sports, recreation (reducing isolation)
- People thrive when their closest personal relationships are healthy and supportive. Personal relationships take many forms and are diverse by nature. This includes with immediate family, family of choice, grandparents, extended family, kinship networks, partnerships, and friendships. This includes First Nations concepts of social and emotional well-being within family, kinship networks, community, and country.

3. **Vocational, educational and economic participation supports**

- Assistance in planning for work or study, developing vocational skills, finding employment or volunteering.
- Education/training supports (to build skills, transitions to new roles)
- Support to maintain or regain economic independence/capacity.

4. **Support coordination, navigation and brokerage**

- Services to help individuals navigate various supports (health, mental health, social services) and connect with them.
- Brokerage funds or discretionary funding to access particular supports (e.g., short-term assistance beyond standard services).
- Support for people to transition from challenging environments and circumstances (e.g. from prison; from involuntary treatment circumstances)

5. **Psychosocial recovery coaching / capacity building**

- Short-term, strength-based interventions focused on recovery of citizenship (rather than focussing only on symptoms).
- Coaching to build resilience, self-management skills, decision-making, coping strategies.

6. **Group-based and community-based programs**

- Programs that bring consumers, families and other community members together to design and implement solutions (such as Peer Open Dialogue)
- Educational groups (for rights education, wellbeing, recovery, mental health education)
- Specialist outreach, assertive community support (for those with complex or hard to reach needs)

7. **Key elements of First Nations Social and Emotional Well-Being Programs**

The federal government has proposed the introduction of several funding "buckets" for support for individuals who are not NDIS participants. These include the Early Intervention Scheme, Targeted Foundational supports, and General Foundational supports, alongside the existing Commonwealth Psychosocial Support Program (CPSP).

The CPSP is delivered through Primary Health Networks (PHNs) to provide short-term support to 25,000 people with "severe mental health challenges". This program will be evaluated between 2025-2027, and builds on the previous National Psychosocial Support Measure and Continuity of Support Program.

We know from the *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme (Unmet Needs* report) published in 2024 that there are 230,500 people with what the government calls "moderate support needs" and a further 263,100 people with "high support needs" that are currently not receiving the psychosocial supports they require. In total, the report estimated there were 493,600 people across Australia, between the ages of 12 - 64 who may benefit from additional psychosocial supports.

The report also stated that in 2022-23, there were 54,992 people over the age of 65 years with "severe mental illness" and 78,266 with "moderate mental illness" who did not receive any psychosocial supports. This cohort of people are also ineligible to apply for the NDIS but may be covered by the NDIS if they are accepted prior to turning 65 years.

Nationally Consistent System

The Alliance has attempted to compile a list of significant community-based psychosocial services and housing supports currently being provided through state/territory governments. We define community-based mental health services as those that are managed by Community Managed Organisations (CMOs), and housing supports as those that provide either a place for a person with mental health challenges to live or support to find a place to live. **This list can be found in Appendix 1.**

This list demonstrates that psychosocial services are not provided, or funded, in a consistent or equitable manner across the country.

One of the reasons for this inconsistency is that in the lead-up to the NDIS being introduced in 2013, some states continued funding some psychosocial support services, while others allocated all or most of their funds to the Commonwealth Government for the NDIS. At the same time, the Commonwealth Government closed some psychosocial programs, including Partners in Recovery (PiR) and Personal Helpers and Mentors (PHaMS). However, not everyone who used PiR or PHaMS was accepted under the NDIS and so they were left without psychosocial support. Further, the NDIS did not replace all state funded community mental health services.

While place-based services should be a key feature of psychosocial supports, a system that funds only specific and discrete projects in particular locations is inherently limited and unfair and will not meaningfully address unmet need. An inconsistent national program also makes data collection and evaluation across different projects and jurisdictions complex and limits the accountability services have to the people who use them, or seek access to them.

As such, **the Alliance recommends a jointly funded State/Commonwealth psychosocial support system, secured through the Mental Health and Suicide Prevention National Agreement, that requires all governments to follow consistent key national principles for implementing psychosocial supports.**

We know that this type of commissioning process already exists to some extent, with some states, including Tasmania and South Australia, directly commissioning mental health services that are funded through the Commonwealth.

Key Principles

People using mental health services have advocated for better mental health services for many decades, including as an organised movement from the 1970s onwards. Across community halls and kitchen tables, survivors formed collectives like the Campaign Against Psychiatric Injustice and Coercion, demanding basic rights, accountability, and an end to institutional abuse.

Their message was disruptive and compelling: mental health consumers are not problems to be fixed. We are people with expertise, insight, and the right to determine our own lives.

These early advocates laid the foundation for the values we still use today - of solidarity, of consumer rights, and of person-led care. They shifted the conversation from pathology to power, from deficit to dignity.

This work paved the way for consumer peak bodies to form, such as VMIAC in Victoria, and NSWCAG (now BEING Mental Health Consumers) in New South Wales. Today, consumer peak bodies call for services to be held accountable by the people using them.

It is these principles that need to be carried forward into contemporary practice.

On the following pages, we explain that we would like to see services which:

- incorporate peer values;
- embed consumer leadership at all levels of the organisation including governance;
- are produced by or co-produced with consumers;
- are accountable to consumers through qualitative and quantitative analysis; and
- are free for individuals to access and affordable for the Australian economy.

A list of peer values and principles are explained in the Lived Experience Governance Framework, with specific examples of how these might be incorporated in a workforce and in a governance setting. These values and principles are:

To ensure that the mental health system is realigned to peer values and principles, consumers want to see a minimum standard set for service providers that ensures they are incorporating these values and principles.

The Alliance's Proposed Model

The Alliance proposes the introduction of a *National Psychosocial Support Scheme* (NPSS), which would be an integrated and consistent national system of psychosocial supports to address unmet need, improve mental health outcomes, and enable mental health consumers to live our best life.

The immediate commencement of co-producing of the NPSS would address Recommendations 2.2, 4.4 and 5.3 from the Productivity Commission's Mental Health and Suicide Prevention Agreement Review:

> *Recommendation 2.2: Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme.*
>
> *Recommendation 4.4: The next agreement should clarify responsibility, funding and planning for psychosocial supports.*
>
> *Recommendation 5.3: The next agreement should support a greater role for people with lived and living experience in governance.*

Joint Consumer/Government Commissioning

The Alliance proposes a commissioning model that involves State/Territory and Commonwealth Governments and lived experience organisations. We believe that a nationally consistent Scheme needs to be 'owned' by each State/Territory, to reduce duplication, increase coordination, maximise structural reform, and maximise 'pooling' of existing funds across both State/Territory and Commonwealth funded mental health programs.

State/Territory based decision making will enable practical, flexible decision-making that builds on what works, and reforms mental health systems that don't. It will also enable psychosocial supports to be delivered in ways that integrate with existing acute and 'community' mental health services, which are predominately provided by State/Territory government agencies.

While we note the outcomes of the Primary Health Network (PHN) Business Model Review and Mental Health Flexible Funding Stream Review are pending, we are advocating that *State/Territory Psychosocial Support Scheme Committees* in each state/territory would replace PHNs in commissioning psychosocial supports. We believe the benefits of joint Commonwealth/State arrangements secured through the next National Agreement, and whole-of-government coordination in the provision of psychosocial supports, outweighs the benefits of retaining the PHN role, provided that people with lived experience are at the centre of the commissioning process. We note that PHNs would retain a role in commissioning clinical supports.

The Alliance proposes that commissioning would be run by *State/Territory Psychosocial Support Scheme Committees* in each state/territory. Consumer State/Territory peaks would jointly govern and oversee the commissioning process with State/Territory governments, and the Indigenous Australia Lived Experience Centre (IALEC) with Aboriginal Community Controlled Health Organisations (ACCHOs). Their remit would include (but not be limited to):

- service scope (aligned with a reformed definition of psychosocial supports);
- service coverage (including in rural, regional and remote areas, and for discrete service populations)
- service requirements and KPIs included in funding agreements and provider plans, including application of the *Lived Experience Governance Framework* (2023)
- merits based selection of providers;
- development of data collection methods for input into a national outcome framework; and
- quarterly performance evaluation and continuous, collaborative improvement.

These State/Territory commissioning bodies would be overseen by a *National Psychosocial Support Committee*. The federal government, the Alliance, IALEC, and MHCA (particularly in relation to youth mental health and older people's mental health) would be represented on the *National Psychosocial Support Committee* (NPSC) to help ensure consistency and share best practice. The NPSC would also look to support from Community Mental Health Australia (CMHA) and Gayaa Dhuwi for expert advice on implementation by service providers.

The NPSS jurisdictional committees would block-fund service providers to deliver psychosocial services under five-year grants. NPSS providers would be existing Community Managed Mental Health Organisations (CMMHOs) that already provide some psychosocial supports. These organisations generally already have a good knowledge of psychosocial supports, infrastructure in place, a peer workforce to implement psychosocial services, and a reasonable understanding of peer values and principles.

The Alliance understands that funding for this flexible NPSS would be re-routed from psychosocial support funding that is currently earmarked for separate buckets such as Foundational Supports (Targeted and General), state-funded psychosocial supports, PHN-commissioned psychosocial supports, and the CPSP. This would ensure that the best supports are consistently available for people right across the country, while less effective support services are closed and consumers who use those services are redirected to other services.

Note that the Alliance does not want to see NDIS participants with psychosocial disability be removed from the NDIS, nor for people with psychosocial disability to be prevented from becoming a participant under the current criteria. The NPSS would be a new service which complements the NDIS to ensure all people with psychosocial disability are able to access appropriate supports.

Novel commissioning arrangements

The Alliance's psychosocial supports commissioning proposal has been informed by commissioning approaches in other sectors, such as:

1. **School Resource Standard** which is based on the Gonski model. Under this model, State and Territory Governments work cooperatively with the Commonwealth to jointly fund schools based on student results, school location, school size, and demographic makeup of student populations. Translating that model into a mental health context might look like funding based on a similar costing model for each State/Territory, ensuring that psychosocial funding per person is consistent. The deliverables could be standardised across the States/Territories but the method used to deliver is flexible to meet local circumstances.

2. **National Housing Infrastructure Facility**. Housing Providers apply to Housing Australia for funding to build crisis and transitional housing, or refurbish existing buildings for the same purpose. Applicants may be State or Territory Governments, Local Governments, or other entities that provide housing. Translating that model into a mental health context might look like the Commonwealth setting up a body such as our proposed *National Psychosocial Support Scheme* that would request applications from State and Territory governments to provide psychosocial supports.

Consumer Embedded Delivery Model

Successful NPSS providers will need to meet minimum requirements. A portion of their funding will be quarantined for:

- Employment of a peer workforce, with all lived experience workers holding appropriate qualifications and registration with the new Peer Workforce Association and access to peer supervision paid for by their employer;
- Governance arrangements that include consumers – as per the *Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All* – who are accredited by the Peer Workforce Association;
- All consumers in identified roles to be accredited by the Peer Workforce Association and have membership of their local state/territory consumer peak body;
- Mental Health Carers Australia (MHCA) will be included in commissioning for family-based services, for example co-living arrangements with young people; and
- Independent evaluation by accredited consumers.

The Alliance is funded to provide capacity-building, quality assurance and network support for each State/Territory peak to be able to fulfil its NPSS role:

- to provide a co-governance and oversight role on each State/Territory Commissioning Committee
- to train and support lived experts to sit on commissioning panels
- to oversee and maintain the consumer co-management and co-governance accreditation requirements for approved providers.

We understand other parties are undertaking research on models for psychosocial supports, however they tend to focus on economic or clinical models which do not consider the experiences of those of us using the system, and have not adequately engaged with the lived experience community in the development or analysis of their models.

Governance

The Productivity Commission's *Mental Health and Suicide Prevention Agreement Review Inquiry Report*, published in October 2025, makes several recommendations that involve people with lived experience having a central role in governance of the next National Agreement:

> *Recommendation 4.1: Governments should endorse a Mental Health Declaration that outlines long-term reform goals [through a co-design process with people with lived experience]*
>
> *Recommendation 4.3: Building the foundations for a successful agreement [including people with lived experience identifying relevant and measurable mental health and suicide prevention objectives and outcomes for the next agreement]*
>
> *Recommendation 5.3: The next agreement should support a greater role for people with lived and living experience in governance*

The Alliance strongly supports these recommendations, which calls for formal roles for the two national lived experience bodies, with the caveat that the Indigenous Australian Lived Experience Centre should also be included.

The Alliance recommends that the Framework could be implemented via the following:

- A *State/Territory Psychosocial Support Scheme Committee (PSSC)* in each state/territory would jointly co-govern the commissioning of psychosocial support services, and comprise state/territory government representatives, along with representatives from the state/territory consumer peak body.
- Likewise, for First Nations services, ACCHOs would jointly commission psychosocial services along with representatives from IALEC.
- A *National Psychosocial Support Committee (NPSC)* would provide oversight of the State/Territory PSSCs together with the Alliance and IALEC to help ensure consistency, accountability, and share best practice.

Ultimately, the NPSC and the relevant PSSC would hold service providers accountable if they underperform. This may include remedies such as performance management, redirecting funding and withdrawing funding.

The Alliance also recommends that the *Lived Experience Governance Framework* (2023) and the *Philosophy of Care* (2022) are incorporated into service provider requirements.

Data collection and analysis

The Alliance suggests that the Australian Institute of Health and Welfare (AIHW) and National Mental Health Commission play independent roles in collecting, monitoring, and assisting the three lived experience peak bodies in holding service providers accountable to their consumer outcome and social impact commitments.

The Alliance together with IALEC and MHCA would also like a role in determining which data are collected. As of recently, data collected about PHN services (whether directly provided or commissioned) is managed by AIHW. However, much of this data is clinical in nature. We would like to see a review of this dataset to ensure that what is collected is meaningful for consumers and based on needs assessment rather than functional assessment of individuals.

Data governance and data privacy are important issues that will be considered in this process.

Co-designed Services

The Alliance has endorsed the Productivity Commission's Recommendation 4.3 to "extend the current National Agreement to enable genuine co-production" *(Mental Health and Suicide Prevention Agreement Review, Inquiry Report, October 2025)* by 12 months. This would ensure that there is enough time to co-design, co-produce, and co-create psychosocial services which would be incorporated within the next National Agreement under the NPSS.

The Alliance is proposing that an analysis of past and present psychosocial support services is carried out prior to co-designing new services.

Ideally, this assessment would involve evaluation against the *Lived Experience Governance Framework* (2023) and cost effectiveness analysis (for example, measuring all services consistently such as by Quality-Adjusted Life Years (QALYs) or by the Strathclyde/Yale citizenship model, and how NPSS would reduce use of hospital emergency departments and hospital admissions).

Unfortunately, there is not yet a standardised measure of psychosocial supports that would help us evaluate and compare services, so initially we will need to draw upon qualitative evidence from mental health consumers who have used these services.

Based on limited qualitative and secondary evaluative evidence that that the Alliance has already analysed, it is anticipated that services such as Clubhouses, Recovery Colleges, PHaMS, and Community Living Supports may be supported by this assessment.

Clubhouses

Clubhouses provide "non-clinical social support for adults living with a diagnosed mental illness or self-reported mental ill-health (referred to as 'members')". In 2024, there were six Clubhouses in Australia (only two accredited) and of those, Stepping Stone in Queensland was the largest and longest running. An independent evaluation published in 2025 stated that "New members had significantly higher rates of mental health-related hospitalization (41%, 31 out of 76 members) than existing members (16%, 26 out of 161 members) and this difference was statistically significant". This demonstrates the powerful difference membership of Clubhouses can have on long-term mental health.

Community Living Supports (CLS)

CLS is a program funded by the NSW Government which "provides psychosocial supports that help people build independence in daily life … the types of support people receive depends on their individual needs and own unique goals for what they want to achieve". An independent evaluation in 2022 found that the estimated cost per QALY was negative over 5 years. The average time consumers stayed in CLS was 10.7 months, and in 2018-2019, the average program cost per consumer was $35,622. Consumers' hospital admissions due to mental health challenges dropped in the year after entering the programs by 44.8%. Year 2 showed a further 29.2% decrease. This adds to a total decrease of 74.0% following program entry.

The Alliance (working closely with Mental Health Carers Australia and IALEC) proposes a co-design process of approximately 9 months, with relevant state/territory and federal departments, and service provider representatives.

Co-design stages and methodology

The process will be executed in four phases:

1. **Discovery** (3 months)
   Focus: Establishing governance and gathering foundational data

2. **Co-design and drafting** (3 months)
   Focus: Analysing findings and developing draft principles

3. **Validation and refinement** (2 months)
   Focus: Securing broad endorsement of principles and refining the outputs

4. **Finalisation and dissemination** (1 month)
   Focus: Preparation for final design

The core methodologies will be as follows:

1. **Empathy Interviews:** This will focus on attaining a deep understanding on complex consumer experiences that demonstrate the critical need for national consistency.
2. **Co-design workshops:** These workshops will translate qualitative findings from the empathy interviews into drafted core policy mandates through cross-jurisdictional journey mapping and principal sense-making co-design workshops.
3. **Validation strategy:** The project will utilise a structured validation sequence which ideally would include an expert policy review and a qualitative validation tool (community endorsement survey).

At the conclusion of these activities, the Alliance with the support of MHCA and IALEC, will write a report of recommendations for adoption via the next iteration of the National Mental Health and Suicide Prevention Agreement.

Funding

To ensure that effective place-based services continue to thrive, funding for psychosocial supports should be provided according to expressed need, and not on a per capita basis.

CMOs would be **directly funded by the Commonwealth Government and State/Territory Governments.** Supports would be provided to:

- people currently receiving psychosocial support; and
- people identified in the *Unmet Needs* report as lacking access.

Challenges with modelling costs

In 2025, the Mental Health Council of Tasmania (MHCT) undertook a comprehensive cost analysis of community-managed psychosocial support programs. This analysis calculated estimated annual per-individual costs for CMOs to support people living with psychosocial disability with "moderate and severe support needs". MHCT included staffing, infrastructure, supervision, and overheads in the cost analysis, making the costs appropriate for modelling a fully integrated and scalable service.

Using the MHCT costing data, the average annual cost of funding CMOs to support people living with psychosocial disability with "moderate needs" is $8,408 per person and for a person with "severe needs" is $23,573. This excludes housing support.

The current reporting of data does not inform what psychosocial supports and services a person identified to have "moderate needs" requires versus the requirement of someone with "severe needs", or how long they may need to receive supports for. The HPA analysis noted that not all people with "severe or moderate" mental health challenges require mental health services during a 12-month period. It estimated that 40% of people aged 25-64 years with "severe non-complex" mental health challenges and 20% of people with "moderate" mental health challenges need "some" psychosocial support in a year.

According to the latest data from the AIHW, of all people requiring residential care, most required it for 1 month or less with half requiring care for up to 2 weeks. 3% of episodes of care lasted greater than 1 year. The Alliance has not been able to identify granular data on:

- specific services required per individual;
- duration of support needed; and
- differentiation between supports required for moderate and severe needs.

There are additional cost discrepancies when it comes to costing residential mental health services – a possible requirement for people with "moderate or severe" needs. The *Unmet Needs* analysis did not include non-acute and sub-acute residential support services many of which have significant psychosocial components of service delivery.

The AIHW reports that some State and Territory governments fund residential mental health services at a total cost of $522 million nationally, supporting 7,400 people. This is an average cost of $70,540 per person.

This difficulty continues when comparing costs of supports included in the proposed policy models Foundational Supports – General Supports and Foundational Supports – Targeted Supports (Psychosocial Supports). Some General Supports, such as evidence-based information supports that help build skills, improve confidence and independence, and supports that will develop connections between peers and within the community and supports to find other services and resources are very similar to some psychosocial supports provided. The lack of service-level cost data prevents accurate separation of these categories.

Additionally, while the NDIS is not intended to support people aged 65 years and over, the provision of psychosocial supports outside of the NDIS continues. The *Unmet Needs* analysis reported 88.1% of 62,420 people (65+) with "severe mental illness" who required some psychosocial support in 2022–23, did not receive any. Of 82,040 people with "moderate mental illness" who required support, 95.4% did not get services. This cohort needs to be included in any modelling carried out for CMO delivery of psychosocial supports.

The limitations in the current data available to the Alliance mean that it is not yet possible to provide a cost estimate for a universal *National Psychosocial Support Scheme* with reasonable confidence. The Alliance looks forward to working with relevant agencies on developing a robust estimate.

It is noted that as at June 2025, there were 65,272 NDIS participants with a primary psychosocial disability, receiving an average payment of $88,700, at a projected annual cost of $5.79 billion.

The above modelling indicates that a *National Psychosocial Support Scheme* would be significantly less expensive per person than the NDIS, and the Alliance believes can be delivered in a highly efficient and targeted manner, including via the use of well-trained and supported peer workers. It should be noted that some people using psychosocial services may also be NDIS participants.

Recognition of Lived Experience

As a consumer lived experience-led organisation, the National Mental Health Consumer Alliance values the skill and expertise of consumers with lived experience. We pay tribute to those we have lost for the work that they have done to advocate for our rights. We acknowledge that we stand on the shoulders of giants who have paved the way for the rights we have today, and we will continue their work today and every day until the mental health system recognises and upholds our human rights.

Nothing about us without us.

Submission prepared November 2025. National Mental Health Consumer Alliance.

See nmhca.org.au for more information about the Alliance.

For questions about this paper, please contact us at policy@nmhca.org.au.

Appendix One

Queensland

- **Community Mental Health Teams**: Provide psychosocial rehabilitation and support.
- **Metro North and Metro South Health Services**: Include assertive outreach and recovery programs.
- **Open Minds** and **Stride**: Offer NDIS and non-NDIS psychosocial supports.
- **Mental Health & Wellbeing Grants (QMHC):**2024-25 Round: $2.9 million to 22 organisations for local psychosocial initiatives (e.g., peer groups, resilience-building).
- **Neighbourhood Centres:** Support for loneliness, isolation, community development and access to services.

New South Wales

- **Community Living Supports**: designed to assist people 16 years and over living with severe mental health challenges in living independently in their communities.
- **Community Mental Health Services**: Delivered through Local Health Districts (LHDs), including Community Living Supports, outreach, case management, and peer support.
- **Partners in Recovery (PIR)**: Coordination of services for people with complex needs.
- **Flourish Australia** and **Neami National**: Provide recovery-oriented psychosocial supports.
- **Mental Health and Wellbeing Locals**: New hubs offering walk-in psychosocial support and peer-led services.

Australian Capital Territory

- **Community Mental Health Teams**: Provide psychosocial rehabilitation and case management.
- **CatholicCare Canberra & Goulburn** and **Woden Community Service**: Deliver peer-led and recovery-oriented supports.

Victoria

- **Mental Health and Wellbeing Locals**: New hubs offering walk-in psychosocial support and peer-led services.
- **Murray PHN Psychosocial Recovery Services**: Focus on recovery goals like housing, employment, and relationships.
- **Mind Australia**: Offers community-based support, housing, and peer programs
- **Wellways Psychosocial Support Service (PSS**) provides flexible one-on-one or group support when and where they need it. The PSS adopts a whole of person approach with a focus on mental and physical health.
- **Mental Health and Wellbeing Locals**: New hubs offering walk-in psychosocial support and peer-led services**.**
- **Murray PHN Psychosocial Recovery Services**: Focus on recovery goals like housing, employment, and relationships.
- **Mind Australia**: Offers community-based support, housing, and peer programs
- **Wellways/Neami Psychosocial Support Service (PSS**) provides flexible one-on-one or group support when and where they need it. The PSS adopts a whole of person approach with a focus on mental and physical health.
- **Wellways Psychosocial Recovery Service**
- **Wellways Prevention and Recovery Care (PARC)**

Tasmania

- **Mental Health Services (MHS)**: Includes community teams and rehabilitation services.
- **Wellways** and **Anglicare Tasmania**: Deliver psychosocial support and peer programs.

South Australia

- **Community Mental Health Centres**: Offer psychosocial rehabilitation and crisis support.
- **Neami National** and **Uniting Communities**: Deliver recovery-focused services and peer support.

- **Intensive Home Based Services (IHBSS)** - Metro & Country: Individual Support and Rehabilitation
- **Individual Psychosocial Rehabilitation Services (IPRSS)**: Individual Support and Rehabilitation
- **Day & Group Programs, Diamond House - Day and Group, Day and Group (Wayville Activities) & Therapeutic Group Program**: Group Support and Rehabilitation.
- **Grow program- Mutual Help groups and support services, Mutual Support and Self Help and Information services**: Group and Individual Peer Support
- **HASP - Housing and Accommodation Support Partnership - Metro, Country, Burnside Cluster & High Support**: Individual Support and Rehabilitation
- **ASP - Accommodation Support Program**: Individual Support and Rehabilitation
- **GP access program**: Adult service. Individual Support and Rehabilitation
- **Community Support Scheme (CSS Program)** - Individual Support and Rehabilitation
- **Avalon**: Individual Support and Rehabilitation.

Western Australia

- **Community Managed Mental Health Services**: Funded by WA Mental Health Commission.
- Community M**ental Health services funded by WA Govt.**
- **Richmond Wellbeing and HelpingMinds** Provide psychosocial recovery, carer support, and ho**u**sing assistance. **(Other CPSP funded services:** 360 Health, Black Swan Health, Chorus, Helping Minds, Neami, Richmond, Ruah, Uniting WA)

Northern Territory

- Darwin, Katherine & Alice Springs only for around 450 people in total over 3 programs. (Note: the NT government contributed approximately **43%** of the total funding, while the Commonwealth covered the remaining **57%.**)