Psychosis and the NDIS

A guide for young people, families and carers working out what the NDIS can and cannot do after psychosis.

FOR PARTICIPANTS & FAMILIES PUBLISHED SEPTEMBER 2026 VERSION 1.0

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About this guide

This guide is for people who have experienced psychosis, and for the families and carers around them. It is written by Independent Life Disability Supports (InLife), a registered NDIS provider working with families across Victoria.

We wrote it because the NDIS is complicated, and the people who need it most usually have the least time to work it out. We have kept it plain. Where the NDIS uses jargon, we explain it. Where psychosis has its own vocabulary, we explain that too.

WHO THIS IS FOR

Three groups of readers

People who have had a first episode of psychosis, or who live with ongoing psychosis. Families and carers supporting someone through it. Health professionals helping a person prepare an NDIS application.

WHAT YOU WILL FIND

Seven sections, and the last is yours

What psychosis is. Whether the NDIS is the right door. How to apply and what happens at a planning meeting. The supports the NDIS commonly funds. How InLife works. Who to call. Pages to fill in and bring with you.

READ THIS PART FIRST

The NDIS is not the first stop after psychosis, and for many people it is not the right stop at all. Treatment comes first, and it is funded through the health system, not the NDIS. Most people who have one episode of psychosis recover well and never need the NDIS. Page 11 explains who the scheme is actually for, and page 12 explains what to do if the answer is no, or not yet. We would rather tell you that on page 2 than let you spend six months on the wrong application.

YOU DO NOT HAVE TO READ IT IN ORDER

Most people go straight to the section they need and come back later. If you are deciding whether to apply at all, start at page 12. If you already have a plan, start at page 20. If today has been long, the workbook at the back is the only part that matters before your meeting.

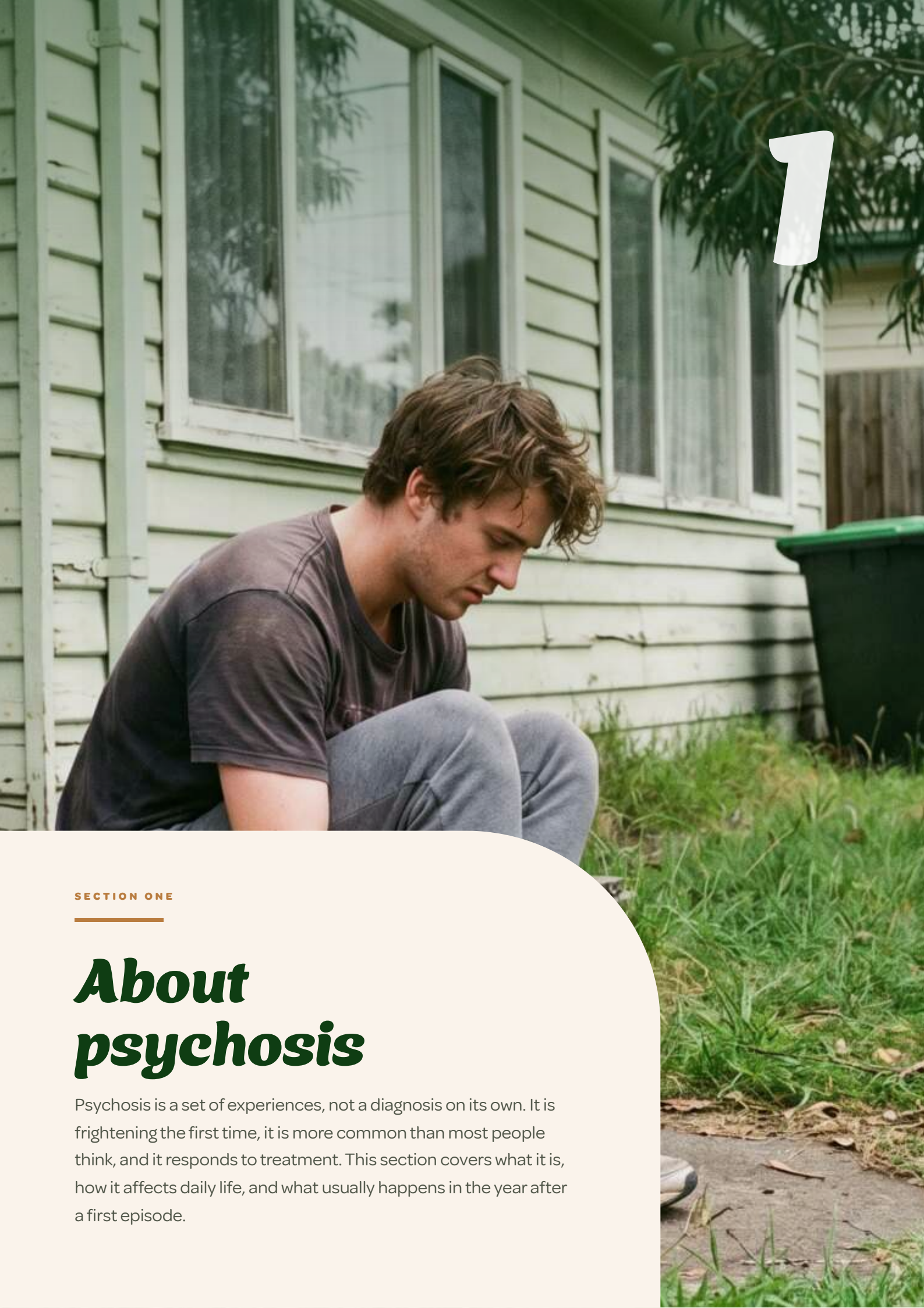
A NOTE ON LANGUAGE

This guide is written in English. InLife supports families in Farsi, Urdu, Hindi, Punjabi and English. Ask, and we will work in the language that suits your household. Interpreters are free at every NDIS meeting, and you never have to ask a young person to interpret their own health conversation.

What is in here

WORKBOOK PAGES AT THE BACK

The last five pages are yours to write on. They cover who you are, what a normal week looks like, and what you want the next twelve months to hold. A planner who can see all three has a much better chance of building a plan that fits. Bring this guide to your meeting.



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SECTION ONE

About psychosis

Psychosis is a set of experiences, not a diagnosis on its own. It is frightening the first time, it is more common than most people think, and it responds to treatment. This section covers what it is, how it affects daily life, and what usually happens in the year after a first episode.

What is psychosis?

Psychosis describes a period where a person loses some contact with shared reality. That usually means hearing or seeing things other people cannot, or holding beliefs that feel completely certain to the person and to nobody else. Thinking becomes harder to organise. Sleep, motivation and concentration often slip before anything else does.

Psychosis is a symptom rather than a diagnosis, in the same way that a fever is a symptom. It can be part of schizophrenia, schizoaffective disorder, bipolar disorder or severe depression. It can follow heavy or prolonged substance use. It can be triggered by a medical condition, a medication, extreme sleep loss or severe stress. And it can happen once, in a single episode, with no diagnosis ever attached to it.

3 in 100 people will experience psychosis at some point in their life. It most often begins between **15 and 25**, which is why so much of Victoria's specialist service system is built around young people.

Onset in the mid-teens is common and is not a sign that the outcome will be worse.

Common experiences

- Hearing voices, or other perceptions others do not share
- Fixed beliefs that do not match the evidence, and that argument does not shift
- Thinking that feels jumbled, jumpy or hard to follow
- A powerful sense that something is wrong, before anything else appears
- Withdrawal from friends, school, work and family
- Flattened motivation, energy and interest, which often outlasts everything else
- Disrupted sleep, which is frequently the earliest visible sign

WHAT PSYCHOSIS IS NOT

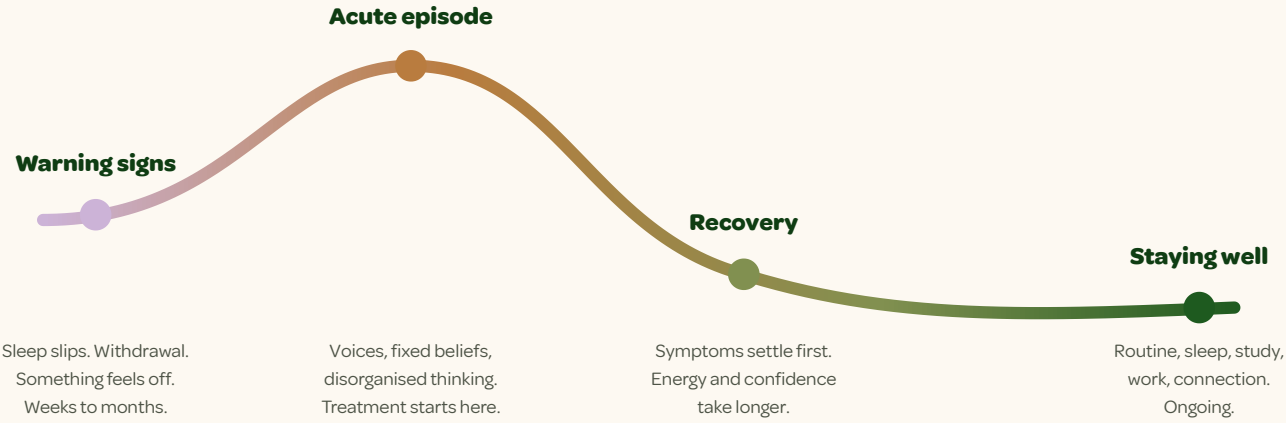
Psychosis is not a split personality. It is not caused by bad parenting or by weak character. People experiencing psychosis are far more likely to be harmed than to harm anyone else. And a first episode is not a life sentence: most people who have one episode recover, and many never have another. Stigma does more lasting damage than the episode does.

WHERE TO LEARN MORE

Orygen leads Australian research on early psychosis and publishes plain-language material for young people and families. headspace runs youth mental health centres across Victoria. SANE Australia covers complex mental health for adults. The Royal Australian and New Zealand College of Psychiatrists publishes clinical information written for the public.

How a first episode usually runs

Psychosis has a shape. Knowing the shape makes it easier to see where you are, what helps at each point, and which system pays for it.



What helps at each phase

1

WARNING SIGNS

A GP appointment, sleep back on track, and someone who knows to keep watching. Nothing dramatic, and it is the cheapest point to act.

2

ACUTE EPISODE

Clinical treatment, fast. Medication, a treating team, and often a hospital or early psychosis service. Not an NDIS question at all.

3

RECOVERY

Routine, sleep, food, movement, and slowly rebuilding contact with people. This is where support workers earn their keep.

4

STAYING WELL

A written early warning plan, study or work at a sustainable pace, and enough support to absorb a bad fortnight without losing the year.

THE SINGLE MOST USEFUL FACT IN THIS GUIDE

The longer psychosis goes untreated, the harder recovery tends to be. Getting to a doctor early genuinely changes the outcome. If you are reading this while waiting to see whether things settle on their own, please make the appointment. Paperwork can wait. Treatment cannot.

How psychosis can affect daily life

Everyone's experience is different, and the list below is not a prediction. These are the areas where support is most often needed, and where the NDIS looks when it assesses functional impact.

DAILY LIVING

How you get through a day

Routines fall apart during an episode and have to be rebuilt afterwards. Meals, showering, sleep and appointments are the scaffolding that holds a day together, and they are usually the first thing to go.

STUDY AND WORK

Where the year gets lost

Psychosis often lands in the middle of school, TAFE or a first job. Time away is normal. Getting back is where support matters most, because the gap grows the longer it is left.

CONNECTION

Who is still around

Withdrawal is one of the hardest parts and one of the least visible. Friends drift, invitations stop, and the world gets small. Rebuilding this is slow work and it is worth funding.

HOME

Where you live

Stable housing underpins everything else. Support can mean keeping a tenancy, managing a share house, or making a family home workable again after a difficult period.

PHYSICAL HEALTH

How your body holds up

Antipsychotic medication often affects weight, appetite and metabolic health. This is manageable, but only if someone is actively watching it. Exercise and diet support belong in the plan from the start.

IDENTITY

Staying yourself

Faith, family, music, sport, cooking, the things that make a person rather than a patient. A good plan is built around those, not in place of them.

FOR FAMILIES

Carers carry a load that nobody funds automatically. Carer Gateway (1800 422 737) and Tandem, the Victorian peak body for mental health carers, both exist for you rather than for the person you care for. Use them early, not at breaking point.

What usually happens after a first episode

Families ask this on day one, and the honest answer is better than most people expect.

1

TREATMENT STARTS

Usually antipsychotic medication, alongside therapy and family work. Most acute symptoms respond within weeks to a few months.

2

THE QUIET MIDDLE

Voices and fixed beliefs settle before energy and confidence do. This stretch is flat and slow, and it is the part people are least warned about.

3

GETTING BACK

Returning to study, work and friendships, usually part-time first. Pushing the pace here tends to cost more than it gains.

4

WHAT COMES NEXT

Many people have one episode and no more. Some have further episodes. Some go on to a diagnosis such as schizophrenia or bipolar disorder.

The quiet middle. Symptoms settle well before energy does, and this stretch is the part almost nobody is warned about.

Why this matters for the NDIS

The NDIS funds impairment that is **permanent, or likely to be permanent**. In the months after a first episode, nobody can yet say whether that describes you. That uncertainty is not a technicality. It is the single biggest reason early NDIS applications are declined, and it is why the health system, not the NDIS, is the right place to be in the first year.

Where psychosis is ongoing, where episodes recur, or where the flat, low-motivation period has stretched well past the acute illness and is holding back daily life, the picture changes. That is when an NDIS application has something solid to stand on.

THE HONEST VERSION

A first episode with a good response to treatment usually does not meet the NDIS access test, and should not. A pattern of psychosis that keeps affecting daily living after treatment often does. The difference is time and evidence, not how severe the worst week was.

An ordinary life

Psychosis is not a closed door. The NDIS exists to fund what a person needs to live an ordinary life: to study or work, to spend time with family, to take part in their community, to enjoy what they enjoy.

> **"Psychosis is part of someone's story. With the right support it is not the whole story, and it is rarely the most interesting chapter."**
>
> INDEPENDENT LIFE · HOW WE BEGIN EVERY PLAN

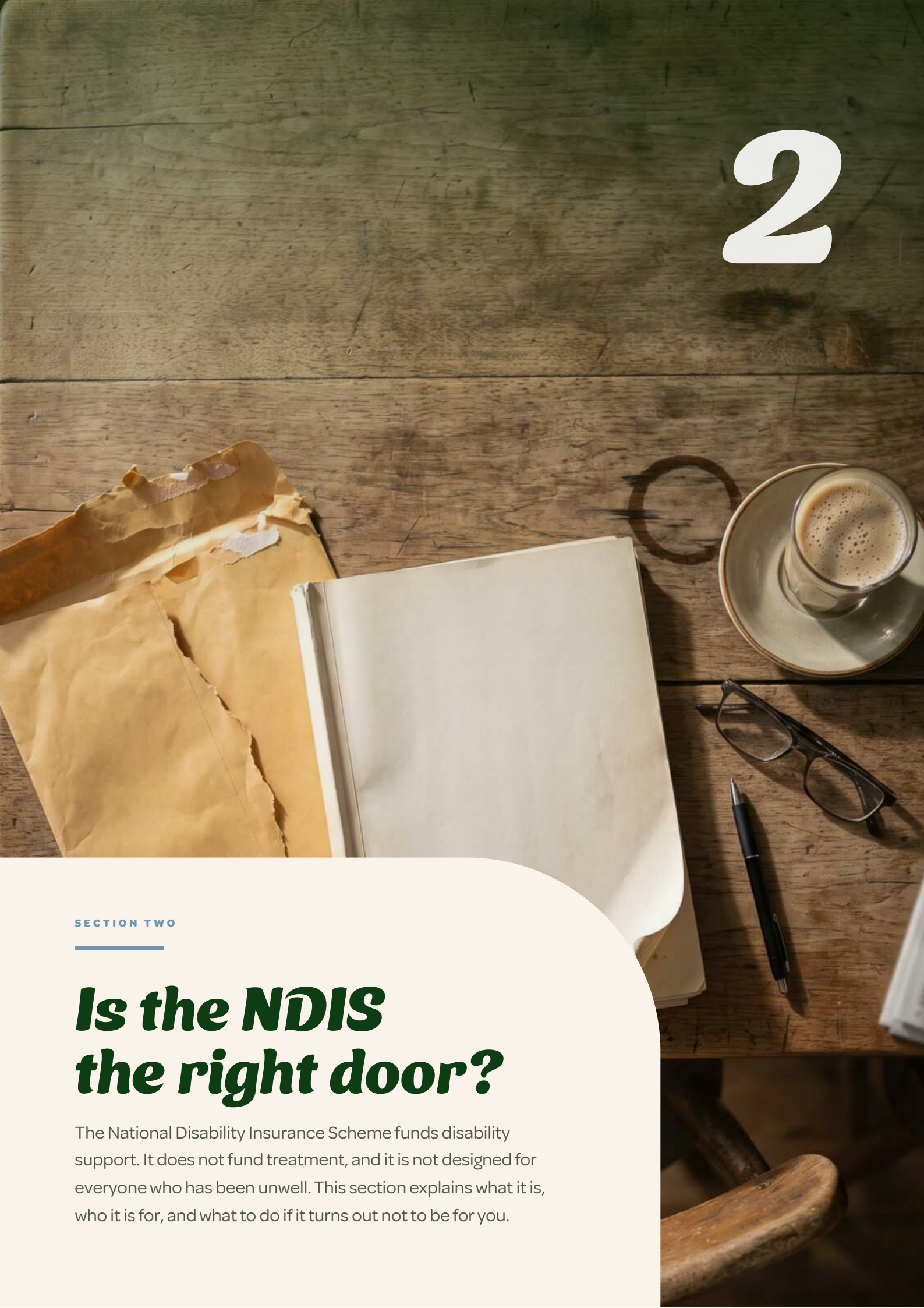
WHAT AN ORDINARY LIFE LOOKS LIKE

Nothing on the list below is a stretch goal. Every item is something people do after psychosis, routinely, with the right support around them.

- Finishing school, TAFE or a degree, at whatever pace works
- Working part-time, full-time or for yourself
- Living in your own place, with the support you choose
- Driving, where it is medically safe
- Sport, the gym, music, making things
- Friendships, relationships, family
- Faith community, at the mosque, gurdwara, church or temple
- Being known for your whole self rather than one hard year

FOR YOUNG PEOPLE READING THIS

You are allowed to want the same things you wanted before. Nobody gets to reduce your plan to symptom management, and you can say so out loud in your planning meeting. Goals about work, study, friends and moving out are all legitimate NDIS goals, and they carry more weight than goals written in clinical language.



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SECTION TWO

Is the NDIS the right door?

The National Disability Insurance Scheme funds disability support. It does not fund treatment, and it is not designed for everyone who has been unwell. This section explains what it is, who it is for, and what to do if it turns out not to be for you.

What is the NDIS?

THE WORD	WHAT IT ACTUALLY MEANS
National	It runs across the whole country, wherever you live.
Disability	It funds support for intellectual, physical, sensory, cognitive, neurological and psychosocial disability. Psychosis sits under psychosocial disability, where the functional impact is substantial and lasting.
Insurance	It takes a lifetime view, investing earlier so that less support is needed later where that is possible.
Scheme	It is not welfare and it is not income support. It funds what you need to build skills, stay independent and live an ordinary life.

Who runs what

The **NDIA**, the National Disability Insurance Agency, is the Commonwealth body that decides who gets in and how much funding a plan holds. The **NDIS Quality and Safeguards Commission** is the separate regulator that oversees providers, handles complaints about them and protects participant rights. If your problem is about money or access, it is the NDIA. If your problem is about how a provider treated you, it is the Commission.

THE SCHEME IN ONE SENTENCE

The NDIS funds supports it considers **reasonable and necessary** so that you can live an ordinary life. What that means in practice is the conversation you will have at your planning meeting, and page 17 sets out the six tests that decision has to pass.

The three budgets in a plan

CORE

The everyday one

Support workers, community access, consumables, some transport. The most flexible of the three, and the one most plans lean on hardest.

CAPACITY BUILDING

The skills one

Allied health, support coordination, a recovery coach, help back into study or work. Funded in hours and tied to your goals.

CAPITAL

The equipment one

Assistive technology and home modifications. It cannot be moved into the other two, so an unspent Capital budget simply goes unused.

WHAT THE NDIS DOES NOT FUND

Psychiatry, medication, hospital care, clinical psychology delivered as treatment, and mental health case management are funded through Medicare and Victorian public mental health services. The NDIS funds what sits around treatment, not the treatment itself. Nobody should ever be asked to give up a clinical service to take an NDIS one.

Can I access the NDIS?

The four basic rules

1. You are **under 65** when you apply.
2. You are an Australian citizen, a permanent resident, or hold a Protected Special Category Visa.
3. You have a disability that is **permanent, or likely to be permanent**, and that substantially reduces how you do everyday activities.
4. You need support in at least one of: communication, social interaction, learning, mobility, self-care, or self-management.

What that means for psychosis

Access is never granted on a diagnosis. It is granted on **demonstrated functional impact**. Two people with the same diagnosis can get opposite answers, and that is the system working as designed rather than a mistake.

An application built on psychosis is strongest when it shows a pattern over time: that the impact has persisted after treatment, that it affects several areas of daily life, and that it is expected to continue. A single acute episode, however severe, rarely demonstrates that on its own.

USUALLY A STRONG CASE

Ongoing impact after treatment

Years of contact with mental health services. Repeated episodes. Persistent low motivation and withdrawal that treatment has not shifted. Daily living, study, work and self-management all affected at once.

USUALLY TOO EARLY

A recent first episode

One episode, responding to treatment, within the last year. The permanence question genuinely cannot be answered yet, and an application now is likely to be declined on that basis.

How to apply

- Call the NDIA on **1800 800 110** and ask for an Access Request Form, or apply through ndis.gov.au.
- Your GP, psychiatrist, occupational therapist or social worker completes the evidence sections. They are the ones whose opinion carries weight.
- The NDIA aims to decide within **21 days** of receiving a complete form.

EVIDENCE IS THE WHOLE GAME

The strongest applications include a recent **Functional Capacity Assessment** from an occupational therapist or other allied health practitioner, a psychiatrist's letter that addresses permanence directly, a record of long-term contact with mental health services, and specific examples of how daily life is affected. Vague applications get declined. Ask your treating team for an FCA if you do not already have one.

If the answer is no, or not yet

A decline is common after psychosis, particularly early on. It is not a judgement about how hard things have been, and it is not the end of the road.

1

READ THE REASON

The letter says which limb failed. Almost always it is permanence, or thin functional evidence. That tells you exactly what to fix.

2

INTERNAL REVIEW

You can ask the NDIA to review its own decision within **three months**. Most decisions that change, change here, with better evidence.

3

EXTERNAL REVIEW

If the internal review still says no, you have **28 days** to apply to the Administrative Review Tribunal. It is free.

4

OR WAIT, AND BUILD

Sometimes the right answer is to reapply in a year with twelve months of evidence behind you. That is a strategy, not a defeat.

DEADLINES WORTH WRITING DOWN

Internal review: three months from the date of the decision notice. **External review at the Tribunal: 28 days** from the day after you receive the internal review decision in writing. The Tribunal can allow more time if you ask in writing and explain the delay, but do not rely on it. Diarise both the day the letter arrives.

What to do in the meantime

The support that matters most in the first year after psychosis is clinical, and it does not require an NDIS plan. Early psychosis programs, headspace, your GP under a mental health treatment plan, and Victorian public mental health services are all available now. Free NDIS Appeals advocacy and Victoria Legal Aid can help with a review if you decide to pursue one.

> #### WHERE INLIFE STANDS
>
> We cannot influence an NDIA access or funding decision, and no provider can. Any provider who tells you otherwise is telling you something the law does not allow them to say. What we can do, if you already receive support from us, is give you the shift notes and progress records that show what daily life actually looks like. Evidence is the part a provider can genuinely help with.

ONE DOOR, NOT THE DOOR

A decline closes one door. Everything on this page is open now and none of it waits on an NDIS decision.

3

SECTION THREE

Planning and preparation

The planning meeting is where your first plan gets built. It runs about ninety minutes, and going in prepared changes what comes out of it.

Before the planning meeting

1
WRITE YOUR GOALS

Big and small. Where do you want to be in twelve months, and in five years? Write them in your own words.

2
MAP YOUR WEEK

Use the workbook at the back. Mark the points in the week where help would change how the day goes.

3
GATHER EVIDENCE

Functional Capacity Assessment, psychiatrist and GP letters, discharge summaries, current medication list.

4
BRING PEOPLE

Family, an interpreter if you want one, a support coordinator, a treating clinician. You do not have to do this alone.

Writing goals that work

Goals are written in everyday language, not clinical language. The NDIA accepts goals like "I want to cook my own dinner three nights a week" and "I want to go back to my course part-time". Goals about recovery, connection, study, work and skill-building all fit the scheme.

EXAMPLE GOALS AFTER PSYCHOSIS

"I want to finish Year 12 with the support I need." · "I want to go back to my apprenticeship part-time." · "I want to manage my own medication and appointments." · "I want to see friends again without my family organising it." · "I want to move out of home in the next two years." · "I want to get my fitness back after the weight I gained."

WHAT TO HAVE IN THE BAG ON THE DAY

Your NDIS number or access letter. Photo ID. The workbook pages from the back of this guide, filled in. Any Functional Capacity Assessment, psychiatrist letter or discharge summary you hold. A current medication list. The name and number of your GP and case manager. Something to write with, and someone who knows your week.

A NOTE ON DESCRIBING YOUR WORST DAYS

Many people describe themselves on a good day, because that is how you get through a hard conversation. The planner then funds the good day. Describe the hard week honestly, and bring someone who will fill in what you play down. This is the most common reason a plan comes back too small.

At the planning meeting

The meeting is run by an NDIA planner or a Local Area Coordinator. Both can build your plan with you.

THEY WILL ASK

About your life

Your details and how you want to be contacted. What support you already have from family, your GP, your faith community. Your safety at home and out. Your goals for the next twelve months. What help would get you there.

YOU CAN

Set the terms

Take your time and ask for a question again. Bring notes, photos or the workbook. Have family speak for you. Ask for an interpreter at no cost. Decline any question that feels invasive without explaining why.

THEY WILL EXPLAIN

What happens next

How reasonable and necessary is decided. Your three funding categories: Core, Capacity Building, Capital. How you want funds managed. Your plan usually arrives in writing within about four weeks.

BRING THIS GUIDE

The workbook pages at the back are built for this meeting. Filled in, they give a planner a coherent picture of who you are and what a real week looks like, which is exactly what they need and rarely get.

If the meeting goes badly

Ask for the planner's name and a written summary of what was discussed. If the plan that arrives does not match the conversation, that gap is the basis of a review request. Write down what was said while you still remember it, on the day.

BRING SOMEONE WHO KNOWS YOUR WEEK

A planner hears ninety minutes of your life. The people around you have watched the whole year, and they will remember the parts you play down.

“Reasonable and necessary” supports

Every funded support has to pass six tests. Reasonable means fair, taking into account what is already available to you. Necessary means you need it to live an ordinary life or to work toward your goals.

The six tests

1. **Related to your disability.** Not general living costs.
2. **Value for money.** Efficient, given the alternatives.
3. **Likely to be effective and beneficial.** There is evidence behind it.
4. **Takes account of informal supports.** Family, carers, community.
5. **Most appropriately funded by the NDIS.** Not by Medicare, a hospital, a school or another system.
6. **Not a day-to-day cost everyone has.** Rent, groceries, ordinary internet.

What passes the test after psychosis

Supports that pass tend to be the ones that rebuild function rather than treat symptoms: support workers trained in mental health, where consistency of staff matters more than usual; help with daily living during flat periods; community participation to rebuild connection; capacity-building therapy such as occupational therapy, psychology delivered as skill-building, and exercise physiology for metabolic health; supported decision-making; and help to get back into study, work and family life. A psychosocial recovery coach may also appear in a plan, a role designed specifically around the episodic nature of mental illness.

TEST FIVE IS THE ONE THAT CATCHES PEOPLE

Clinical treatment fails test five, because it is most appropriately funded by the health system. This is why an NDIS plan will not pay for your psychiatrist or your medication, no matter how essential they are. It is a boundary between systems, not a judgement about importance.

The legal phrase is “reasonable and necessary”. The plain-English version is whatever it takes to have an ordinary Saturday.

Three ways to manage your funds

At the planning meeting you choose how your funding gets paid out. You can change this at any time during the plan.

OPTION 1

NDIA-managed

The NDIA pays your registered providers directly. No admin for you, and no invoices to handle. The trade-off is that you can only use registered providers.

OPTION 2 · MOST COMMON

Plan-managed

A plan manager handles the paperwork and pays your invoices. You can use both registered and unregistered providers. Plan management is funded by the NDIS on top of your other budgets, at no cost to you.

OPTION 3

Self-managed

You pay providers and claim back from the NDIA. The most flexibility and the most control over price, and all of the admin and record-keeping sits with you.

WHAT WE WOULD SUGGEST

For most households new to the scheme, **plan-managed** is the lowest-stress option. Someone else tracks the budget and pays the invoices, you keep full choice of provider, and it costs you nothing from your other budgets. InLife works under all three.

What a plan manager does not do

A plan manager pays invoices and tracks your budget. They do not choose your providers, they do not decide what your funding covers, and they have no say in what the NDIA approves. If a plan manager ever steers you toward a particular provider, that is worth questioning, and the NDIS Commission is the place to raise it.

Changing your mind

You can switch between the three at a plan review, and sometimes sooner if your circumstances change. Plenty of people start plan-managed while they learn how the scheme works, then move to self-managed once they are confident. Going the other way is just as normal, and neither direction is a failure.

> **FUNDING PERIODS**
>
> Plans now release funding in set periods rather than as one lump sum for the whole plan. It is worth asking your planner how your periods are structured, because it changes how quickly a budget can be spent and how a quiet month followed by a heavy one gets handled.

4

SECTION FOUR

Your supports

What the NDIS commonly funds after psychosis: the therapies, the technology, the support workers who make an ordinary week work, and the plan for staying well.

Allied health after psychosis

Allied health is the professional layer of your supports. After psychosis, these are the disciplines that appear most often in plans.

OCCUPATIONAL THERAPY

Routines and daily function

Rebuilding the shape of a day, sensory and sleep strategies, getting back to study or work, home and community access. OTs with mental health experience are central to psychosocial plans, and they write the assessments the NDIA relies on.

PSYCHOLOGY

Skills, not treatment

Cognitive behavioural therapy for psychosis has a solid evidence base, as does trauma-focused work where trauma is present. Psychology funded through Capacity Building works alongside your psychiatrist, never instead of them.

PEER WORK

Someone who has been there

Workers with their own lived experience of psychosis and recovery, in a paid professional role. For young people in particular this is often the support that lands when nothing else does.

SOCIAL WORK

Systems and family

Centrelink, housing, school and university negotiations, family relationships, supported decision-making. Social workers connect the systems that do not talk to each other.

EXERCISE PHYSIOLOGY

Metabolic health

Antipsychotic medication commonly affects weight and metabolic health, and exercise has direct mental health benefits on top. Programs designed to be sustainable rather than punishing.

DIETETICS

Eating, practically

Often funded alongside exercise physiology, for managing medication side effects and rebuilding regular eating after a period where meals stopped happening.

HOW THIS IS FUNDED, AND WHO DELIVERS IT

Allied health sits under **Capacity Building, Improved Daily Living**, and is funded in hours. Rates are capped by the NDIS price limits, so there is no advantage to a provider in charging more. InLife does not deliver therapy itself: allied health comes from independent practitioners you choose. What we do is help you find them, get you to appointments, and make sure their strategies actually happen between sessions.

Equipment and technology

The NDIS funds disability-related equipment under Capital, Assistive Technology. After psychosis the useful items are mostly small, cheap and unglamorous.

THE CHEAPEST THING ON THE LIST

A fridge door is assistive technology. So is a phone calendar set up properly. Both change more days than anything at the expensive end.

ITEM	WHAT IT IS FOR	USUAL PATHWAY
Medication management aids	Webster packs, vibrating watches, app reminders. Adherence is one of the strongest protections against relapse.	OT or pharmacist recommendation
Sleep supports	White noise, blackout blinds, sleep tracking, light boxes. Sleep is the earliest warning sign and the biggest lever.	OT or psychologist recommendation
Reminder and calendar technology	A phone set up properly, with structured calendars and alarms for appointments, medication and routines.	OT recommendation, often Capacity Building
Sensory regulation tools	Noise-cancelling headphones, weighted blankets, items that reduce distress in busy environments.	OT assessment
Transport supports	Where anxiety or symptoms make public transport hard: structured travel plans, ride-share set-up, travel training.	Support coordinator plus OT

How a request works

1. An OT or other clinician assesses the need and writes a report.
2. The report, with quotes, goes to the NDIA.
3. Higher-cost items need approval first. Lower-cost items can usually be bought from the existing budget.
4. Home modifications follow a separate and slower pathway.

Support workers

Support workers do the daily things psychosis makes harder: getting to appointments, preparing meals, personal care, medication routines, getting out of the house, staying connected to people.

Most participants have a small team of three to five workers across the week. The right team feels like a small group of familiar people who know how you like things done, not a rotating cast from a call centre. After psychosis this matters more than it does almost anywhere else in disability support, because trust is the working material and trust does not survive a new face every shift.

What good looks like

- The same workers, week after week
- Workers who speak your home language at the door
- Respect for your faith, food and household norms
- Trained on your specific needs before the first shift
- Backup workers you have already met and approved
- Shift notes shared within 24 hours, in plain language
- One person to escalate to when something is wrong
- The right to change your team without explaining why

THE INLIFE MEET-AND-APPROVE PROMISE

No worker meets a participant for the first time on a shift. You meet them, you decide, and then we roster. This holds across every plan we deliver, and it holds for backup workers too.

BEHAVIOUR SUPPORT PLANS

Some plans include a positive behaviour support plan written by a qualified practitioner. InLife is registered to implement behaviour support plans under NDIS Practice Standards Module 2A, which means our workers are trained in your plan's strategies, follow them consistently, record what the practitioner needs, and take part in reviews.

MOSTLY ORDINARY

Cooking, getting out, keeping the week upright. The work is unremarkable, and that is exactly what makes it work.

Staying well: the early warning plan

Psychosis rarely arrives without notice. Almost everyone has a pattern, and the pattern is usually visible to the people around them before it is visible from the inside. Writing it down while things are steady is one of the most useful hours you will spend.

What goes in it

PART ONE

My early signs

What changes first, in your case. Often sleep, appetite, withdrawing from messages, or a particular thought that starts turning up again. Be specific. "I stop answering my phone" is more useful than "I get stressed".

PART TWO

What helps early

The small things that have worked before: sleep back on track, cutting back commitments, an earlier appointment, someone staying over, a particular person who is easy to be around.

PART THREE

Who to call, in order

Names and numbers, ranked. Your case manager or GP first, then your area mental health triage service, then emergency services. Written down so nobody has to work it out at 2am.

PART FOUR

What I want, and do not want

Your preferences if you become unwell enough that decisions get made around you. Who to contact, who not to. What has helped in hospital before, and what made it worse.

> IN A CRISIS
>
> Your area mental health service runs a triage line 24 hours a day, seven days a week. If you are unsure, NURSE-ON-CALL is **1300 60 60 24** and Lifeline is **13 11 14**. If anyone is at immediate risk, call **000**. Support workers are trained to notice deterioration and escalate quickly, and they are not a substitute for a clinical response.

A FLAT WEEK IS NOT A RELAPSE

Knowing your own difference between the two is what the plan on this page is for.

5

SECTION FIVE

Why InLife

A registered NDIS provider in Victoria, built around one idea: the same workers, in the right language, every shift.

How InLife is different

Plenty of providers run rotating casual rosters drawn from several agencies, filling shifts with whoever is free. For someone rebuilding trust after psychosis, that is the wrong shape. We roster deliberately instead: a named team around each household, and no worker on a shift the household has not approved.

CONSISTENCY

The same workers

A small team who know your routine, your preferences and your early warning signs. No strangers on a Tuesday because somebody called in sick.

LANGUAGE

Your language at the door

Our team works in Farsi, Urdu, Hindi, Punjabi and English. Workers are matched to the language your household actually speaks, including the language you prefer when things are hard.

ESCALATION

One number that works

One phone and one email, both reaching the Managing Directors. No call trees and no waiting to be called back.

RECORDS

Written so you can read them

Shift notes and reports in plain language, not clinical shorthand. Monthly summaries of how your funding is tracking, copied to your support coordinator.

ONE PLAN, READ BY EVERYONE

Nothing sits in a folder

Your risk assessment, early warning plan and emergency plan are written once and read by every worker before they start. Allied health reports reach the support worker, not just the office.

CULTURE

Matched by design

Faith observance, food, gender preferences for personal care, and family structure are all part of the match rather than something you raise later.

WHAT WE ARE REGISTERED TO DO

InLife is a **Registered NDIS Provider**, registered with the NDIS Quality and Safeguards Commission. Our registration covers daily living and personal supports, high-intensity supports, community participation, life-stage transition, household tasks and behaviour support plan implementation. We do not deliver therapy or clinical treatment, and we do not provide Specialist Disability Accommodation.

How we match workers to households

Matching is the part most providers skip. We treat it as the most important conversation we have with a family.

ONE

Language

The languages spoken at home, including the one a person reaches for under stress, which is often not English.

TWO

Gender

Cultural and personal preferences about who delivers personal care, taken as given rather than negotiated.

THREE

Culture

Faith observance, food, household norms, and how a family makes decisions together.

FOUR

Competency

The specific skills your situation needs: medication support, mental health training, de-escalation, early warning signs.

FIVE

Geography

Close enough that workers arrive on time and keep arriving, which is what makes consistency possible at all.

SIX

Availability

Hours that match a real week: early mornings, evenings, weekends, and overnight where it is needed.

HOW IT RUNS IN PRACTICE

When a family says yes, we shortlist matched workers and arrange for you to meet them. You approve, and then we roster. If a match is not working, you say so and we change it, with no explanation required and no awkward conversation about why.

WORKING WITH YOUNG PEOPLE

Where the participant is under 18, we work with the young person and the family as two conversations, not one. A sixteen-year-old gets a say in who comes into their home and what gets shared with their parents, within what the law and their safety allow. Getting this wrong is the fastest way to lose a young person's engagement altogether.

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SECTION SIX

Resources and next steps

Where to learn more, who to call, how to reshape your plan when it is not working, and what to do when something goes wrong.

Where to turn: the NDIS

ABOUT THE NDIS

ORGANISATION	HOW TO REACH THEM	WHAT THEY DO
NDIA	1800 800 110 · ndis.gov.au	Access decisions, plans, plan reviews, general enquiries.
NDIS Commission	1800 035 544 · ndiscommission.gov.au	Complaints about providers and workers, restrictive practices.
Administrative Review Tribunal	1800 228 333 · art.gov.au	External review of NDIA decisions. Free for NDIS matters.
Disability Advocacy Network Australia	1300 365 085 · dana.org.au	Finding an independent advocate when you feel unheard.
TIS National	131 450	Free interpreting, including for calls to the NDIA.

Which number first

IF THIS IS THE PROBLEM	START HERE
You want to apply, or your plan has run out	NDIA, 1800 800 110
Your plan does not match what was discussed	NDIA first. Ask for an internal review in writing
The internal review went against you	Administrative Review Tribunal, 1800 228 333
A worker or provider did something wrong	NDIS Commission, 1800 035 544
You are not being listened to anywhere	An independent advocate, 1300 365 085
You are worried about someone's safety today	Area mental health triage, or 000

> FREE INTERPRETING
>
> TIS National covers calls to the NDIA, to providers and to most health services, at no cost to you. You can ask any of the organisations on these two pages to call you back through an interpreter.

Where to turn: mental health

MENTAL HEALTH AND PSYCHOSIS

ORGANISATION	HOW TO REACH THEM	WHAT THEY DO
Your area mental health service	Triage, 24/7 · find yours at health.vic.gov.au	The main entry point to Victorian public mental health care.
NURSE-ON-CALL	1300 60 60 24	24-hour health advice from a registered nurse when you are unsure who to call.
headspace	1800 650 890 · headspace.org.au	Youth mental health, ages 12 to 25. Centres across Victoria, plus online and phone.
Orygen	orygen.org.au	Early psychosis and youth mental health research, with plain-language resources for families.
SANE Australia	1800 187 263 · sane.org	Complex mental health. Helpline, peer support, online community.
Mind Australia	1300 286 463 · mindaustralia.org.au	Psychosocial support and NDIS services across Victoria.
Wellways	1300 111 400 · wellways.org	Mental health support, peer programs and family education.
Tandem	1800 314 325 · tandemcarers.org.au	The Victorian peak body for mental health carers, families and kin.
Carer Gateway	1800 422 737	Counselling, respite and practical support for carers.
Lifeline	13 11 14 · lifeline.org.au	24-hour crisis support and suicide prevention. Free and confidential.

IN AN EMERGENCY

If anyone is at immediate risk of harm, call **000**. Ask for ambulance, and say that it is a mental health emergency.

Reviewing your plan

About two months before your plan ends you will be contacted to start the review. This is your chance to reshape supports based on the year that just happened rather than the year you predicted.

Questions worth bringing

- What worked, and what did not?
- Which goals did you reach, and which need more time?
- Where did you underspend or overspend, and why?
- Are the funding categories the right shape for how you actually live?
- Has your clinical picture changed?
- What do you want next year to hold?

Reasons to ask for a change before the plan ends

- A hospital admission or a significant change in your mental health
- You need more support hours than the plan funds
- Equipment you did not know you needed at the start
- A new diagnosis on top of psychosis
- A change in informal support, such as a carer becoming unwell or the family moving
- A change in living situation, including moving out of the family home

WHEN YOU ASK FOR A CHANGE

Bring evidence: shift notes that show the gap, allied health reports, hospital letters. Your support coordinator can help you build the case. InLife will provide every shift note and report you need, and we will provide them whether or not you intend to keep using us.

> **UNDERSPENDING IS NOT A SAVING**
>
> Unused funding does not roll over, and a budget that goes unspent is often read as a budget that was not needed. If your supports are not being used, work out why now rather than at review time.

Your rights, and raising a concern

As an NDIS participant you have the right to

1. Decide what supports you receive, and who provides them.
2. Be treated with dignity and respect.
3. Receive support that is safe and culturally appropriate.
4. Get information in your preferred language.
5. Make a complaint without losing your supports.
6. Choose someone to act with you or for you: a nominee, an advocate, or a guardian.
7. An interpreter, at no cost, at every NDIS meeting.

If something is wrong

THE PROBLEM	WHO TO CONTACT
A decision about access or funding	NDIA · 1800 800 110
A provider or a worker	NDIS Commission · 1800 035 544
Something InLife did	admin@independentlife.au · reaches both Managing Directors
Appealing an NDIA decision	Administrative Review Tribunal · 1800 228 333
You want someone in your corner	Disability Advocacy Network Australia · 1300 365 085
You need an interpreter	TIS National · 131 450

COMPLAINING IS PROTECTED

Making a complaint is a legally protected action. No provider may reduce your support, treat you differently, or end your service because you complained. The NDIS Commission enforces this, and you can go straight to them without telling your provider first.

WHAT NO PROVIDER IS ALLOWED TO DO

Offer you cash, gift cards, vouchers, devices or free services to sign with them or stay with them. Pay anyone a fee for referring you. Claim to be "NDIS approved" or to be able to increase your funding. If you are offered any of these, that is a matter for the NDIS Commission.

The words the NDIS uses

ARF	Access Request Form. What you submit to apply to the NDIS.
ART	Administrative Review Tribunal. Hears appeals against NDIA decisions. Replaced the AAT in October 2024.
Capacity Building	Funding for building skills: allied health, support coordination, employment and study supports.
Capital	Funding for equipment and home modifications. Cannot be moved to other categories.
Core	The flexible everyday budget: personal care, community access, consumables, some transport.
FCA	Functional Capacity Assessment. An allied health report on what you can and cannot do day to day.
Funding period	The block of time a portion of your budget is released across, rather than the whole plan at once.
LAC	Local Area Coordinator. An NDIA partner who can build and review plans with you.
NDIA	National Disability Insurance Agency. Makes access and funding decisions.
NDIS Commission	NDIS Quality and Safeguards Commission. Regulates providers and protects participant rights.
Plan manager	A funded third party who processes your invoices and tracks your budget.
Psychosocial disability	The NDIS term for the lasting functional impact of a mental health condition. The access pathway for psychosis.
Recovery coach	A psychosocial recovery coach. A funded role built around the episodic nature of mental illness, often held by someone with lived experience.
Reasonable and necessary	The legal test every funded support has to pass. Six criteria, set out on page 17.
Support coordinator	A funded role that helps you put your plan into action and connect with services.
s100 review	An internal review. Asking the NDIA to reconsider its own decision, within three months.

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SECTION SEVEN

Your workbook

These pages are yours. Fill them in before your planning meeting and bring them with you. A planner who can see a real week has a much better chance of funding one.

About me

Take this page to your planning meeting. The planner wants to know who you are before they decide what you need.

MY NAME

NDIS NUMBER

DATE OF BIRTH

PHONE

MY ADDRESS

PERSON HELPING ME

THEIR RELATIONSHIP TO ME

MY LANGUAGE(S)

CULTURAL BACKGROUND

MY GP

MY PSYCHIATRIST OR CASE MANAGER

Three things that help when I am not doing well

Three things that make it worse

My week

Sketch what a typical week looks like now. Mark the points where help would change how the day goes.

Monday

MORNING

AFTERNOON

EVENING

OVERNIGHT

HELP NEEDED

Tuesday

MORNING

AFTERNOON

EVENING

OVERNIGHT

HELP NEEDED

Wednesday

MORNING

AFTERNOON

EVENING

OVERNIGHT

HELP NEEDED

Thursday

MORNING

AFTERNOON

EVENING

OVERNIGHT

HELP NEEDED

My week, continued

Friday

MORNING

AFTERNOON

EVENING

OVERNIGHT

HELP NEEDED

Saturday

MORNING

AFTERNOON

EVENING

OVERNIGHT

HELP NEEDED

Sunday

MORNING

AFTERNOON

EVENING

OVERNIGHT

HELP NEEDED

The hardest part of the week

WHEN

WHAT HAPPENS

WHAT HELPS

WHO IS THERE

My goals

Write these in your own words. Everyday language works better here than clinical language, and the planner is required to build the plan around them.

My top three goals for the next twelve months

1 _____

2 _____

3 _____

Three things I need to do them

1 _____

2 _____

3 _____

Where I want to be in five years

_____

_____

_____

Psychosis is part of the story. The right team helps you write the rest of it.

If you want to talk it through with a person rather than a document, call us. There is no cost to a conversation and no obligation at the end of it.

TALK TO US

03 7056 6625
admin@independentlife.au
independentlife.au

FIND US

Suite 329
98–100 Elizabeth Street
Melbourne VIC 3000

INLIFE SERVES

Victoria
Farsi · Urdu · Hindi
Punjabi · English

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