

Analysis of unmet needs for psychosocial supports

Summary Report on Stakeholder Consultation Workshop 1: Friday 18 August 2023 – Methodology

This report summarises key themes from workshop participants' feedback on the consultation questions (questions outlined on page 2). In addition, this report outlines how the Project Team intends to address the feedback on the project methods, in light of stakeholder feedback and subsequent consultation with the inter-jurisdictional Psychosocial Project Group that is steering the analysis of unmet need.

Workshop purpose:

To test the proposed methodology for the analysis of unmet needs for psychosocial supports outside of the National Disability Insurance Scheme (NDIS). Further information about the analysis project is available on the Department of Health and Aged Care [website](#).

Workshop invitees and attendees:

Key national stakeholders were approached to participate. Approximately 115 attendees participated at the workshop, representing:

- Department of Health and Aged Care
- State and territory health agencies
- Members of the Psychosocial Project Group
- Department of Social Services
- National Indigenous Australians Agency
- Non-Government Organisation (NGO) service providers and peak bodies
- National Mental Health peaks bodies and advocacy groups
- Australian Institute of Health and Welfare
- Primary Health Networks
- Universities, including Queensland Centre for Mental Health Research (QCMHR)

An attendees list, at the organisation level, is at [Attachment A](#).

Workshop format:

The workshop was held virtually via Microsoft Teams. Before the workshop, a methodology working paper (at [Attachment B](#)) was circulated to attendees, which introduced the project and posed questions on which views were going to be sought at the workshop.

The workshop was held over 3 hours with two short breaks. Participants were divided into 6 breakout groups during three sessions (see page 2). The breakout groups ensured that all participants had opportunities to express their views and raise questions. The sessions were recorded and transcribed.

Overview of methodology questions posed at Workshop 1

1. *Breakout session 1:*

- a. Question: What is one key thing that the Project Team should consider in undertaking this work?

2. *Breakout session 2:*

- a. Question 1: Should refinements be considered to the working definition of psychosocial supports?
- b. Question 2: Do you agree that for the purpose of this project, “psychosocial support” be aligned with the Specialised Mental Health Community Support Services stream defined in the National Mental Health Services Planning Framework?
- c. Question 3: Do you agree with the proposal to produce final estimates at the SA3, Local Hospital Network (LHN) and Primary Health Network (PHN) levels?
- d. Question 4: Should the project explore additional factors that result in geographical variation in prevalence in mental health needs around the national average? If so, what are some of the factors that should be explored?
- e. Question 5: For the purposes of this analysis, can we assume that the psychosocial needs of NDIS participants with a psychosocial disability as a secondary disability are being met by the NDIS?

3. *Breakout session 3:*

- a. Question 6: Are there additional data sources that reflect current level of access to psychosocial supports that should be considered?
- b. Question 7: What are your views on directly surveying NGO providers of psychosocial supports?

Key themes from workshop participants' feedback

Breakout session 1

Question: What is one key thing that the Project Team should consider in undertaking this work?

- Engaging with people with lived experience is vital to the success of this project.
- Underscored importance of estimating the unmet psychosocial support needs for people with moderate or severe mental illness.
- Recognition of challenges in achieving an accurate assessment of need and unmet needs, given:
 - needs for psychosocial supports (such as consumer need to achieve independence) can be more difficult to measure compared to clinical needs;
 - unmet need does not necessarily equate with unmet demand;
 - holistic needs, e.g. family support, natural support networks, residential support, and long-term interventions, early intervention, rehabilitation, engaging with NGOs, and system navigation.
 - understanding and addressing the specific needs of diverse populations, including Aboriginal communities, culturally and linguistically diverse populations, refugees, young people and people experiencing homelessness, is paramount. The Project Team should also incorporate the socioeconomic factors that impact access to services.
- Consider the impact of the National Disability Insurance Scheme (NDIS), Disability Support reform, and potential overreliance on services outside of NDIS.
- Access to data and data quality were recognised as general issues/challenges for this project.
- While stakeholders recognised that delivery of services is out of scope for the project, it was emphasised that planning needs to be followed through with delivery of services.
- Beyond this project, the work should be frequently updated, and recommendations developed to address data gaps for measuring unmet need for psychosocial supports.

Breakout session 2

Question/stakeholder response	Handling of methodology, following feedback
<p>Question 1: Should refinements be considered to the working definition of psychosocial supports?</p>	
<p>Stakeholders generally supported the definition of psychosocial services proposed for this project.</p> <p>Suggestions for strengthening the definition and further inclusions or issues mentioned were:</p> <ul style="list-style-type: none"> • “Support” is potentially passive in the definition and needs to better reflect coaching and capacity-building for people to self-manage/self-regulate. • Related to the above, supports should be time-limited; the goal should be for people to move towards independence. • Supports should include connecting people to naturally occurring community resources. • The definitions should recognise that people’s needs change over time (they are not fixed). • Co-ordination and assistance with access to services should be reflected in the definition. • Needs of carers and families should be reflected in the definition. • Complexity of needs should be reflected in the definition. 	<p>On balance, the Psychosocial Project Group (PPG) and Project Team have agreed to retain the definition of psychosocial support as originally identified by the PPG for the project.</p> <p>This was owing to the need to retain alignment of the definition with the ‘Specialised Mental Health Community Support Services’ stream of the National Mental Health Service Planning Framework and reflecting the variation in psychosocial services across jurisdictions – including that some can be provided on an ongoing, longer-term basis (e.g. maintenance) owing to client need. Overall, PPG underscored the importance of not restricting the definition, including by introducing ‘time-limited’, ‘capacity-building’ concepts.</p> <p>Where the project encounters challenges around interpreting whether a service is in or out of scope, the Project Team will document these and present to the PPG. Where necessary, the Project Team will conduct sensitivity analysis to inform PPG considerations.</p>
<p>Question 2: Do you agree that for the purpose of this project, “psychosocial support” be aligned with the Specialised Mental Health Community Support Services stream defined in the National Mental Health Services Planning Framework?</p>	
<ul style="list-style-type: none"> • Include translational services; that is, step-up step-down services that are providing some clinical but also some psychosocial support. • Need to recognise that supports are not just about people’s mental health; they are about people’s whole lives. • Some stakeholders were not sure where residential services fit into the definition. <p>There was a comment that services delivered by Aboriginal Community Controlled Health Services (ACCHSs) are not included in the service stream. However, others suggest the “stream” is agnostic to which organisation provides the psychosocial support.</p>	<p>Following feedback from the Workshop, the project will use the Specialised Mental Health Community Support Services stream defined in the National Mental Health Services Planning Framework.</p> <p>The Project Team will further investigate the issues around how psychosocial supports provided by ACCHSs should be included in the assessment of service provision.</p>

Question/stakeholder response	Handling of methodology, following feedback
<p>What is important is that the nature of the supports provided by the ACCHSs are reflected in the definition.</p>	
<p>Question 3: Do you agree with the proposal to produce final estimates at the SA3, LHN and PHN levels?</p>	
<p>Stakeholders generally agreed with producing estimates at the SA3, LHN, and PHN levels (as proposed), though some suggested the addition of Local Government Areas (LGA) and more granular analysis at the SA2 level for rural and remote areas.</p>	<p>In considering Workshop feedback and the requirements of underlying data, PPG and the Project Team agreed that the analysis will be performed at the SA3 level generally.</p> <p>The Project Team will undertake work to align these with PHN and LHN boundaries.</p> <p>Understanding the needs in rural and remote areas, the Project Team will work with individual jurisdictions to break up larger SA3s that have significant population gradients where the underlying data can support it.</p>
<p>Question 4: Should the project explore additional factors that result in geographical variation in prevalence in mental health needs around the national average? If so, what are some of the factors that should be explored?</p>	
<p>Stakeholders highlighted the need to explore factors leading to geographical variation in mental health needs, including refugees, socioeconomic disadvantage and digital inclusion.</p> <p>Stakeholders also suggested that disaster-prone areas (floods, fires) could also be considered for reflecting geographic variation in the analysis.</p>	<p>The Project Team will investigate the feasibility of whether the following can be included in the analysis:</p> <ul style="list-style-type: none"> • socio-economic disadvantage • the distribution of refugee populations.
<p>Question 5: For the purposes of this analysis, can we assume that the psychosocial needs of NDIS participants with a psychosocial disability as a secondary disability are being met by the NDIS?</p>	
<p>Stakeholder’s opinions were divided about whether NDIS participants with a psychosocial disability as a secondary disability should be excluded from the analysis of unmet need of the general population.</p> <p>There was a strong view that participants in the NDIS with a primary or secondary psychosocial disability were not having their needs fully met by the NDIS. However, there was also a view that their needs should be met by the NDIS, and that the focus of this current work, as set out by Ministers, is on needs of populations not covered by the NDIS.</p>	<p>Following workshop feedback and consideration by the PPG, the analysis undertaken by the Project Team will segment estimates of need into:</p> <ul style="list-style-type: none"> (a) NDIS participants with a primary psychosocial disability (b) NDIS participants with a secondary psychosocial disability and (c) other population groups. <p>Methods to estimate the proportion of consumers, activity and hours related to NDIS</p>

Question/stakeholder response	Handling of methodology, following feedback
A suggestion made was that NDIS participants should be included in the analysis but treated as a separate group.	participants will also be applied (within the data collated for Step 2 of the methods).

Breakout session 3

Question/stakeholder response	Proposal for methodology
<p>Question 6: Are there additional data sources that reflect current level of access to psychosocial supports that should be considered?</p>	
<p>A range of potential additional data sources were suggested, including:</p> <ul style="list-style-type: none"> • ABS survey of Disability, Aging and Carers • the Living in the Community survey • analysing the use of resources within NDIS plans • GP mental health related presentations • hospital utilisation data • ED presentations • Data on use of non-mental health services that provide psychosocial services to people with a mental illness – for example the Department of Community and Justice in NSW, homelessness services. <p>Mention was also made of “proxy measures” and persona modelling.</p> <p>Concerns were raised about double counting, variation in definitions, data quality, and the labour-intensity of data collection and impact on organisations providing data.</p> <p>Gaps in existing data were identified, and suggestions were made on how to improve data availability and to use existing research to inform data collection methods.</p>	<p>Several of the additional data sources suggested relate to “clinical” services provision, which are outside the scope of the definition of psychosocial services, although it is acknowledged that these services are often involved in addressing psychosocial issues for consumers.</p> <p>GP (MBS) data, emergency department and hospitalisation data will not be analysed for this project given its clinical focus.</p> <p>The project team will further explore the use of ABS surveys, including the survey of Disability, Aging and Carers and the National Study of Mental Health and Wellbeing, particularly investigating what these data can offer in relation to access to and use of services. These data sources will also be explored to determine how they could inform estimates of geographic variation in need.</p> <p>The project team is aware of the potential for aggregate data to result in double counting of individuals, particularly where a consumer receives psychosocial support from more than one service provider. To address this, the project teams will work with data providers to provide estimates to inform modelling assumptions around the extent to which double counting may be a factor, performing a sensitivity analysis. Published evidence will also be consulted to assist in estimations where available.</p> <p>It is not within the scope of this project to conduct a community survey, or survey of mental health consumers. However, recommendations on how to address gaps in information will be incorporated into the final report for the project and these may include consideration of surveys of this nature.</p>

Question/stakeholder response	Proposal for methodology
Question 7: What are your views on directly surveying NGO providers of psychosocial supports?	
<p>Responses generally supported surveying NGO providers directly but they highlighted challenges, including the burden on organisations, particularly smaller ones. Stakeholders emphasised that the survey must be relatively simple to reduce the burden on NGOs.</p> <p>Any survey needs to build on existing data collected by national, state and territory agencies. Alternatives that were suggested included a hybrid approach of state and NGO data and referral information from NGOs.</p> <p>The sector needs to have a good understanding of the value of any survey conducted for this project.</p> <p>Concerns were raised about inconsistent and inaccurate data, low response rates, and ethical issues surrounding direct consumer and carer surveys.</p>	<p>The project team will progress with requesting psychosocial support program data from state, territory and Commonwealth agencies as the primary activity or service data source for the project.</p> <p>Following careful consideration, the PPG opted against surveying NGO service providers for those same reasons identified in the workshop. State, territory, and Commonwealth agencies will work directly with the project team and NGO service providers to address any gaps. This may include aggregate data numbers where NGOs routinely collect that data or by providing estimates or proportions to inform modelling assumptions.</p>

Attachment A – Methodology Workshop Organisational Attendees

Analysis of unmet needs for psychosocial support outside of the NDIS: Workshop 1 (virtual), 18 August 2023

List of organisations represented

State and Territory Governments

NSW Ministry of Health, Mental Health Branch
Victorian Department of Health
Queensland Health - Mental Health Alcohol and
Other Drugs Branch - QLD
Western Australia Mental Health Commission
SA Health
NT Department of Health

Commonwealth Government Agencies

Department of Health and Aged Care
Department of Social Services
National Indigenous Australians Agency
National Mental Health Commission
Australian Institute of Health and Welfare

Primary Health Networks

PHN Cooperative (national)
Adelaide PHN
Brisbane South PHN
Capital Health Network / ACT PHN
Central Queensland, Wide Bay, Sunshine Coast
PHN
Central and Eastern Sydney PHN
Coordinare - SENSW PHN
Country to Coast QLD / PHN
Darling Downs & West Moreton PHN
Eastern Melbourne PHN
Gold Coast PHN
Gippsland PHN
Healthy North Coast - North Coast PHN
The Hunter New England and Central Coast
Primary Health Network
Murray PHN
Murrumbidgee PHN
North Coast PHN
North Western Melbourne PHN
Northern Queensland PHN

Primary Health Tasmania
South Eastern Melbourne PHN
South Western Sydney PHN
Sydney North Health Network
Western Australia Primary Health Alliance
Western Victoria Primary Health Network

Academic Organisations

The University of Queensland/Queensland Centre
for Mental Health Research
The University of Sydney

Peak Bodies

Community Mental Health Australia
Mental Health Australia
Mental Health Carers Australia
Mental Health Coordinating Council - MHCC
Mental Illness Fellowship Australia
Queensland Alliance for Mental Health
Western Australian Association for Mental Health

Provider Organisations

Flourish Australia
Mind Australia, Victoria, QLD, SA, WA
Neami National
One Door Mental Health

*Note: Two Lived Experience representatives were
also in attendance.*



Analysis of unmet needs for
psychosocial support:
Consultation workshop on
methodology

Prepared by Health Policy Analysis for
the Australian Government Department of Health and
Aged Care and Psychosocial Project Group

16 August 2023

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1 Introduction

Under the [National Mental Health and Suicide Prevention Agreement](#) (the National Agreement), the Commonwealth and state and territory governments have committed to analysing unmet need for psychosocial supports outside the National Disability Insurance Scheme (NDIS). The analysis is to be completed in March 2024. The analysis will be used to inform future arrangements for the provision of psychosocial supports outside of the NDIS, including roles and responsibilities between the Commonwealth and states and territories.

To progress this work and other issues related to psychosocial support, a Psychosocial Project Group (PPG) has been established. The PPG is represented by each state and territory, except the Northern Territory (which is kept informed about developments and provides input and feedback on an out of session basis), and a representative with lived experience.

The Australian Government Department of Health and Aged Care (the Department), working on behalf of the PPG, has engaged Health Policy Analysis (HPA) to quantify the level of unmet need for psychosocial supports outside the NDIS.

This document provides an overview of the methods that will be employed to undertake this work. It will be used to obtain feedback from stakeholders at an online workshop to be held on 18 August 2023.

Beyond the workshop, stakeholders are invited to provide further input in writing to Joel Tuccia via email: jtuccia@healthpolicy.com.au

Project aim

The National Agreement commits all parties to undertake a further analysis of unmet demand for psychosocial supports outside of the NDIS. This project builds on the work undertaken by the Productivity Commission in its 2020 Inquiry into Mental Health.¹

The project will be estimating the population predicted to need psychosocial supports modelled from the **National Mental Health Service Planning Framework** (NMHSPF) and comparing this to the populations currently receiving psychosocial support services.

Text Box 1: National Mental Health Service Planning Framework (NMHSPF)²

First developed between 2011 and 2013, the **NMHSPF** is a comprehensive model designed to help plan, coordinate and resource mental health services to meet population demands. It's an evidenced-based framework providing national average benchmarks for optimal service delivery across the full spectrum of mental health services in Australia.

The NMHSPF builds on state and territory expertise in population-based mental health service planning and has collated expert input from around 250 service managers and planners, public and private sector clinicians, community sector professionals, consumers, carers, technical experts and academics.

¹ Productivity Commission. (2020). *Mental Health, Report no. 95*. <https://www.pc.gov.au/inquiries/completed/mental-health/report>

² Diminic, S., Gossip, K., Page, I., & Comben, C. (2023). *Introduction to the National Mental Health Service Planning Framework – Commissioned by the Australian Government Department of Health*.

The project will aim to provide its estimates at a level of geography and population subgroups suitable for regional service planning.

The scope of the project, as developed by the PPG, does not include modelling the extent to which an individual's psychosocial needs are met by the psychosocial supports they receive. Additionally, the project is not examining what future psychosocial support arrangements should look like.

Following completion of the unmet demand analysis, the Commonwealth, states and territories have committed to working together to develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS.

Conduct of the project

The project is being undertaken by HPA, with additional support being provided through the Queensland Centre for Mental Health Research (QCMHR) based at the University of Queensland. The project is overseen by the Department and the PPG. The PPG was established as part of governance structures to support implementation of the unmet need analysis commitment under the National Agreement.

The project is being undertaken in 5 stages between July 2023 and March 2023 (Figure 1). The current stage is focussed on developing project methods and collating relevant data.

Figure 1: Project stages and timeline

Project stages	2023						2024			
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
1. Initiate project & manage ongoing										
2. Define methods										
3. Undertake preliminary analysis										
4. Refine analysis										
5. Finalise analysis										

Stakeholders will be engaged at various points during the project through interviews, workshops and opportunities to provide written feedback on the project methods and deliverables. Three rounds of consultation are planned:

- **Round 1:** Focused on obtaining data from relevant custodians and understanding and interpreting that data, and on developing the methods for the analysis. This includes Workshop 1 which is focussed on the project methodology.
- **Round 2:** Currently scheduled for later in 2023 (around November), will focus on obtaining feedback on the preliminary unmet needs analysis. This will include workshops conducted in each jurisdiction involving stakeholders from health authorities, non-Government providers, advocacy groups and Primary Health Networks (PHNs).
- **Round 3:** Currently scheduled for January 2024, will focus on the refined analysis which have incorporated feedback from Round 2. This will also include stakeholder workshops conducted in each jurisdiction.

Other unmet needs analyses

South Australia recently released a report prepared by David McGrath Consulting³ that examined both the population receiving psychosocial support services and the level of services provided in dollar terms, each compared to predicted outputs from the NMHSPF. The approaches taken in the SA analysis will provide a reference point for this project to build on.

The following sections will detail the steps set out in Figure 2, along with available data to inform the purpose of those steps, as well as any options and decisions to be taken at the workshop.

2 Proposed methodology

Methodology overview

The methodology described in Figure 2 follows the basic approach adopted by the Productivity Commission in 2020.⁴ Modifications of the Productivity Commission’s approach will be required to reflect developments of a maturing NDIS, as well as changes in national programs since 2021. Figure 2 describes the main steps planned to estimate unmet need for psychosocial services.

Figure 2: Overview of methods to estimate unmet need for psychosocial services

Step 1	Step 2	Step 3
<p>ESTIMATE PSYCHOSOCIAL SUPPORT NEEDS</p>	<p>ESTIMATE CURRENT SERVICE UTILISATION</p>	<p>ESTIMATE LEVEL OF UNMET NEED</p>
<ul style="list-style-type: none"> • Calculate number of people with a mental illness needing psychosocial supports • Estimate the number of people requiring one or more psychosocial support services at a regional level. • Estimate the number of people provided psychosocial support through the NDIS. • Estimate the number of hours of support required for each person 	<ul style="list-style-type: none"> • The number of people receiving support through these services at a regional level who are not participating in the NDIS and estimate psychosocial support services currently being received. 	<ul style="list-style-type: none"> • People receiving no psychosocial supports.

The NMHSPF is a comprehensive model designed to help plan, coordinate and resource mental health services to meet population demands and will provide the starting point in estimating psychosocial support needs. QCMHR (at the University of Queensland), currently maintains the

³ David McGrath Consulting. (2023). *Unmet mental health service need in South Australia that could be met by the NGO sector*.

⁴ Productivity Commission. (2020). *Mental Health, Report no. 95*. <https://www.pc.gov.au/inquiries/completed/mental-health/report>

NMHSFP tool, and is providing expert advice on the framework and unmet needs analysis methodology, as well as specific analysis inputs. These steps are described in more detail in sections 3, 4 and 5 below.

Target populations

The NMHSFP builds estimates of need based on **care profiles**, which are mutually exclusive groups of people defined by age group and severity of mental illness. Three broad levels of severity are specified: Mild, Moderate and Severe. The Severe level is further subdivided in creating the care profiles. There are some additional profiles, including those related to “selected prevention” and “indicated prevention” that cut across levels of severity.

In its initial modelling the Productivity Commission focussed on estimating unmet needs for people with severe mental illness. In the original terms of reference set for this project, the aim was to estimate unmet psychosocial needs for people with moderate and severe mental illness.

The care profiles developed for NMHSFP reflect age groups including 0–4, 4–11, 12–17, 18–24, 25–64 and 65+ years. In the original terms of reference set for this project, the aim was to estimate unmet psychosocial needs for aged 12–24 and 25–64 years, with an option also to explore the inclusion of the unmet needs for people aged 65+ years.

Note: the *needs analysis* component of the project, will address all mental illness severity levels, and all age groups. This will also include psychosocial needs for carers and families.

The care profiles have additional dimensions for Indigenous/non-Indigenous and urban/rural populations.

It is proposed that modelling for this project be based on Estimated Resident Population (ERP) data released by the Australian Bureau of Statistics (ABS). Regional estimates by age and sex for 30 June 2022 will be made available on 28 September 2023. For the baseline estimates produced for this project, we propose to use the ERPs for 30 June 2021 but will update these with the 2022 population data when it becomes available. ABS population projections for later years are now significantly out of date due to the impact of COVID-19.

Definition of psychosocial supports

Psychosocial supports are non-clinical and recovery-oriented services delivered in the community and tailored to individual needs. Responsibility for provision of psychosocial supports is shared between the Commonwealth (through the NDIS and other programs, such as the Commonwealth Psychosocial Support Program) and states and territories. The Productivity Commission’s Inquiry into Mental Health described these services as follows:

“Psychosocial supports — which include a range of services to help people manage daily activities, rebuild and maintain connections, build social skills and participate in education and employment — can facilitate recovery in the community for people experiencing mental ill-health.”⁵

“Psychosocial supports are a key facilitator of recovery, can help alleviate some risks of illness relapse and support people as they develop skills to self-manage the effects of

⁵ Ibid. Page 825

variations in their mental health. Services typically provided under this label include respite services, building social skills and relationships in a culturally supportive way, assistance with transport, tenancy or household management and finances, and coordination and support in complying with clinical treatment needs.”⁶

The PPG has developed a definition of psychosocial supports, which is being used for this project (See Text Box 2).

Text Box 2: Working definition of psychosocial supports adopted for this project

“Psychosocial supports are non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community. A preliminary list is provided as a guide:

- *daily living skills;*
- *support to obtain and maintain housing;*
- *support to identify client needs for other services (such as NDIS, AOD, clinical care etc.), connect with and maintain engagement with these services;*
- *support to socialise and build and maintain relationships; and*
- *support to engage (and maintain engagement) with appropriate education (including vocational skills) and employment opportunities.”*

Workshop questions:

1. Should any refinements to the working definition of psychosocial supports (Text Box 2) be considered?

Identifying psychosocial supports within the NMHSPF

The NMHSPF identifies a range of services that are required for people with different levels of mental illness severity and age. The services required are grouped into six service streams:

1. Population-based universal services – Mental health promotion
2. Population-based universal services – Mental health prevention
3. Primary and Specialised Clinical Ambulatory Mental Health Care Services
4. Specialised Mental Health Community Support Services
5. Specialised Bed Based Mental Health Services
6. Medications and procedures

Under each of these streams “service categories” and “service elements” are identified.

Round 1 consultation identified **Specialised Mental Health Community Support Services** as those that best align with the definition of psychosocial supports being used for this project. These are described in Table 1. Stakeholders reported that services under the streams “Primary and Specialised Clinical Ambulatory Mental Health Care Services”, “Specialised Bed Based Mental Health Services” and “Medications and procedures” generally involved clinicians and therefore were not in the scope of the working definition of psychosocial supports developed by the PPG.

⁶ Ibid. Page 42.

Table 1: Description of service categories and service elements included in the *Specialised Mental Health Community Support Services* stream and most closely aligned with psychosocial supports

Service category	Service element	Description
Group Support and Rehabilitation Services	Group Support and Rehabilitation	Group support and rehabilitation services aim to improve the quality of life and psychosocial functioning of people using mental health services, through the provision of group-based social, recreational or prevocational activities. With the exception of peer support services, group support activities are led by a member of the community managed organisation. This category does not include self-help or mutual support activities delivered on a group basis.
	Group Based Peer Work	Non-clinical support services that must be provided by someone with lived experience as a mental health service consumer or carer of an individual(s) with mental illness (i.e., as peer workers), in a group setting. Sub-types: Group Based Consumer Peer Support, Group Based Carer Peer Support.
Individual Support and Rehabilitation Services	Individual Support and Rehabilitation	Individual support and rehabilitation services aim to improve the quality of life and psychosocial functioning of people using mental health services, through the provision of personalised individual social, recreational or prevocational activities. The service occurs in the context of outreach to the appropriate setting and may be linked to an individual's accommodation. This is a non-clinical service.
	Individual Peer Work	Non-clinical support services that must be provided by someone with lived experience as a mental health service consumer or carer of an individual(s) with mental illness (i.e., as peer workers), provided in a one-on-one basis. Sub-types: Individual Consumer Peer Support, Individual Carer Peer Support.
Other Residential Services	Residential Crisis and Respite Services	This category refers to residential mental health services in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychosocial disability. These services employ a workforce to provide rehabilitation, treatment or extended care onsite. This category does not include services occupied by admitted patients located on hospital grounds or clinical residential services.
Family and Carer Support	Flexible Respite, Day Respite, Family Support, Group Carer Support, Individual Carer Support Services	This category refers to services that provide support, information, education and skill development to families, friends, support people and carers of people living with a mental illness. The services are explicitly targeted at family, friends, support people and carers. Residential respite services are not included in this category.

Source: Summary supplied by the University of Queensland, adapted from the NMHSPF Service Element and Activity Descriptions and Technical Appendices for the NMHSPF; See also Comben, C., Page, I., Gossip, K., John, J., Wright, E., & Diminic, S. 2022. *The National Mental Health Service Planning Framework – Service Element and Activity Descriptions – Commissioned by the Australian Government Department of Health. Version AUS V4.1. The University of Queensland, Brisbane.*

As well as the services identified for each care profile, the NMHSPF includes additional services or ‘Top-ups’. Top-ups are standalone resource estimates and are defined in the NMHSPF as, “Unlike a care profile, the top-ups are not associated with one specific need group, instead these resource estimates may apply across multiple need groups or be estimated as a standalone cost or activity”. An example of a top-up is Respite, which models resources associated with different types of respite care needed to support the families and carers of individuals in any of the need groups in the NMHSPF.”⁷ In relation to psychosocial services, there are top-up services for respite care for each age group and top-ups for intensive individual support and rehabilitation for the older three age groups. Table 2 describes the full range of services within the NMHSPF that align with psychosocial supports for the purpose of this project.

Table 2: Consumer vs carer/family-focused services

Consumer services	Carer/family services
<p>Consumers needing psychosocial support services includes an identified need for any one or more of the following NMHSPF service types:</p> <ul style="list-style-type: none"> • Individual Support and Rehabilitation • Individual Peer Support • Group Support and Rehabilitation • Group Based Consumer Peer Support 	<p>The number of carer/family members needing psychosocial support services will be based on the number of consumers for whom there is an identified need for any one or more of the following NMHSPF carer support service types:</p> <ul style="list-style-type: none"> • Individual Carer Support Services • Individual Carer Peer Support • Group Carer Support Services • Group Based Carer Peer Support • Family Support Services • Flexible Respite • Day Respite • Residential Crisis and Respite Services

Workshop questions:

2. Do you agree that for the purpose of this project, “psychosocial support” be aligned with the Specialised Mental Health Community Support Services stream defined in the National Mental Health Services Planning Framework (as described in Table 1 and Table 2).

⁷ Diminic, S., Page, I., Gossip, K., Comben, C., Wright, E., Pagliaro, C., John, J., & Wailan, M. (2023). *Technical Appendices for the Introduction to the National Mental Health Service Planning Framework – Commissioned by the Australian Government Department of Health.*

Regional boundaries used estimates

HPA propose to develop estimates for three regional boundaries: Statistical Area 3 (SA3), Local Hospital Networks (LHN) and PHNs. There are 340 SA3 regions across Australia, 164 LHNs and 31 PHNs. While the boundaries for SA3s, LHNs and PHNs don't fully coincide, the misalignment is relatively minor and can generally be handled without significant issues.

Workshop questions:

3. Do you agree with the proposal to produce final estimates at the SA3, LHN and PHN levels?

Step 1: Estimating psychosocial support needs for the target populations

Table 3 describes the main sub-steps in the methods for Step 1. Most of this work will be undertaken by QCMHR (UQ). Within the table, several issues are described that may still need to be explored through this work.

Table 3: Step 1 Estimating psychosocial support needs for the target populations

Description	How undertaken	Issues	# of people	Support required
1.1 Estimate the number of people by severity level and age group at the SA3 level.	National prevalence rates for Indigenous and non-Indigenous populations will be applied to SA3 populations. The prevalence rates are shown in Table 4. This work will be undertaken by the UQ.	The NMHSPF currently doesn't adjust for differences in prevalence related to remoteness or for socio-economic disadvantage. These could be considered in modelling to estimate how these factors might affect variation in prevalence.	✓	
1.2 Estimate the number of people within each severity level and age group who require psychosocial supports at the SA3 level.	The NMHSPF includes estimates of the proportion of people within each care profile who require different service elements. There are multiple psychosocial support service elements related to most care profiles. UQ will undertake work to estimate the proportion within each care profile who require at least one psychosocial support service.		✓	
1.3 Estimate the number of NDIS participants receiving psychosocial support by severity level, age group and SA3 and deduct these from the estimated number of people requiring psychosocial supports at the SA3 level (from 1.2)	Number of NDIS participants by SA3 where the main disability is a psychosocial disability can be estimated using publicly available data. An estimation process can be used to break these up by age group. Data is also available for NDIS participants where psychosocial disability is an additional disability.	An approach to estimate the severity level for NDIS participants is required. An appropriate assumption is that NDIS participants with a primary psychosocial disability most closely align with the severe and complex cohorts in each age group. An approach is required on how to account for NDIS participants who have psychosocial disability as a secondary disability. The psychosocial support needs for NDIS participants could be considered to be met through the NDIS.	✓	
1.4 Estimate the level of support required for each person requiring psychosocial supports outside the NDIS	The NMHSPF provides the basis for estimating these requirements which can be summarised using measure of Occasions of Service (OOS), Hours, and Cost. This can be multiplied through the number of people calculated in 1.3 to generate estimates of psychosocial support needs	It is feasible to break services down into consumer services and family/carer services. Other breakdowns of the type of psychosocial services are also feasible. However, at this stage these aren't the focus of this work.		✓

- Prevalence estimates for the NMHSPF take account of age and Indigenous status, but not variation related to socioeconomic disadvantage or remoteness. There are components of the NMHSPF that address differences in the nature of services needed for urban and rural populations.
- Every quarter, the National Disability Insurance Agency (NDIA) release tables describing NDIS participants.⁸ Participants may be accepted into the NDIS where they have been assessed as having a significant psychosocial disability.⁹ For the NDIS, the term “psychosocial disability” is to describe a disability that may arise from a mental health issue. Psychosocial disability may be the main disability impacting a participant who has been accepted into the NDIS. It may also be a secondary disability, where the participant has another main disability. In March 2023 there were around 61,000 NDIS participants whose primary disability was a psychosocial disability, and a further 69,608 participants where a psychosocial disability was present, but this wasn’t the main disability (**Error! Reference source not found.**). **An appropriate assumption is that NDIS participants with a primary psychosocial disability most closely align with the severe and complex cohorts in each age group.** An approach to addressing participants with a psychosocial disability as an additional disability needs to be considered.

Table 4: Number of NDIS participants with a psychosocial disability as their primary disability and number with a psychosocial disability that is not their primary disability

Diagnosis categories for NDIS identified psychosocial disability	Psychosocial as Primary	Psychosocial as other	Either primary or other
F20 Schizophrenia	30,403	4,876	35,279
F25.9 Schizoaffective Disorder	3,033	425	3,458
F31 Bipolar affective disorder	5,872	4,148	10,020
F32 Major depressive illness	5,255	9,943	15,198
F41 Other Anxiety disorders	1,836	25,515	27,351
F42 Obsessive-compulsive disorder	299	2,536	2,835
F43 Post traumatic stress disorder (PTSD)	2,768	3,487	6,255
F60.3 Borderline personality disorder	2,410	2,749	5,159
F99 Other psychosocial disorders	8,918	14,630	23,548
Other specified conditions	70	1,299	1369
All	60,864	69,608	130,472

Source: Publicly available NDIS data as of 31 March 2023¹⁰

Workshop questions:

4. Should the project explore additional factors that result in geographical variation in prevalence in mental health needs around the national average? If so, what are some of the factors that should be explored?
5. How should NDIS participants who have a psychosocial disability as a secondary disability be addressed in modelling?

⁸ National Disability Insurance Scheme. (2023). *Data downloads*. Retrieved 31 Jul 2023 from <https://data.ndis.gov.au/data-downloads#participant>

⁹ National Disability Insurance Agency. (2017). *Accessing the NDIS: A guide for mental health professionals*. <https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis#what-is-psychosocial-disability>

¹⁰ National Disability Insurance Scheme. (2023). *Data downloads*. Retrieved 31 Jul 2023 from <https://data.ndis.gov.au/data-downloads#participant>

Step 2: Assess current service utilisation for target groups

The aim in this step will be to collate available data on access to services and use of services by the target populations, where possible disaggregated by region.

An initial round of interviews has been conducted with relevant people in national, state and territory agencies, and to a more limited extent the NGO sector. These interviews have been used to identify state-funded psychosocial support programs and potential data sources. These consultations are ongoing and further information is being sought on psychosocial services provided through Aboriginal Community Controlled Health Services (ACCHS) and other Commonwealth agencies. Key points from these consultations include:

- Analysis of client level data is feasible for several Commonwealth programs including PHN commissioned services, where data are supplied to the Primary Mental Health Care Minimum Data Set (PMHC-MDS). Data on client plans for NDIS participants can also be analysed, although these data are limited in the capture of information about the actual use of services.
- Activity reported nationally through the Community Mental Health Care (CMHC) National Minimum Data Set (NMDS) was not in-scope, as this largely relates to services delivered by clinicians.
- Most residential mental health services reported through the Residential Mental Health Care (RMHC) NMDS are not in scope for psychosocial support. Key informants indicated that 24-hour staff residential services were not in-scope. There is optional reporting to the national data collection of residential mental health services that are not staffed for 24 hours a day.
- At the state and territory level the consultations identified several client level data collections. However, for most other psychosocial support services it is more realistic to expect information on the nature of the psychosocial support provided as aggregate data counts such as number of clients supported and services provided, with a breakdown by age group and other characteristics.
- The total value of grants to NGOs by states and territories is reported in the Mental Health Establishments (MHE) NMDS. However no further detail is available. Collection of aggregate data on NGO supported services is not consistent across the states and territories. NGOs supported by state authorities in Queensland and Western Australia currently report data and aggregate activity using the **Mental Health Non-Government Organisation Establishments National Best Endeavours Data Set** (NGOe NBEDS). Text Box 3 sets out the taxonomy used for describing services through the NGOe NBEDS. Other states and territories indicated that they would have access to aggregate activity counts for supported NGOs.

Text Box 3: Service taxonomy used in the NGOe NBEDS

- Counselling—face-to-face
- Counselling, support, information and referral:
 - Telephone
 - Online
- Self-help—online
- Group support activities
- Mutual support and self-help
- Personalised support:
 - Linked to housing
 - Other
- Staffed residential services
- Family and carer support Individual advocacy
- Care coordination
- Service integration infrastructure
- Education, employment and training
- Sector development and representation
- Mental health promotion
- Mental illness prevention

Outside of government there are several initiatives that have been identified including the Assisting Communities through Direct Connection (ACDC) Project, and projects in mental health service mapping undertaken by the University of Canberra and Professor Luis Salvador-Carulla.

To progress this step to the next stage the following will be undertaken:

- **Analyses based on client level data:** Data requests will be prepared for analysing the national data sources (including the PMHC-MDS and RMHC) and the selected state/territory level services. The tables generated from these analyses will yield aggregated counts. However, these tables can be constructed to be relevant to questions addressed for this project. For example, the data requests can be specified to filter data to ensure the analyses align with the definition of psychosocial supports defined for this project and generate counts of number of clients supported, number of services provided by modality (using an appropriate measure such as occasions of service or days) by relevant dimensions such as:
 1. SA3 of the service location
 2. SA3 of the client's residence
 3. Type of psychosocial support being accessed
 4. Age group
 5. NDIS participation

Separate data governance processes will need to be undertaken for each data request. The data requests will be for aggregate data rather than client level data.

- **Analyses based on aggregate data:** Data requests will be prepared for each state and territory and relevant national bodies requesting information related for funded organisations (principally NGOs). The data request will align with the NGOe NBEDS. The data request will focus on data related to:
 1. Organisation name
 2. Funded service name
 3. Financial year to which data supplied related
 4. Funding provided during that year
 5. A description of the funded service using the service taxonomy shown in Text Box 2.
 6. SA3 of the service location
 7. SA3s that are in the main catchment for the service
 8. Target age group(s) for the service

9. Total number of individual clients supported in the most recent financial year
10. Number of individual clients by NMHSPF age groups
11. Number of clients who are NDIS participants.
12. Number of clients who identify as Aboriginal or Torres Strait Islander.
13. Number of carers supported through the service
14. Number of individual client contract
15. Number of group client contract

It is recognised that the aggregate data described above, is unlikely to be available for all organisations and services funded by the states and territories. Additionally, some modification to the structure of the request will be required for certain types of services. To address missing or incomplete data there are two options:

- a. The analytic workflow could incorporate steps to address missing and incomplete data.
- b. A survey is conducted through which NGOs are approached directly (through the relevant state authority). The survey will aim to obtain more granular data than is available from states and territories. It is also an opportunity to capture information about psychosocial supports that are supported through other funding sources.

The analysis of the collated data will need to address how the collated data is to be interpreted. For example:

- Some individual clients receive psychosocial support from more than one organisation.
- An approach to assigning clients to levels of severity/care profiles will be required.
- Clients of services will be assigned to an SA3.

The approach to these issues will be further refined later in this project and brought to the PPG for consideration.

At the end of the Step 2 an estimate will be generated of the number of people receiving psychosocial supports outside the NDIS, together with an estimate of the average of hours being delivered and level of funding associated with that support. The analysis will identify areas of uncertainty in these estimates and be accompanied by sensitivity analysis of any assumptions applied in generating the estimates.

Workshop questions:

6. Are there additional data sources that reflect current level of access to psychosocial supports that should be considered?
7. What are your views on directly surveying NGO providers of psychosocial supports?

Step 3: Estimate level of unmet need

Step 1 outlined how we will estimate the total number of people requiring psychosocial support outside the NDIS and the level of their need for psychosocial support based on the NMHSPF, broken down into the levels of severity and age groups used to define care profiles within the NMHSPF.

Step 2 will generate estimates of people currently receiving psychosocial support. These estimates will be broken down into the levels of severity and age groups used to define care profiles within the NMHSPF.

In Step 3 we will compare the estimates from Step 1 and Step 2 to calculate the gap between these for people within the moderate and severe levels of severity. This can be expressed as an estimate of the number of people who are not currently accessing any psychosocial support. The analysis will also allow estimation of the resource gaps.

Data visualisation

The results of the analysis from this project will be incorporated into a report and associated tables that will be provided to the Department and the PPG in March 2024. In addition, an interactive data visualisation tool will be prepared that will give users access to maps, tables and charts that of the results. The visualisation tool will provide users the ability to select all or a subset of the data (for example related to the level severity) and visualise summary statistics for various geographic areas such as SA3, LHN or PHN.

The Round 2 consultations and Workshop 2 will provide an opportunity for stakeholders to review design and functionality of the data visualisation tool.

Appendix A: Prevalence estimates from the National Mental Health Services Planning Framework

Table 5: Prevalence of mental illness by age group, level of severity and care profiles

Age group (years)	Severity	Care profile	Prevalence per 100,000 people	
			Non-Indigenous	Indigenous
0 to 4	Mild	Mild	3,141	4,711
	Moderate	Moderate	2,152	3,228
		Severe - standard	705	2,115
	Severe	Severe - complex	705	2,115
	Top-up	Respite	165	495
5 to 11	Mild	Mild	5,219	7,829
	Moderate	Moderate	2,435	3,653
		Severe - standard	599	1,797
	Severe	Severe - complex	599	1,797
	Top up	Respite	165	495
12 to 17	Mild	Mild	7,861	15,722
	Moderate	Moderate	5,169	10,337
		Severe - standard	843	2,107
	Severe	Severe - complex	1,264	3,161
		First Episode Psychosis – Intensive	185	464
		First Episode Psychosis – Maintenance	35	88
	Top up	Respite	165	412
18 to 24	Mild	Mild	9,576	19,247
	Moderate	Moderate	6,019	12,097
		Severe - standard	1,185	3,556
	Severe	Severe - complex	1,174	3,523
		Perinatal mental illness	71	214
		First episode psychosis – intensive	400	1,201
		First episode psychosis – maintenance	76	227
	Top up	Intense ISR	80	240
Respite		165	495	
25 to 64	Mild	Mild	8,638	17,362
	Moderate	Moderate	5,411	10,876
		Severe - standard	1,925	7,509
	Severe	Severe - complex	631	2,460
		Perinatal mental illness	75	291
	Top up	Intense ISR	80	312
	Respite	94	368	
65+	Mild	Mild	5,985	11,491
	Moderate	Moderate	3,733	7,168

Age group (years)	Severity	Care profile	Prevalence per 100,000 people	
			Non-Indigenous	Indigenous
	Severe	Severe – standard	1,015	1,725
		Severe – complex	435	739
	Top up	Intense ISR	72	122
		Respite	284	483
65+BPSD	Mild	Mild	465	1,163
	Moderate	Moderate	130	325
	Severe	Severe – complex	401	1,003

Notes: BPSD: Behavioural and Psychological Symptoms of Dementia; ISR: Individual Support and Rehabilitation

Prevalence estimates for mental disorders in the NMHSPF are developed for severity groups and age groups. For the age groups of 12 to 24 years and older, prevalence estimates for Australia were derived from the Global Burden of Disease (GBD) study 2017. The GBD estimates are described further in a following section of this Appendix. NMHSPF Technical Appendix¹¹ provides details of the steps used to apply the GBD estimates to the Framework:

1. Estimates of prevalence by age and mental disorder diagnosis are taken from GBD.
2. The GBD estimates are adjusted as follows:
 - a. Adjust point prevalence estimates for major depressive disorder and anxiety disorders to 12-month estimates using GBD adjustment factors.
 - b. Adjust schizophrenia prevalence estimates to represent overall non-affective psychosis prevalence estimates using an adjustment factor derived from the Survey of High Impact Psychosis.¹²
 - c. Adjust personality disorder prevalence estimates (which in GBD represent non-comorbid personality disorder prevalence) so that they represent all personality disorder prevalence, using an adjustment factor from the 1997 National Survey of Mental Health and Wellbeing.
 - d. Re-label conduct disorder cases over the age of 18 as antisocial personality disorder.
3. Use MH-CCP¹³ severity splits to divide cases in each diagnostic group and age group into different levels of severity (see below), as an indicator of service needs.
4. Sum across severity-specific estimates to obtain overall prevalence estimates by level of service need (regardless of specific diagnosis), adjusting for comorbidity between disorders.
5. Add in the estimated additional proportion of the population in each age group who would not have been captured by population mental health surveys (e.g., those with intellectual disability, dementia, living in residential aged care, or homeless) but have mental disorders.

The prevalence of mental illness for Aboriginal and Torres Strait Islander people is not available from representative samples of the Australian population. The NMHSPF applies multipliers to the estimates developed for the non-Indigenous population to obtain the estimates for the indigenous population. Multipliers vary by severity and age group, with values of the multipliers provided in Table 20 of the

¹¹ Diminic, S., Page, I., Gossip, K., Comben, C., Wright, E., Pagliaro, C., John, J., & Wailan, M. (2023). *Technical Appendices for the Introduction to the National Mental Health Service Planning Framework – Commissioned by the Australian Government Department of Health*.

¹² Morgan, V. A., Waterreus, A., Jablenskey, A., Mackinnon, A., McGrath, J. J., Carr, V., Bush, R., Castle, D., Cohen, M., Harvey, C., Galletly, C., Stain, H. J., Neil, A. L., McGorry, P., Hocking, B., Shah, S., & Saw, S. (2012). People living with psychotic illness in 2010: The second Australian national survey of psychosis. *Aust N Z J Psychiatry, 46*(8), 735-752.

¹³ The MH-CCP was a predecessor of the NMHSPF

Technical Appendices of the NMHSPF V4.3.¹⁴ An example is the multiplier for severe disease among people aged 25 to 64 years is 3.9. That multiplier is based on 2016-19 AIHW data on utilisation of public sector mental health services – specialised clinical mental healthcare.

Severity levels

The NMHSPF has a specific way of defining severity which may differ from other sources. In the framework “*SEVERE, MODERATE and MILD [categories] refer to the intensity of mental health service needs for people with a formally diagnosed mental illness, which is more closely related to role impacts and impairment in psychosocial functioning than clinical symptoms.*”¹⁵ The estimates of prevalence by severity group are derived by dividing “*the estimated total prevalence rate of mental illness in each diagnostic group (e.g. psychosis, affective disorders) and age group into different levels of severity of MILD, MODERATE and SEVERE illness*”.

Table 6 shows the definition of mild, moderate and severe as described in the glossary and Table 7 shows the percentage of people with a specific mental disorder that are classified as severe or moderate.

Table 6: Definitions of severity as described in the Technical Appendices of the NMHSPF V4.3¹⁶

Level of severity	Definition
Mild	People who have diagnosed mental illness that has a low impact on their day-to-day lives. For example, their mental illness does not impact heavily on their ability to attend school or work and maintain healthy relationships.
Moderate	MODERATE, as used in the NMHSPF, refers to people who have a diagnosed mental illness that has a moderate impact on their day-to-day lives. They may experience problems with psychosocial functioning that impede their ability to attend school or work, carry out household responsibilities or maintain healthy relationships.
Severe – standard	Refers to people who have a diagnosed mental illness that has a high impact on their day-to-day lives. They experience lower risks and/or fewer problems with their psychosocial functioning than those in the SEVERE - Complex category.
Severe – complex	Refers to people who have a diagnosed mental illness that has high impact on their day-to-day lives. They have severe, persistent, or episodic mental illness and many experience significant social and environmental stressors.

Table 7: Proportion of people with a mental disorder by severity level

Mental disorder	Age group	Severity level		
		Severe	Moderate	Mild
Anxiety, Affective disorders, ADHD, Eating disorder	All ages	14%	29%	57%
Personality disorders	All ages	3%	32%	65%
Psychosis	All ages	100%		
Behavioural and psychological symptoms of dementia	All ages	22%	29%	49%
Remainder	12 to 17	10%	26%	64%
	18 to 24	10%	25%	65%
	25 to 64	10%	25%	65%
	65+	9%	26%	65%

¹⁴ Diminic, S., Page, I., Gossip, K., Comben, C., Wright, E., Pagliaro, C., John, J., & Wailan, M. (2023). *Technical Appendices for the Introduction to the National Mental Health Service Planning Framework – Commissioned by the Australian Government Department of Health.*

¹⁵ Ibid.

¹⁶ Ibid.

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