UnitingSA NDIS Peer Support Program:

Sustaining recovery-oriented psychosocial services in a National Disability Insurance Scheme funding environment

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for UnitingSA

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Executive Summary

UnitingSA has been a provider of psychosocial supports for 20 years via block-funded programs, working with people experiencing a range of complex mental health issues and multiple needs. The organisation and the people they support were directly impacted by the transition to the NDIS. This was particularly evident for people in the Metro Options and Metro Adelaide Community Living programs who experience severe mental illness, with complex comorbidities including acquired brain injuries and other physical and psychosocial disabilities. As the NDIS was rolled out, funding ceased for these programs and people were required to be transitioned to NDIS. UnitingSA considered this cohort of people to have been achieving good outcomes with the support received under UnitingSA's model of care. Consequently, UnitingSA wanted to determine the extent to which this same quality of care could be continued within the NDIS funding environment. UnitingSA developed the NDIS Peer Support Program to try and provide the person-driven, recovery-oriented supports these people had been receiving, and wanted to continue receiving. The new pilot service provides assertive, trauma-informed, recovery-oriented outreach support by a lived experience team.

This report provides insight into the capacity of UnitingSA's NDIS Peer Support Program to deliver a recovery-oriented model of care in a National Disability Insurance Scheme (NDIS) funding environment. In doing so it seeks to inform policy to facilitate the delivery of quality psychosocial support services are under the NDIS. Although this report captures a brief snapshot of NDIS transition experiences, it did not set out to explore these. Instead, it seeks to explore the potential for innovative recovery-informed models, co-designed with people who have lived experience, to successfully operate within a consumer-driven funding environment. Furthermore, this report contributes to an evidence base for the psychosocial support sector to draw on in advocating to the National Disability Insurance Agency (NDIA) around significant issues with the current funding model and the necessity for the system to recognise the link between quality work environments, jobs and care. Moreover, this report adds evidence to support the view that there must be an allowance for the episodic nature of mental illness in relation to hours, plan flexibility and crisis support when needed, for the NDIS to deliver a truly person-driven model.

This project employed a lived experience co-design methodology. Stage one investigated the current model of care at UnitingSA and its congruity with psychosocial support best practice literature. Subsequently, in stage two, the UnitingSA NDIS Peer Support Program and its fit with the foregoing model of care was explored through a review of program documentation, a focus group with seven staff from the NDIS Peer Support Program and eight semi-structured interviews with people receiving support from the NDIS Peer Support Program. The data collected was thematically analysed using the conceptual framework for recovery-oriented mental health practice developed by Le Boutillier et al. (2011). The key themes which emerged from the findings focus on the capacity of UnitingSA's NDIS Peer Support Program to be delivered under the NDIS and operate within the practice domains identified by Le Boutillier et al. (2011) as core to the recovery model: working relationships; supporting personally defined recovery; promoting citizenship; and organisational commitment.

Findings and recommendations

Although opportunities for improvement exist, overall UnitingSA operates a model of care congruent with international perspectives on recovery-oriented practice. The key recommendations from stage one of the evaluation support the ongoing implementation of a recovery-informed model of care at UnitingSA. The people UnitingSA support via their programs were generally satisfied with this model, but it was evident that they were worried about the ongoing availability of this support within an NDIS environment. The NDIS Peer Support Program was explored in relation to the recovery-oriented model of care identified in UnitingSA's existing psychosocial programs. It was found that there was evidence that it had been able to adopt and implement this model within an NDIS funding environment. There were areas where the program was notably exceeding requirements, particularly in relation to engagement with lived experience, peer work and an embedded attitude towards person-centred recovery-oriented support and language. However, there were also significant challenges to the capacity of programs to continue to deliver recovery-oriented care and remain financially viable. Most notable were limitations which arose from being unable to bill transport mileage, and insufficient on-costs to cover supervision. The inability to claim non-labour mileage costs directly impacted on the capacity to provide person-directed supports and facilitate community access. The low billable hourly rate was identified as an inadequacy in current pricing to fully accommodate on-costs associated with service delivery. It is important to note that these on-costs need to incorporate the costs of providing a supportive work environment that allows for the 'space between' activities that occur outside direct support, such as supervision, training, debriefing and self-care. This report notes that this is a serious issue, not only for UnitingSA, but the broader NDIS psychosocial support sector, due to the existing evidence that these activities directly impact on worker wellbeing and the delivery of quality support.

To ensure the sustainability of quality, recovery-oriented psychosocial support as provided by the NDIS Peer Support Program, it is recommended that UnitingSA continue to work collaboratively with other psychosocial support providers to advocate to the NDIA for:

- the allocation of NDIS packages that include a guaranteed minimum funding amount over several years for people experiencing psychosocial disability to increase stability for the market and individuals in relation to their support needs;

- flexibility in the use of plans for all people, regardless of their plan management status;

- an understanding of the distinction between *'doing for'* transactional core support services and *'doing with'* relational core support services. The latter being central to recovery-oriented care and requiring a higher skilled level of support worker;

- inclusion of transport to cover the non-labour travel costs to a person's home and the costs of transportation with a person for the purpose of community engagement or self-care activities as a billable item and choice for people receiving NDIS support;

- improvements to processing times for psychosocial funding reviews, especially in relation to increased needs in times of crisis;

- continued work on engaging more appropriately with recovery-oriented language and concepts, and a guarantee that increased wellness will not result in decreased supports;

- a review of the current NDIS support worker cost model to better reflect the skills and costs associated with providing quality psychosocial support including:
    - a reduction to the current utilisation rates for ‘very high intensity’ supports from 87% to 80% to support ‘space between’ activities;
    - an increase in overheads percentage from 10.5% to 15%;
    - a fourth category of higher intensity supports at SCHADS level 4.1, to recognise the skill level required for supporting people with significant barriers to engagement and recovery;
    - an increase in the salary costs of the supervisor to SCHADS level 6.1 to recognise the stakeholder engagement and relationship management skills required to navigate systemic barriers to people’s recovery and the degree of supervision and coaching required for support workers to ensure quality psychosocial support.

Definitions

For the purpose of this project the following definitions have been used. This report acknowledges that these meanings are debated and recognises the varied experiences of those that use and work within the sector in relation to this.

Acute care/service: Acute mental health services provide specialist psychiatric care for people who present with acute or crisis episodes of mental illness. In general, acute services provide relatively short-term treatment.

Clinical: Clinical services focus on the treatment and or reduction of clinical symptoms and are usually undertaken by someone in a qualified, professional role such as psychiatrists, doctors and mental health nurses.

Community-based services: Service and support outside hospitals or acute settings to people experiencing mental illness. These can include clinically-focused services, psychosocial services, outpatient services, domiciliary and other visiting services, and consultation and liaison services to general practitioners, primary health care and private sector providers.

Carer: Someone who provides or invests time and energy to support and care for another experiencing mental illness.

Consumer: A person experiencing mental illness who has received or is utilising clinical or psychosocial supports. They may or may not have a formal diagnosis.

Consumer Directed Care (CDC): A funding and service delivery model which aims to provide consumers with more choice and control regarding the types of services they receive, who delivers those services and when. This is typically done via an individualised package of funding for the consumer based on their assessed level of need.

Lived experience: The knowledge and expertise a person gains when they have lived through something is called lived experience. When we talk about people with mental health lived experience, we mean people who have or do live with mental illness, and family or friends who have supported or who are supporting someone living with mental illness.

Peer work/er: Peer work is increasingly recognised as a best practice approach in mental health support. People undertaking a peer role will have a lived experience of, or care/have cared for someone with, mental illness. This lived experience gives peer workers specialist skills they can draw on to provide peer support.

Psychosocial Disability: Disability that may arise from the experience of a mental illness. Not everyone experiencing mental illness will experience psychosocial disability.

Adapted from:

Fifth National Mental Health and Suicide Prevention Plan (FNMHSPP) 2017-2022. Department of Health, Commonwealth of Australia, Canberra.

Mackay, T. & Goodwin-Smith, I. (2016). Mental Health: Exploring Collaborative Community Reform in South Australia. Adelaide: Australian Centre for Community Services Research, Flinders University, Bedford Park SA.

Mind Australia, Helping Minds, Private Mental Health Consumer Carer Network (Australia), Mental Health Carers Arafmi Australia and Mental Health Australia (2016). A practical guide for working with carers of people with a mental illness, Australia.

Abbreviations

NDIA: National Disability Insurance Agency

NDIS: National Disability Insurance Scheme

Introduction

The National Disability Insurance Scheme (NDIS) began in Australia via a trial phase on the 1st of July 2013. The scheme aims to provide individualised packages of support to eligible people with a disability, thus allowing people increased choice and control over the services they require and use, in line with consumer directed care models. The NDIS includes supports for those experiencing psychosocial disabilities, which for many people arise from their experiences of mental illness. Since the transition to the NDIS, concerns have been raised regarding a disconnect between recognised best practice recovery-oriented models of care, and a requirement (for NDIS eligibility) of permanent disability which does not reflect the episodic nature of mental illness. Furthermore, the sector has questioned the appropriateness of current pricing levels for psychosocial care and raised concerns regarding the capacity to provide continuity of care for the people they support (Mental Health Council of Australia (MHCA), 2013). There has also been significant advocacy for those that have not met the eligibility criteria to access ongoing support. The National Disability Insurance Agency (NDIA) has recognised some of these concerns and developed initiatives to improve access to the NDIA by people with psychosocial disability. This includes currently looking at reforms to introduce recovery-oriented support lines. However, some of these supports are time limited and the impacts of these changes are yet to be seen.

UnitingSA has been a provider of psychosocial supports for more than 20 years via block-funded programs, working with people experiencing a range of complex mental health issues and multiple needs. The organisation and the people they support were directly impacted by the aforementioned challenges with the transition to the NDIS. This was particularly evident for a cohort of clients who were in the Metro Options and Metro Adelaide Community Living programs, some of whom had been with the services for 19 and 17 years respectively. The people who were in these programs experience severe mental illness, with complex comorbidities including acquired brain injuries and other physical and psychosocial disabilities. The Metro Options and Metro Adelaide Community Living programs were funded to support people to live independently and well in the community. However, as the NDIS was rolled out, funding ceased and people were required to be transitioned to NDIS by July 2019. UnitingSA provided in-kind support to ensure continuity of care whilst they co-designed the NDIS Peer Support Program to try and provide the person-driven, recovery-oriented supports these people had been receiving, and wanted to continue receiving. The new pilot service provides assertive, trauma-informed, recovery-oriented outreach support by a lived experience team. The team assists people to build their life skills and increase social and community connections. This report explores UnitingSA's NDIS Peer Support Program's integrity with, and capacity to, deliver a recovery informed model of care and remain sustainable and viable in an NDIS funding environment. This not only provides insight for service improvements, it informs necessary and broader advocacy around adequate pricing and recognition of the resourcing and skill required to provide quality, person-directed recovery-oriented care.

UnitingSA Background

UnitingSA is a non-government organisation that has been providing a range of community services over the past century, commencing in 1919 as the Port Adelaide Central Methodist Mission. All services provided by UnitingSA are guided by their vision of a compassionate, respectful and just community in which all people participate and flourish. Additionally, these programs are underpinned by a mission that UnitingSA is an influential and vibrant organisation providing services to the community and empowering people. The core values of UnitingSA are respect, compassion, courage and integrity, with all services aiming to deliver the following pillars:

- Inclusion: People live and participate in thriving communities
- Independence: People have choice and control
- Wellbeing: People live meaningful lives
- Social Justice: People live in a just and equitable society

UnitingSA Psychosocial Mental Health Programs

Prior to the implementation of the NDIS, UnitingSA operated a range of block-funded programs delivering psychosocial supports for people experiencing mental illness. These programs were, and continue to be, underpinned by policy that states people receiving psychosocial support at UnitingSA are:

- treated with dignity and respect;
- to have their abilities recognised;
- to have choice about the support they receive;
- able to receive support based on their needs;
- able to work in partnership with their support workers; and
- to have their rights and responsibilities clearly explained to them.

Staff across these programs were employed with a range of qualifications, including; Degrees in Social Science, Degrees in Social Work, Diplomas in Community Mental Health, Certificate IV Community Mental Health and a Certificate IV Mental Health Peer Support.

Metro Options

The Metro Options program was a collaborative psychosocial service developed by UnitingSA and the State Government’s Brain Injury Options Coordination Unit for people with a dual diagnosis of acquired brain injury and a mental illness. Most of the funding for this program was received from Home and Community Care via DisabilitySA. To be eligible they were required to satisfy Brain Injury Options Coordination service eligibility criteria and ongoing primary case management was provided by Brain Injury Options Coordination. The program aimed to support people to increase their independence, engage and maintain their connection to community and enhance their quality of life. On average they received approximately five hours of support per week. This program ceased to be operational in July 2019 due to the NDIS funding transition. In October 2016 the program supported 18 people through three FTE staff, these numbers remained unchanged until the program terminated in 2019. Nine of these people have been transitioned to the NDIS Peer Support Program at UnitingSA, whilst nine have moved to other NDIS providers.

Metro Adelaide Community Living (MACL)

Metro Adelaide Community Living was a community support and housing program which incorporated the Prospect Community Living (PCL) and Daw Park Community Living (DPCL) programs and operated across most of metropolitan Adelaide. The program was funded by DisabilitySA and was aimed at people experiencing a mental illness who were either affected by the closure of a Supported Residential Facility (SRF) or were seeking to exit an SRF or boarding house and live independently in the community. The program works with people to increase their ability to participate in social, recreational and educational activities and can include facilitating accommodation access and support to remain in accommodation, support developing daily living skills such as cleaning, shopping and public transport use, financial supports and support with physical and mental health. Like Metro Options this program is no longer operating as a result of the NDIS funding transition. In October 2016 MACL supported 14 people with three FTE staff; in 2019 when this program transitioned to NDIS there were ten people receiving support from three FTE staff. Seven of these people have been transitioned to the NDIS Peer Support Program at UnitingSA, one has have moved to another NDIS provider, one has withdrawn from service and one person has since passed away.

NDIS Peer Support Program

Metro Options and Metro Adelaide Community Living had been operational at UnitingSA for the past 19 and 17 years (respectively) supporting individuals experiencing severe mental illness, with complex comorbidities including acquired brain injuries and other physical and mental disabilities and illnesses, to live safely and well in the community. This group of people have high intensity, complex support needs and have historically experienced disadvantage and risk associated with high rates of homelessness, forensic activity, and exploitation and criminal behaviour from others. Upon NDIS transition all 31 people from the two programs were successful in receiving NDIS plans, however individual plan levels vary. UnitingSA developed the NDIS Peer Support program as a 12-month pilot to ensure continuity of care for these people whose DisabilitySA funding ceased due to the transition. The program has been designed to deliver very high intensity core support, as well as capacity building services to people with high and complex needs. Amongst participants an average of 90% of the total value of a person’s plan sit within core supports. The program is designed to provide proactive, trauma informed, recovery-oriented outreach support via a lived experience team. The team currently consists of a Coordinator, four Mentors and one Practitioner on 12-month contracts who work with 18 people for a range of hours dependent on their NDIS plans. The program has achieved a substantial increase in efficiencies since its inception and is operating at 78% utilisation. The Coordinator position and organisational on-costs are currently provided ‘in-kind’ by UnitingSA for the life of the pilot but would need to be covered by NDIS income to ensure ongoing viability of the program model. This report details research exploring the NDIS Peer Support Program’s capacity to achieve its aim of operating a financially sustainable program consistent with recovery-oriented practice, as well as highlighting current challenges in doing so.

Methods

With the transition to NDIS and consequent changes to psychosocial support, it is increasingly important to explore service model and funding innovation. This project, developed by UnitingSA in partnership with The Australian Alliance for Social Enterprise at UniSA, aimed to describe and evaluate UnitingSA's current model of psychosocial care against best practice perspectives. In doing so it provided insight into best practice recovery approaches facilitating the evaluation of the pilot NDIS Peer Support Program's capacity to deliver high quality, sustainable support in an NDIS funding environment.

Lived Experience Approach

Reflecting the increasing recognition of lived experience expertise in mental health research, this project employed a lived experience co-design methodology. The research team included lived experience researchers, whilst the project governance and advisory groups included lived experience consultants. Peer workers were consulted during the designing of the project for further insight into the most appropriate ways of connecting with participants. To optimise opportunities for people with lived experience to share their experiences, a flexible and reflexive approach was used for data collection. In practice, this meant allowing people a range of options as to what their participation would look like, including choice about location, time, format (telephone or in person), activity undertaken during interview (e.g. coffee, drawing, walking) and a choice of support person (e.g. peer worker, support worker, family or friend).

Stage One Method

The initial stage of this project investigated the current model of care at UnitingSA through the following four-step evaluative research method:

1. A review of key program documentation.
2. Three interviews with program management staff.
3. Four focus groups with 30 UnitingSA staff, including country, metropolitan, lived experience and non-lived experience staff. Another three focus groups were undertaken with 16 people engaged with a psychosocial service at UnitingSA.
4. A review of relevant literature (see Appendix One) exploring consumer directed care models and psychosocial support best practice. The findings of step 1-3 were compared against this literature. The conceptual framework for recovery-oriented mental health practice developed by Le Boutillier et al. (2011) was employed as a framework for analysis, due to its synthesis of international recovery perspectives. This analysis explored UnitingSA's psychosocial service engagement with the four domains of practice identified by the framework (working relationship, supporting personally defined recovery, promoting citizenship and organisational commitment).

Stage Two Method

The UnitingSA NDIS Peer Support Program was reviewed against stage one findings via a three-step method:

1. One focus group with seven staff from the NDIS Peer Support Program.
2. Seven semi-structured interviews with people receiving support from the NDIS Peer Support Program and one semi-structured interview with a carer of someone receiving support from the program. For these interviews the 'Your Experience of Service' tool was used to help guide the interview structure.
3. The findings of steps 1-2 were analysed with a focus on the NDIS Peer Support Program's fit with the foregoing recovery-oriented model of care and service recommendations, noted best practice approaches of psychosocial support and viability in an NDIS funding environment. This analysis informed recommendations for service improvement for the program and highlighted innovative practices that provide successful client outcomes in an NDIS structure. Additionally, recommendations were developed for advocacy to the NDIA to enhance not only the sustainability of the NDIS Peer Support Program, but NDIS psychosocial support programs more broadly.

It is important to note that as part of the evaluation process, UnitingSA also commissioned independent financial modelling. The aim of this was to determine the extent to which the NDIS Peer Support Program was able to achieve a financially viable model within 12-months. The findings of this financial modelling have also been drawn upon to inform the recommendations of this report.

Data Analysis

The data collected in this project was analyzed using a thematic approach. Notes were taken during the staff focus groups in addition to discussions being recorded. Extensive notes were taken for interviews with participants from UnitingSA's programs. These interactions were not recorded at the request of the people participating, and the advice of lived experience consultants engaged in the project. During analysis, notes and recordings were reviewed and compared to ensure in-depth exploration of the data. The Halcomb and Davidson (2006) method of analysis was used in lieu of verbatim transcripts for staff recordings. This method has been recognised as being an effective and reflexive process, allowing comprehensive engagement with the data.

The steps for this process are as follows:

- Combined audiotaping (where appropriate) and note taking at interview
- Reflective completion of field notes immediately following an interview
- Listening to the audiotape to amend/revise field notes and observations
- Preliminary content analysis
- Secondary content analysis
- Thematic review (Halcomb & Davidson, 2006).

Roundtable Feedback

The final report recommendations were presented and workshopped with a group of 49 people. This group included people with lived experience, and government and non-government sector stakeholders. This process allowed these various groups to work together to enhance the report and recommendations, ensuring not only optimal engagement by policymakers, but that lived experience and practical, operational expertise was embedded in the report. Information from these roundtable sessions was gathered in written format and thematically analysed before being utilised in the final drafting of the report.

Ethics

All participation in this project was voluntary. This was communicated in both written and verbal formats, using participant information sheets and discussion with participants. Where concerns were identified regarding a participant's capacity to give informed consent, data was not collected. It must be acknowledged that as people participated during work hours evidence of participation exists in organisational records. Due to the potential for this to be a coercive pressure to participate in the project, each focus group was given verbal confirmation of their ability to not participate, leave the group at any stage and to decline to comment on any specific questions. Information about participation was distributed broadly to both staff and people receiving support, and the information packages directed people to contact the researchers to volunteer. This was intended to mitigate any sense of pressure from senior staff or support workers. Consent forms were completed at the beginning of the focus groups or interviews and given directly to the research team. All data was de-identified and raw data stored at the University. This was communicated to people via information sheets and consent forms. With regard to the focus groups, the research team could not guarantee anonymity to participants as they were identifiable to each other. This was communicated via paperwork and at the beginning of focus groups. The research team also asked participants to respect the confidentiality of the group and not share the information discussed. Whilst strict ethical standards were adhered to, this project was undertaken as a continuous improvement exercise.

Findings and Discussion

Model of Care Summary

The UnitingSA model of care is summarised in Figure One. This model was developed as a result of the findings of stage one of the evaluation. Although opportunities for improvement exist, overall the organisation operates a model of care congruent with international perspectives on recovery-oriented practice. The key recommendations from stage one of the evaluation support the ongoing implementation of a recovery-informed model of care at UnitingSA. The people UnitingSA support via their programs were generally satisfied with this model, but it was evident that they were worried about the ongoing availability of this support within an NDIS environment. This was also reflective of staff perspectives. UnitingSA has developed the pilot NDIS Peer Support Program in an effort to continue providing this model of care within the NDIS as well as to offer continuity for the people they support with complex support needs. The subsequent section will discuss the capacity of the NDIS Peer Support Program to achieve these aims.

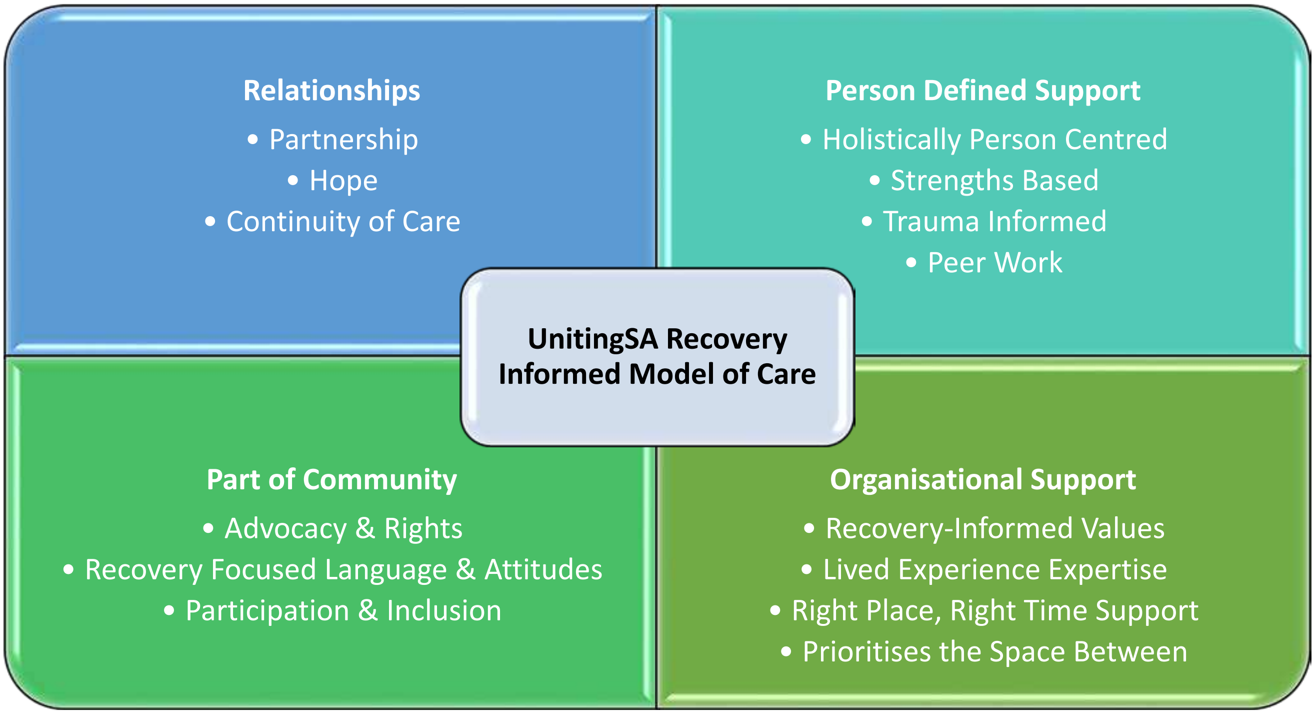

Figure One: UnitingSA model of care.

UnitingSA's NDIS Peer Support Program

The following findings discuss the NDIS Peer Support Program with focus on where it is congruent with good practice recovery-informed principles and the challenges it currently faces in maintaining the integrity of UnitingSA's psychosocial model of care within the service.

Relationships

'With not to' partnerships

The NDIS Peer Support Program staff were extremely passionate about ensuring that they were working in partnership with the people they support. As a program developed to deliver NDIS services, the team actively seeks to work with people to support them with their support plan development, and in turn the activities they undertake as part of support hours. In practice this partnership was described as understanding what an individual's desires and needs are then working together to try and achieve them, but also providing assertive challenging where necessary around behaviours, opportunities for growth and in recognising success. It was clear that for this team this was only possible due to having developed successful working relationships in which they understood what would be acceptable and respectful for the person they were supporting. This program evidences the distinction between *'doing for'* transactional core support services and *'doing with'* relational core support services. '*Doing with'* relational core supports are a key aspect of recovery-oriented care. In order to deliver these relational core supports a worker must be highly skilled in developing respectful and effective working partnerships. The NDIS Peer Support Program staff can be described as having these skills. However, concerns about the time available to use these skills as well as the ability to retain staff at current remuneration rates is evident.

NDIS Peer Support Program Participant: They listen to what I want to do then we work together to try and get it sorted.

Continuity of Care

To foster these successful working partnerships this program has been developed in a manner that allows several staff to act as a support team for an individual person. This in effect allows for continuity of care and is a contrast to traditional casualised workforce structures associated with consumer directed care models. The team consists of a Lived Experience Practitioner employed at a Social, Community, Home Care and Disability Services Industry Award (SCHADS) Level 4 rate and Lived Experience Mentor employed at a SCHADS Level 3.2 rate, working together to provide person directed supports. These staff are employed on 12-month fixed term contracts, to foster continuity. The Lived Experience Practitioner is allocated approximately 20% of a person's support time and is responsible for assessment and planning support in line with the person's goals, systems navigation (e.g. housing, Public Trustee, health) required to meet a person's NDIS goals, capacity building, carer liaison and crisis response. The remaining support time is undertaken with a consistent team of Lived Experience Mentors supporting people in line with their individually developed plans. This system means people know who is attending their support times, and who they can speak to if any issues arise. It also means the team can cover illness or leave without disrupting a person's supports or sense of stability as they are familiar with several Mentors and the Practitioner. However there are challenges based on team capacity, as each team member has been employed for a specific number of hours in accordance with the available support hours individuals have chosen to spend at UnitingSA. Where the team lacks capacity the Coordinator or casual team member, both of whom are familiar to the people using the program, will take on support hours where possible. The Coordinator also oversees the reflexive and often changing roster, with a goal of ensuring continuity of care. It can be seen that without adequate pricing or increased revenue to reflect the costs of the Coordinator and team flexibility, the program will not be able to maintain integrity in relation to continuity of care, and would need to move to a casualised workforce. Given the complex needs of the people the program works with, this raises significant concerns, as both staff and the people they work with noted they would not feel comfortable with a rotating door of workers, and in turn may disengage from the service.

NDIS Peer Support Program Participant: Important to have the same worker, seeing the same people so you know who they are when they turn up.

NDIS Peer Support Program Participant: Yeah, it's safe, they listen. They know where I'm coming from and I know where they're coming from.

It is also important to note the impacts of being 'Plan Managed' or 'NDIS Managed' on flexibility and continuity. All participants of the NDIS Peer Support Program are currently 'Plan Managed' or 'NDIS Managed' and as such can only choose services based on the NDIS stipulated hourly rates. People who self-manage their plans can pay hourly rates at their discretion. It could be argued if this flexibility was allowed across all plans people would have the ability to choose how much they paid for their services, and in turn the level of worker they needed. This would allow the option to have continuity with workers of an individual's choosing with appropriate skills for high intensity complex support needs.

It is important to note that the staff in the program did have concerns regarding continuity of care, and what would occur if the program were to be discontinued. They voiced concerns about the people they support and the potential hardship they will face if they were to move to a care model with less continuity, and therefore less familiarity with the people they are receiving support from. The NDIS model poses significant challenges for continuity, not only in relation to the provision of supports but the ongoing continuity of the program itself. Participants of the NDIS Peer Support Program reported worry about their package reducing and receiving less support, having new workers and losing the current support program. Staff also talked of fears for their ongoing employment and access to meaningful contracted hours, and the impact this could have on their ability to provide quality care. This issue has also been identified within the aged care sector in relation to providing consumer directed packages of funding (Howe et al., 2012; King et al., 2013; Mackay & Goodwin-Smith, 2019). The NDIS Peer Support Program reported people reducing hours or leaving solely due to fears associated with longevity and continuity of program-based support. Additionally, continuity is at risk for this program due to a large proportion of the funding required to maintain a model of recovery-informed care having only being committed in kind for the 12-month pilot. Without capacity to guarantee continuity, programs such as the NDIS Peer Support Program have the potential to lose income. Without income these programs will not be able to continue, and without programs people will lose the choice and control the NDIS is intended to champion. These issues may directly impact on the wellbeing of people receiving support and the wellbeing of staff. It can also be argued that they contribute to challenges associated with a thin market as identified by the Productivity Commission (2019).

Hopefulness

However, despite these concerns the staff described working in ways that were hopeful for the people they supported, describing interactions that demonstrated growth and success not only in their view, but also from the perspectives of the people in the program. The workers showed the principles of mutual support in their connections with participants. They did not describe the people they work with in ways that stigmatised or limited them, instead choosing to highlight positives and give examples of people who had improved their wellbeing and had demonstrated behaviour or emotional changes where previous workers had noted limits or incapacities. The team believed going in with an attitude of optimism, and seeing each person as having capacity, was the foundation to allowing them to work innovatively and constructively without being hindered by labels or assumptions. People using the program also spoke of the workers positivity and belief in them.

NDIS Peer Support Program Staff Participant: It's the little things, the day to day things, you don't realise there is potential in your life if it's never existed, we help open doorways for them to see the good things.

Clearly the Peer Support Program, through focusing on working alongside people in partnership, from a position of hope, and prioritising a continuity of care, reflective of recovery-informed approaches within the working relationship domain of practice (Le Boutillier et al., 2011). However, the capacity of the program to maintain this, particularly in relation to continuity of care, is heavily reliant on financial sustainability. In order to improve sustainably it is recommended UnitingSA continue to work collaboratively with other psychosocial support providers to advocate to the NDIA for:

- the allocation of NDIS packages that include a guaranteed minimum funding amount over several years for people experiencing psychosocial disability to increase stability for the market and individuals in relation to their support needs;
- flexibility in the use of plans for all people, regardless of their plan management status;
- an understanding of the distinction between *'doing for'* transactional core support services and *'doing with'* relational core support services. The latter being central to recovery-oriented care and requiring a higher skilled level of support worker.

Person Defined Support

Person-Centred Approach

As the NDIS Peer Support Program has been developed to meet NDIS billing model requirements, activities undertaken are inherently driven by the person receiving care and what has been documented in their plan. UnitingSA currently utilises three NDIS billing codes. Assistance with Self-Care Activities, Access Community, Social and Recreational Activities, which are support codes, and Development of Daily Living and Life Skills, a capacity building code. The NDIS Peer Support Program currently use an internal policy in which activities in the home are billed as Assistance with Self-Care and activities outside the home are billed as Access Community, Social and Recreational Activities. Capacity building is undertaken by the Lived Experience Practitioner, and it is important to note not all individuals have access to capacity building funds. Reflective of NDIS requirements to provide Very High Intensity core supports, workers are employed at a minimum of a Social, Community, Home Care and Disability Services Industry Award level (SCHADS) 3.2. All other (lower intensity) core supports only require SCHADS level 2 workers.

NDIS Peer Support Program Staff Participant: We are peer support workers, the first thing we do is enter a person's space and ask them what they need and what they want to do.

NDIS Peer Support Program Participant: Help with shopping, getting to go out, just someone to talk to and help. We do appointments; it just varies with what I need to do.

NDIS Peer Support Program Staff Participant: *All that relational work happens in the context of a wide array of areas of daily living we might support and work with someone around. There is a lot of nuts and bolts, day to day stuff, forms, aspects of self-care, through to transport and shopping.*

Transport was a specific area in which achieving a person-centred model of care within this program has been challenged. UnitingSA traditionally run an outreach model, meeting people in their homes or community, and supporting them to engage in their community wherever that might be. In practice this can often involve workers transporting the people they work with to various locations, which as previously highlighted provides significant opportunity for rapport building, talking and sharing.

NDIS Peer Support Program Staff Participant: You are talking the entire way [in relation to transport]. We are constantly working in a very therapeutic space.

NDIS Peer Support Program Staff Participant: For some people the best conversations are had in the car.

The Peer Support Program was initially run in this manner, however due to NDIS limitations on billing transport, there is now a policy for all transports to be within a 10km radius to limit the impact of unbillable transport on the program. This can be argued to limit capacity to operate in a person-centred way, as the staff can now only meet a person's need or request within a specific radius. This could result in restricted opportunities for community engagement, reduce capacity to build rapport and in some instances the inability of the program to meet a need identified by a person they support. This is a risk not only to the working partnership between staff and people receiving support, but a business risk. Given the NDIS environment allows people to change providers if they are dissatisfied with a service, there is potential for organisations to lose consumers based on an inability to meet their need.

It can be argued that at its core this is an NDIS pricing issue, rather than a deficit of the Peer Support Program's design. If transport was able to be recouped the program would be congruent with recovery-oriented practice in relation to being person-centred. Currently the NDIS only allows the hours required to travel to a person, and time spent with them to be billed. All other transport money is allocated to the person directly for them to spend on travel as they require. This places an unnecessary pressure on people who previously did not have to manage transport costs associated with support, and on people who already require Public Trustee support to manage their finances.

NDIS Peer Support Program Staff Participant: They won't even acknowledge it might need to go to the Public Trustee. The Public Trustee are saying they won't touch it, and the client, the person affected the most is not even considered.

NDIS Peer Support Program Participant: Taxi vouchers are gone now; I used to get them from my doctor. Now the NDIS does that, it's not as good.

Furthermore, this process provides questionable choice and control if a person cannot choose to have this money allocated to a service provider or to a plan coordinator to manage. It also could in effect cost more for individuals to have their support worker catch public transport with them.

NDIS Peer Support Program Staff Participant: If I transport person A to this activity it takes 30 minutes in my car and around 15kms [if billed at UnitingSA's transport rate of $0.78 per KM this would equal $11.70]. If I drive to the person's house, walk to the bus, catch two buses there and two buses back, that takes two to three hours, which are billed at a higher amount. It's inefficient, wastes people's packages and reduces the time we could provide more effective supports.

If the NDIS pricing guide is not updated to reflect the importance of transport in psychosocial services, UnitingSA will need to reconsider how to continue to facilitate person-centred care and choice in a way that is financially sustainable. The burden of travel costs has been noted in various iterations of consumer directed care, and strategies for addressing these include increased scale with small hub and spoke teams that operate out of an existing organisational structural footprint (Mackenzie et al., 2017; Mackay & Goodwin-Smith, 2019).

NDIS Peer Support Program Participant: They need more cover staff, there's a lot of pressure on a small team with travelling. Also, if someone is sick or something. And they only work 9-5, someone at night would be good so when you needed to talk or have a crisis you can contact them.

Trauma Informed Care and Strengths-Based Approach

Although the Peer Support Program team utilised strengths-based language and gave examples of strengths-based practice consistent with a recovery model they did identify challenges in doing so within an NDIS program. This echoes concerns held throughout the mental health sector that the NDIS is inherently a deficit-based model that does not reflect the concept of personal recovery and the celebration of strengths. Instead, the NDIS asks participants to describe how unwell they are in order to receive a funding package. It is also important to note that this was highlighted by people being supported by the program, who explained that although their workers constantly championed them and their successes during support, they contradictorily helped them identify only challenges or problems and the impacts of these when undertaking NDIS applications and reviews.

Peer Work

This program fundamentally embodies the concept of peer work, with all roles being developed to engage with peer work principles as demonstrated in current role statements and by every staff member having lived experience. It is evident the Peer Support Program is congruent with recovery-oriented practice around access to peer work supporting personally defined recovery, in addition to being reflective of UnitingSA's psychosocial support policies around employing a peer workforce. It could be proposed that the staff in this program demonstrated a higher level of engagement with peer work practice then UnitingSA's broader psychosocial programs. For the staff of the NDIS Peer Support Program their lived experience and role as a peer worker enabled them to effectively empathise and understand the experiences of the people they are supporting. They also described being able to work alongside people, and utilising appropriate disclosure to share their experiences with mental health. They gave examples of where their peer approach allowed them to see past labels and limitations that had been given to people by previous workers or other supports such as clinicians.

NDIS Peer Support Program Staff Participant: Our lived experience that we bring into each encounter is the opportunity to change shame into courage.

Notably when the people receiving support from the NDIS Peer Support Program were asked if they were satisfied with their access to a peer worker, most did not know what a peer worker was, or that their workers were undertaking a peer role. When the peer role was explained to participants several said that they learnt through talking about the workers' life experiences and sharing their own. Participants identified that they can have challenges associated with understanding or remembering information, and this may impact on their capacity to understand the concept of peer work. Additionally, in line with the peer work guidelines, the decision to disclose is up to the worker, and this may also have played a role in the participant's knowledge of peer work. Furthermore, some workers noted they had not reached a point in the support relationship where discussions around lived experience would have been useful. However, to ensure the program is optimising choice and control for people in a person-centred way, it would be beneficial to reflect on how the peer aspect of the program is communicated to people on intake. This may include communicating the value of peer workers and the principles of peer support (e.g. NSW Mental Health Commission 2016).

To continue to provide best practice psychosocial service delivery in relation to personally defined recovery it is recommended that UnitingSA continue to work collaboratively with other psychosocial support providers to advocate to the NDIA for:

- inclusion of transport to cover the non-labour travel costs to a person's home and the costs of transportation with a person for the purpose of community engagement or self-care activities as a billable item and choice for people receiving NDIS support.

Part of Community

Participation in Community

Reflecting UnitingSA's outreach model, the Peer Support Program is undertaken in the homes and communities of the people they work with. Activities can include attending community-based events, shopping and accessing community resources such as libraries and parks. The capacity for this program to facilitate access to community-based activities is limited by transport challenges as previously discussed. Although no staff member or person utilising the program described engagement in employment or volunteering through the service, several described being able to undertake meaningful activities due to the support provided which they would not have done otherwise. For some this was the ability to get out of the house, and for others it was the ability to have someone to help with tasks around their home, such as preparing for a rental inspection.

NDIS Peer Support Program Staff Participant: We are the only connection to society he has.

NDIS Peer Support Program Participant: They helped me clean up, and get things organised. I just get overwhelmed looking at it all on my own; it's just having someone to do it together with.

Capacity Building and Rights

When asked if they felt they had been given clear information around their rights within the service, most people felt this had been done well. It is notable not all knew the process of making complaints, but those that did felt extremely comfortable in doing so. The NDIS Peer Support Program was described as including capacity building. This was said to occur when workers support a person to overcome a challenge or undertake a task together. Furthermore, staff did explain that in some instances, particularly in times of crisis, the worker would need to undertake things like negotiating bills or accommodation issues on behalf of the person they were working with.

Service Language and Attitudes

The staff in the program used recovery-oriented language, avoiding terms such as service user or consumer and instead speaking about 'the people they work with'. None of the staff utilised a diagnosis to describe a person and talked about people having capacity to overcome the challenges they face in relation to their mental health, and their lives more broadly.

NDIS Peer Support Program Staff Participant: We [the program] differ in that we offer meeting people with the language of their choice.

Organisational Support

Values

The NDIS Peer Support team identified values congruent with recovery-oriented practice models including, respect, empathy, reliability and hope. It is significant that the people they work with also nominated similar values as important to them in their workers, and that they felt their current support team did demonstrate these values in their work together.

Lived Experience Expertise

Due to the role requirements for staff in this program, lived experience expertise can be considered embedded at all levels of the program. The team felt that they were able to draw on their lived experience in practice and in relation to program design and policy, and that this expertise was accepted and respected by management. They also noted feeling highly supported by the UnitingSA mental health management team. The people the NDIS Peer Support program works with generally did feel they had opportunities to contribute to improving the service, and most nominated speaking to the Coordinator if they had an idea or suggestion. The program also utilised lived experience on the interviewing panel when hiring staff, and seeks out opportunities to undertake capacity building activities with the people they work with, to contribute to discussions around quality care and the needs of people experiencing mental illness.

Supports at the right time and place

The NDIS Peer Support Program was described as providing flexible supports at the right place and right time, reflective of recovery-oriented models of care. Notwithstanding, the capacity of the program to do so is limited by the allowable billable hours ascribed by the NDIS. To maximise flexibility the NDIS Peer Support Program has developed the option for people to bank support hours in case of crisis or increased need. However, staff and carers still remarked on challenges for this program to scale up and scale down services quickly. This could be said to be in part due to the program employing a specific number of people based on the number of support hours individuals had in their packages that they choose to spend with UnitingSA. This means that the ability to be as flexible as UnitingSA's traditional psychosocial model is not possible, as worker's hours are effectively completely allocated to account for their salary. To ensure service integrity the Coordinator can step in to provide support, but this is only possible where a client has banked hours or where they have capacity in their package. If funding for an individual has been exhausted there is no capacity to scale up services until a NDIS review for additional funding has been completed, a process which was reported by staff to take up to six months, and by people receiving support, as slow or taking too long. This poses risks to the integrity of the service as a recovery-oriented model, as well as risks to individuals who need reactive support to their episodic and fluctuating levels of psychosocial disability.

NDIS Peer Support Program Staff Participant: Trust and rapport are built by showing you can be reliable.

NDIS Peer Support Program Staff Participant: One of the things that's different with this program is we will keep turning up.

The workers in the Peer Support Program also felt they had been required to build rapport somewhat more quickly than in other UnitingSA programs, due to less plan flexibility in scaling up or down support times and an urgency to get the program underway to ensure continuity of support for people from UnitingSA's MACL and Metro Options programs. However, they did not feel they had needed to force supports onto people, and described respecting their desires in relation to when they may not wish to see a support worker despite a booked service. This is evident in the program’s cancellation approach where people are only billed if cancellation is under 24 hours and at 90% of the billable cost. All other cancellations are not billed to avoid leaving someone requiring ongoing support with no funds left in their package. This can be said to be consistent with concepts of appropriate, person-centred support, but does impact on the program’s financial viability over time. Furthermore, workers did note instances where they chose not to bill despite being within the 24 hour window due to what was going on for the individual they worked with at that time. This aligned to their difficulties with billing time which was not meaningful for an individual, and in their view was an unethical use of their funding.

NDIS Peer Support Program Staff Participant: We are billing even if maybe it doesn’t feel meaningful because it’s within the cancellation policy, because we [the program] need income to maintain jobs, and keep the program running.

NDIS Peer Support Program Staff Participant: It does bring up that ethical question, I think every time we go to enter something in when someone’s called to cancel support or not just been up for it at the last minute or had to cancel they can’t make it because things are not going okay, how do you sit with yourself if it were you, what would you want that person to enter?

Space Between

The NDIS Peer Support Program currently operates at an 78% utilisation rate but is confident in achieving 80%; this is 7% under the ‘NDIS Cost Model for Disability Support Workers’ (NDIA, 2020). Billable time includes travel to people’s homes, direct support and a small amount for reporting. For the Peer Support team, activities other psychosocial programs nominated as non-negotiable aspects of service primarily fall into non-billable time. This includes weekly team meetings, group practice supervision and practice development. Non-billable time is also used for general administration, informal support and debriefs, self-care and monthly one on one supervision with the Coordinator. Three days per year are also factored in as non-billable time for induction, training and development activities. Staff explained the program has attempted to facilitate space between time to the best of its ability, but that it’s limited due to the costs. They described using time between supports to informally debrief and collaborate but did note that they felt they had less time to do these things than their peers in block funded programs. This limitation to space between is evident in that current income from billable hours was reported by UnitingSA to be projected to cover the costs of the Lived Experience Practitioner and Mentor salaries, but not space between tasks or the Coordinator’s role. This role can be argued to function as the conduit for most of the space between activities as well as a backup support worker for individuals requiring urgent scaling up of service. Furthermore the Coordinator also undertakes complex stakeholder engagement and relationship management to support people to navigate systematic barriers to recovery. It can be said that the current price model for this role insufficiently recognises the skills and responsibility of supervisors in recovery-oriented support. Thus, it can be proposed a review of the current supervisor award rate by the NDIA to better reflect the role of supervisors in direct support, staff supervision and coaching is warranted.

NDIS Peer Support Program Staff Participant: There is that issue of not being able to bill for non-face to face time, where there's a lot of stuff that does need to happen when we are not with a person, administration, follow up, negotiating systems.

Furthermore, to ensure the delivery of quality care that stems from these activities some program staff noted undertaking these tasks in their own time. They also gave examples of utilising small windows where a client's support activity may finish early in a billable hour, to complete unbillable support work for that client back at the office. Staff noted this as a 'catch 22' situation. They felt that it was important to demonstrate a peer based, high intensity support NDIS psychosocial service could provide quality, recovery-oriented care, but they also felt that this effectively would shroud the difficulties associated with the NDIS not accurately accounting for the costs associated with providing this kind of service in the pricing guide.

NDIS Peer Support Program Staff Participant: We don't want to prove a bad system is viable, but we do want to see this grow and prosper.

Limited time for these vital tasks can be considered a risk for this service, and NDIS psychosocial support programs more broadly, due to the evidence demonstrating vicarious trauma, burn out and compassion fatigue can be associated with increasing workloads and less time for space between activities (Adams et al., 2006; Louth et al., 2019; Mackay & Goodwin-Smith, 2019). The independent financial modelling undertaken as part of the evaluation found that the 20% non-billable rate is critical to ensure both worker wellbeing and quality services. Currently some of the time required for these activities is provided in kind, as is the cost associated with running the program such as rent, ICT infrastructure and corporate administration functions. The financial component of the evaluation also found that the NDIS Peer Support program operates at a 15% on-cost rate. As the 'NDIS Cost Model for Disability Support Workers' is based on 10.5% for overheads, the NDIS Peer Support Program will be running at a 15% deficit after the pilot phase has ceased (NDIA, 2020). Given that a 80% utilisation rate, and a 15% on-cost rate are critical to this program providing quality recovery-oriented care there is a compelling case that the NDIA must review its cost modelling to more truly reflect the cost of providing psychosocial support for people with high intensity, complex support needs.

The staff and individuals receiving support who participated in this project clearly described and gave examples of recovery-oriented practice congruent with the organisational commitment recovery domain of practice. However, there are significant challenges to maintaining the quality of this practice within current NDIS pricing models. Therefore, it is recommended that UnitingSA continue to work collaboratively with other psychosocial support providers to advocate to the NDIA for:

- improvements to processing times for psychosocial funding reviews, especially in relation to increased needs in times of crisis;
- continued work on engaging more appropriately with recovery-oriented language and concepts, and a guarantee that increased wellness will not result in decreased supports;

- a review of the current NDIS support worker cost model to better reflect the skills and costs associated with providing quality psychosocial support including:
    - a reduction to the current utilisation rates for ‘very high intensity’ supports from 87% to 80% to support ‘space between’ activities;
    - an increase in overheads percentage from 10.5% to 15%;
    - a fourth category of higher intensity supports at SCHADS level 4.1, to recognise the skill level required for supporting a minority of people with significant barriers to engagement and recovery;
    - an increase in the salary costs of the supervisor to SCHADS level 6.1 to recognise the stakeholder engagement and relationship management skills required to navigate systemic barriers to people’s recovery and the degree of supervision and coaching required for support workers to ensure quality psychosocial support.

Experiences of the NDIS Peer Support Program

Although the interviews with people using the NDIS Peer Support Program were guided by the ‘Your Experience of Service’ survey, the intention was not to evaluate the program’s performance but rather gain an insight into what has been working, challenges and opportunities for improvement. Most people using the service reported that it was excellent, or that it has allowed, or provided, them with better or increased support hours than previous psychosocial services. However, there was a desire to see more groups for social and skill development. Most reported that the activities during support had not significantly changed, which indicates UnitingSA has achieved their aim to deliver an NDIS program that provided quality, recovery-oriented psychosocial support.

Participants felt the organisation had hired workers who were good at building relationships and used terms such as friend and mate to describe them. The service was described as responsive; people felt they could contact someone when needed. Participants explained that they felt their workers ‘got them’, listened to them and did not make them feel bad about their mental ill health and associated behaviours. However, participants receiving support did note concerns with losing workers again, longevity of the program and the ongoing funding they will receive in NDIS.

NDIS Peer Support Program Participant: We are mates.

Summary

It is evident that the NDIS Peer Support Program is delivering best practice recovery-oriented care as described by Le Boutillier et al. (2011). The NDIS Peer Support Program has enhanced support in several areas, especially in relation to peer work and lived experience expertise. However, despite the program’s success in implementing UnitingSA’s model of care, there are significant risks to the ongoing viability of that model in a NDIS funding environment. This is particularly notable in relation to the sustainability of organisational commitment for space between tasks and flexible care that enables continuity. Further issues are inadequate hourly rates, as well as challenges to person-centred supports due to travel costs not being billable as an aspect of core support. There is a clear need for the NDIA to review its financial model to more accurately reflect the skills and costs required for a successful recovery-oriented psychosocial support service. If these costs are better recognised by the NDIA, not only will psychosocial programs remain viable, reducing concerns of thin markets, more importantly quality care for those experiencing complex mental health issues can be ensured.

Conclusion

The importance of psychosocial programs in facilitating mental wellbeing and personal recovery is immense. These services are often the support that helps people remain in their communities and prevents or reduces acute hospital admissions. The NDIS has opened new possibilities for psychosocial care and allows for an increased focus on person-driven supports that meet individual needs. There is a sense of optimism around what mental health services will look like and achieve if these supports can be effectively synthesised into an accessible, flexible and recovery-oriented system. There have been recognised challenges to this, especially regarding the transition from block-funded psychosocial services to NDIS funding packages. Although these challenges and people's experience of the transition are not specifically explored as part of this study, it was important to highlight the views people shared. What this work has done more specifically is explore an existing model of psychosocial care that was previously delivered via block-funding, and an innovative program that has set out to deliver this same model integrity in a new funding environment. At a time when there has been significant focus on the deficits and limitations of the NDIS, UnitingSA have not only seen an opportunity to enhance service, but also an opportunity to ensure continuity of care for the people they support.

This report has captured the voices of the people receiving support and staff, to identify the critical elements of UnitingSA's model of care and explore the implementation of this within the NDIS Peer Support Program. These findings have been contrasted with literature to examine congruency with recognised good practice and possibilities for model and program improvement. The report has found that UnitingSA's existing model of care is, in most aspects, working from a recovery-oriented approach. When the NDIS Peer Support Program was explored in relation to UnitingSA's model of care there was evidence that it was demonstrating integrity with a recovery-oriented approach. There were domains the program was notably exceeding in, and these included engagement with lived experience, peer work, and a positive, embedded attitude towards person-centred recovery-oriented support and language. Several challenges to maintaining quality care and financial viability for the NDIS Peer Support Program were identified. These were primarily centred around limitations of billing for transport mileage when supporting people to engage in their community, inadequate pricing to reflect the on-costs associated with service delivery and appropriately trained staff. These on-costs are not only comprised of ordinary, baseline business costs, but the costs and time for 'space between' support activities such as supervision, training, debriefing and self-care. It was noted that research has shown that when these activities are limited or reduced, there are concerning impacts on worker wellbeing and quality service provision.

In highlighting these issues, this report contributes to an evidence base for all psychosocial service providers to draw on in advocating to the NDIA around significant issues with the current funding model. It demonstrates the link between quality work environments, jobs and care, whilst also recognising that, for a truly person-driven system to operate, there must be allowance for the episodic nature of mental illness in relation to hours, pricing for flexibility and crisis support when needed. The NDIS has the potential to greatly enhance the support and wellbeing of people experiencing mental illness, but to do so the identified issues regarding appropriate pricing for psychosocial care must be addressed. The NDIS Peer Support Program has provided evidence that recovery-oriented practice can be delivered within the parameters of the NDIA and the individualised care model. However, the program is not independently financially viable. Greater flexibility and choice for participants in how they can pay for their services or an increase in the pricing model is required if the program is to continue delivering high quality recovery-oriented supports.

Appendix One: Literature Review and References

Literature Review

This review aims to give an overview of literature regarding good practice in the delivery of psychosocial support for people experiencing mental illness. Additionally it aims to provide an overview of the implementation of the NDIS and its capacity to support people experiencing psychosocial disability. A narrative approach was used for this review with searches conducted electronically via Google Scholar and scientific databases. A 'snowball' approach was also employed, where sources were identified from reviewed literature to further explore connected concepts and research. The key search terms used were: community mental health, mental health service, holistic, psychosocial, National Disability Insurance Scheme, NDIS, peer work, recovery model and consumer-directed care. The sources used for this project included:

- Peer-reviewed journal articles;
- 'Grey' literature (e.g. government and non-government reports or policy documents and reports from academic institutions or research centres in Australia and overseas);
- Literature and practice resources from government and non-government organisation websites.

The World Health Organisation (WHO) defines mental health 'as a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community' (2014, p.12). It is important to note here that the lack of a clinical diagnosis does not necessarily mean a person is experiencing mental wellbeing (WHO, 2014). A range of socio-emotional, socio-economic and biological factors impact on people's mental health (The Fifth National Mental Health and Suicide Prevention Plan (FNMHSPP), 2017-2022; Mackay & Goodwin-Smith, 2016; WHO, 2014). These can include social and life conditions such as early childhood experiences, homelessness, unemployment, grief and family breakdown, genetics and brain chemistry (Council of Australian Governments (COAG), 2012; WHO, 2014). When defined within a clinical paradigm, a mental illness is a '*significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning'* (American Psychiatric Association, DSM-5, 2013, p.20). The impact of the burden of mental health disorders worldwide is significant, with 450 million people internationally estimated to experience a mental health issue (COAG, 2012; Whiteford et al., 2013; WHO, 2013). For many of these people, ongoing mental illness may lead to disability and impact on their physical health and life expectancy (American Psychiatric Association, DSM-5, 2013, p.20; FNMHSPP, 2017-2022 p.05; Whiteford et al., 2013; WHO, 2013). In Australia it is widely acknowledged that approximately one in five people will experience a mental health disorder in a twelve-month period (FNMHSPP, 2017-2022; Slade et al., 2009). The Australian Government has indicated that 690,000 Australians live with chronic mental illness and that a third of this population will require some form of psychosocial support, ranging from group activities to individually tailored disability support (Department of Health, 2015a).

Since deinstitutionalisation in the 1980s Australia's system for mental health support has been implemented via a combination of clinical and community-based services (Doessel et al., 2015). This model has been described as a stepped system, providing opportunities for people to move between varying levels of service intensity reflective of their need (National Mental Health Commission (NMHC), 2014; Mackay & Goodwin-Smith, 2016). Contemporary Australian policy has placed increased focus on collaborative services, early intervention, holistic support and personal recovery journeys, reflecting the international paradigm shift towards person-centred practices (Doessel et al., 2015; FNMHSPP, 2017-2022; Mackay & Goodwin-Smith, 2016). Psychosocial support is considered a vital component in holistic stepped care, helping people to remain connected to their community as well as contributing to a reduction in acute hospital admissions (Mackay & Goodwin-Smith, 2016). Psychosocial supports aim to enhance personal wellbeing at the intersection of psychological, social or environmental experiences and systems (National Mental Health Consumer & Carer Forum (NMHCCF) 2011). Traditionally psychosocial services in Australia have been community based, delivered by non-government organisations (NGOs) and resourced primarily by State governments through a block-funded model (KPMG, 2014; Mental Health Coordinating Council, 2016). Furthermore, these services have been varied in their delivery and approaches, drawing on a wide range of theories and evidence regarding best practice for psychosocial support delivery.

It is important to note that there are a variety of approaches and extensive literature that seeks to define and measure 'best practice' interventions. Evidence based supports that have been identified as effective include: appropriate medications, training in illness self-management, assertive community treatment or outreach, care coordination, family psychoeducation, supported employment, supported housing, skills building and integrated supports for co-occurring substance use disorders (see Brophy et al., 2014b; Drake et al., 2001; Hayes et al., 2016; Kaplan & McGrath, 2018; Lyman et al., 2014; Marshall et al., 2014; Nicholas & Reifels, 2014; Reif et al., 2014; Rog et al., 2014). Contemporary literature also includes trauma informed approaches as crucial to good practice when working with people with complex needs (Muskett et al., 2014; Sweeney et al., 2016; Sweeney et al., 2018). The Camberwell Assessment of Need is often utilised as an assessment measure in mental health services to identify unmet need and possible supports or interventions. Nicholas and Reifels (2014) explored research across the top 12 ranked domains within the Camberwell Assessment of Need Short Appraisal Schedule and found that the company of others, food, looking after the home, physical health, psychological distress and psychotic symptoms, daytime activities, the need for information about treatment, intimate relationships and money were consistently among the top 12 areas of need for people (pp.47-48). This supports the concept that people experiencing mental illness see their mental wellbeing as being connected to, and impacted by, a range of social, economic and biological factors, and therefore that any supports should be holistic and person-driven (Brophy et al., 2014a; Kaplan & McGrath, 2018; NMHC, 2014; WHO, 2014).

This shift to more person-centred systems that work in partnership with people on their individual recovery journeys stemmed from the same movement that underpinned increasing community-based services and the reduction of institutionalisation (Davis & Gray, 2015; Doessel et al., 2015). These ideas have become core across social services broadly and share key principles including working with and respecting people in relation to their goals and desires instead of only focusing on needs or interventions as identified by clinicians or professions. They also include valuing support networks as defined by the individual and enabling personal choice and control in the services people receive (Beresford et al., 2011, p.50; Davis & Gray, 2015). These principles are also reflected in concepts of recovery-oriented services and recognition of personal recovery journeys, which are increasingly considered non-negotiable aspects of mental health support (Davis & Gray, 2015; Sowers, 2005). Recovery-oriented approaches have also been described as the best practice model for services and policy reform internationally (Department of Health, 2013; Shepherd et al., 2008; Slade, 2009).

It is important to differentiate between personal recovery and clinically defined recovery. A person experiencing clinical recovery no longer demonstrates identifiable clinical symptoms of a diagnosed mental illness, whereas personal recovery is recognised as an individual and unique experience, dependent on a person's own sense of being well, satisfaction with their life, engagement with their community and personal values and goals, with or without the presence of clinical systems (Anthony, 1993; Davis & Gray, 2015; Kaplan & McGrath, 2018; Onken et al., 2007; Slade, 2009). Anthony (1993) defines personal recovery in mental health as

… 'A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness' (Anthony, 1993, p. 527).

Anthony's definition has had a seminal impact in mental health care and reflects the approach of personal recovery as emerging from lived experience within the consumer movement, not from clinical perspectives.

Leamy et al. (2011) undertook a systematic literature review to develop a conceptual framework for the process and experience of personal recovery, and consequently developed the CHIME framework. This model identified thirteen characteristics of the recovery journey and five recovery processes: connectedness; hope and optimism about the future; identity; meaning in life and empowerment (producing the CHIME acronym) (Leamy et al., 2011). It also describes a range of recovery stages using a transtheoretical model of change. The framework has been noted to play a part in delivering recovery-oriented practice via workers reflecting on how their role and activities facilitate the identified characteristics and process (Leamy et al., 2011). Notwithstanding this, it is important to recognise that there have been various iterations of the recovery-model in practice and policy (Ellison et al., 2018; Jacobson & Greenley, 2001; Law & Morrison, 2014; Meehan et al., 2009; Oades et al., 2005; Sowers, 2005; Stuart et al., 2017). However, it can be argued these all share similar holistic principles of allowing choice and control, a strengths-based focus, inclusion, dignity, flexibility, hope and recognition of lived experience expertise (Anthony, 2000; Beresford et al., 2011; Borg & Kristiansen, 2004; Davis & Gray, 2015; Farkas et al., 2005; Kaplan & McGrath, 2018; Onken et al., 2007; Slade, 2009). It can be surmised that these principles and approaches stem from the personal recovery experience of individuals as captured in the CHIME framework and are reflective of the person-centred movement that championed self-help, empowerment, and advocacy (Leamy et al., 2011; Slade, 2009; Stuart et al., 2017). Moreover, to facilitate personal recovery, it is evident that services should engage with all areas of a person's life, thus drawing on aforementioned good practices around holistic models of psychosocial care (Davis & Gray, 2015; Slade, 2009). In 2011, Le Boutillier et al. continued to build from the CHIME framework with the aim of identifying the core aspects of international recovery-oriented practice to inform a conceptual practice framework. Their review identified 16 key recovery themes, which were nested within four domains of recovery practice, as shown in Table One.

Promoting citizenship Seeing beyond "service user" Service user rights Social inclusion Meaningful occupation	**Organisational commitment** Recovery vision Workplace support structures Quality Improvement Care pathway Workforce planning Individuality
Supporting personally defined recovery Informed choice Peer support Strengths focus Holistic approach	**Working relationship** Partnerships Inspiring hope

Table One: Recovery Practice Framework (Le Boutillier et al., 2011)

Lived experience expertise has been noted as a core concept of recovery-informed approaches and entails engagement at all levels of service delivery from individual support through to program design, evaluation and advocacy (Le Boutillier et al., 2011; Byrne et al., 2019c; Mental Health Coalition of South Australia (MHCSA), 2018). Peer work roles, either operating in the peer support movement or within mental health service contexts, are an extension of lived experience expertise, with a peer worker defined as being, '*someone who is living well with, [or has experienced] a mental illness and who has been engaged to share their experience to assist and support other people with a mental illness*' (Courage Partners, 2011, p. 99; Mackay & Goodwin-Smith, 2016; Mead & MacNeil, 2006; Nestor & Akins, 2006). As an expression of the consumer movement, the values of peer work closely align to those of recovery-oriented practice, with working relationships built on mutuality, respect, hope, experience, authenticity, responsibility and empowerment (Billsborough et al., 2017; Health Workforce Australia; 2014; Scottish Recovery Network Experts by Experience, 2012). There is significant evidence that peer workers positively contribute to people's recovery journeys, including reduced hospital admissions, improved quality of life indicators and increased levels of community engagement and inclusion (Billsborough et al., 2017; Chinman et al., 2014; Davidson et al., 1999; Davidson et al., 2006; Davidson, et al., 2012; Gallagher & Halpin, 2014; Lawn et al., 2008; Repper & Carter, 2011; Roberts & Fear, 2016; Siskind et al., 2012).

There have been a number of systematic reviews into the outcomes of peer work in relation to stand alone clinical or paraprofessional services (Bellamy et al., 2017). A review and analysis of 18 randomised controlled trials of non-residential peer support interventions by Lloyd-Evans et al. (2014), concluded that they found little evidence for the effectiveness of peer interventions for people with severe mental illness. This was specifically related to the authors being unable to find significant positive impact on hospitalisation, overall symptoms and overall satisfaction with services. However they did acknowledge a positive effect on hope, recovery and empowerment (Lloyd-Evans et al., 2014). A Cochrane review, undertaken by Pitt et al. (2013), examined 11 randomised controlled trials, with the authors concluding that peer workers engaged in mental health services resulted in equivalent psychosocial, service use and symptom reduction outcomes to services where peer workers were not involved. Some of the studies in the review indicated that peer work services might result in less use of crisis and emergency services, although the evidence base of these studies was low. In 2017, Bellamy et al. consolidated the previous reviews and included a number of recent studies. Their summation of the field was that peer services are found to be equally effective on traditional clinical outcomes but may have improved scope for positive impacts on hope, empowerment and quality of life. These findings were noted in the context of research with significant differences in types of programs and services studied and that the field featured studies with low methodological quality. They also indicated that a new approach may be required for the study of peer work outcomes:

'These findings raise additional questions regarding whether we are in fact targeting the mechanisms of recovery-oriented care and community outcomes, rather than the focus being on traditional psychiatric and medical-related outcomes. Peer supporters are trained to connect with other people in recovery by using their shared lived experiences in ways in which many providers are not trained to do. Few studies measure or describe these mechanisms. More qualitatively driven questions may add to the development of quantitative instruments that can be used to further test the mechanisms of peer support' (Bellamy et al., 2017 p. 166).

Within industry, there has been increasing recognition of the benefits of ensuring access to peer workers and the provision of adequate support systems for the workers themselves, including supervision and training in guidelines and policy (Byrne et al., 2019c; FNMHSPP, 2017-2022; MHCSA, 2018; NSW Mental Health Commission, 2016, Health Workforce Australia, 2014; NMHC, 2014; Oades et al., 2012). This is important as peer workers have faced challenges associated with differentiating their role, lack of organisational supports and stigmatising workplace cultures that devalue their contributions and lived experience expertise in support (Byrne, 2014; Byrne et al., 2019b; Community Mental Health Australia (CMHA), 2015; Gillard et al., 2013; Kemp & Henderson, 2012; Mackay & Goodwin-Smith, 2016; Mental Health Commission of NSW, 2016).

It is evident that there has been a fundamental change in how mental health is perceived and how supports are delivered with personal recovery now considered a cornerstone of care. Although best practice evidence based interventions have been identified, it has been noted that these need to be positioned within a holistic and person-driven support approach. Given the contested nature of what ultimately constitutes 'best practice' psychosocial support, and the significant support for recovery-oriented practice principles, this project will explore UnitingSA's model of care against the framework of recovery practice as developed by Le Boutillier et al. (2011). This model has been chosen for its concise summary of recovery-oriented practice principles recognised in a variety of models and policies (Department of Health 2013; FNMHSPP, 2017-2022; Law & Morrison, 2014; Leamy et al., 2011; Meehan et al., 2009; Oades et al., 2005; Sowers, 2005).

National Disability Insurance Scheme and Psychosocial Support

There have been immense changes to how psychosocial support is funded and provided in Australia. Historically, funding for psychosocial disability support has been provided via block-funding to providers who deliver a range of services to meet defined outcomes (KPMG, 2014; Mental Health Coordinating Council, 2016). In 2013 Australia began implementation of the NDIS at trial sites, with full roll out occurring in 2016 (Mavromaras et al., 2018; Mental Health Coordinating Council, 2016). The scheme can be argued to be reflective of the paradigm shift to consumer-directed care funding models within the international disability field (Iannos & Goodwin-Smith, 2015; KPMG, 2014; Williams, 2008). The NDIS model provides an annual individual funding sum to eligible people with disabilities, including psychosocial disability (Kaplan & McGrath, 2018; Mental Health Coordinating Council, 2016; NDIA, 2019; Williams, 2008). Packages have three aspects of support; capital support, capacity building and core support (Kaplan & McGrath, 2018). Once approved, people are able to purchase their services from a range of providers, according to their individual support plan (NDIA, 2019). This is said to allow people choice and control over their supports (Davis & Gray, 2015; NDIA 2019; Williams, 2008). However this does position the sector as a consumer-driven market, which has had a substantial impact on how services are delivered (Brophy et al., 2014a; Mental Health Coordinating Council, 2016). Although the NDIS advertises a recovery-informed approach, the ability to truly deliver this in the context of mental health has been queried (Mental Health Commission of NSW, 2015; NDIA, 2019; Smith-Merry et al., 2018). This has been attributed in part to the scheme's language and limited staff knowledge of psychosocial disability and recovery concepts (Hancock et al., 2019; Mental Health Commission of NSW, 2015; Smith-Merry et al., 2018). Examples of the disconnect between the NDIS and recovery-based support highlighted in literature include: language in eligibility criteria that requires permanent and ongoing disability, reliance on formal diagnosis, annual reviews of funding that increase anxiety for people receiving support and hinder capacity for continuity of care and arguments that the system is designed for disability maintenance and dependence, rather than personally defined recovery, wellbeing and independence (Hancock et al., 2018; Joint Standing Committee on the National Disability Insurance Scheme, 2017; Roberts & Fear, 2016; Rosenberg et al., 2019; Smith-Merry et al., 2018).

The Productivity Commission has estimated that under the NDIS model proposed in 2011, only 60,000 of the 489,000 people identified as experiencing a serious mental illness would qualify for a NDIS package of support. This is due to criteria requiring a 'permanent impairment' associated with a 'serious and persistent mental illness with complex interagency needs' (Mental Health Council of Australia, (MHCA) 2013, p.01; Productivity Commission, 2011). This policy context has been noted as problematic, with concerns raised regarding confusing and exclusionary criteria for eligibility and the potential that level of need and complexity of mental illness has been underestimated (MHCA, 2013). In 2019 the Productivity Commission released a draft report detailing their findings from a national inquiry into mental health. This report identified almost 200,000 more (690,000) people as experiencing a severe mental illness than in 2011 (Productivity Commission, 2019). Approximately 21,700 of the total 690,000 people were estimated to be receiving psychosocial support in a NDIS package, whilst 42,300 people were identified as likely to be eligible for NDIS psychosocial support but were not yet in receipt of a package (Productivity Commission, 2019). These numbers highlight a telling gap between anticipated need and the number of people that have successfully obtained a package of support (Hancock et al., 2019; Productivity Commission, 2019; Smith-Merry et al., 2018).

Research exploring the transition for people who had been utilising the Commonwealth funded Personal Helpers and Mentors Service, Partners in Recovery program and Day to Day Living program found that approximately 26% to 28% of people they received transition data for had been deemed ineligible, with Personal Helpers and Mentors Service clients generally reporting a larger ineligibility rate (Hancock et al., 2019). This is important in relation to aforementioned concerns regarding the NDIS being reliant on formal diagnosis as Personal Helpers and Mentors Service clients were not required to hold a clinical diagnosis to receive supports. Additionally, more than half of the people deemed ineligible did not appeal or reapply during the study period (Hancock et al., 2019). Various reports exploring the NDIS transition have noted that the low uptake to NDIS could be in part attributed to fear of the application process, feeling overwhelmed, poor or unstable mental health, people facing more urgent issues such as housing or income, distrust of government agencies, struggles with obtaining the required documentation and evidence, lack of formal diagnosis and lack of appropriate support during the process (Hancock et al., 2018; Mental Health Coordinating Council, 2016; Mavromaras et al., 2018; Smith-Merry et al., 2018; Hancock et al., 2019; Joint Standing Committee on the National Disability Insurance Scheme, 2017). The NDIA has developed the psychosocial disability stream and committed to full roll out by 2020 to try and resolve some of the issues associated with applying for and navigating the NDIS, but limited information is available regarding its current effectiveness (Productivity Commission, 2019).

Furthermore, fears have continued to be raised regarding those deemed not eligible to receive a NDIS package having reduced access to psychosocial services due to block-funding for psychosocial programs being redistributed into the NDIS (Joint Standing Committee on the National Disability Insurance Scheme, 2017; Mavromaras et al., 2018; MHCA, 2013). New government funded psychosocial services for people who are not eligible, or have not yet tested eligibility, for NDIS have been implemented through measures such as the National Psychosocial Support Measure, Continuity of Support funding and the Psychosocial Extension Program (Hancock et al., 2019). However, there are still outstanding questions regarding how these time limited programs will be able to meet the increasing level of need as block-funded psychosocial services cease (Joint Standing Committee on the National Disability Insurance Scheme, 2017; Hancock et al., 2018; Hancock et al., 2019; Smith-Merry et al., 2018). The Productivity Commission (2019) has recommend that certainty should be provided by governments that funding will be maintained for psychosocial supports after June 2022 to ensure continuity of care and prevent people who do not have NDIS funding falling through system gaps. Furthermore it was also recommended that funding cycles for psychosocial programs be extended to a minimum five year term to increase stability and continuity of services (Productivity Commission, 2019). This echoes views from the psychosocial supports sector for the ongoing provision of community based, block-funded psychosocial supports (Brophy et al., 2014a; Naughtin & Grigg; 2015).

In addition to difficulties navigating the NDIS application process, and the alarming possibility that people deemed ineligible will be left with minimal or no supports, there have also been challenges for those who have successfully received a package. A study by Mavromaras et al. (2018) found that people receiving support via the NDIS for psychosocial disability and their carers were more likely to feel like they have less choice and control since engaging with the scheme, as well as feeling less satisfied that their support was ‘reasonable or necessary’ (p. xvii). It was reported by carers that they are experiencing anxiety impacting their wellbeing associated with uncertainty regarding the sustainability of packages or services in addition to the burden of the NDIS system and administration processes (Mavromaras et al., 2018). Most notably, evidence suggested that people receiving NDIS support for psychosocial disability have been experiencing poorer outcomes and receiving a lower level of service than they had prior to the NDIS (Mavromaras et al., 2018). This is reflected in NDIS psychosocial recipients recording psychological, personal and social connection measures at levels lower than other NDIS disability groups (Mavromaras et al., 2018). Notably, this was compounded for those living in rural areas. People and their support networks also reported difficulties regarding a lack of funding for respite, employment skills, support coordination and psychosocial support (Mavromaras et al., 2018). Concerns regarding support coordination have been noted elsewhere, particularly regarding capacity of NDIS staff to effectively work with psychosocial disability due to limited knowledge about the complexity and impacts of mental illness (Hancock et al., 2018; Hancock et al., 2019; MHA, 2017; Smith-Merry et al., 2018). People in receipt of NDIS packages and their carers have also noted difficulties in actioning plans due to a lack of services associated with thin markets (inadequate availability of services to meet need), challenges understanding their plan and available supports, inappropriate funding or hours to receive the right supports and not enough capacity building support to meet psychosocial need (Mavromaras et al., 2018; Hancock 2018; Hancock et al., 2019; Rosenberg, 2019; Smith-Merry et al., 2018).

In addition to the direct impacts experienced by people in receipt of an NDIS support package for psychosocial disability, literature provides evidence that there have been effects on service providers' capacity to deliver sustainable, quality recovery-informed supports (CMHA, 2015). Since implementation, service providers have argued that current pricing for NDIS psychosocial service supports is inadequate to cover the true costs of providing quality recovery-oriented care (Hancock et al., 2018; Mavromaras et al., 2018; MHA, 2017; Mental Health Coordinating Council, 2016; Roberts & Fear, 2016; Rosenberg, 2019; Smith-Merry et al., 2018). This pricing has been linked to concerns about the sector's ability to retain a quality workforce with appropriate training and qualifications to meet the complex support needs of people with mental illness (Hancock et al., 2018; Mavromaras et al., 2018; MHA, 2017; Rosenberg et al., 2019; Smith-Merry et al., 2018).

There has been notable work regarding the impact that reduced time for self-care and professional 'space between' activities such as training, debriefing, supervision and team connectedness has on worker wellbeing and resulting issues such as vicarious trauma and burnout (Adams et al., 2006; Louth et al., 2019; Berger & Quiros, 2014; Baird & Kracen, 2006; McCann & Pearlman, 1990; McFadden et al., 2014). Quality work environments allow time for these activities and evidence from the consumer-directed aged care sector suggests that the support or lack thereof for these activities may have a direct impact on quality care provision (Howe et al., 2012; King et al., 2013; Mackay & Goodwin-Smith 2019; Skinner et al., 2016). Thus, in the NDIS environment where inappropriate pricing has been argued to shrink provider capacity to support these activities there is significant risk that people experiencing mental illness may not have access to quality supports when needed (CMHA, 2015; Hancock et al., 2018). Moreover, pricing concerns and workforce retention may impact on the ability of service providers to develop and provide sustainable programs and supports (CMHA, 2015; Hancock et al., 2018). This instability has been noted previously as a concern for NDIS participants and carers (Mavromaras et al., 2018). It can also be argued to contribute to issues associated with thin markets, which have been identified as a risk in relation to NDIS service provision for people with complex and multiple needs (Productivity Commission, 2017). If current pricing means that recovery-informed programs are not only unable to retain well trained and supported staff, but are financial unviable, it can be argued organisations will either opt not to provide NDIS support, or will move to lower cost approaches that may not be congruent with recovery-informed best practice (Hancock et al., 2018).

Summary

The positive impact the NDIS has had for some people with psychosocial disability cannot be ignored (Hancock et al., 2019), however it is clear that there have been challenges in the transition to consumer-directed mental health care via the NDIS. Consumers and carers are required to navigate a service context which now includes the additional layers of the NDIA as well as the various service providers to receive supports. Furthermore, service providers have been required to navigate the challenges of the transition and try and mitigate the impacts to the people they work with, particularly in relation to ensuring ongoing recovery-focused supports. As a provider of psychosocial support UnitingSA has not only been engaged in sector-wide advocacy regarding the NDIS, they have also identified that for some of the people they were providing supports to, the transition posed a serious risk to wellbeing if continuity of care was not provided. Consequently the organisation has developed the NDIS Peer Support Program in an effort to ensure ongoing recovery-oriented support.

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