

# Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme

Final report

Prepared by Health Policy Analysis

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# Acronyms and abbreviations

Acronyms and Abbreviations	Description
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
HPA	Health Policy Analysis
LHN	Local Hospital Network
LHD	Local Health District
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NMHSPF	National Mental Health Service Planning Framework
NSW	New South Wales
NT	Northern Territory
OOS	Occasions of Service
PHN	Primary Health Network
PPG	Psychosocial Project Group
QCMHR	Queensland Centre for Mental Health Research
Qld	Queensland
SA	South Australia
SA3	Statistical Area Level 3
SEWB	Social and emotional wellbeing
Tas	Tasmania

<b>Acronyms and Abbreviations</b>	<b>Description</b>
UQ	University of Queensland
Vic	Victoria
WA	Western Australia

# Terms used in this report

In this report, the term “**consumer**” has been used to refer to *a person who has used or may use a mental health service* (Australian Commission on Safety and Quality in Health Care, 2024). In some sections the term “client” has been used, which is preferred by some agencies. Both terms are used to refer to a person who has used a mental health service.

The term “**carer**” has been used to refer a person *who has responsibility for major aspects of the care of a family member or friend living with a mental health condition. A carer could also be colleagues and/or members of a shared community* (Mental Health Coordinating Council, 2020).

HPA have used the term “**severity**” to reflect the approach adopted within the National Mental Health Service Planning Framework (NMHSPF) (Australian Institute of Health and Welfare, 2022). The NMHSPF has a specific way of defining severity of a mental health condition, which may differ from other sources. In the NMHSPF, “severe”, “moderate” and “mild” 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.

- “**Severe**” mental illness refers to people with significant days out of role, who experience distress or impairment, and who are seen as requiring support from specialised mental health services. The NMHSPF also has subcategories that include “severe standard” and “severe complex”, which further differentiate individuals based on the complexity and intensity of care they may require.
- “**Moderate**” severity 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 psychological functioning that impede their ability to attend school or work, carry out household responsibilities or maintain healthy relationships.
- “**Mild**” severity refers to people who have a 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 and mild mental illnesses are expected to be largely managed in a primary care setting with limited input from specialist mental health services.

The term “**need**” has been used in this report to describe need at a system level rather than at an individual level, aligning with the NMHSPF. As described in the Introduction to the NMHSPF V4.3, “NMHSPF is modelled from a system-level perspective in order to calculate estimates of the overall resources required to meet the needs of a population group and does not provide individualised care pathways” (Diminic, Gossip, et al., 2023, p. 23).

# Executive summary

In its 2020 Inquiry Report into Mental Health, the Productivity Commission identified a large gap in Australia's provision of psychosocial supports and recommended further work be undertaken to estimate the extent of unmet psychosocial support needs at a regional and state/territory level (Productivity Commission's recommended action 17.3) (Productivity Commission, 2020b, p. 42).

This technical report provides detailed estimates of unmet psychosocial support needs in Australia. The methods used in developing these estimates are broadly consistent with those used in the Productivity Commission's Inquiry Report into Mental Health (2020b), including the use of the National Mental Health Service Planning Framework (NMHSPF).

## Why the analysis was undertaken

This technical report addresses a commitment made by the Australian Government and state and territory governments under section 128 of the *National Mental Health and Suicide Prevention Agreement* (the National Agreement) to undertake further analysis of psychosocial supports outside of the National Disability Insurance Scheme (NDIS), in response to the Productivity Commission's recommendation. The estimates generated from this analysis will inform further work on future arrangements, including roles and responsibilities, for psychosocial supports outside of the NDIS (section 127 of the National Agreement), which will also need to consider the recommendations of the Independent Review into the NDIS (2023) (the NDIS Review).

As part of the National Agreement governance structures, a Psychosocial Project Group (PPG) was established to steer the work. The PPG includes representatives from the Australian Government, state/territory governments, and a representative with lived experience of a mental health condition. On behalf of the PPG, the Australian Government Department of Health and Aged Care engaged Health Policy Analysis (HPA) in June 2023 to undertake unmet need analysis, with support from the Queensland Centre for Mental Health Research (QCMHR) at the University of Queensland (UQ) on the use of the NMHSPF.

## What the analysis aims to estimate

This technical report presents estimates of unmet need for psychosocial supports outside the NDIS for the 2022–23 financial year.

Unmet need is calculated by comparing 2022–23 estimates of the need for psychosocial supports using the NMHSPF, with estimates of the psychosocial supports delivered in 2022–23 in community mental health settings and funded by the Australian Government or state and territory governments, or the NDIS. The estimates are based on the agreed definition of psychosocial supports developed by the PPG for this analysis:

***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”. (Psychosocial Project Group, 2023)

They include services that assist people with mental illness to:

- manage daily living skills

- obtain and maintain housing
- identify client needs for other services (such as the NDIS, alcohol and other drug treatment services, clinical care), connect with and maintain engagement with these services
- socialise, build and maintain relationships
- engage, and maintain engagement, with appropriate education (including vocational skills) and employment opportunities.

In this analysis, the target cohort is people aged 12 to 64 years with moderate or severe mental illness and associated psychosocial impairment impacting on their functional capacity.<sup>1</sup> However, where possible, analysis relating to people older than 64 years and carers of the target cohort has also been presented.

This analysis presents point-in-time estimates of unmet need through two measures, broken down by state/territory:

1. the number of people not receiving psychosocial support services.
2. the gap between the hours of psychosocial support recommended within the NMHSPF, and the hours of psychosocial support estimated to be provided.

## How the analysis was undertaken

There were three main steps in the methodology for the unmet need analysis:

1. *Estimate need for psychosocial supports:* The number of people who would benefit from psychosocial support was estimated using the NMHSPF. The NMHSPF is an evidence-based framework that supports coordinated planning across Australia's mental health system, offering a comprehensive model of the mental health care required to meet population needs. The NMHSPF models the types and amounts of mental health care required for different population groups in care profiles. Using the care profiles from NMHSPF V4.3, the proportion of individual people within each care profile who need at least one psychosocial support service (defined as services within the 'Specialised Mental Health Community Support Services' stream of the NMHSPF Taxonomy) was estimated. This method is an update of that used by the Productivity Commission in its 2020 report.
2. *Estimate current psychosocial supports provision:* Current availability of psychosocial supports was estimated by collating and analysing data from the Australian Government and state and territory government-funded programs. A total of 63 Australian Government and state/territory government-funded programs were deemed in-scope by the PPG. Data related to NDIS participants with primary and secondary psychosocial disability was also analysed (see Section 3.3 for details).
3. *Estimate unmet need for psychosocial supports:* The number of people, within the target cohort, who are not receiving psychosocial supports was estimated by comparing the need for psychosocial support (step 1) with the current psychosocial supports provision (step 2).

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<sup>1</sup> Note that the Productivity Commission's target cohort was people with severe and persistent mental illness.

Stakeholders were engaged throughout the analysis via interviews, workshops, and requests for written feedback. An online workshop focused on methodology was held with key national stakeholders on August 18, 2023. Additionally, from February to March 2024, jurisdiction-specific stakeholder workshops gathered input on initial estimates of psychosocial need, service provision, and data assumptions and limitations. Appendix A provides details of the consultations and feedback.

## Key findings

### Step 1: Estimated need for psychosocial supports

In 2022–23, it is estimated in Australia that:

- 335,800 people aged 12–64 years **with severe mental illness** would benefit from 21.9 million hours of psychosocial support services. This reflects an increase of around 46,000 additional people compared to the Productivity Commission’s 2019–20 estimate of 290,000 people needing psychosocial supports.<sup>2</sup>
- A further 311,500 people aged 12–64 years **with moderate mental illness** would benefit from 3.3 million hours of psychosocial support services.

Note: Figures are rounded.

Figure 1 shows the key steps in using the NMHSPF V4.3 to estimate the number of people with a severe or moderate mental illness, who would benefit from psychosocial support services in 2022–23.<sup>3</sup>

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<sup>2</sup> The increase of around 45,000 (14%) is principally related to updates to the NMHSPF. The Productivity Commission analysis used NMHSPF V2, whereas the present analysis uses NMHSPF V4.3. Key changes between V2 and V4.3 include revised epidemiology estimates and enhanced psychosocial support service modelling for young people aged 12–24 years. See Step 1: Estimated psychosocial support need (p17) for further detail.

<sup>3</sup> It is noted that individuals with severe and moderate mental illness may also need other types of mental health care such as acute, sub-acute, and non-residential services, as well as support from community mental health teams. Additionally, the NMHSPF estimates that 20% of people within the moderate cohort will not need support from formal service providers within a 12-month period.

Figure 1: NMHSPF Version 4.3 steps in estimating the number of people with moderate or severe mental illness requiring psychosocial support services, Australia, 2022–23

	Level of severity:	
	Severe	Moderate
People with a mental illness (all ages)	686,000 <sup>(a)</sup>	1,598,000 <sup>(b)</sup>
People with a mental illness requiring psychosocial support (all ages)	398,000	394,000
People with a mental illness requiring psychosocial support, aged 12–64 years	336,000	311,000
Hours of psychosocial support required	21.9 million	3.3 million

Numbers are rounded to the nearest 1000. (a) Within the NMHSPF, not all people with a severe or moderate mental illness need some mental health services during a 12-month period, for example QCMHR at the UQ estimated that 40% of people aged 25 to 64 years with severe non-complex mental illness and (b) 20% of people with a moderate mental illness need some psychosocial support. Appendix B outlines the prevalence assumptions.

## Step 2: Assess current psychosocial support service provision

Psychosocial support service provision data was obtained for Australian Government and state and territory government-funded programs. A total of 63 government-funded programs delivered in community mental health settings were deemed in-scope by the PPG and included in the analysis. Data related to NDIS participants with primary and secondary psychosocial disability was also analysed.

### People with severe mental illness

In 2022–23, for people with severe mental illness, it is estimated that:

- Outside of the NDIS, around 43,700 people aged 12 to 64 years received psychosocial supports through:
  - Australian Government programs: 10,500 people (209,000 hours)
  - State and territory government programs: 33,200 people (3.05 million hours)
- Within the NDIS, around 61,600 participants aged 12 to 64 years received psychosocial supports through their individualised NDIS packages.

This estimate of consumers receiving psychosocial support services outside the NDIS—approximately 43,700—is significantly lower than the Productivity Commission's earlier estimate of 75,000, a difference of about 31,300 consumers. This discrepancy is primarily due to

methodological differences in estimating service provision. The Productivity Commission's analysis partly relied on program expenditure, while the current analysis used aggregated client data and employed a more detailed method to align to service types of the NMHSPF taxonomy and to the target cohort of this analysis.

The estimated number of NDIS participants with a severe mental illness accessing psychosocial supports through their individualised packages (around 61,600) aligns closely with the Productivity Commission's estimate, which projected that 64,000 individuals with a primary psychosocial disability would access individualised supports under the NDIS at full scheme (Productivity Commission, 2020c, p. 851).

#### People with moderate mental illness

In 2022–23, for people with moderate mental illness, it is estimated that:

- Outside of the NDIS, around 20,400 people aged 12 to 64 years received psychosocial support through:
  - Australian Government programs: 15,300 people (70,000 hours)
  - State and territory government programs: 5,100 people (203,000 hours)
- Within the NDIS, around 28,000 participants aged 12 to 64 years received psychosocial support through their individualised NDIS packages.

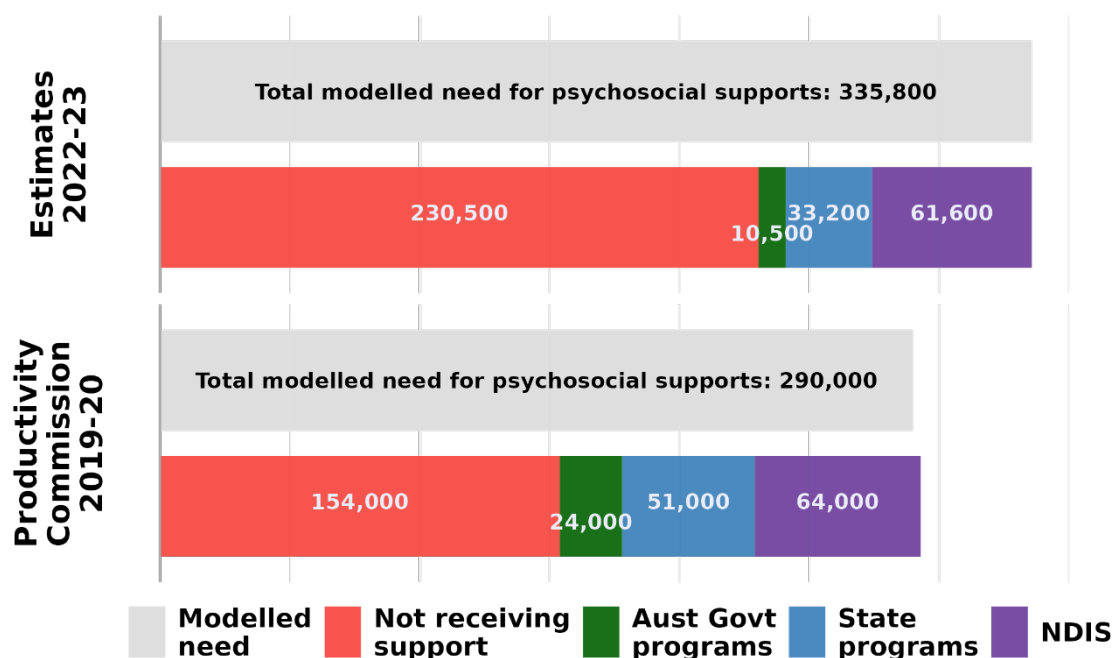
### Step 3: Estimated unmet need for psychosocial support

#### People with severe mental illness

In 2022–23, it is estimated that there were approximately 230,500 people with severe mental illness aged 12 to 64 years who required psychosocial support but were not receiving psychosocial support through the NDIS or other government-funded programs. The total hours of psychosocial support required for people with severe mental illness but not provided were estimated to be 14.07 million in 2022–23.

This unmet need estimate is higher—by around 76,500 people—than the Productivity Commission's estimate of 154,000 people (Figure 2). The increase in this analysis' estimate arises from both a higher number of people estimated as needing psychosocial supports (about 46,000 more people, compared to the Productivity Commission's estimate) and a lower number of consumers receiving support outside of the NDIS (about 31,300 fewer consumers, compared to the Productivity Commission's estimate).

Figure 2: Comparison of this analysis' estimates (2022–23) and the Productivity Commission's estimates (2019–20): psychosocial need, service provision and unmet need (severe mental illness, 12–64 years)



*Note: This analysis's figures are rounded to the nearest 100. Productivity Commission's estimates are also rounded, and therefore does not correspond exactly with the sum of the component figures.*

#### People with moderate mental illness

In 2022–23, it is estimated there were approximately 263,100 people with moderate mental illness aged 12 to 64 years who required psychosocial support but were not receiving psychosocial support through the NDIS or other government-funded programs. The total hours of psychosocial support required for people with moderate mental illness but not provided were estimated to be 2.76 million in 2022–23.

The Productivity Commission did not estimate unmet need for people with moderate mental illness. As such, comparisons have not been made between this analysis' estimates and the Productivity Commission for people with moderate mental illness.

Figure 3 shows the steps in deriving the unmet need estimates, for people with severe or moderate mental illness.

Figure 3: Steps in estimating unmet need for psychosocial support services and results by level of mental illness severity, 2022–23

		Level of severity:	
		Severe	Moderate
<b>Step 1</b>	Estimated need for psychosocial support (aged 12-64 years)	335,800	311,500
<b>Step 2</b>	Estimated psychosocial supports consumers – <i>within NDIS</i> (aged 12-64 years)	- 61,600	28,000
<i>Subtract step 2 from step 1</i>	Estimated psychosocial supports consumers – <i>outside NDIS</i> (aged 12-64 years)	- 43,700	20,400
<b>Step 3</b>	Estimated unmet need for psychosocial supports (aged 12-64 years)	230,500	263,100

Numbers are rounded to the nearest 100.

## Limitations

It is recognised this analysis has several key limitations, which are elaborated on in Chapter 6:

- The analysis does not account for a broader range of services available through Australian Government and state or territory government programs that may have impacts on the need for psychosocial services.
- Planned programs yet to be implemented, or that commenced during the 2022–23 reference year, are not accounted for.
- The data used varies in detail and quality and that data provided by jurisdictions are not always directly comparable.
- It is also acknowledged that while only non-clinical programs were analysed in this report, clinical services may also include psychosocial supports.
- NMHSPF has a health sector lens rather than a rights-based conceptualisation preferred by many people with lived experience. NMHSPF models the amount of support and resourcing required in an ideal service system. It does not measure the effectiveness of existing service delivery or advise on specific workforce training requirements, implementation guidance for local service models or monitoring of quality and safety within services.
- NDIS participants' needs (which were excluded in the calculations of unmet need) may not be completely met through the NDIS.
- The report does not address whether the psychosocial support provided meets individual needs adequately nor does it include cost estimates for addressing identified gaps.
- There are also gaps in robust data analysis for First Nations people, and needs of other specific population groups were not separately analysed. The lack of First Nations disability

data is a problematic limitation, based on anecdotal experiences of unmet need for this cohort.

- It will be essential that any future analysis should include expanded and diverse lived experience engagement and perspectives, noting there has been limited meaningful lived experience engagement due to the technical nature of the project.

## First Nations Social and Emotional Wellbeing programs

The Social and Emotional Wellbeing (SEWB) model of care for Aboriginal and Torres Strait Islander peoples encompasses connection to self, country, spirit, culture, community and kinship. SEWB programs provide a range of services to First Nations peoples with the aim of enhancing protective factors that support wellbeing. Services may include psychosocial-like supports, such as referrals to alcohol and other drug services and non-clinical therapies and counselling that build resilience and strengthen relationships and connection to family, kin and culture. SEWB services are most effective when they build on existing community, family and individual strengths and capabilities.

Due to a range of contextual factors, including data access, granularity (which is needed to disentangle psychosocial supports from the other services and supports provided through SEWB programs) and data sovereignty, this analysis has not been able to capture the range of SEWB programs that include psychosocial supports as part of their service offerings. It would also not be appropriate for this analysis to make arbitrary decisions about the proportion of SEWB programs that are psychosocial in nature, particularly given they vary across the country. There are also other relevant activities underway with a focus on SEWB services that are being managed through the [SEWB Policy Partnership](#) under the National Agreement on Closing the Gap.

# 1. Background and methods

## 1.1. Project background

The following definition of psychosocial supports (Text Box 1), developed by the Psychosocial Project Group (PPG) was adopted for this project.

### **Text Box 1: Definition of psychosocial supports and target cohorts for the purposes of the analysis**

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.

They include services that assist people with mental illness to:

- manage daily living skills
- obtain and maintain housing
- identify client needs for other services (such as the National Disability Insurance Scheme (NDIS), alcohol and other drug treatment services, clinical care), connect with and maintain engagement with these services
- socialise, build and maintain relationships
- engage, and maintain engagement, with appropriate education (including vocational skills) and employment opportunities.

### **Target cohort for psychosocial supports:**

In this analysis, the target cohort is people aged 12 to 64 years with moderate or severe mental illness and associated psychosocial impairment impacting on their functional capacity. However, where possible, analysis relating to people older than 64 years and carers of the target cohort has also been presented.

## Productivity Commission's Inquiry into Mental Health

In its 2020 Inquiry Report into Mental Health, the Productivity Commission described the importance of psychosocial supports in assisting people with mental illness:

*...[They] 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 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.” (Productivity Commission, 2020b, p. 42)*

The Productivity Commission's report was prepared in the first half of 2020, and at that time psychosocial support was in a “state of transition as the NDIS roll out was in progress” (Productivity Commission, 2020c, p. 827). For March 2020, the Productivity Commission reported that 34,000 people with severe and persistent mental illness were covered by the NDIS, a further 24,000 were covered by transitional Australian Government programs, and 51,000 were supported through state- or territory-funded programs (Productivity Commission, 2020b, p. 42). The Productivity Commission reported using estimates of need from the National Mental Health Service Planning Framework (NMHSPF):

*Estimates from the NMHSPF suggest that about 690,000 people with mental illness would benefit from some type of psychosocial support in 2019–20. Among them are 290,000 people with severe and persistent mental illness who are most in need of psychosocial support (Productivity Commission, 2020c, p. 827).*

*But there is a massive gap in Australia’s provision of psychosocial supports. Only about 34,000 people with a primary psychosocial disability receive psychosocial supports under the NDIS (just over 50% of those expected to be eligible once the scheme completes its roll out); and about 75,000 people receive psychosocial support directly from other Australian, State and Territory Government-funded programs (Productivity Commission, 2020b, p. 42)*

The Productivity Commission estimated that “[w]hen the NDIS roll out is completed, about 64,000 people with the highest psychosocial needs would access individualised supports through the NDIS” (Productivity Commission, 2020c, p. 827). In a later section, the Productivity Commission refers to these 64,000 people as being those “with a primary psychosocial disability” (Productivity Commission, 2020c, p. 844).

The Productivity Commission estimated that by that time, a further “75,000 people [will] receive such support from Australian, State and Territory Government funded programs ...[leaving a gap of] up to 154,000 people ...[not able] to receive the services they require, based on current policy settings” (Productivity Commission, 2020c, p. 844).

The Productivity Commission’s (2020a, p. 238) estimate of the number of people who are supported outside of the NDIS (approximately 75,100) is based on:

- 2016–17 estimates of the number of people supported by Australian, state and territory government-funded programs (90–95,000) (Department of Health, 2017).
- State and territory recurrent expenditure on grants to non-government organisations for specialised mental health services in 2017–18 (Australian Institute of Health and Welfare, 2020, table EXP.3)
- Information about funding for transitional psychosocial support programs funded by the Australian Government at that time: National Psychosocial Support Transition (NPS-T), National Psychosocial Support Measure (NPS-M) and Continuity of Support (CoS) (Department of Health, 2020).
- The number of people being supported on NPS-T (Department of Health, personal communication 1 May 2020).
- Unpublished acceptance rates data for previous Australian Government-funded community mental health programs: Partners in Recovery, Personal Helpers and Mentors Service and Day to Day Living programs.

The Productivity Commission recommended that further work be undertaken to estimate needs at a regional and state/territory level (Productivity Commission’s recommended action 17.3 refers).

## National Mental Health and Suicide Prevention Agreement

Following the Productivity Commission's report, the *National Mental Health and Suicide Prevention Agreement* (the National Agreement) was signed by Australian Government, state and territory governments. The National Agreement came into effect 8 March 2022 and will expire on 30 June 2026. The National Agreement committed the parties to working together "to support and implement a whole-of-government approach to mental health and suicide prevention" (section 7). Section 127 and 128 of the Agreement specify steps to "to develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS" (see Text Box 2).

### Text Box 2: National Mental Health and Suicide Prevention Agreement

127. The Parties will work together to develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS.

128. To inform future arrangements, the Parties agree to undertake further analysis of psychosocial supports outside of the NDIS, to commence within the first twelve months from the commencement of this Agreement and be completed as soon as possible within the first two years of this Agreement. This work will include:

- a. Developing and agreeing a common definition for psychosocial support that builds on the work already being undertaken through the NMHSPF, or other nationally agreed frameworks.
- b. Estimating demand for, compared to current availability of, psychosocial supports outside of the NDIS according to the agreed common definition. This will be achieved by:
  - i. Comprehensive state-based mapping of all current psychosocial support services outside of the NDIS, led by the States and supported by the Australian Government;
  - ii. Sharing of appropriate and relevant data, including from the NDIS (subject to applicable NDIS legislation and associated definition of 'psychosocial disability'); and
  - iii. State-based analysis of the target cohort and demand for psychosocial supports outside of the NDIS, compared to current availability, to be jointly undertaken by the Parties through information sharing about funding, commissioning, services and clients.

## Psychosocial Project Group

To progress this work and other issues related to psychosocial support, the **Psychosocial Project Group (PPG)** was established in September 2022 (Department of Health and Aged Care, 2023). The PPG includes a representative with lived experience of a mental health condition and representatives from the Australian, state and territory governments. To address the commitment under section 128(a) of the National Agreement, the PPG developed a definition of psychosocial supports and target cohorts for the purposes of the analysis, shown in Text Box 1 above.

The PPG also initiated actions to address the commitment under section 123 (b) of the Agreement. The Australian Government Department of Health and Aged Care (the Department), working on behalf of the PPG, engaged Health Policy Analysis (HPA) to assist with developing estimates of the level of unmet need for psychosocial supports outside the NDIS. The Department also engaged the Queensland Centre for Mental Health Research (QCMHR) at the University of Queensland (UQ) to provide expert advice on the NMHSPF, which is an important input to estimation of needs for psychosocial support.

PPG members, HPA and QCMHR worked collaboratively to undertake the work described in section 123 (b) of the National Agreement. The work involved national and jurisdiction consultations,

compiling data from multiple sources, analysing these data and preparing a report. Details of the methods for developing estimates of unmet need are described in section 1.3.

In undertaking this work, the methods have followed the general approach taken by the Productivity Commission. Estimates of need have been updated and more detailed information on the provision of psychosocial supports has been collated and analysed. This report extends beyond the estimates included in the Productivity Commission report in the following ways:

- The Productivity Commission focused on people with severe mental illness (aged between 12 and 64 years). The estimates provided in this report have been extended to include people in the same age group with moderate mental illness severity.
- The Productivity Commission presented a national estimate of unmet need for psychosocial support. In this report, estimates are also provided at a state and territory level.
- The Productivity Commission included estimates of people supported outside the NDIS by Australian Government, state and territory government programs, to some extent based on analysis of psychosocial program expenditures. This report includes a more detailed analysis of people supported outside the NDIS and the psychosocial support services delivered under Australian Government, state and territory government programs, based largely on analysis of aggregated client data.

In this report, gaps in available data have been identified and areas of uncertainty highlighted. The report includes comprehensive documentation of these issues and an assessment of the sensitivity of estimates to key assumptions that have been required in analysing available data (see Chapter 5).

It should be emphasised that the analysis undertaken for this project does not consider the impact of any future reforms to the NDIS, including the establishment of foundational supports outside the NDIS as recommended in the 2023 Independent Review of the NDIS (the NDIS Review). The findings of this project, together with the NDIS Review and broader disability and health reforms, will help inform governments' consideration of future psychosocial supports for people whose needs are not supported by the NDIS.

## 1.2. Report structure

The report is structured as follows:

- **Chapter 1** provides a background to the work undertaken and describes the methods used.
- **Chapter 2** details the approach for **estimating the need for psychosocial services** (step 1). Estimates of the number of people with mental illness who require psychosocial support have been developed based on the NMHSPF. Estimates of need were developed for levels of mental illness severity and age group.

The chapter also includes estimates of the number of people with mental illness who require psychosocial support aged 65 years and over.

The psychosocial needs of carers of people requiring psychosocial support have also been estimated and are described in this Chapter.

- **Chapter 3** provides the assessed **volume of psychosocial service activity delivered** (step 2) by state and territory governments (section 3.1), Australian Government programs (section 3.2) and the estimated number of NDIS participants with psychosocial supports needs (section 3.3).
- **Chapter 4** presents the estimates of unmet need for psychosocial supports (step 3).

- **Chapter 5** includes sensitivity analysis around the assumptions that were required for developing estimates of unmet need, exploring how changes in these assumptions may affect the estimates of unmet need.
- **Chapter 6** describes limitations of the analysis undertaken in this project and initiatives that could be taken to improve the data sources available for estimating unmet need for psychosocial support in future efforts.

## 1.3. Project methods

### Deliverables

HPA was engaged in June 2023 to deliver:

- A detailed analysis of the number of people with severe mental illness needing psychosocial supports at the Statistical Area Level 3 (SA3) or more granular level, using the NMHSPF.
- A detailed analysis of the number of people with severe mental illness already accessing psychosocial supports at the SA3 or more granular level through state/territory psychosocial programs, the Commonwealth Psychosocial Support Program and the NDIS.
- A high-level analysis of the number of people with moderate mental illness needing psychosocial supports at the SA3 or more granular level, using the NMHSPF.
- A high-level analysis of the number of people with moderate mental illness already accessing psychosocial supports at the SA3 or more granular level through Australian Government, state and territory government programs and the NDIS.
- A report presenting a final SA3 or more granular level analysis of unmet need for psychosocial supports outside the NDIS, with a detailed analysis for people with severe mental illness, and a high-level analysis for people with moderate mental illness.
- A final report, containing details of the modelling methodology and any underlying model assumptions. It should also include a comparison with the Productivity Commission's modelling, explaining any differences and why they came about.

In undertaking the analysis of Australian Government, state and territory psychosocial programs, it emerged that data on place of residence of the consumers of psychosocial support services was not always available. Data was more often available on the location of the service delivering psychosocial support. It was concluded that applying assumptions around place of residence at the SA3 level was problematic. Consequently, it was agreed with the PPG that in meeting points b, d and e of the deliverables for this project, the geographic analysis would not be undertaken at the SA3 level and was instead undertaken and presented at the national and state/territory levels.

Further, it was originally envisaged that the final report would be accompanied by a data visualisation tool to enable geospatial analysis with interactive maps. However, given the data limitations, particularly the shift away from SA3 level of analysis coupled with limitations of a visual tool in conveying the complexity of the analysis – the PPG decided not to progress with a data visualisation tool.

The project has been undertaken in five stages between July 2023 and May 2024 (Figure 4).

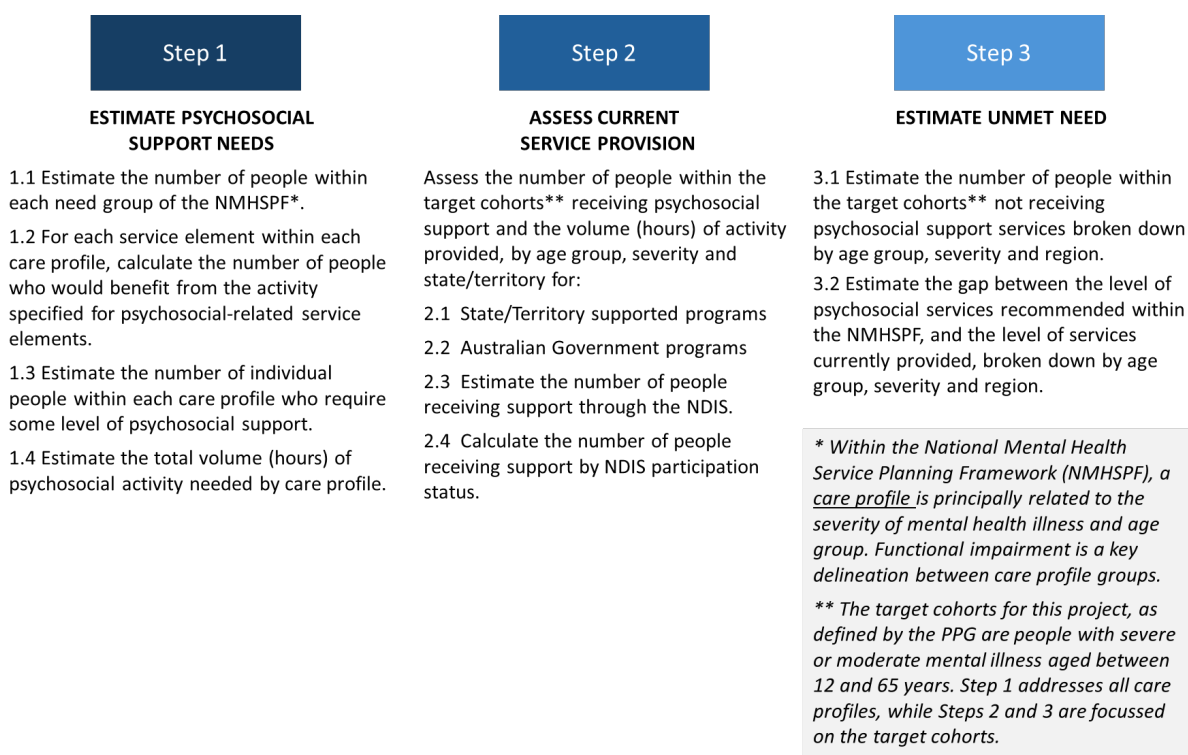
Figure 4: Project stages and timeline

Project stage	2023						2024				
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

1. Project governance												
2. Project methods												
3. Preliminary analysis												
4. Refined analysis												
5. Final analysis												

Figure 5 provides an overview of the methods for estimating unmet need for psychosocial support for this project.

Figure 5: Overview of methods to estimate unmet need for psychosocial support



## Step 1: Estimated need for psychosocial supports

Step 1 of the project involved estimating need for psychosocial support. Following the Productivity Commission's approach, and reflecting the National Agreement provisions, this project also used the NMHSPF as the starting point for estimating need. The NMHSPF is an epidemiological planning model for mental health services in Australia, combining estimates of population mental health needs and care requirements to estimate the numbers of people, services, workforce, and costs required to deliver adequate mental health care across the system nationally by geographic area. Version 4.3 of the NMHSPF was used, which was released in June 2023. The Productivity Commission used Version 2 in its 2020 Mental Health Inquiry Report.

The estimates of psychosocial support need are higher than previous estimates generated for earlier years from the NMHSPF Version 2. In addition to the increasing Australian population over time, there are several changes to the modelling in NMHSPF Version 4 that have affected these estimates, such as significantly enhanced care profile modelling of psychosocial support services for young adults, adolescents and children, and changes to the epidemiology estimates of need for mental health services, particularly for mild to moderate mental illness in adults. Of note is that a broader

range and number of consumer psychosocial support services have been modelled for people aged 12 to 24 years in NMHSPF Version 4.3 compared with Version 2, leading to increased estimates of consumer psychosocial support need in youth age groups, especially for non-severe populations.

Later versions of the NMHSPF and the associated planning tool have used the revised population estimates and projections issued by the Australian Bureau of Statistics (ABS) in 2018 (see Section 2.1 of this report). The Productivity Commission used earlier population estimates and applied a general population increase to bring estimates up to later years.

For Step 1.1, 1.2 and 1.3, HPA worked closely with the QCMHR. The QCMHR undertook additional manual analysis, building on the NMHSPF, to extract consumer counts. The NMHSPF includes 'unique' estimates of consumers needing services at the care profile population level. Within each care profile, proportions of the need group are modelled as requiring different types of services (service elements), such as Individual Support and Rehabilitation, or Individual Peer Support. These service elements all fall within Stream 2: Specialised Mental Health Community Support Service of the NMHSPF, which was the selected as in scope for this analysis. However, when each line of a care profile (each line reflecting a different service type) are added together they will generally sum to more than 100% of the people within the care profile as it is expected that most people require multiple types of supports. Therefore, the NMHSPF and its associated Planning Support Tool cannot reliably calculate numbers of individual people requiring specific service types or groups of service types (such as psychosocial support). The QCMHR has previously developed a method for determining whether lines in a care profile represent the same or different people and for manual calculation of these person counts outside the NMHSPF's Planning Support Tool. The QCMHR report on this analysis is reproduced in Appendix C of this report.

Building on earlier NMHSPF analyses, the QCMHR team analysed care profiles from the NMHSPF V4.3 and separated the number of consumers across all ages and severity levels requiring psychosocial support services, and separately the number of consumers who have a carer/family member(s) requiring psychosocial supports.

The proportion of people was determined at the care profile level as a percentage of the total care profile population. Rules for how these proportions were determined are documented in Appendix C1.

Consideration was also given to care profiles related to "top-ups" where they identified additional carers/family members with a psychosocial support need.

Percentages of each care profile population estimated as requiring psychosocial support were then applied to population data to yield estimates at the SA3 level, which could be aggregated to state and territory, PHN and LHN (with some additional calculations required for SA3s that lie across PHN or LHN boundaries).

The PPG required in this analysis the inclusion of "People aged 12 to 65<sup>4</sup> years (split into 12 to 24 and 25 to 65<sup>4</sup> year old cohorts) with mental illness and associated psychosocial impairment impacting on functional capacity."

In Step 1, the volume of psychosocial support services required was also estimated for the target cohorts. The primary measure used for volume of services is hours of support required.

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<sup>4</sup> 12–65 years refers to up to but not including 65 years.

Psychosocial support needs for carers were also estimated using the NMHSPF V4.3.

## Step 2: Assess current psychosocial service provision

In Step 2, data on psychosocial services was requested from states and territories, various Australian Government agencies and the National Disability Insurance Agency (NDIA). Before issuing data requests, consultations were held with each agency to discuss which programs or initiatives fell under the PPG definition of psychosocial supports and the nature of data available for the program. Information about the program or initiative was also sought. To help guide decisions on inclusion of programs, additional exclusion criteria were developed and agreed by the PPG in November 2023 (see p38). To ensure a consistent approach of inclusion and exclusion of programs, an approach to handling issues identified in consultation were agreed upon by the PPG in March 2024 (Table 16). The final list of programs included can be found in Appendix D and excluded programs in Appendix E.

The data requests were structured to obtain information on:

- The nature of the program, including target groups in terms of age and severity of mental illness.
- Funding provided through the program.
- Organisations funded.
- Location of service delivering the services.
- Number of individual consumers supported by age group, First Nations status, NDIS participation, and place of residence.
- Number of individual carers supported.
- Number of occasions of service provided and hours of support provided.

Specific data requests were created for the NDIA and relevant Australian Government agencies, as well as with state or territory agencies.

Data was obtained from the NDIA on NDIS participants for whom either a primary or secondary psychosocial disability had been identified. The data included information on the SA3 of residence for the participant, age group, and summaries of expenditures under NDIS plans, broken into the core support, capacity building and capital categories. For each of these categories, data was provided for average annual committed support and the total payments made. Following a range of consultations, HPA determined a method to assign NDIS participants to a severe or moderate severity level. The details and rationale for this approach is described further in section 3.3.

Following the issuing of data requests, further consultations were held with each agency to discuss issues around the request. Data was received from between December 2023 and April 2024. The data were analysed, and clarifications followed up with agencies.

While best efforts have been made to align the types of psychosocial support programs included in the analysis with the NMHSPF, it is acknowledged that jurisdictions each have different programs and service systems, which mean that data provided by jurisdictions are not directly comparable and some programs delivering components of psychosocial supports have been excluded.

The analysis estimated the unmet need for psychosocial services for people with severe or moderate mental illness. Service providers tend not to collect information that would allow their consumers to be allocated to a severity group but generally they are funded to provide services to a particular cohort. Each jurisdiction provided information on the target cohort of each program. If the target cohort was people with moderate and severe mental illness, 50% of the clients and 50% of the hours

were allocated to these groups, unless stakeholder feedback suggested otherwise. For the Australian Government data (other than the two Clubhouses) it was assumed that 40% of clients had a severe mental illness and those with a severe mental illness received 4 times the number of hours of service than those with a moderate mental illness. For the two clubhouse programs it was assumed all clients had a severe mental illness. Further details on the assumptions made in this analysis can be found at Appendix F.

### Step 3: Estimated unmet need for psychosocial supports

Unmet need was estimated by comparing the need for psychosocial supports (step 1) with the current psychosocial supports provision (step 2). This analysis presents point-in-time estimates of unmet need through two measures, broken down by state/territory:

1. the number of people not receiving psychosocial support services.
2. the gap between the hours of psychosocial support recommended within the NMHSPF, and the hours of psychosocial support estimated to be provided.

Additionally, sensitivity analysis was undertaken to assess how changes in assumptions affect the estimates of unmet need (see Chapter 5).

### Stakeholder consultation

Stakeholders were 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 were undertaken:

- **Round 1:** This focused on obtaining data from custodians, understanding and interpreting that data, and on developing analytical methods. A national external stakeholders online Methodology Workshop was held on 18 August 2023 that focused on analytical methods.
- **Round 2:** This round was originally scheduled for late 2023 but occurred in February and March 2024. The focus of these consultations was on obtaining feedback on an initial estimate of need for the jurisdiction and initial analyses of data on provision of psychosocial support within the jurisdiction. Within each jurisdiction, two workshops were held, one with policy advisers and data custodians and a second with external stakeholders from the jurisdiction. The workshops also provided an opportunity for HPA to test assumptions and their interpretation of data and gain further clarity on the nature of psychosocial supports funded by the jurisdiction.
- **Round 3:** Following the jurisdictional workshops, an additional PPG workshop was held, which addressed the consistency with which jurisdictions had interpreted the definition of psychosocial supports. Exclusion criteria had previously been agreed by the PPG in November 2023 (see page 38), but further work was required to maximise consistency. At this workshop, the PPG agreed to additional criteria to inform in and out of scope services. Following the PPG workshop, each jurisdiction was consulted to work through the implications of these criteria. The additional criteria were subsequently agreed by the PPG (see Table 16).

A final online national external stakeholder session was held on 22 March. This involved 8 people with lived experience of mental health conditions and representatives from national stakeholder groups. Australian Government programs that had been identified as offering psychosocial support services and preliminary results from the analysis were reviewed. State and territory stakeholders did not participate in the final national stakeholder workshop.

Table 1 outlines the key consultation aims and dates of when each of these were held.

Table 1: Key consultation aims and dates

Consultation	Aim	Date held
Round 1: Interviews with each jurisdiction – methodology (internal stakeholders)	<p>To obtain an understanding and interpret data from relevant custodians and develop the methods of analysis.</p> <p>Two rounds of consultation (interviews) were undertaken with jurisdictional health authorities, Australian Government departments and agencies regarding the psychosocial support services they deliver, manage, and/or commission.</p>	July to November 2023
Round 1: National Methodology Workshop (external stakeholders)	For national key stakeholders to consider the draft methodological roadmap for how the technical aspects of the analysis are proposed to be undertaken – including key steps, assumptions, and data sources.	18 August 2023
Round 2: Initial analysis consultation (internal stakeholders)	Prior to the jurisdictional stakeholder workshops, an initial analysis consultation was undertaken with data custodians/program managers from state/territory health authorities to seek their feedback on the initial analysis, test interpretation and assumptions made, in addition to identifying any data gaps and possible strategies to address those gaps.	22 January – 6 February 2024
Round 2: Jurisdiction workshop 1 (internal stakeholders)	<p>To obtain feedback from internal stakeholders of the state/territory health authorities on the refined analysis of draft estimates of need and service provision in the state/territory, and an early data visualisation tool. The workshops were an opportunity for HPA to:</p> <ul style="list-style-type: none"> <li>• Provide an overview of the analysis.</li> <li>• Test interpretation and validate results of the analysis of local service provision data.</li> <li>• Discuss assumptions used and face validity of local service provision data and identify any required sensitivity analysis.</li> <li>• Demonstrate an early data visualisation tool and seek feedback on design and functionality.</li> </ul> <p>The general methodology adopted for the project was presented, but the primary focus was on reviewing specific questions related to the analysis for the jurisdiction.</p>	12 – 26 February 2024
Round 2: Jurisdiction workshop 2 (external stakeholders)	<p>To obtain feedback from broader state/territory-specific stakeholders on the refined analysis of draft estimates of need and service provision in the state/territory. The workshops were an opportunity for HPA to:</p> <ul style="list-style-type: none"> <li>• Provide an overview of the analysis.</li> <li>• Test interpretation and validate results of the analysis of local service provision data.</li> </ul>	12 February – 20 March 2024

Consultation	Aim	Date held
	<ul style="list-style-type: none"> <li>Discuss assumptions used and face validity of local service. provision data and identify any required sensitivity analysis.</li> </ul> <p>The general methodology adopted for the project was presented, but the primary focus was on reviewing specific questions related to the analysis for the jurisdiction.</p>	
Round 3: Workshop to finalise the list of included programs (PPG only)	<p>The aims of this workshop were to:</p> <ul style="list-style-type: none"> <li>Review the definition of psychosocial support developed by the PPG and, after discussion, identify any refinements to the list of examples included in the definition.</li> <li>Review the PPG's definition's alignment with the NMHSPF service streams and service elements.</li> <li>Review programs the state and territory governments and the Australian Government had nominated for inclusion and identify any issues and approaches to achieving consistency.</li> </ul>	12 March 2024
Round 3: National stakeholder session (external stakeholders)	<p>Delivered to national stakeholders including representatives from peak bodies, national non-government organisations and lived experience representative to:</p> <ul style="list-style-type: none"> <li>Provide an overview of the analysis.</li> <li>Present examples of draft extracts of need and service provision estimates relating to Australian Government-funded psychosocial support services.</li> <li>Discuss limitations and common issues raised in jurisdictional workshops.</li> </ul>	22 March 2024

## 2. Estimated need for psychosocial support (Step 1)

This chapter describes the results from the first three components in Step 1 of the methodology (Figure 5). Estimates presented in this report are based on the 2022–23 financial year.

### 2.1. Population

The population data used for estimating need are those used in the NMHSPF V4.3. In the NMHSPF V4.3 the populations for the 2022–23 financial year are based on projections for 30 June 2023, that is, the end of the financial year. These data are based on Australian population projections issued by the ABS in 2018 (Australian Bureau of Statistics, 2018b), supplemented by additional analysis undertaken by the Australian Institute of Health and Welfare (AIHW) (2022).

The population data used for the NMHSPF Planning Support Tool (PST) V4.3 for 30 June 2023 are shown in Table 2. In 2018, the ABS projected that Australia would have 27,147,000 people in June 2023.

Table 2: Projected Australian population by age group, rurality and First Nations status based on the NMHSPF Planning Support Tool V4.3, June 2023

Region and First Nations status	Australian population		Proportion by age group (%)					
	June 2023							
	'000	%	00–04	05–11	12–17	18–24	25–64	65+
<b>Rural</b>								
Indigenous	434.4	1.6%	11.1%	14.5%	12.0%	11.8%	44.0%	6.6%
Non-Indigenous	4,694.6	17.3%	5.5%	8.3%	7.2%	6.6%	49.6%	22.7%
<b>Urban</b>								
Indigenous	483.0	1.8%	11.3%	14.3%	12.6%	13.6%	42.8%	5.4%
Non-Indigenous	21,535.2	79.3%	6.4%	8.5%	7.1%	9.4%	52.8%	15.8%
<b>Total</b>	<b>27,147.2</b>	<b>100.0%</b>	<b>6.4%</b>	<b>8.6%</b>	<b>7.3%</b>	<b>9.0%</b>	<b>52.0%</b>	<b>16.7%</b>

Table 2 also includes projections for urban versus rural regions, First Nations status and age group. These subpopulation estimates are important inputs for the NMHSPF calculations because they are multiplied by the prevalence to obtain the estimated number of people with a need. Population data from the NMHSPF V4.3 has also been used to develop estimates at the national, state/territory, PHN, LHN and SA3 geographical levels.

In September 2023, the ABS updated estimates of resident populations for June 2022 (Australian Bureau of Statistics, 2023b) and in November 2023 the ABS released revised population projections for Australia for states and territories and capital cities (Australian Bureau of Statistics, 2023a). Unfortunately, these later data do not provide information by all the subcategories required to update the NMHSPF estimates in full. Therefore, the analysis presented in this report is based on the

population data used for the latest version of the NMHSPF Planning Support Tool V 4.3. In Chapter 5 sensitivity analysis of the results is presented, including the potential impact of revisions to population data.

## 2.2. Number of people within each need group

The starting point for the NMHSPF is the estimated or projected population followed by estimates of the rates of mental illness per 100,000 people within each of the relevant subpopulations (see Appendix B). The NMHSPF contains three levels of severity of mental illness (mild, moderate, and severe). Table 3 presents these levels of severity as described in the Technical Appendices of the NMHSPF V4.3 (Diminic, Page, et al., 2023). Rates are estimated for each combination of age group, severity and First Nations status. The severe group is further divided into ‘Standard’ and ‘Complex’, using proportions developed from analyses undertaken in earlier versions of the NMHSPF.

Step 1

ESTIMATE PSYCHOSOCIAL  
SUPPORT NEEDS

1.1 Estimate the number of people within each need group of the NMHSPF.

Table 3: Levels of severity of mental illness as defined in the NMHSPF V4.3

Severity	Description
Mild	Mild, as used in the NMHSPF, refers to 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– Complex	Severe – Complex, as used in the NMHSPF, 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.
Severe – Standard	Severe – Standard, as used in the NMHSPF, 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

Source: Diminic, Page, et al. (2023).

People are considered to have a severe mental illness if they have a diagnosed mental illness that has a high impact on their day-to-day lives. Their illness is categorised in the NMHSPF as complex if their mental illness is severe, persistent or episodic, and they may experience significant social and environmental stressors. It is categorised as standard if they have lower risks and/or fewer problems with their psychosocial functioning than those in the complex category (Diminic, Page, et al., 2023). The Severe-Standard group includes young people experiencing a first episode of psychosis, mothers with severe mental illness during the 12 months following giving birth, and people aged 65 years or

older in sub-acute hospitals or residential aged care facilities. Terminology and classification used in the NMHSPF may differ from those used by other government services, including the NDIS.

Multiplying the rates of mental illness by each population group yields an estimate of the number of people in that population who have a mental illness. These subpopulations are referred to as need groups, and mostly contain mutually exclusive groups of people with mental illness. These need groups have corresponding care profiles in the NMHSPF, which describe the level of care required to appropriate support consumers. It could be said that care profiles are tailored to different population groups defined by age, location, and level of service needs.

In addition to care profiles related to levels of severity, the NMHSPF includes some additional care profiles. These include:

- Prevention related care profiles, which include people who do not currently have a mental illness but may be targeted for prevention.
- Top-ups, which are standalone resource estimates not associated with any one need group, and they may apply to any individuals in any other care profiles. Top-ups relate more to service provision and are discussed in more detail below. The mental health service consumers who require support under a top-up care profile are also counted within the mental illness severity groups. The QCMHR has advised that top-up care profiles should be assumed to apply to consumers with severe mental illness.

Table 4 shows estimates of the Australian population who have a mental health service need in 2022–23, by severity. The Table also includes the target populations for the prevention care profiles (people who are not currently experiencing mental illness). The first row of the Table shows the Australian population estimate. Based on the NMHSPF V4.3, it is estimated that in 2022–23:

- An estimated 15.3% of the Australian population had some level of mental illness that demands some mental health services (4.164 million people).
- An estimated 7.4% of the Australian population experienced a mental illness (moderate (4.9%) or severe (2.5%) mental illness) that requires some mental health services (2.023 million people).

**Table 4: The number of people estimated to have a mental health service need and target populations for prevention, by age group, 2022–23**

Group	Severity	Population		Distribution across age group (%)					
		% of total	N '000	00–04	05–11	12–17	18–24	25–64	65+
Population total	-	100.0%	27,147	6.4%	8.6%	7.3%	9.0%	52.0%	16.7%
Without a current mental health service need	Prevention	4.6%	1,241	6.0%	16.3%	20.4%	5.7%	45.7%	5.9%
With a current mental health service need	Mild	7.9%	2,142	2.6%	5.9%	7.7%	11.5%	58.5%	13.8%
	Moderate	4.9%	1,337	2.9%	4.4%	8.1%	11.6%	58.7%	14.3%
	Severe	2.5%	686	4.0%	4.6%	7.3%	11.5%	59.2%	13.4%
	<b>Total</b>	<b>15.3%</b>	<b>4,164</b>	<b>2.9%</b>	<b>5.2%</b>	<b>7.8%</b>	<b>11.5%</b>	<b>58.7%</b>	<b>13.9%</b>

*Total includes the severity groups of mild, moderate and severe (does not include prevention).*

## 2.3. Number of people within each care profile needing psychosocial support

For each care profile within the NMHSPF, a range of services are modelled to meet the needs of the population (need groups) during a 12-month period. Services within the NMHSPF are grouped according to a taxonomy (Diminic, Gossip, et al., 2023). The levels of the taxonomy and a short description are in Table 5. The second level of the taxonomy relates to **service streams**. There are six service streams. Standalone psychosocial supports fall under one service stream: **Specialised Mental Health Community Support Services**. For this report, only services that fall within this stream are considered to meet the PPG’s definition of psychosocial support.

Within the **Specialised Mental Health Community Support Services** stream, there are several service categories (third level of the taxonomy) and service elements (fourth level of the taxonomy).

For each service element, the NMHSPF identifies the proportion of people within a care profile who need that service element. This may be all people in the care profile, but this is often not the case. **Individual people within a care profile may need multiple service elements in a service stream.** The NMHSPF does not directly identify the number of people in a care profile who need at least one service element within a service stream. Consequently, there is a need for an approach to address multiple counting of individuals across service elements.

The QCMHR used its expertise with the NMHSPF to address this issue and generated a set of rules to identify the proportion of individual people within each care profile who need at least one service element within the Specialised Mental Health Community Support Services stream. The method used by the QCMHR was an updated version of that used in analyses undertaken to support the previous Productivity Commission’s estimates. The QCMHR Report on the Estimated numbers of people needing psychosocial supports is at Appendix C.

The analysis below describes the results of applying these assumptions and arriving at an estimate of individual people requiring psychosocial supports.

### Step 1

#### ESTIMATE PSYCHOSOCIAL SUPPORT NEEDS

1.2 For each service element within each care profile, calculate the number of people who would benefit from the activity specified for psychosocial-related service elements.

1.3 Estimate the number of individual people within each care profile who require some level of psychosocial support.

Table 5: Levels of the taxonomy that defines types of services

Name	Level of taxonomy	Description
Service Group	First	There are two service groups that divide the services into either population-based universal services or services tailored to individual needs.
Service Stream	Second	The only service stream that includes standalone psychosocial services is specialised mental health community support services.

Name	Level of taxonomy	Description
Service Category	Third	There are a series of categories within each service stream. These categories help group similar service elements and activities together.
Service Element	Fourth	Used to model service needs in the care profiles. Each service element relates to a specific aspect or type of mental health care. For example, there are service elements for different types of Structured Psychological Therapies (SPT) including SPT – Brief Intervention, SPT Low Intensity Intervention, SPT – Individual, and SPT – Family.
Service Activity	Fifth	Sub-types of a service element. For example, within the service element Care Coordination and Liaison, there is a service activity for Rural Therapy Liaison.

Table 6 shows the number of individual people (consumers) with mental illness (or within prevention target groups), who required psychosocial supports. This is broken down by severity and age group. There are no consumers identified in the 0 to 11 years age group, as the NMHSPF identifies psychosocial support needs for carers within this group rather than the consumers themselves. Figure 6 summarises the relevant data for the target cohorts identified for this project.

In 2022–23 it is estimated there were 311,500 people with moderate mental illness aged 12 to 64 years who required psychosocial support and 335,800 people with severe mental illness aged 12 to 64 years who required psychosocial support, a total of 647,300 people (rounded to the nearest 100). Outside these target groups the NMHSPF indicates there were an additional 362,200 people who would benefit from psychosocial support, including 144,500 aged 65+ years, 123,100 people with mild severity mental illness and 94,600 people in the prevention need groups.

Table 6: Number of consumers who require psychosocial supports, Australia, 2022–23

Severity	Individuals by consumer's age group (n)				Total	Aged 12–64
	12–17	18–24	25–64	65+		
Without current mental illness						
Prevention	71,640	22,960	0	0	94,590	94,590
With current mental illness						
Mild	49,360	73,740	0	0	123,100	123,100
Moderate	54,100	100,410	156,990	82,040	393,540	311,500
Severe	39,440	73,500	222,860	62,420	398,220	335,800
Total	142,900	247,650	379,860	144,460	914,860	770,400

*Total includes people in mild, moderate and severe severity groups and does not include people in the prevention care profiles.*

Figure 6: Steps in estimating the number of people with mental illness, by level of severity of mental illness, aged 12 to 64, requiring psychosocial support services, based on the NMHSPF, Australia, 2022–23

	Level of severity:	
	Severe	Moderate
People with a mental illness (all ages)	686,000 <sup>(a)</sup>	1,598,000 <sup>(b)</sup>
People with a mental illness requiring psychosocial support (all ages)	398,000	394,000
People with a mental illness requiring psychosocial support, aged 12-64 years	336,000	311,000
Hours of psychosocial support required	21.9 million	3.3 million

Numbers are rounded to the nearest 1000. (a) Within the NMHSPF, not all people with a severe or moderate mental illness need some mental health services during a 12-month period, for example QCMHR at the UQ estimated that 40% of people aged 25 to 64 years with severe non-complex mental illness and (b) 20% of people with a moderate mental illness need some psychosocial support. Appendix B outlines the prevalence assumptions.

Table 7 shows estimates of people aged 12 to 64 years with severe or moderate mental illness requiring psychosocial support by the state or territory in which they reside. The Table also shows a breakdown of estimates for the subgroups within the severe mental illness category.

Table 7: Consumers aged 12–64 years with moderate or severe mental illness who require psychosocial supports by state of residence, 2022–23

State/territory <sup>2</sup>	Severity group		Severe subgroups <sup>1</sup>	
	Moderate	Severe	Severe standard	Severe complex
NSW	98,880	106,950	59,370	47,580
Vic	80,970	84,860	47,140	37,720
Qld	64,050	69,500	38,490	31,000
WA	31,950	34,900	19,350	15,550
SA	19,880	21,260	11,790	9,470
Tas	6,050	6,770	3,750	3,020
ACT	5,560	5,830	3,240	2,590
NT	4,160	5,740	3,190	2,550
<b>Total across states/territories</b>	<b>311,500</b>	<b>335,810</b>		

<sup>1</sup>The sum of the severe subgroups may not equal the total due to rounding.

<sup>2</sup>The total across states may not equal the total for Australia as it excludes people living in "Other territories".

## 2.4. Estimated volume of activity needed

The NMHSPF Version 4.3 provides the basis for estimating the volume of psychosocial supports required for the target population. Several measures of service activity are provided within the NMHSPF, including hours of support and occasions of service required per annum.

### Service needs of consumers

Services in the NMHSPF are classified into service categories and service elements. The estimate of consumer service requirements used for this project is based on the service categories related to supports provided to consumers, which are described in Table 8 (Comben et al., 2023). Later sections discuss service categories related to carers and the *Residential Crisis and Respite Services* category, which also form service categories for this NMHSPF stream.

Table 8: Specialised Mental Health Community Support Services stream:

Service categories and service elements related to consumers

Service category	Service element	Description
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. <b>This is a non-clinical service.</b>
	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.
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.

Source: Comben et al. (2023)

Step 1

### ESTIMATE PSYCHOSOCIAL SUPPORT NEEDS

1.4 Estimate the total volume (hours) of psychosocial activity needed by care profile

Data on psychosocial services (that is the Specialised Mental Health Community Support Services Stream) were extracted from a modified version of Report 7A from the online NMHSPF-PST 4.3. This provided a count of the psychosocial services required. Information on volume of services was extracted as **occasions of service (OOS)** and **hours of client demand**.

Table 9 shows the number of hours of psychosocial support suggested by the NMHSPF for people aged 12 to 64 years with moderate or severe mental illness. The Table shows hours of support by level of mental illness severity. The Table also includes requirements for the top-up care profiles, as these are principally related to people with moderate or severe mental illness.

In 2022–23, a total of 21.9 million hours of psychosocial support was required for people with severe mental illness and 3.3 million hours of psychosocial support was required for people with moderate mental illness. This comprises of the hours of support recommended for Individual and Group Support and Rehabilitation, Individual and Group Peer Work and top-ups for the severe group only.

In the NMHSPF, these specific top-ups are modelled for people with severe and complex mental illness requiring a high intensity of support.

Table 9: Hours of support ('000) required by people aged 12–64 years  
with moderate or severe mental illness, 2022–23

Severity	Support & Rehabilitation ('000)		Peer Work ('000)		Total ('000)
	Individual	Group	Individual	Group	
Moderate	1,730	-	478	1,081	3,289
Severe	9,068	320	3,243	1,358	21,849*
Top-up	7,860	-	-	-	-
<b>Total</b>	<b>18,659</b>	<b>320</b>	<b>3,721</b>	<b>2,439</b>	<b>25,139</b>

\* Severe total includes "Top-up".

Table 10 shows estimates of hours of support required by state or territory of residence for people aged 12 to 64 years with moderate or severe mental illness.

Table 10: Hours of service ('000) required by state of residence, for people aged 12–64 years with moderate or severe mental illness, 2022–23

Severity	Support & Rehabilitation ('000)		Peer Work ('000)	
	Individual	Group	Individual	Group
NSW	5,946	102	1,189	779
Vic	4,742	82	940	630
Qld	3,839	65	766	494
WA	1,935	33	382	252
SA	1,180	20	237	155
Tas	374	6	75	48
ACT	326	5	65	43
NT	317	6	66	38

Severity	Support & Rehabilitation ('000)		Peer Work ('000)	
	Individual	Group	Individual	Group
<b>Total</b>	<b>18,659</b>	<b>320</b>	<b>3,721</b>	<b>2,439</b>

## Service needs of carers

The NMHSPF also provides a basis for estimating the service needs of carers. The service categories and elements for carer support are shown in Table 11. Table 12 shows the estimates of hours of support for carers of people with a moderate or severe mental illness. Overall, 1.9 million hours of carer psychosocial support was required over a 12-month period in 2022–23, of which 0.4 million relates to support provided by peer workers (individual and group peer support), 0.8 million for day and flexible respite support and 0.7 million for other individual, group and family support services.

Table 11: Specialised Mental Health Community Support Services stream:

### Service categories and service elements [related to carers](#)

Service category	Service element	Description
Family and Carer Support	Flexible Respite, Day Respite, Family Support Services, Group Carer Support Services, 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.
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.
Individual Support and Rehabilitation Services	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 Carer Peer Support.
Group Support and Rehabilitation Services	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 Carer Peer Support.

Source: Comben et al. (2023)

Table 12: Hours of support ('000) required by carers of consumers aged 12–64 years with moderate or severe mental illness, 2022–23

Severity	Family and carer support			
	Day and flexible	Individual and group	Other <sup>1</sup> ('000)	Total ('000)
	Respite ('000)	based peer work ('000)		
Moderate	-	70	221	291
Severe	-	341	493	833
Top-up	769	-	-	769
<b>Total</b>	<b>769</b>	<b>411</b>	<b>713</b>	<b>1,893</b>

<sup>1</sup>Other includes individual, group, and family support services; residential crisis and respite services are in Table 13.

## Residential crisis and respite care

*Residential Crisis and Respite Services* form an additional service category under the Specialised Mental Health Community Support Services stream (see Table 11). These services are in addition to the residential care service categories identified in the *Specialised Bed Based Mental Health Care Services* stream, which includes service categories for non-acute and sub-acute residential services. As discussed, the Specialised Bed Based stream is not in-scope for psychosocial support.

*Residential Crisis and Respite Services* category is assigned to a top-up care profile. Consequently, a split of activity across other severity groups is not feasible. The QCMHR has advised that top-up care profiles should be assumed to fall into severe levels of mental illness. Additionally, these services are not split between whether they relate to the consumer or carer.

The activity measures for this service element include bed days and separations. It is assumed that separations (or episodes) have an average length of stay of 10 days. Table 13 shows the number of days of residential crisis and respite care required related to consumers aged 12 to 64 in 2022–23. Across Australia it is estimated that there is a need for around 138,000 bed days related to around 13,800 separations in 2022–23. Two states reported data on residential crisis and respite care.

Table 13: Number of days of residential crisis and respite care required for consumers aged 12–64 years by state and territory, 2022–23

State/ territory	Ages 12–64			
	12–17	18–24	25–64	Total
NSW	6,859	8,588	28,313	43,761
Vic	5,301	7,022	22,825	35,149
Qld	4,850	5,774	18,086	28,709
WA	2,349	2,757	9,298	14,404
SA	1,412	1,729	5,617	8,758
Tas	473	517	1,809	2,800
ACT	347	526	1,517	2,389

State/ territory	Ages 12–64			
	12–17	18–24	25–64	Total
NT	338	449	1,567	2,354
<b>Total</b>	<b>21,930</b>	<b>27,362</b>	<b>89,033</b>	<b>138,325</b>

<sup>1</sup>Totals may be slightly different due to other extracts, the level of geography requested and rounding.

## 2.5. First Nations people

First Nations peoples have greater need for mental health services than non-Indigenous Australians (Diminic, Page, et al., 2023, p. 52). This report was unable to estimate the unmet need for psychosocial services for First Nations people because data on First Nations status is not captured sufficiently well across all the programs included in this analysis that provided psychosocial services. However, it is worth noting that the consumers of the psychosocial support programs being counted in the analysis (at Step 2) are inclusive of people with Aboriginal and/or Torres Strait Islander background accessing support via these programs.

Table 14 shows the number of distinct consumers with a severe mental illness who require psychosocial support and the number of hours of psychosocial support required, by First Nations status, in 2022–23. The Table shows that 37,400 First Nations people with a severe mental illness, aged 12–64 years, required psychosocial supports. This figure represents around 11.1% of the total people with severe mental illness, aged 12–64 years, who required psychosocial supports in 2022–23. It also shows that 2,387,800 hours of psychosocial support are required for First Nations people with severe mental illness, aged 12–64 years, in 2022–23. This represents 10.9% of the total hours required for all people, aged 12–64 years, with severe mental illness in 2022–23.

Table 14: Number of people who require psychosocial support and hours of psychosocial support needed for people in Australia with severe mental illness, by First Nations status, 2022–23

Age group (years)	First Nations people			Non-Indigenous Australians		
	Population	Distinct <sup>1</sup> People	Hours of psychosocial support needed	Population	Distinct <sup>1</sup> People	Hours of psychosocial support needed
12–24	218,200	14,700	670,300	4,196,200	98,200	4,383,200
25–64	395,600	22,600	1,717,500	13,706,200	200,200	15,079,000
65+	45,300	1,500	86,900	4,470,400	60,900	3,926,200
<b>12–64</b>	<b>613,800</b>	<b>37,400</b>	<b>2,387,800</b>	<b>17,902,400</b>	<b>298,400</b>	<b>19,462,200</b>
<b>Total</b>	<b>659,100</b>	<b>38,900</b>	<b>2,474,700</b>	<b>22,372,800</b>	<b>359,300</b>	<b>23,388,400</b>

<sup>1</sup>Distinct consumers who require some psychosocial support; Number of hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported.

Table 15 shows the number of distinct consumers with a moderate mental illness who require psychosocial support and the number of hours of psychosocial support required, by First Nations status. The Table shows that 23,700 First Nations people with a moderate mental illness, aged 12–64 years, required psychosocial supports in 2022–23. This represents 7.6% of the total people with a moderate mental illness, aged 12–64 years, who required psychosocial supports in 2022–23. First

Nations people with a moderate mental illness, aged 12–64 years, required 280,000 hours of psychosocial support in 2022–23. This is 8.5% of the total hours of psychosocial support required for all people aged 12–64 years with a moderate mental illness in 2022–23.

Table 15: Number of people who require psychosocial support and hours of psychosocial support needed for people in Australia with moderate mental illness, by First Nations status, 2022–23

Age group (years)	First Nations people			Non-Indigenous Australians		
	Population	Distinct <sup>1</sup> People	Hours of psychosocial support needed	Population	Distinct <sup>1</sup> People	Hours of psychosocial support needed
12–24	218,200	15,000	228,100	4,196,200	139,500	2,119,700
25–64	395,600	8,600	51,900	13,706,200	148,300	890,000
65+	45,300	2,100	10,100	4,470,400	80,000	372,100
<b>12–64</b>	<b>613,800</b>	<b>23,700</b>	<b>280,000</b>	<b>17,902,400</b>	<b>287,800</b>	<b>3,009,800</b>
<b>Total</b>	<b>659,100</b>	<b>25,800</b>	<b>290,200</b>	<b>22,372,800</b>	<b>367,800</b>	<b>3,381,900</b>

<sup>1</sup>Distinct consumers who require some psychosocial support; Number of hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported.

### 3. Assess current psychosocial service provision (Step 2)

Psychosocial services are funded by Australian, state and territory governments. Through these programs, non-government organisations (NGOs) may be funded, although in some circumstances psychosocial services are delivered by government operated services. To identify programs (or parts of programs) that are within scope of the definition of psychosocial services, HPA engaged with the relevant health authorities in each of the states and territories, and program managers at an Australian Government level. These consultations identified data available and the approach through which psychosocial support could be identified within the data sets. Data requests that were issued reflected these consultations.

This chapter presents descriptions and analysis of psychosocial support programs managed by state and territory governments and the Australian Government, which is Step 2 of the methodology for this project. Appendix D provides a list of all programs included in this analysis.

#### Data requests and assumptions

HPA received data from the Australian Government and all state and territory governments. The Australian Government, states and territories were asked to describe the programs and their target populations, and provide information on the location of the service, and catchment SA3s for the service. Activity data was requested on counts of individual clients, hours of service, occasions of service and total funding for the service. First Nations status for clients and NDIS participation status were also requested.

The level of detail provided varied between jurisdictions and assumptions were required to allocate the services to severity categories, the service categories within the NMHSPF, age groups and regions.

Severity of mental illness was assigned according to the target group severity reported for the program. In most instances state and territory programs targeted a single level of severity, and the most common was people with severe mental illness. Whereby a program targeted various levels of severity of mental illness, an estimated proportion of the service was assigned to the relevant severity, informed by key contacts at the state, territory or Australian Government where possible. If an estimate was unable to be provided, it was assumed the service was divided equally between targeting consumers with moderate or severe mental illness.

In most instances, states and territories were able to provide counts of clients by age group. Where age group was not available the nominated target age group for a program was used. Where the target age group extended across several age groups, an assumption was applied that clients will be equally spread across the target age groups.

The location of the residence of the clients receiving the psychosocial services was not reported in most instances. HPA requested information on the catchment area for a service, although this was not provided in many data returns. In cases where the jurisdiction did not provide the catchment, the suburb of the service location was used to assign clients to a geographic area.

## Waitlist data

The possibility of using consumer waiting list data for psychosocial programs to estimate unmet need was raised in the Methodology Workshop held in August 2023 and further discussed by the PPG. HPA explored the availability of these data and discussed its potential use with stakeholders.

It was found that most jurisdictions do not currently collect waiting list data from NGOs delivering psychosocial support programs. Gaining access to these data would require a specific data request to NGO service providers. PPG members reported on the limitations and inconsistencies in data on waiting lists data maintained by some NGOs.

The conclusion was that analysis of waitlist data was not feasible for this project. However, several jurisdictions were open to the idea of adding waiting list information to their NGO reporting requirements if this type of need analysis were to be maintained into the future. Those jurisdictions were also open to discussions and working towards minimum data set that could be built into their current NGO service partner reporting requirements.

## Data review and clarification of exclusion and inclusion criteria

### Initial exclusion criteria, November 2023

The starting point for consultations with agencies and program managers was the PPG definition of psychosocial support and the preliminary list of inclusions. Following receipt of information on programs that potentially fell within the definition, HPA drafted additional criteria to be used to exclude programs that may not fall within the scope of the definition. These additional criteria were put forward to the PPG in October 2023 and subsequently agreed in November 2023. The criteria were that programs would be excluded where the program:

- Was a once-off program based around a single event or point in time.
- Had a broad or non-specific target population and did not specifically target people with mental illness (e.g. programs involving psychosocial supports available for the general population). It was recognised that people with moderate or severe mental illness may receive support under these programs, but that these programs would fall outside the scope of the NMHSPF.
- Provides linkage/referral services only.
- Where services do not align with psychosocial supports as defined by the PPG.
- Is not yet operational or was not operational during 2021–22 or 2022–23.

### Data review

A first draft of the estimated psychosocial supports funded by the states and territories was prepared. This was shared with the jurisdictional staff and further consultations held to clarify issues. The focus of these consultations included to:

- Ensure services reported and included in the analysis met the definition of psychosocial services.
- Confirm that the psychosocial services reported were allocated to the service category within the NMHSPF.

- Confirm that the distribution of clients across age groups was appropriate, particularly where assumption based on the service target group were required.
- Obtain additional information that would assist in assigning consumers to an SA3 place of residence.
- Assess whether there might be double counting of individual consumers within the data, for example where a consumer received support from more than one funded service.
- Discuss missing programs and information.
- Discuss the relationship between consumers supported under state/territory programs and the NDIS.

## Further inclusion/exclusion criteria, March 2024

As described in section 1.3, jurisdictional workshops were held in February and March 2024, to work through the preliminary results. Further discussion was held with relevant stakeholders from state or territory health authorities on 12 March 2024 to establish a common approach to handle specific issues, with the aim of improving consistency on inclusion and exclusion criteria across Australian Government and state or territory funded programs. The recommended approaches to these issues were finalised at a PPG meeting held on 18 March 2024. Table 16 outlines the approaches that were decided.

Through this process, the states, territories and Australian Government decided to exclude certain programs from the analysis (see Appendix E for details on these programs).

One of the more difficult issues to be addressed in this process has been how to address the situation in which a service provides a mix of clinical and non-clinical support. The definition of psychosocial support excludes clinical services. The approach to addressing this issue is described in Table 16. However, it is important to highlight that in each jurisdiction there are components of psychosocial support delivered as part of other services such as clinical mental health multidisciplinary teams. These have not been included in this analysis, as needs for clinical mental health multidisciplinary teams are addressed through the *Primary and Specialised Clinical Ambulatory Mental Health Care Services* stream of the NMHSPF. It should be acknowledged that variation between regions in services delivered by clinical mental health multidisciplinary teams is likely to impact the level of need for psychosocial support.

Another issue was the approach to non-acute residential services, which are addressed in a separate stream of the NMHSPF. It was recognized, however, that there are additional psychosocial support services that are provided to people who are receiving non-acute residential care.

Following the 18 March meeting of the PPG, individual meetings were held with the Australian Government, states/territories, and HPA to confirm the final list of programs for each jurisdiction and apply the consistent approach to issues of inclusion. Jurisdictions were invited to submit revised data where necessary.

These additional consultations resulted in the exclusion of several programs that were previously included in HPAs analysis, a few additional programs being included, and an update of program descriptions and their target cohorts. Alignment with the NMHSPF stream *Specialised Mental Health Community Support Services* and the related elements of several services required further discussion with the QCMHR at the University of Queensland, in particular how the remaining in-scope residential or in-reach services aligned with the NMHSPF. As per advice from QCMHR, these services have been aligned with the service element *Individual Support and Rehabilitation* where applicable.

Despite effort to achieve consistency in the approach, the number of clients and total number of hours of psychosocial services provided to those clients varies between states and territories. This variation is not fully explained by the population of each jurisdiction, but a range of other factors are potentially relevant. For example, the nature of programs within some states may place a greater emphasis on consumers with complex severe mental health issue and provide a higher level of hours of support for these consumers.

The final list of programs included within the analysis can be found in Appendix D.

Table 16: Proposed handling of program inclusion issues from PPG meeting on 18 March 2024

Issue	Description	Psychosocial Project Group proposed handling
Clinical and non-clinical programs	Some government-funded programs contain both clinical and non-clinical psychosocial services. The analysis needs to consistently handle these types of services/programs.	<p>Overall, where the data can clearly show the psychosocial elements of these programs in isolation, this can be included in the analysis.</p> <p>Otherwise, these programs will be excluded from the analysis but described in contextual information in the report.</p> <p>Specifically, where a program involves a mix of clinical and non-clinical services, the following approach will be taken:</p> <ol style="list-style-type: none"> <li>In the absence of data on the mix for clinical and non-clinical, a “best fit” approach will be adopted in which the program is included as psychosocial support if it broadly aligns with the <i>Specialised Mental Health Community Support Services</i> stream of the NMHSPE.</li> <li>Where there is data available to separate clinical from non-clinical services and the clinical services component is significant, then data can be used to identify the activity that is primarily psychosocial.</li> <li>In other cases, where the program involves a mix of clinical and non-clinical services, and it is unclear whether the program (or components) should be included as “psychosocial support”, the program will be excluded. However, the final report will document relevant information about clients and services delivered under the program.</li> <li>Programs must also provide services to clients with moderate and/or severe mental illness (to align with the target cohort of the analysis).</li> </ol>
Counselling	Counselling can mean clinical therapeutic support or non-clinical supportive counselling, which is a function of many psychosocial services. The word ‘counselling’ or ‘counsellor’ can be interpreted in multiple ways. The analysis needs to consistently handle whether counselling is a type of psychosocial support.	<p>Counselling will not be considered a type of psychosocial support for the purposes of the analysis.</p> <p>Counselling elements of psychosocial programs, and the reason for their exclusion, will be noted in contextual information in the report.</p>

Issue	Description	Psychosocial Project Group proposed handling
First Nations Social and Emotional Wellbeing	First Nations Social and Emotional Wellbeing programs provide a range of supports, including psychosocial. However, it is difficult to disentangle psychosocial supports from other supports. Care is also needed to uphold data sovereignty when accessing certain data sources.	<p>Social and Emotional Wellbeing programs will be largely excluded from the analysis.</p> <p>Psychosocial elements of Social and Emotional Wellbeing programs, and the reason for their exclusion, will be outlined as contextual information in the report. Contextual information about Social and Emotional Wellbeing psychosocial supports will be developed in consultation with the National Indigenous Australians Agency and other stakeholders as necessary.</p>
Carers	Some jurisdictions provided data for carer support services which are being excluded on the basis that carers do not necessarily have a moderate or severe mental illness (per the target cohort of this analysis).	<p>Carer support programs will be excluded from the analysis.</p> <p>The modelled estimate of psychosocial need among carers (based on the NMHSPF) has been included in this report on p33. Carer-specific programs, where data was received, are outlined in Appendix E along with other out-of-scope programs. Whereby a program included in this analysis provides services to both consumers and carers, only the data relating to consumer counts and hours have been included.</p>
Phoneline based psychosocial supports	It is difficult to determine the nature and extent of psychosocial supports provided by phoneline services, and the severity of mental illness that callers may present with.	Phoneline based psychosocial supports will be excluded from the analysis unless the data clearly demonstrates that callers have moderate or severe mental illness.
Residential services	Some residential services fall into more acute, 24/7 bed-based settings, which were not in scope for the Productivity Commission's analysis. The analysis needs to consistently handle these types of services/programs.	<p>Specialised Bed Based Mental Health Care Services will be excluded from the analysis.</p> <p>To stay aligned with the Productivity Commission's analysis, the PPG agreed to limit in-scope services/programs to the <i>Specialised Mental Health Community Support Services</i> stream of the NMHSPF. This may include services that involve in-reach into residential care to provide psychosocial support.</p> <p>Programs must provide psychosocial services to clients with moderate and/or severe mental illness (to align with the target cohort of the analysis) in order to be considered in scope.</p>

Issue	Description	Psychosocial Project Group proposed handling
Individual advocacy	The analysis needs to consistently handle whether individual advocacy services are considered psychosocial supports.	<p>Programs where individual advocacy is the main focus will be excluded from the analysis.</p> <p>Where individual advocacy forms a small part of a predominantly psychosocial program or service, it may still be included (dependent on data availability and alignment with target cohort).</p>
Case management	The analysis needs to consistently handle whether case management services are considered psychosocial supports.	<p>Programs where case management is the main focus will be excluded from the analysis.</p> <p>Where case management forms a small part of a predominantly psychosocial program or service, it may still be included (dependent on data availability and alignment with target cohort).</p>
Alcohol and other drug services	Alcohol and other drug services programs provide a range of supports, including psychosocial. However, limited data collection makes it difficult to disentangle psychosocial supports from other services.	<p>Programs where alcohol and other drug services are the main focus will be excluded from the analysis.</p> <p>Where alcohol and other drug services form a small part of a predominantly psychosocial program or service, they may still be included (depending on data availability and alignment with target cohort).</p>
Eating disorders	Eating disorder programs provide a range of supports, including psychosocial. However, limited data collection makes it difficult to disentangle psychosocial supports from other services.	<p>Programs where eating disorder services are predominantly providing psychosocial supports will be included in the analysis if they provide services to clients with moderate and/or severe mental illness.</p> <p>Where eating disorder services are not predominantly providing psychosocial supports (e.g. primarily clinical services), these programs will be excluded from the analysis.</p>

## 3.1. State and territory psychosocial programs

This section provides estimates of consumers receiving psychosocial supports from state and territory government-funded programs that have been included in this analysis, together with estimates of the number of hours of psychosocial support provided. Appendix D provides the full list of all programs included within the analysis.

It is important to note that a broad range of additional programs were considered and assessed to be out of scope for this analysis. These have been listed and described in Appendix E. In the following sections, additional information is provided on the state and territory programs that have been included in this analysis. Following the consultations described above, several state programs were excluded from analysis based on agreed criteria (Appendix E). Some states have announced important initiatives that will bolster the level psychosocial supports but as these were not fully operational in 2022–23, they have not been included in this analysis. Additionally, data for some programs or services were not available, and where this was the case, the programs have been described.

The sections below include tables that show estimates of consumers receiving psychosocial supports under the various state and territory programs and the number of hours of support provided.

Appendix F outlines the assumptions applied in the estimates presented in this report about how consumers were allocated across severity and age groups.

### New South Wales

Table 17 describes the NSW Health-funded psychosocial programs included in this analysis.

Table 17: NSW Health-funded psychosocial programs included in this analysis

Program and description	Target population
<b>Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS)</b> programs provide community based psychosocial support to people with severe mental illness throughout NSW, to live and participate in the community including helping people to achieve their own, unique goals.	Consumers Severe mental health condition NSW 16 years and over
<b>HASI Plus</b> is a transitional mental health rehabilitation and recovery program. It provides integrated high intensity clinical and psychosocial supports (16–24 hours per day, seven days per week) with stable community-based fit-for-purpose accommodation to support people transitioning from hospital or prison to the community.	Consumers transitioning from inpatient to community care. Severe mental health condition Statewide Ages all (predominantly adult)
<b>Mental Health Community Living Supports for Refugees (MH-CLSR)</b> is an enhancement of the Community Living Supports program for refugees and	Consumers (Refugee and asylum seekers) Severe and Moderate mental

#### Step 2

##### ASSESS CURRENT SERVICE PROVISION

Assess the number of people within the target cohorts receiving psychosocial support and the volume (hours) of activity provided, by age group, severity and state/territory for:

2.1 State/Territory supported programs

2.2 Australian Government programs

2.3 Estimate the number of people receiving support through the NDIS.

2.4 Calculate the number of people receiving support by NDIS participation status.

Program and description	Target population
asylum seekers of any age who are experiencing psychological distress, mental ill health and/or impaired functioning.	health condition NSW Ages all
Program provides trauma informed, recovery-oriented, culturally safe, and responsive psychosocial supports	
<b>Youth Community Living Support Services (YCLSS)</b> provides community-based psychosocial support services to young people aged 16–24 years with severe and complex mental illness and their families, in areas of their life where they would like to make positive change.	Consumers Severe mental health condition NSW Ages 15–24

*Note: NSW data only includes large centrally-funded psychosocial support services. It does not include smaller, localised psychosocial supports that are funded by local health districts. This is primarily because these programs do not collect the level of data required to be included in the analysis.*

Table 18 shows there were around 4,730 consumers receiving psychosocial support from NSW programs in 2022–23, and they were receiving around 1,571,600 hours of psychosocial support. Table 19 shows the alignment of these estimates with the target cohorts for this analysis.

**Table 18: Number of consumers who received psychosocial support from a service funded under a NSW program and hours received, by program and age group, 2022–23**

Program	Consumers		Hours	
	12–64 years	Total*	12–64 years	Total*
Community Living Supports	1,430	1,540	409,700	440,100
Housing and Accommodation Support Initiative	2,430	2,690	875,400	970,100
Housing and Accommodation Support Initiative Plus	80	80	87,700	92,100
Mental Health Community Living Supports for Refugees	280	280	48,500	49,600
Youth Community Living Support Services	140	140	19,600	19,600
<b>Total</b>	<b>4,350</b>	<b>4,730</b>	<b>1,441,000</b>	<b>1,571,600</b>

*Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.*

**Table 19: Number of consumers who received psychosocial support from a service funded under a NSW program and hours received, by severity and age group, 2022–23**

Metric	Severity	Age group					Total*
		00–11	12–24	25–64	65+	(12–64)	
Consumers	Moderate	<11	10	120	<11	140	140
	Severe	<11	690	3,520	380	4,210	4,590
	<b>Total</b>	<b>&lt;11</b>	<b>710</b>	<b>3,640</b>	<b>380</b>	<b>4,350</b>	<b>4,730</b>
Hours	Moderate	100	2,500	21,700	400	24,300	24,800
	Severe	100	205,900	1,210,800	130,000	1,416,700	1,546,800
	<b>Total</b>	<b>200</b>	<b>208,500</b>	<b>1,232,500</b>	<b>130,400</b>	<b>1,441,000</b>	<b>1,571,600</b>

*Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.*

## Victoria

Table 20 describes the state-funded psychosocial programs included in the analysis provided by Victoria.

Table 20: Department of Health, Victoria-funded psychosocial programs included in this analysis

Program and description	Target population
<p><b>Early Intervention Psychosocial Support Response (EIPSR)</b> targets consumers who do not qualify for the NDIS or are waiting for an access decision and their NDIS plan to begin. The program delivers wellbeing supports for people with ongoing mental illness, unmet wellbeing needs and/or psychosocial disability. (10 Providers)</p>	<p>Consumers Severe, moderate mental health condition Vic Ages 16–64</p>
<p><b>Youth Outreach Recovery Support (YORS)</b> program delivers wellbeing supports for young people with ongoing mental illness, unmet wellbeing needs and/or psychosocial disability. This service is delivered in community-based settings. The aim of this program is to assist the young person to learn or re-learn skills and confidence for independent living, better cope with and manage their mental illness and support them to achieve healthy, functional lives. (7 providers)</p>	<p>Consumers Severe, moderate mental health condition and psychosocial disability Vic Ages 16–25</p>
<p><b>Youth Residential Rehabilitation/Recovery (YRR)</b> service provides psychosocial rehabilitation support to young people with a mental health condition and an emerging or existing psychosocial disability in a residential setting.</p> <p>The aim is to assist the young person to learn or re-learn skills and confidence for independent living, better cope with and manage their mental illness and support them to achieve healthy, functional lives. This service consists of both 24-hour and non-24-hour beds. (7 providers).</p> <p>It was agreed that the twenty 24-hour beds should be excluded from this analysis; the 139 non-24-hour beds remain included.</p>	<p>Consumers who:</p> <ul style="list-style-type: none"> <li>• have a disability that is attributable to a psychiatric condition and</li> <li>• have impairment or impairments that are permanent, or are likely to be permanent and</li> <li>• have an impairment or impairments that results in substantially reduced psychosocial functioning in undertaking one or more of the following activities: communication, social interaction, learning, self-care, self-management; and</li> <li>• have an impairment or impairments that affect their capacity for social and economic participation.</li> </ul> <p>Ages 16–25 years Vic</p>
<p><b>Mutual support and self-help (MSSH) services</b> provide information and peer support to people with a mental illness (who are not eligible for the NDIS) and/or their carers. Operates across Victoria (9 providers). The MSSH data provided in this report only includes a portion of the Eating Disorders programs delivered by Eating Disorders</p>	<p>Consumers Moderate to Severe mental health condition through Eating Disorders Victoria only (EDV). This program targets support to people with severe and enduring eating disorders. Adults 18+</p>

Program and description	Target population
Victoria (EDV). Other out-of-scope services have been excluded.	Vic
<b>Continuity of Support (CoS)</b> Ongoing continuity of support to current clients of MHCSS who have been identified as ineligible for the NDIS because they do not meet age or residency requirements. All clients who were eligible have now transitioned to the NDIS. No new clients will be eligible for COS.	Moderate to severe mental health condition  Consumers 16 years and over who were transitioned to CoS during roll-out of NDIS in Victoria. They were part of the mental health community support services assessed as having a psychosocial disability. They were not eligible for NDIS.

Table 21 shows there were around 3,870 consumers receiving psychosocial support from Vic programs in 2022–23, and they were receiving 474,700 hours of psychosocial support. Table 22 shows the alignment of these estimates with the target cohorts for this analysis.

Table 21: Number of consumers who received psychosocial support from a service funded under a Vic program and hours received, by program and age group, 2022–23

Program	Consumers		Hours	
	12–64 years	Total*	12–64 years	Total*
Continuity of Support	50	50	800	800
Early Intervention Psychosocial Support Response	2,540	2,560	196,700	198,500
Mutual Support Self Help (EDV)	150	150	1,100	1,100
Youth Outreach Recovery Support	820	820	50,300	50,300
Youth residential rehabilitation	280	280	224,000	224,000
<b>Total</b>	<b>3,850</b>	<b>3,870</b>	<b>472,900</b>	<b>474,700</b>

Consumer numbers rounded to the nearest 10 and hours rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

Table 22: Number of consumers who received psychosocial support from a service funded under a Vic program and hours received, by severity and age group, 2022–23

Metric	Severity	Age group					Total*
		00–11	12–24	25–64	65+	(12–64)	
Consumers	Moderate	0	610	1,150	10	1,760	1,770
	Severe	0	870	1,210	10	2,090	2,100
	<b>Total</b>	<b>0</b>	<b>1,480</b>	<b>2,360</b>	<b>20</b>	<b>3,850</b>	<b>3,870</b>
Hours	Moderate	0	40,100	84,000	900	124,100	125,000
	Severe	0	241,800	107,000	900	348,800	349,700
	<b>Total</b>	<b>0</b>	<b>281,900</b>	<b>191,000</b>	<b>1,700</b>	<b>472,900</b>	<b>474,700</b>

Consumer numbers rounded to the nearest 10 and hours rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

## Queensland

Table 23 describes the state-funded psychosocial programs included in the analysis provided in Queensland.

Table 23: Qld Health-funded psychosocial programs included in this analysis

Program and description	Target population
<b>The Individual Recovery Support Program (IRSP)</b> is a non-clinical psychosocial wraparound support on a one-on-one basis, including peer to peer support in the individual's local community.	Consumers Severe mental health condition Qld Ages 18 and above Seen clinically and referred by the Hospital and Health Services (HHS)
<b>Group Based Peer Recovery Support Program (GBPRSP)</b> provides the individual with access to group-based peer led activities complementary to the supports provided through the IRSP.	Consumers Severe mental health condition Qld Ages 18 and above Referral by IRSP program.
<b>Individual Recovery Support – Transition from Correctional Facilities Program (IRS-TCFP)</b> is designed to offer a range of non-clinical psychosocial wraparound supports to an individual at least two weeks prior to release from the correctional facility (where the date is known) and for up to 12 months post release.	Consumers – From corrections Severe mental health condition Qld Ages 18 and above Referral from correctional facility.
<b>The Individual at Risk of Homelessness Program (IRHP)</b> offers a range of nonclinical psychosocial wraparound supports that focuses on breaking the cycle of homelessness and supporting individuals to transition to secure and stable tenancy and housing	Consumers Severe mental health condition Qld Ages 18 and above living in a boarding house, crisis accommodation or hostel and seen clinically and referred by the HHS
<b>Clubhouses</b> provide support for people 18 years and over experiencing severe mental illness following the International Clubhouse model	Consumers Severe mental health condition (small element that is moderate (2%) but mostly severe) Ages 18 and above
<b>Aboriginal and Torres Strait Islander Mental Illness – Individual Recovery Support</b> for Aboriginal and Torres Strait Islander people with moderate to severe mental illness	Consumers Moderate to severe mental health condition (50/50 estimate)

Program and description	Target population
<b>Consumer Operated Services</b> Peer support for individuals 18 years and over with severe mental illness. Support for individuals 18 years and over with severe mental illness	Consumers Severe mental health condition Ages 18 and above
<b>Eating Disorders</b> support for people 16 years and over who experience eating disorders and for carers and support people.	Consumers and carers Ages 16 and over Severe mental health condition
<b>Music and Arts Based Supports</b> Four arts-based program streams to support individuals 18 and over with mental illness.	Consumers Ages 18 and over Very Severe mental health condition
<b>Perinatal and Infant Mental Health</b> Peer support for women and their partners who have an infant or child 0–5 years, experiencing perinatal mental health problems.	Consumers 30–40% severe mental health condition.
<b>Integrated Hub</b> Stride Hub. Support for individuals over 18 years of age experiencing severe mental illness.	Consumers and carers Severe mental health condition
<b>Specialist psychosocial support program for individuals with severe mental illness from Cultural and Linguistically Diverse Communities</b> – provision of individual support and rehabilitation, may include peer work, may include group support and rehabilitation for people 18 years and above with severe mental illness.	Consumers and carers Severe mental health condition Ages 18+
<b>Transitional Recovery Service (TRS)</b> Support for individuals 18 years and over with a severe mental illness – both individual residential support and transitional outreach support	Consumers Severe mental illness Aged 18–65
<b>Mental Health Continuity of Support</b> enables people with a psychiatric disability to live in the community with stable social housing and enjoy an improved quality of life. Sustainable housing and independent living support for program participants are seen as key elements in supporting their recovery and reducing the need for hospital care.	Consumers with severe mental illness Ages 18 and above

Table 24 shows were around 18,570 consumers receiving psychosocial support from Queensland programs in 2022–23 and they were receiving 520,200 hours of psychosocial support. Table 25 shows the alignment of these estimates with the target cohorts for this analysis.

Table 24: Number of consumers who received psychosocial support from a service funded under a Qld program and hours received, by program and age group, 2022–23

Program	Consumers		Hours	
	12–64 years	Total*	12–64 years	Total*
Aboriginal and Torres Strait Islander Mental Illness –				
Individual Recovery Support	880	950	36,300	38,700
Clubhouses	1,370	1,510	103,000	111,900
Consumer Operated Services	300	320	18,800	20,000
Eating Disorders	540	560	1,700	1,800
Group Based Peer Recovery Support Program	2,800	2,990	34,900	37,400
Mental Health Continuity of Support	10	20	14,000	16,400
Individual Recovery Support – Transition from				
Correctional Facilities Program	590	590	23,600	23,900
Individual Recovery Support Program	7,730	8,240	178,400	192,500
Individual at Risk of Homelessness Program	800	810	15,700	16,000
Integrated Hub	170	170	4,200	4,300
Music and Arts Based Supports	160	190	4,500	5,200
Perinatal and Infant Mental Health	840	1,040	4,000	4,800
Specialist Cultural and Linguistically Diverse				
Communities Mental Health Community Supports	1,060	1,120	15,100	15,700
Transitional Recovery Service	70	70	31,000	31,700
<b>Total</b>	<b>17,330</b>	<b>18,570</b>	<b>485,300</b>	<b>520,200</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

Table 25: Number of consumers who received psychosocial support from a service funded under a Qld program and hours received, by severity and age group, 2022–23

Metric	Severity	Age group					Total*
		00–11	12–24	25–64	65+	(12–64)	
Consumers	Moderate	0	120	870	160	990	1,150
	Severe	0	2,910	13,440	1,080	16,340	17,420
	<b>Total</b>	<b>0</b>	<b>3,020</b>	<b>14,310</b>	<b>1,240</b>	<b>17,330</b>	<b>18,570</b>
Hours	Moderate	0	3,900	16,800	1,800	20,700	22,500
	Severe	0	66,900	397,600	33,200	464,500	497,700
	<b>Total</b>	<b>0</b>	<b>70,800</b>	<b>414,400</b>	<b>34,900</b>	<b>485,300</b>	<b>520,200</b>

Consumer numbers rounded to the nearest 10 and hours rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

## Western Australia

Table 26 describes the WA Mental Health Commission-funded psychosocial programs included in the analysis that are provided in WA.

Table 26: WA Mental Health Commission-funded psychosocial programs included in this analysis

Program and description	Target population
<b>Staffed Residential Short-Term Community-Based Crisis/Respite</b> accommodation for people who may be experiencing a social crisis, are homeless or at risk of becoming homeless or require respite from their usual place of residence. Variable hours of support dependent on individual needs.	Severe mental health condition
<b>Individualised Community Living Support (ICLS)</b> is an innovative and collaborative partnership approach between the Health Service Providers, Community Managed Organisations, Community Housing Organisations and the Department of Communities – Housing to provide clinical and psychosocial supports and services, in addition to appropriate housing for individuals to maximise their success in recovery and living in the community.	Severe mental health condition WA Ages 18–65 (under 18 can access a package but not housing) Referral by public mental health service Case Manager or Psychiatrist.
<b>Personalised support – linked to housing</b> – includes services that provide personalised psychosocial support that is coordinated with provision of social housing or privately negotiated housing at the point of entry into the program (but not necessarily tied to such indefinitely). A mental health recovery framework through the provision of personalised individual social, recreational or prevocational activities.  <b>Personalised support – other</b> – are flexible psychosocial services tailored to a mental health consumer's individual and changing needs. They include a range of services that provide personalised support that is independent of housing arrangements (e.g. provision of social housing or privately negotiated housing) at the point of entry into the program. 'Personalised support – other' is primarily delivered in the consumer's home or own environment.	Consumers Severe mental health condition
<b>Education, employment, and training</b> includes services where the principal function is to provide or support people with lived experience of mental illness, in gaining education, employment and/or training.	Consumers Ages 18–64 Moderate and Severe mental health condition
<b>Mutual Support and Self Help</b> includes services that provide information and peer support to people with a lived experience of mental illness. People meet to discuss shared experiences, coping strategies and to provide information and referrals.	Consumers Not specified (typically ages 18–65 years) Severe mental health condition
Self-help groups are usually formed by peers who have come together for mutual support and to accomplish a specific purpose.	
<b>Group Support Activities</b> services aim to improve quality of life and psychosocial functioning of people experiencing mental health and co-occurring alcohol and other drug issues through group-based social,	Consumers Not specified (typically ages 18–65 years)

Program and description	Target population
recreational and psychoeducational activities. Psychoeducational activities include education on mental health and wellbeing, healthy lifestyle behaviours and pre-vocational activities, inclusive of services that cater to the individual needs of Aboriginal people, people from CaLD backgrounds and the LGBTIQ+ community.	Severe mental health condition
<b>Staffed Residential – Transitional accommodation</b> staffed between 12 to 25 hours per week at each house, dependent on beds per house, occupancy and individual need, by appropriate skilled and trained staff. Independent living skills needed.	Consumers Severe mental health condition Not specified (typically 18–65 years)
<b>Staffed Residential – Long stay accommodation</b> in stable, affordable housing and support to enable accommodation stability and reduce the need for hospital based care. 24/7 support of 2 to 4 hours per person per day. They are evolving to have a stronger mental health recovery focus towards transitioning people into more independent community living arrangements rather than the CSRU being permanent accommodation. They need independent living skills.	Consumers Severe and moderate mental health condition Not specified (typically 18–65 years)

Table 27 shows there were around 8,340 consumers receiving psychosocial support from WA programs in 2022–23 and they were receiving around 609,500 hours of psychosocial support. Table 28 shows the alignment of these estimates with the target cohorts for this analysis.

Table 27: Number of consumers who received psychosocial support from a service funded under a WA program and hours received, by program and age group, 2022–23

Program	Consumers		Hours	
	12-64 years	Total*	12-64 years	Total*
Education, employment & training	1,460	1,460	2,200	2,200
Group support activities	760	760	21,800	21,900
Mutual support & self-help	1,190	1,200	3,100	3,100
Personalised support-linked to housing	1,410	1,440	361,600	369,100
Personalised support-other	3,270	3,330	131,700	134,400
Staffed residential (Long stay accommodation)	30	30	18,900	19,300
Staffed residential (Residential Crisis and Respite)	70	70	19,100	19,500
Staffed residential (Transitional Accommodation)	40	40	39,200	40,000
<b>Total</b>	<b>8,230</b>	<b>8,340</b>	<b>597,600</b>	<b>609,500</b>

Consumer numbers rounded to the nearest 10 and hours rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

Table 28: Number of consumers who received psychosocial support from a service funded under a WA program and hours received, by severity and age group, 2022–23

Metric	Severity	Age group					Total
		00-11	12-24	25-64	65+	(12-64)	
Consumers	Moderate	0	110	640	<11	750	750
	Severe	0	1,140	6,350	110	7,490	7,600
	<b>Total</b>	<b>0</b>	<b>1,250</b>	<b>6,980</b>	<b>110</b>	<b>8,230</b>	<b>8,340</b>
Hours	Moderate	0	1,500	9,000	200	10,500	10,700
	Severe	0	88,200	498,900	11,700	587,100	598,700
	<b>Total</b>	<b>0</b>	<b>89,700</b>	<b>507,900</b>	<b>11,900</b>	<b>597,600</b>	<b>609,500</b>

Consumer numbers rounded to the nearest 10 and hours rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

## South Australia

Table 29 describes the Department for Health and Wellbeing (DHW)-funded psychosocial programs included in the analysis that are provided in SA.

Table 29: SA DHW-funded psychosocial programs included in this analysis

Program and description	Target population
<b>Intensive Home-Based Support Services (IHBSS)</b> One on one intensive rehabilitation and support services available for up to 3 months to provide support to people with mental health conditions to live in their homes independently and prevent unnecessary hospital admissions.	Consumers Severe mental health condition and functional impairment SA Ages 16 and above Referral from Community Mental Health Teams.
<b>Individual Psychosocial Rehabilitation and Support Services (IPRSS)</b> One on one rehabilitation and support services delivered from 6 months to 2 years to support people with mental health conditions to live independently in the community.	Consumers Severe mental health condition and functional impairment SA Ages 16–65 Referral from Community Mental Health Teams.
<b>Housing and Accommodation Support Programs, including Housing and Accommodation Support Partnership (HASP), Accommodation Support Program (ASP) and Avalon.</b> Long term or transitional individual or cluster housing with up to 24 hour 7 days one on one support (Burnside HASP 24/7 only) to support people with mental health conditions to live independently in their homes in the community.	<b>HASP:</b> Consumers Severe mental health condition and functional impairment SA Ages 18–65 Individuals with limited independent living skills and at risk of homelessness. <b>ASP:</b> Consumers – Women who have a mental illness and/or psychosocial disability or who are at risk of developing a psychiatric

Program and description	Target population
	disability and who are homeless or at risk of becoming homeless. Moderate to severe mental health condition <b>Avalon:</b> Consumers Severe mental health condition Ages 18–65 Southern Mental Health Services At risk of homelessness
<b>GP Access Program</b> One on one rehabilitation and support services for people with mental health conditions who are referred by their GP and live in the western/southern Adelaide region.	Consumers Severe mental health condition Ages 18 years and over
<b>Day and Group Programs</b> Group programs for people with mental health conditions focussed on skills building and pre-vocational activities.	Consumers Severe mental health condition Ages 18 years and over
<b>Mutual Support and Self-Help Programs</b> One on one or group programs for people with mental health conditions and their carers focussed on the provision of information, counselling, skills building and advocacy.	Consumers Ages 18 years and over Moderate to severe mental health condition

Table 30 shows there were around 2,650 consumers receiving psychosocial support from SA programs in 2022–23, and they were receiving around 238,900 hours of psychosocial support. Table 31 shows the alignment of these estimates with the target cohorts for this analysis.

Table 30: Number of consumers who received psychosocial support from a SA DHW-funded service and hours received, by program and age group, 2022–23

Program	Consumers		Hours	
	12–64 years	Total	12–64 years	Total
Accommodation and Support Program	20	20	4,700	4,700
Avalon	20	20	3,200	3,200
Day and Group Rehabilitation Program	140	160	9,600	11,500
GP Access	80	90	8,000	9,000
Housing & Accommodation Support Partnership	120	130	27,700	28,000
Housing & Accommodation Support Partnership Burnside	20	20	5,400	5,400
Individual Psychosocial Rehabilitation and Support Services	780	1,020	109,500	131,600
Intensive Home Based Support Services	300	310	27,300	28,800
Mutual Support and Self-Help	710	870	14,100	16,800
<b>Total</b>	<b>2,200</b>	<b>2,650</b>	<b>209,400</b>	<b>238,900</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

Table 31: Number of consumers who received psychosocial support from a DHW-funded service and hours received, by severity and age group, 2022–23

Metric	Severity	Age group					Total
		00–11	12–24	25–64	65+	(12–64)	
Consumers	Moderate	0	80	290	80	370	450
	Severe	0	260	1,570	380	1,830	2,210
	<b>Total</b>	<b>0</b>	<b>350</b>	<b>1,850</b>	<b>450</b>	<b>2,200</b>	<b>2,650</b>
Hours	Moderate	0	1,800	7,600	1,300	9,400	10,700
	Severe	0	21,400	178,600	28,200	200,000	228,200
	<b>Total</b>	<b>0</b>	<b>23,200</b>	<b>186,200</b>	<b>29,600</b>	<b>209,400</b>	<b>238,900</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

## Tasmania

Table 32 describes the state-funded psychosocial programs included in the analysis provided in Tasmania.

Table 32: Tasmanian Department of Health-funded psychosocial programs included in this analysis

Program and description	Target population
<p><b>Community Recovery Outreach Program</b> – Designed for individuals diagnosed with mental illness aged 18–65 the program provides support to individuals to assist them to live in your own home, while still enabling the individual to take advantage of the organisations care-coordination services. The aim of the program is to support clients to identify ways their mental health could be improved utilising our recovery model, to maintain their community living choices and also engage them in other services of their choice.</p> <p>The outreach mental health service is a one-on-one support program that aims to support people to live in their own homes while connecting them with relevant services in their community. This service is available on the North-West Coast (from Deloraine all the way through to Smithton).</p>	<p>Consumers</p> <p>Severe, moderate mental health condition and psychosocial disability</p> <p>Tas</p> <p>Age 18–65 years of age</p>
<p><b>Residential Rehabilitation and Recovery</b></p> <p><b>Anglicare:</b> Non-clinical community based residential rehabilitation and recovery service for adult mental health consumers.</p> <p>Anglicare is similar to the Richmond Fellowship description below</p> <p><b>The Richmond Fellowship:</b> Residential rehabilitation and recovery, support for physical and mental health and wellbeing, and psychosocial rehabilitation service for socially disadvantaged people with a mental illness. To enable residents to develop the ability to live independently in the community, have an increased level of social inclusion and to enable individual self-management for future options and opportunities.</p> <p>To provide access to services for people who:</p> <ul style="list-style-type: none"> <li>• Are not eligible for, are choosing not to test or have not yet tested eligibility to access the NDIS.</li> <li>• Are accessing NDIS supports but haven't yet met the requirements for Supported Independent Living (SIL) through their NDIS plan.</li> <li>• Have had SIL approved in their plan but require transitional support until they are able to access appropriate SIL accommodation (up to 12 weeks).</li> </ul>	<p><b>Anglicare:</b></p> <p>Consumers</p> <p>Severe and persistent mental health condition</p> <p>Tas</p> <p>16–64 years of age</p> <p><b>Richmond Fellowship:</b></p> <p>Consumers</p> <p>Severe, moderate mental health condition and psychosocial disability</p> <p>Tas</p> <p>Age 18+ years of age</p>
<p><b>Packages of Care</b></p> <p><b>Anglicare:</b> Packages of care and recovery focused support for people with a mental illness who live in independent accommodation, to achieve goals across areas of life and social inclusion.</p> <p>The program provides community based, flexible and recovery focused support for people with psychiatric disabilities who live in independent accommodation. It supports participants to develop or relearn skills, confidence and motivation to pursue and achieve goals across areas of life and social inclusion.</p>	<p><b>Anglicare:</b></p> <p>Consumers</p> <p>Severe, moderate mental health condition and psychiatric disability</p> <p>Tas</p> <p>16–64 years of age</p> <p><b>Life Without Barriers:</b></p> <p>Consumers</p>

Program and description	Target population
<p><b>Life Without Barriers:</b> Individualised community based, flexible support through packages of care for young people with, or at risk of, severe mental illness who are clients of Public child and adolescent mental health services or Forensic mental health services and their families. Services are provided to those that may require additional therapeutic support to implement a range of strategies to assist in their recovery and/or ongoing management of their illness. These packages may include: re-engagement in education and training, access to housing and accommodation, participation in community activities including recreation and social interaction, links to other relevant supports, and home and domestic help.</p>	<p>Severe and moderate mental health condition Tas 12–18 years of age</p>
<p><b>Baptcare – MICare and MICare Plus – Foundations Program</b> – Intensive psychosocial recovery-based program offering tailored packages of care to people with severe and persistent mental health conditions who are case managed through public Mental Health Services.</p> <p>The program includes outreach services, working one-on-one with individuals to promote recovery, encourage progress and support life skills. the program supports individuals to have more control in their life, identifying resources that will help meet their particular needs – supporting them towards their recovery goals. The program offers wrap-around, intensive support in a range of areas including; accommodation, independent living skills, social connectedness, overall social and emotional wellbeing, connection to the community, increased independence and remaining well.</p>	<p>Consumers Super and extremely complex Severe and persistent mental health condition Tas 18–64 years of age</p>
<p><b>Mindset – Choices Program</b> Support packages for people with severe and complex mental illness who would benefit from psychosocial support. The mindset program utilises the Foundations Program (above) as a foundation but also delivers a further range of psychosocial programs across Tasmania that build people’s capacity to improve their mental health and make progress towards their recovery. Mental Health Practitioners and Peer Workers use evidence-informed practices and work with clients collaboratively to identify goals and remove barriers to living the life they want to lead. The program supports people public mental health services, and may include transitional accommodation when necessary, as well as providing group and short-term individual interventions for people with severe and episodic mental health issues.</p>	<p>Consumers Severe and complex mental health condition Tas 18–65 years of age</p>
<p><b>Eureka Clubhouse</b> is a psychosocial non-clinical community mental health program which operates using The International Clubhouse Model that supports individuals by giving opportunities to explore friendships, participate in a work ordered day, recreational and educational activities and employment support.</p>	<p>Consumers and carers Moderate mental health condition Tas All ages</p>
<p><b>Housing and Accommodation Support Initiative (HASI)</b> community based psychosocial support to people with severe mental illness throughout Tasmania at risk of homelessness, to live and recover in the community including helping people to achieve their own, unique goals.</p>	<p>Consumers Severe mental health condition Tas All ages</p>

Program and description	Target population
<p><b>Mental Health Homeless Outreach Program (MHHOP)</b> providing a daytime psychosocial outreach service to socially disadvantaged people with psychosocial concerns and/or mental ill-health accessing a homelessness/rough sleeping service in the North and South of the state.</p> <p>MHHOP is a mental health recovery focused program supporting Tasmanian's who are experiencing, or at risk of homelessness focusing on identifying recovery goals, developing action plans to achieve these goals through uncovering resourcefulness and resilience, supports people as the experts in their own lives, reconnects with own capabilities and strengths</p> <p>Some of the psychosocial intervention support the MHHOP provides are:</p> <ul style="list-style-type: none"> <li>• Skills to manage daily tasks</li> <li>• Assistance to engage in work or study</li> <li>• Supports people to consider housing options</li> <li>• Alcohol and drug support</li> <li>• Managing money</li> <li>• Making connections with family and friends</li> </ul> <p>The program is offered in the South, North and North-west of the state and focuses on inclusion, building connections and increasing confidence and self-esteem. Referral in can be self-referral, from medical practitioners, family members or support workers.</p>	<p>Consumers</p> <p>Severe, moderate mental health condition and psychosocial disability</p> <p>Tas</p> <p>Age 18+ years of age</p>
<p><b>Recreation Program</b> Providing a mental health recovery service for people with psychosocial concerns and/or mental ill-health. To enable participants to develop the ability to integrate into their local community and build networks to support their physical, mental health, and wellbeing.</p> <p>TasRec creates and provides links to a diverse range of community-based recreational and social activities, events, and opportunities for skill building and creative expression, all with a focus on enjoyment and wellbeing. The TasRec philosophy is all about inclusion, building connections, increasing confidence and self-esteem, and having fun!</p> <p>Conduct of four x 11 week programs throughout the year with some activities continuing all year round while others change with the seasons, providing a broad range of ongoing favourites and fresh opportunities throughout the year. All our programs and activities are open to anyone with a living or lived experience of mental ill-health.</p>	<p>Consumers</p> <p>Severe, moderate mental health condition and psychosocial disability</p> <p>Tas</p> <p>Age 18+ years of age</p>
<p><b>Recovery and Carer Support Services</b> – through the engagement of a peer workforce to provide community-based support for people with an eating disorder and their carers and families to achieve and maintain recovery in their own community with the lowest level intensity intervention appropriate to their care.</p>	<p>Consumers and carers</p> <p>Moderate mental health condition</p> <p>Tas</p> <p>All ages</p>

Table 33 shows there were around 1,570 consumers receiving psychosocial support from Tasmanian programs in 2022–23 and they were receiving around 12,600 hours of psychosocial Support. Table 34 shows the alignment of these estimates with the target cohorts for this analysis.

Table 33: Number of consumers who received psychosocial support from a service funded under a Tas program and hours received, by program and age group, 2022–23

Program	Consumers		Hours	
	12–64 years	Total*	12–64 years	Total*
Community Recovery Outreach Program	60	70	500	600
Mental Health Homeless Outreach Program	130	150	1,000	1,200
Mental Health: Eating Disorder Peer Workforce Partnership	140	140	1,100	1,100
Mental Health: Eureka Clubhouse	110	120	800	1,000
Mental Health: Housing and Accommodation Support Initiative	30	30	200	300
Mental Health: Life Without Barriers	60	60	500	500
Mental Health: MICare and MICare Plus	160	180	1,300	1,500
Mental Health: Mindset – Choices	70	80	500	600
Mental Health: Packages of Care	270	310	2,200	2,400
Mental Health: Residential Rehabilitation and Recovery	150	180	1,200	1,400
Recreation Program	200	230	1,600	1,900
<b>Total</b>	<b>1,380</b>	<b>1,570</b>	<b>11,000</b>	<b>12,600</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

Table 34: Number of consumers who received psychosocial support from a service funded under a Tas program and hours received, by severity and age group, 2022–23

Metric	Severity	Age group					Total*
		00–11	12–24	25–64	65+	(12–64)	
Consumers	Moderate	30	170	600	70	770	870
	Severe	30	100	510	70	610	710
	<b>Total</b>	<b>50</b>	<b>270</b>	<b>1,110</b>	<b>140</b>	<b>1,380</b>	<b>1,570</b>
Hours	Moderate	200	1,400	4,800	600	6,100	6,900
	Severe	200	800	4,100	600	4,900	5,700
	<b>Total</b>	<b>400</b>	<b>2,200</b>	<b>8,900</b>	<b>1,100</b>	<b>11,000</b>	<b>12,600</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

## Australian Capital Territory

Table 35 describes the territory-funded psychosocial programs included in the analysis provided in the ACT.

Table 35: ACT Health-funded psychosocial programs included within the analysis

Program and description	Target population
<b>Wellways DECO</b> provides psychosocial support to people with a diagnosed mental illness who are exiting or transitioning out of detention. Participants must be aged between 16 and 65 years and be clinically managed or treated by ACT public mental health services or a GP.	Consumers – out of corrections Severe, moderate mental health condition Ages 16–65
<b>Transition to Recovery Program (TRec)</b> provides services to adults living in the ACT who have subacute mental health symptoms and would benefit from psychosocial outreach supporting during a time of transition and can manage in the community with support. While not a residential Step-Up, Step-Down program, TRec similarly targets people either at risk of hospitalisation or those who need assistance with their transition from hospital back to the community.	Consumers Severe, moderate mental health condition Ages 18–65
<b>St Vincent De Paul Compeer Friendship Program</b> is a befriending program that links adults living with a diagnosed mental illness (Compeer participants) with volunteers in the community. The aim of the program is to increase participants' social connection and community participation as well as improve participants' wellbeing and quality of life through social connections.	Consumers Severe, moderate mental health condition Ages 18+
<b>Wellways Women's transitional Accommodation Program</b> provides 8 short to medium term supported accommodation places to accommodate women living with mental illness (for 3–6 months, longer on a case by case basis). It also provides transitional outreach support for participants exiting the program, and outreach to women in the community who are at risk of homelessness due to mental illness.	Consumers Severe mental health condition Ages 18+
<b>Youth and Wellbeing Program</b> provides home-based outreach for young people experiencing mental health difficulties, using a case-management model. The program supports young people to look at their mental health and how it affects all different parts of their life, such as: relationships, school/work, housing, family life, coping and self-esteem. The service provides therapeutic support and help to develop skills to better manage young people's mental health and wellbeing in accordance with their own recovery goals.	Consumers Moderate/severe mental health condition Ages 10–25

ACT also contributed \$500,000 in 2021-22 and 2022-23 to the Commonwealth Psychosocial Supports Program.

Table 36 shows there were around 560 consumers receiving psychosocial support from ACT programs in 2022–23, and they were receiving around 10,000 hours of psychosocial support. Table 37 shows the alignment of these estimates with the target cohorts for this analysis.

Table 36: Number of consumers who received psychosocial support from a service funded under an ACT program and hours received, by program and age group, 2022–23

Program	Consumers		Hours	
	12–64 years	Total*	12–64 years	Total*
Commonwealth Psychosocial Support Program <sup>1</sup>	100	100	1,300	1,300
Compeer Friendship Program	20	30	300	400
Detention Exit Community Outreach	50	50	800	800
Transition to Recovery Program	200	200	2,700	2,700
Womens Residential Program	10	10	1,200	1,200
Youth & Wellbeing	170	170	3,500	3,600
<b>Total</b>	<b>540</b>	<b>560</b>	<b>9,800</b>	<b>10,000</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; <sup>1</sup>ACT Health contributed funding, via the Primary Health Network, to the Commonwealth Psychosocial Support Program. The Primary Mental Health Care Minimum Data Set (PMHC MDS) data that was provided for this analysis suppressed small numbers and totals, where these appear for PMHC MDS data they are estimates generated by HPA; \*Includes consumers aged 65+ years.

Table 37: Number of consumers who received psychosocial support from a service funded under an ACT program and hours received, by severity and age group, 2022–23

Metric	Severity	Age group					
		00–11	12–24	25–64	65+	(12–64)	Total*
Consumers	Moderate	<11	120	150	<11	280	280
	Severe	<11	120	150	<11	270	270
	<b>Total</b>	<b>&lt;11</b>	<b>240</b>	<b>300</b>	<b>10</b>	<b>540</b>	<b>560</b>
Hours	Moderate	0	2,200	2,200	100	4,400	4,500
	Severe	0	2,200	3,100	100	5,400	5,500
	<b>Total</b>	<b>100</b>	<b>4,400</b>	<b>5,400</b>	<b>200</b>	<b>9,800</b>	<b>10,000</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; The PMHC MDS data that was provided for this analysis suppressed small numbers and totals, where these appear for PMHC MDS data they are estimates generated by HPA; \*Includes consumers aged 65+ years.

## Northern Territory

Table 38 describes the territory-funded psychosocial programs included in the analysis provided in the NT. It is important to note that Social and Emotional Wellbeing programs – which have not been included in this analysis – are a significant service type for Aboriginal and Torres Strait Islander people in the NT, particularly through primary health care services in remote areas.

Table 38: NT Health-funded psychosocial programs included in this analysis

Program	Target population
<b>Top End Mental Health Consumers Organisation (TEMHCO)</b> – Drop-in support service provides a social and emotional support and advocacy service to consumers with a mental illness. Programs and services are focused on assisting clients to maintain and increase their independence.	Consumers Severe mental health condition
<b>MiPlace</b> – Drop-in support service provides a drop-in style centre with tailored recovery focused activities for people with mental illness. Mi Place provides a psychosocial recovery focused program that promotes good mental health, recovery assistance, life skills development and psycho-education and focuses on the reduction of stigma surrounding mental health.	Consumers Severe mental health condition
<b>NT Housing Support Program</b> is to support people experiencing mild, moderate to severe mental illness and related psychosocial disability who experience episodic deterioration of condition(s) to live independently in the community.	Consumers Moderate and severe mental health condition
<b>Recovery Assistance Program</b> provides community access and capacity building supports to people experiencing diagnosed mental illness or undiagnosed mental ill health in the Top End and Big Rivers regions. It supports people through recovery plans, in assertive engagement with the provision of psychosocial recovery supports to achieve individualised recovery goals.	Consumers Moderate and severe mental health condition – diagnosed and undiagnosed
<b>Housing and psychosocial support program (HPSP)</b> has 2 programs that provide participants with individualised recovery-oriented support to improve personal wellbeing and enhance community living. HPSP provides assistance to adults who live with a mental health condition and reside in public, community and private housing.	Consumers (homeless, at risk of homelessness or inappropriately house and require intensive support to gain or sustain housing in the community)  Diagnosed mental illness – severity unknown

Table 39 shows there were around 460 consumers receiving psychosocial support from NT programs in 2022–23, and they were receiving around 29,100 hours of psychosocial support. Table 40 shows the alignment of these estimates with the target cohorts for this analysis.

Table 39: Number of consumers who received psychosocial support from a service funded under a NT program and hours received, by program and age group, 2022–23

Program	Consumers		Hours	
	12–64 years	Total*	12–64 years	Total*
Housing Support Program	30	30	900	1,000
Housing and psychosocial support program	50	50	4,200	4,400
MiPLace Drop-in support service	130	140	7,700	8,000
Recovery Assistance Program	70	80	5,500	5,800
TEMHCO – Drop in support service	160	170	9,400	9,900
<b>Total</b>	<b>440</b>	<b>460</b>	<b>27,800</b>	<b>29,100</b>

Consumer numbers rounded to the nearest 10 and hours rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

Table 40: Number of consumers who received psychosocial support from a service funded under a NT program and hours received, by severity and age group, 2022–23

Metric	Severity	Age group					Total*
		00–11	12–24	25–64	65+	(12–64)	
Consumers	Moderate	0	<11	50	<11	50	50
	Severe	0	40	350	20	390	410
	<b>Total</b>	<b>0</b>	<b>40</b>	<b>400</b>	<b>20</b>	<b>440</b>	<b>460</b>
Hours	Moderate	0	300	2,900	100	3,200	3,400
	Severe	0	2,400	22,200	1,200	24,600	25,700
	<b>Total</b>	<b>0</b>	<b>2,700</b>	<b>25,100</b>	<b>1,300</b>	<b>27,800</b>	<b>29,100</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; \*Includes consumers aged 65+ years.

## 3.2. Australian Government psychosocial support programs

HPA received data for a range of Australian Government-funded programs and subprograms, where there is an indication that the program/subprogram is specifically targeted for people with moderate or severe mental illness and involves significant provision of psychosocial support.

To ensure alignment with the target cohort of this analysis, the Australian Government data presented in this report only includes psychosocial support services provided to consumers with moderate and/or severe mental illness. The programs that were assessed as being clearly in-scope for the analysis are shown in Table 41, together with information of the program target population.

Information is provided in Appendix E on programs that were not included in this analysis, including further information on the First Nations Social and Emotional Wellbeing program.

### Step 2

#### ASSESS CURRENT SERVICE PROVISION

Assess the number of people within the target cohorts receiving psychosocial support and the volume (hours) of activity provided, by age group, severity and state/territory for:

2.1 State/Territory supported programs

2.2 Australian Government programs

2.3 Estimate the number of people receiving support through the NDIS.

2.4 Calculate the number of people receiving support by NDIS participation status.

Table 41: Australian Government-funded psychosocial programs included in this analysis

Program and description	Target population
<p><b>Commonwealth Psychosocial Support Program</b></p> <p>Short-term, low-intensity psychosocial support to function day-to-day (individual or group psychosocial support) and live independently in the community. Covers a range of non-clinical supports that focus on building personal capacity and stability in one or more of the following areas:</p> <ul style="list-style-type: none"> <li>• social skills, friendships and family connections</li> <li>• day-to-day living skills</li> <li>• financial management and budgeting</li> <li>• finding and maintaining a home</li> <li>• vocational skills and goals</li> <li>• maintaining physical wellbeing, including exercise</li> <li>• managing substance use issues</li> <li>• building broader life skills, including confidence and resilience; and</li> <li>• building capacity to live independently in the community.</li> </ul> <p>Commissioned through the 31 PHNs.</p>	<p>People with severe, often episodic, mental illness and associated functional impairment – who are:</p> <ul style="list-style-type: none"> <li>• not accessing similar supports through the NDIS or state/territory-based psychosocial program</li> <li>• not restricted in their ability to fully, and actively, participate in the community because of their residential setting (e.g. prison or a psychiatric facility)</li> <li>• aged 16 years and over (exceptions can be made)</li> </ul> <p>A clinical diagnosis is not required.</p>
<p><b>Online mental health services for people with complex mental health needs</b></p>	<p>Eligible participants must:</p>

Program and description	Target population
<p>Delivered by SANE Australia: Specialised digital mental health service for people with complex mental health needs who find it hard to access mainstream services. This includes people with co-occurring conditions, such as intellectual disability and autism.</p> <p>Offers a range of individual and group based digital mental health services, care coordination and service navigation.</p> <p>Guided service program (14 weeks) includes:</p> <ul style="list-style-type: none"> <li>digital and telehealth mental health support</li> <li>support planning (personalised support plan)</li> <li>counselling or peer support 1:1 sessions</li> <li>mental health recovery groups.</li> </ul> <p>The 1:1 sessions and mental health recovery groups assist people with goal setting, building connections and supports, and planning for the future.</p> <p><u>Note:</u> In line with the agreed scope of this analysis, counselling elements have been excluded from the analysis, as have the small number of carers that receive supports through this program.</p> <p>There is also a self-guided service that provides drop-in channels as well as resources and forums (24/7 online community) for information and support.</p> <p>Currently available to people living in 13 PHN regions.</p>	<ul style="list-style-type: none"> <li>have complex mental health needs or be caring for someone who does</li> <li>be over 18 years of age,</li> <li>live within an eligible PHN region.</li> </ul>
<p><b>Kindred Clubhouse</b></p> <p>Non-clinical drop-in centre in the Frankston/Mornington Peninsula area of Victoria for people with moderate to severe mental illness, who are not supported by the NDIS. The clubhouse provides opportunities for social connection, skill development, vocational employment and meaningful activities. It also assists members with referral pathways to other services and to apply for support under the NDIS.</p>	<p>Consumers, aged 16 years and over, with moderate and severe mental illness who:</p> <ul style="list-style-type: none"> <li>live in the Frankston/Mornington Peninsula region (Victoria)</li> <li>are not accessing similar supports through the NDIS or state programs</li> </ul>
<p><b>Canefields Clubhouse</b></p> <p>Non-clinical drop-in centre in Beenleigh area of Queensland for people with severe and complex mental illness who are not funded through the NDIS. The service provides non-clinical psychosocial support that includes social events and activities as well as one-on-one individual support that provides a recovery-focused approach to enable people with severe mental illness to live independently within the community. The clubhouse also supports clients to transition to the NDIS if they are eligible.</p>	<p>Consumers, aged 16 years and over, with severe and complex mental illness who:</p> <ul style="list-style-type: none"> <li>live in Beenleigh and surrounding suburbs (Queensland)</li> <li>are not accessing similar supports through the NDIS or state programs</li> </ul>
<p><b>Disability Support for Older Australians</b></p> <p>Closed program that provides a range of specialist disability support services, including Psychosocial Recovery Coaching services, for</p>	<p>People aged 65 years and over (and Aboriginal and Torres Strait Islander people aged 50 years and over) with disability (e.g. psychosocial</p>

Program and description	Target population
<p>older people with disability who were not eligible for the NDIS at roll-out.</p> <p>Psychosocial Recovery Coaching funding provides assistance for clients with psychosocial disability to build capacity and resilience. Recovery coaches work collaboratively with clients, families, carers and other services to identify, plan design and coordinate DSOA supports.</p> <p>Clients receive an Individual Support Package overseen by a DSOA service coordinator.</p> <p>There are only a small handful of participants in this program that continue to receive psychosocial supports.</p>	<p>disability) who were not eligible for the NDIS due to their age at the time the scheme was rolled out.</p>
<p><b>Early Psychosis Youth Services (EPYS)</b></p> <p>Provides early intervention treatment and support to young people aged 12 to 25 years who are at ultra-high risk of, or actively experiencing, their first episode of psychosis. The EPYS Program aims to reduce the risk of transition to full-threshold psychosis and long-term mental ill-health through prevention, early detection, and coordinated care delivery.</p> <p>The model focusses on working towards functional recovery, increased community participation, and re-engagement with education and employment, through timely access to specialist medical, psychological, and psychosocial support, care coordination, and psychoeducation for young people and their families and carers.</p> <p>In line with the agreed scope of this analysis, only the psychosocial components are included in this analysis.</p>	<p>People aged 12 to 25 years who are at ultra high risk of, or actively experiencing, their first episode of psychosis.</p> <p>Moderate-severe mental illness</p>

Table 42 and Table 43 show the number of consumers (all ages) who received psychosocial support services under Australian Government-funded programs (28,220) and the hours they received (627,800) – by program and age group (Table 42) and by severity of mental health condition and age group (Table 43).<sup>5</sup>

The hours of support were based on the number of service contacts/occasion of service reported. Consumers within the Commonwealth Psychosocial Support Program were allocated across severity groups as follows: Severe: 40%; Moderate 60%.<sup>6</sup> This assumption was based on assessment made by HPA, following discussion of the issues in the various stakeholder workshops. Further information on this assumption can be found in Appendix F.

<sup>5</sup> In the PMHC MDS clients are not unique across the dataset. A client may be counted more than once if receiving services from more than one service provider.

<sup>6</sup> Assigning severity based on diagnosis is not the Department's general position because many mental health conditions exist across a spectrum of severity and functional impacts.

Table 42: Number of consumers who received psychosocial support from a service funded under an Australian Government program and hours received, by program and age group, 2022–23

Program	Consumers		Hours	
	12–64 years	Total	12–64 years	Total*
Commonwealth Psychosocial Support Program <sup>1,2</sup>	20,240	22,490	229,300	254,600
Early Psychosis Youth Services	3,640	3,640	22,600	22,600
Online mental health services for people with complex mental health needs (SANE Australia)	1,550	1,590	3,100	3,200
Canefields Clubhouse	200	200	15,000	15,000
Kindred Clubhouse	110	110	8,400	8,400
Disability Support for Older Australians	0	190	0	323,900
<b>Total</b>	<b>25,740</b>	<b>28,220</b>	<b>278,500</b>	<b>627,800</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; <sup>1</sup>The PMHC MDS data that was provided for this analysis suppressed small numbers and totals, where these appear for PMHC MDS data they are estimates generated by HPA; <sup>2</sup>Relevant data on the Commonwealth Psychosocial Support Program from the PMHC-MDS was unavailable from one Primary Health Network: Western Queensland. As such, the data figures presented in relation to Commonwealth Psychosocial Support Program do not include data from the Western Queensland Primary Health Network region. \*Includes consumers aged 65+ years.

Table 43: Number of consumers who received psychosocial support from a service funded under an Australian Government program and hours received, by severity and age group, 2022–23

Metric	Severity	Age group				
		12–24	25–64	65+	(12–64)	Total*
Consumers	Moderate	4,500	10,760	1,490	15,250	16,750
	Severe	3,050	7,430	1,000	10,480	11,480
	<b>Total</b>	<b>7,550</b>	<b>18,180</b>	<b>2,490</b>	<b>25,740</b>	<b>28,220</b>
Hours	Moderate	14,700	54,900	95,300	69,600	164,800
	Severe	43,200	165,700	254,000	208,900	462,900
	<b>Total</b>	<b>57,900</b>	<b>220,600</b>	<b>349,300</b>	<b>278,500</b>	<b>627,800</b>

Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; The PMHC MDS data that was provided for this analysis suppressed small numbers and totals, where these appear for PMHC MDS data they are estimates generated by HPA; \*Includes consumers aged 65+ years.

Table 44 shows the total number of consumers (aged 12–64 years only) and hours of support received by state or territory of residence.

Table 44: Number of consumers aged 12–64 years who received psychosocial support from a service funded under an Australian Government program and hours received, by severity and state/territory, 2022–23

Metric	Severity	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Consumers	Moderate	4,610	3,050	3,680	1,620	1,600	150	200	350	15,250
	Severe	3,070	2,140	2,660	1,080	1,070	100	130	230	10,480

<b>Metric</b>	<b>Severity</b>	<b>NSW</b>	<b>Vic</b>	<b>Qld</b>	<b>WA</b>	<b>SA</b>	<b>Tas</b>	<b>ACT</b>	<b>NT</b>	<b>Total</b>
	<b>Total</b>	<b>7,680</b>	<b>5,190</b>	<b>6,340</b>	<b>2,700</b>	<b>2,670</b>	<b>250</b>	<b>330</b>	<b>580</b>	<b>25,740</b>
Hours	Moderate	25,100	14,200	13,900	7,300	7,000	300	900	900	69,600
	Severe	66,900	46,300	51,900	19,500	18,700	800	2,400	2,400	208,900
	<b>Total</b>	<b>91,900</b>	<b>60,500</b>	<b>65,800</b>	<b>26,800</b>	<b>25,800</b>	<b>1,200</b>	<b>3,200</b>	<b>3,300</b>	<b>278,500</b>

*Consumer numbers are rounded to the nearest 10 and hours are rounded to the nearest 100, which accounts for minor discrepancies in totals reported; The PMHC MDS data that was provided for this analysis suppressed small numbers and totals, where these appear for PMHC MDS data they are estimates generated by HPA.*

Stakeholders from the NT PHN suggested there was under-reporting in the PMHC-MDS of the services provided through the Commonwealth Psychosocial Support Program to consumers in the NT. Additional data was provided to HPA, which indicated there were 1,089 people registered with the program at the end of the 2022–23 financial year and 666 of these were new people to the program. The data indicated that 194 people received individual support and 354 received group support. Assuming that the recipients of individual support and group support are different people, then it could be concluded that 548 consumers in NT received psychosocial support via the Commonwealth Psychosocial Support Program in the 2022–23 financial year, which is 58 more consumers than the 490 consumers included in the analysis from PMHC-MDS data for that year in NT.

### 3.3. NDIS participants with a psychosocial disability

This chapter addresses the issues around identifying NDIS participants (see Text Box 3) and how they can be accounted for in the analysis for this project.

In the Productivity Commission’s main estimates of unmet need, people who were receiving support from Australian Government and state or territory programs, including the NDIS, were counted as having their psychosocial support needs met, even though it was recognised that the level of support provided may not be adequate. For this project, a similar approach was adopted.

However, overall, the approaches do not fully address the issue of whether the psychosocial support provided to an individual adequately meets the individual’s needs. This is a limitation of this analysis, and it reflects several issues.

- First, the NMHSPF provides a basis on which average levels of service provision can be estimated for care profiles. These are not prescriptions of the actual level of service required for individuals. Individual people within each care profile are likely to have levels of need that may be greater or less than the recommended average.
- Secondly, data is not always available at an individual consumer level.
- Thirdly, for NDIS participants, it is not straightforward to identify the components of their plans that relate to psychosocial support. A theme in stakeholder feedback received during this project is that not all psychosocial needs of NDIS participants are met through the NDIS in practice and that some NDIS participants also access psychosocial supports through Australian Government and/or state/territory government programs.
- Finally, recommendations from the NDIS Review are currently being considered by governments. The analysis presented in this report reflects a point in time.

Currently, NDIS participants may be accepted into the Scheme where they have been assessed as having a significant psychosocial disability. For the NDIS, the term ‘psychosocial disability’ describes a disability that may arise from a mental health issue. The psychosocial disability may be the primary disability impacting a participant or it may be a secondary disability, where the participant has another disability that has met the eligibility criteria.

**Text Box 3: NDIS participant definition**

“NDIS participants” means people in the NDIS who have been determined to be eligible and have an approved plan at the date of reporting. The NDIA uses the more precise term “active participant” for this group (National Disability Insurance Agency, 2023).

**Step 2**

**ASSESS CURRENT  
SERVICE PROVISION**

Assess the number of people within the target cohorts receiving psychosocial support and the volume (hours) of activity provided, by age group, severity and state/territory for:

2.1 State/Territory supported programs

2.2 Australian Government programs

2.3 Estimate the number of people receiving support through the NDIS.

2.4 Calculate the number of people receiving support by NDIS participation status.

HPA requested two datasets from the NDIA:

1. The first dataset contained a summary of the number of NDIS participants in June 2022 (2021–22) and June 2023 (2022–23) with a psychosocial disability that was recorded as their primary disability or as a secondary disability. The data were summarised by age group, disability classification and SA3. Counts of the number of clients less than 11 were reported as '<11' to adhere to the NDIA's data sharing policy. The data also contained the dollar amount of the average annual committed support, and the total payments made. In the data provided by the NDIA, there was no further information available as to whether participants had used their approved plans.
2. The second dataset contained counts by First Nations status, although these data have not been used in the analysis.

Values were imputed for counts reported as less than 11. The imputed estimates were then scaled so that the total number of participants was equal to control totals provided by the NDIA for each disability type, state and age group. The total value of the imputed cells in 2022–23 was 2,354 participants with a primary disability and 428 participants with a secondary disability. These estimates were subsequently aggregated to yield estimates at state/territory, PHN and LHN levels. In this report, all tables reporting on the number of NDIS participants are based on the aggregation of the SA3 summaries. According to publicly available data, in March 2023, there were about 61,000 NDIS participants whose primary disability was a psychosocial disability (Table 45). The most commonly reported diagnosis for these participants was schizophrenia (50% of participants), followed by bipolar affective disorder (10%), major depressive illness (9%) and schizoaffective disorder (5%).

Table 45: Diagnosis categories of NDIS participants with a psychosocial disability recorded as a primary disability, March 2023

Diagnosis categories	Participants
F20 – Schizophrenia	30,403
F25.9 – Schizoaffective Disorder	3,033
F31 – Bipolar affective disorder	5,872
F32 – Major depressive illness	5,255
F41 – Other Anxiety disorders	1,836
F42 – Obsessive-compulsive disorder	299
F43 – Post traumatic stress disorder (PTSD)	2,768
F60.3 – Borderline personality disorder	2,410
F99 – Other psychosocial disorders	8,918
Other specified conditions	70
<b>Total</b>	<b>60,864</b>

Source: National Disability Insurance Agency (2023)

Other than Table 45, the tables below relating to NDIS participants are based on summarising data obtained from the NDIA. Data for the 2022–23 financial year is based on statistics for June 2023.

Table 46 shows the number of NDIS participants at June 2023 by age group where there is a primary or secondary psychosocial disability. The NDIA reported NDIS participants aged less than 18 years in a 0 to 17 year age group. For the purpose of this analysis, these participants are allocated to the 12 to 24 year age group.

Table 46: Number of participants in the NDIS by age group, and primary or secondary psychosocial disability, 2022–23

Disability group	Age group				Total
	12-24 <sup>2</sup>	25-64	65+	12-64 years	
Primary <sup>1</sup>	2,340	55,050	4,110	57,390	61,500
Secondary	11,800	20,420	2,210	32,210	34,420
<b>Total</b>	<b>14,130</b>	<b>75,470</b>	<b>6,320</b>	<b>89,600</b>	<b>95,930</b>

<sup>1</sup>The sum of participants across the age groups may not equal the total due to rounding.

<sup>2</sup>The 12–24 years age group is based on data from participants aged 0–18 and 19 to 24 years.

Overall, there were 61,500 NDIS participants with a primary psychosocial disability reported and approximately 34,420 with a secondary psychosocial disability. The Productivity Commission analysis did not include people with a secondary psychosocial disability in their analysis.

Through the consultations held for this project, views were heard on how people with a secondary psychosocial disability should be included in the analysis. At one national workshop it was heard from people with lived experience that people applying for the NDIS with a psychosocial and another disability, may not always identify their psychosocial disability as their primary disability, even though this may have a very significant impact on their lives. A consideration for people applying to the NDIS was the additional challenges they may have faced in being approved to participate in the scheme where the primary disability was identified as being psychosocial.

In that workshop it was also heard from people with lived experience that the nature of psychosocial support provided under an NDIS plan may extend beyond the *capacity building* categories within the plan. HPA heard from other stakeholders that the psychosocial support needs from NDIS participants may be underestimated. This may be due to the nature of the approved plan or availability of psychosocial services within their community. Consequently, it may be difficult for participants to access all the psychosocial supports they need under the scheme.

Based on the above, it was concluded that it is important that a portion of NDIS participants with a secondary psychosocial disability are included in the analysis as receiving some psychosocial supports through the NDIS<sup>7</sup>. Based on stakeholder feedback, all people with a primary psychosocial disability were considered as having a severe mental illness. Using analysis of NDIS diagnosis categories, HPA estimated that 13.6% of people with a secondary psychosocial disability would be allocated to the severe mental illness severity group and the other 86.4% to the moderate severity group. Among these people, 7.0% were reported as having schizophrenia, 0.6% schizoaffective

<sup>7</sup> A limitation of the report is that there could be potential double counting of people in the NDIS. Some participants can have both a primary and secondary psychosocial disability. This cohort may be approximately 16,000 participants.

disorder and 6.0% bipolar affective disorder, conditions which are allocated to the severe category in the epidemiological analysis that underpins the NMHSPF. Consultations did not identify an alternative approach to this issue. This approach makes no assumption about the extent to which NDIS participant needs are being met. The approach represents a divergence from the approach taken by the Productivity Commission which only focussed on people with severe mental illness and did not count people with a secondary psychosocial disability receiving support through the NDIS.

The steps described above result in an estimate of around 57,390 NDIS participants aged 12 to 64 years who have a primary psychosocial disability and 32,210 (28,020 + 4,190) NDIS participants who have a secondary psychosocial disability (Table 47). Table 47 also shows the number of NDIS participants aged 12 to 64 years with a moderate (28,020) or severe mental illness (61,580) by their state or territory of residence.

Table 47: NDIS participants aged 12–64 years with a primary or secondary psychosocial disability by state and territory, and estimated assignment across mental illness severity categories, June 2023

State	Secondary		Primary <sup>2</sup>	Total <sup>1</sup>	By Severity	
	Moderate	Severe			Moderate	Severe
NSW	9,360	1,400	17,000	27,760	9,360	18,400
Vic	7,460	1,120	18,200	26,770	7,460	19,310
Qld	5,870	880	11,120	17,870	5,870	12,000
WA	2,180	330	4,920	7,420	2,180	5,240
SA	1,900	280	3,520	5,700	1,900	3,800
Tas	630	90	1,060	1,780	630	1,150
ACT	480	70	1,030	1,580	480	1,100
NT	150	20	550	730	150	570
<b>Total<sup>1</sup></b>	<b>28,020</b>	<b>4,190</b>	<b>57,390</b>	<b>89,600</b>	<b>28,020</b>	<b>61,580</b>

<sup>1</sup>The sum of participants across the states may not equal the total due to rounding.

<sup>2</sup>NDIS participants who have a primary diagnosis of psychosocial disability are assumed to be in the severe cohort.

## NDIS service provision

In the original methods developed for this project, it was planned to analyse the provision of psychosocial supports provided under the NDIS. As reported above, data supplied for this analysis by the NDIA did not include data on services accessed by participants. The data did include summaries of expenditures under NDIS plans, broken into the core support, capacity-building and capital categories. For each of these categories, data was provided for average annual committed support and the total payments made. The information provided did not identify participants for whom there was no actual expenditure.

In the final methods adopted for the project, it was not necessary to assess the level of services provided under the NDIS.

The assessment of what services are received by NDIS participants is potentially relevant to the second measure of unmet need: the gap between the hours of psychosocial services recommended within the NMHSPF and the hours of psychosocial services provided. However, the approach

calculating this second measure of unmet need (see Chapter 4), does not rely on estimating NDIS service provision.

An analysis conducted by David McGrath for the South Australian Health Department (David McGrath Consulting, 2023) did describe an approach to identifying the psychosocial components of NDIS plans, and converting reported expenditures under the plans to estimates of service provision. McGrath considered the three types of support categories within NDIS plans and concluded that the “... capacity building categories are the most analogous to psychosocial disability support activities funded from other sources outside the NDIS, and therefore most analogous to NMHSPF taxonomy elements”. Two other types of service, which fall under the core support category, were also identified as being aligned with psychosocial supports. McGrath analysed publicly available data for South Australia on “line item” expenditures for NDIS plans to estimate psychosocial supports. Benchmarks for the NMHSPF were then used to convert expenditures into measures of service delivery. A comparison of the analysis in this report and the analysis completed by David McGrath (2023) for South Australia can be found in Appendix G.

In national stakeholder consultations for this project, it was heard from people with lived experience that the nature of psychosocial support provided under NDIS plans may extend beyond capacity-building supports and include core supports and/or capital supports. This perspective was also emphasised in consultations held with the NDIA representatives.

# 4. Unmet need for psychosocial support (Step 3)

This chapter brings together information on the number of people estimated to need some psychosocial services, their psychosocial service requirements and compares this with the number who received services under programs funded by the Australian Government, state and territory governments and the NDIS, and the level of service (reflected in hours of support) received under these programs. This results in an estimate of unmet need that can be reflected in two measures:

- Measure 1: The number of people not receiving psychosocial support services.
- Measure 2: The gap between the hours of psychosocial services recommended within the NMHSPF, and the hours of psychosocial services provided.

The key results of the estimate of unmet need in Australia in 2022–23 by these two measures were:

*Measure 1:* In 2022–23, 493,600 people aged 12–64 years with a severe or moderate mental illness who required psychosocial support but were not receiving psychosocial supports through the NDIS or other government-funded programs. This comprised:

- 230,500 people aged 12–64 years with a severe mental illness.
- 263,100 people aged 12–64 years with a moderate mental illness.

*Measure 2:* In 2022–23, 16.8 million hours of psychosocial support were required for people aged 12–64 years with a severe or moderate mental illness but not provided. This comprised:

- 14.07 million hours of psychosocial support for people aged 12–64 with a severe mental illness.
- 2.76 million hours of psychosocial support for people aged 12–64 with a moderate mental illness.

Note: Figures above are rounded.

One feature of these two approaches (the number of people not receiving psychosocial supports and the gap in hours of psychosocial services recommended and provided) to estimate unmet need for psychosocial supports, is that although the number of people with severe or moderate mental illness not receiving psychosocial support are similar, the estimate of the number of hours of psychosocial support not provided is much higher for people with a severe mental illness.

Appendix G provides a comparison of the analysis of unmet need in SA presented in this report with the “Unmet mental health service need in South Australia that could be met by the NGO sector” report by David McGrath Consulting (2023).

## Step 3

### ESTIMATE UNMET NEED

3.1 Estimate the number of people within the target cohorts not receiving psychosocial support services broken down by age group, severity and region.

3.2 Estimate the gap between the level of psychosocial services recommended within the NMHSPF, and the level of services currently provided, broken down by age group, severity and region.

## Measure 1: People not receiving psychosocial support services

To determine the number of people who were not receiving psychosocial services, the total number of recipients from state and territory, Australian Government, and NDIS programs was subtracted from the overall estimated need for psychosocial support. This approach used data on need as modelled by the NMHSPF, alongside actual service use from governmental and NDIS sources, to identify the unmet need within the target cohort. Figure 7 shows the steps and the results of this analysis. As described earlier in this report, this approach is consistent with the approach adopted for the estimates included in the Productivity Commission report.

Figure 7: Steps in estimating unmet need for psychosocial support services  
and results by level of severity, 2022–23

		Level of severity:	
		Severe	Moderate
<b>Step 1</b>	Estimated need for psychosocial support (aged 12-64 years)	335,800	311,500
<b>Step 2</b> <i>Subtract step 2 from step 1</i>	Estimated psychosocial supports consumers – <i>within NDIS</i> (aged 12-64 years) -	61,600	28,000
	Estimated psychosocial supports consumers – <i>outside NDIS</i> (aged 12-64 years) -	43,700	20,400
<b>Step 3</b>	Estimated unmet need for psychosocial supports (aged 12-64 years)	230,500	263,100

Numbers are rounded to the nearest 100.

Table 48 shows the results of this approach and subsequently the total number of people not receiving psychosocial supports in 2022–23, by severity of mental illness and age group. This Table also shows the percentage of consumers receiving psychosocial supports and not receiving psychosocial support out of the total estimated people (consumers) requiring psychosocial support. The Table shows that 230,520 (68.6%) people with severe mental illness and 263,120 (84.5%) people with moderate mental illness, giving a total of 493,640 people (76.3%), required psychosocial support but were not receiving psychosocial support through the NDIS or other government-funded programs in 2022–23.

Table 48: Number of people (n) aged 12–64 years and the percentage (%) of people requiring but not receiving psychosocial support services, by severity, age group and program funder, 2022–23

Severity	Age group	People requiring psychosocial support	People receiving psychosocial support:			People not receiving psychosocial support
			NDIS	State	Aust Govt	
<b>People</b>	-	n	n	n	n	n
Moderate	12-24	154,510	10,260	1,230	4,500	138,510
	25-64	156,990	17,760	3,870	10,760	124,610
	<b>Subtotal</b>	<b>311,500</b>	<b>28,020</b>	<b>5,100</b>	<b>15,250</b>	<b>263,120</b>
Severe	12-24	112,940	3,870	6,130	3,050	99,890
	25-64	222,860	57,710	27,100	7,430	130,630
	<b>Subtotal</b>	<b>335,800</b>	<b>61,580</b>	<b>33,230</b>	<b>10,480</b>	<b>230,520</b>
<b>Total</b>	<b>Total</b>	<b>647,300</b>	<b>89,600</b>	<b>38,330</b>	<b>25,740</b>	<b>493,640</b>
<b>Percentage</b>	-	%	%	%	%	%
Moderate	12-24	100	6.6	0.8	2.9	89.6
	25-64	100	11.3	2.5	6.9	79.4
	<b>Subtotal</b>	<b>100</b>	<b>9</b>	<b>1.6</b>	<b>4.9</b>	<b>84.5</b>
Severe	12-24	100	3.4	5.4	2.7	88.4
	25-64	100	25.9	12.2	3.3	58.6
	<b>Subtotal</b>	<b>100</b>	<b>18.3</b>	<b>9.9</b>	<b>3.1</b>	<b>68.6</b>
<b>Total</b>	<b>Total</b>	<b>100</b>	<b>13.8</b>	<b>5.9</b>	<b>4</b>	<b>76.3</b>

Consumer numbers are rounded to the nearest 10, which accounts for minor discrepancies in totals reported.

#### Comparison to Productivity Commission's estimates of unmet need

The unmet need estimate of 230,500 people with a severe mental health condition is higher—by around 76,500 people—than the Productivity Commission's estimate of 154,000 people (Figure 8). The increase in this analysis' estimate arises from both:

- a higher number of people estimated as needing psychosocial supports (335,800 people aged 12-64 years with severe mental illness requiring psychosocial supports in 2022-23, which is about 46,000 more people, compared to the Productivity Commission's estimate of 290,000 people needing psychosocial supports in 2019-20); and
- a lower number of consumers receiving psychosocial support outside of the NDIS (43,700 consumers aged 12-64 years with severe mental illness in 2022-23, which is about 31,300 fewer consumers, compared to the Productivity Commission's estimate of 75,000 consumers outside of the NDIS).

The estimates of psychosocial support need for people with severe mental illness are higher in this analysis, which used the latest version 4.3 of the NMHPSF, than previous Productivity Commission's estimates of need, generated for 2019–20 using NMHSPF Version 2. In addition to the increasing Australian population over time, there are several changes to the modelling in NMHSPF Version 4

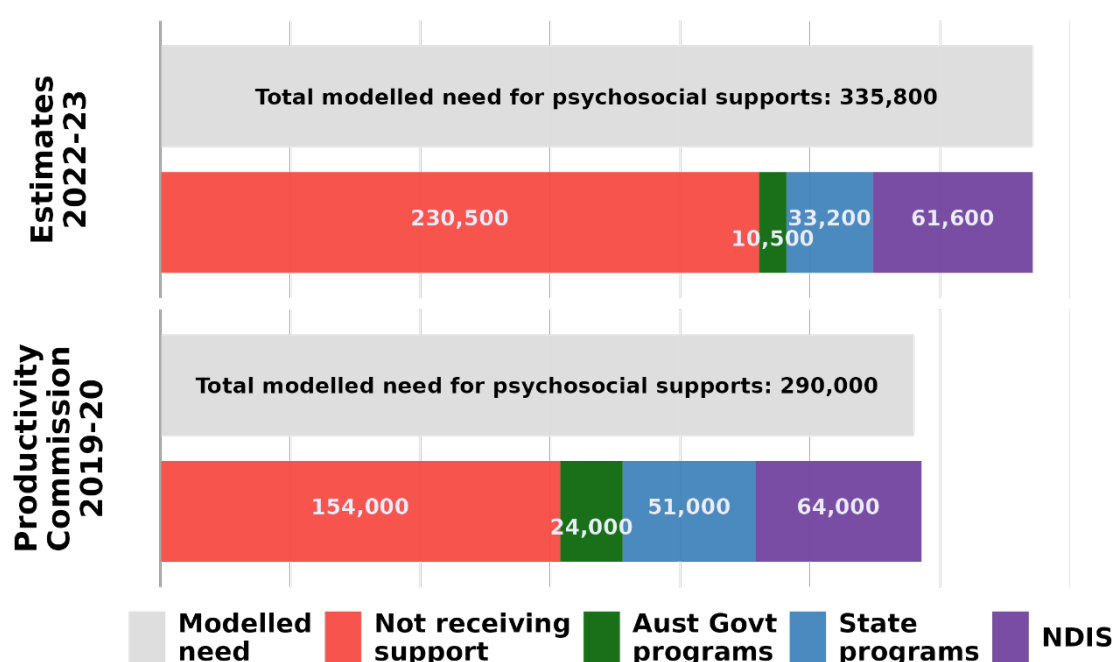
that have affected these need estimates – as explained earlier in section 1.3 Project Methods (Step 1 refers).

The estimates of consumers with severe mental illness receiving psychosocial support services outside the NDIS is significantly lower than the Productivity Commission's earlier estimate. This discrepancy is primarily due to methodological differences in estimating service provision. The Productivity Commission's analysis partly relied on program expenditure, while the current analysis used aggregated client data and employed a more detailed method to align to service types of the NMHSPF taxonomy and to the target cohort of this analysis.

The estimated number of NDIS participants with severe mental illness accessing psychosocial supports through their individualised packages (around 61,600) aligns closely with the Productivity Commission's estimate, which projected that 64,000 individuals with a primary psychosocial disability would access individualised supports under the NDIS at full scheme (Productivity Commission, 2020c, p. 851).

The Productivity Commission did not estimate unmet need for people with a moderate mental health condition. As such, comparisons have not been made between this analysis' estimates and the Productivity Commission for people with a moderate mental health condition.

Figure 8: Comparison of this analysis' estimates (2022–23) and the Productivity Commission's estimates (2019–20): psychosocial need, service provision and unmet need (severe mental illness, 12–64 years)



*Note: This analysis's figures are rounded to the nearest 100. Productivity Commission's estimates are also rounded, and therefore does not correspond exactly with the sum of the component figures.*

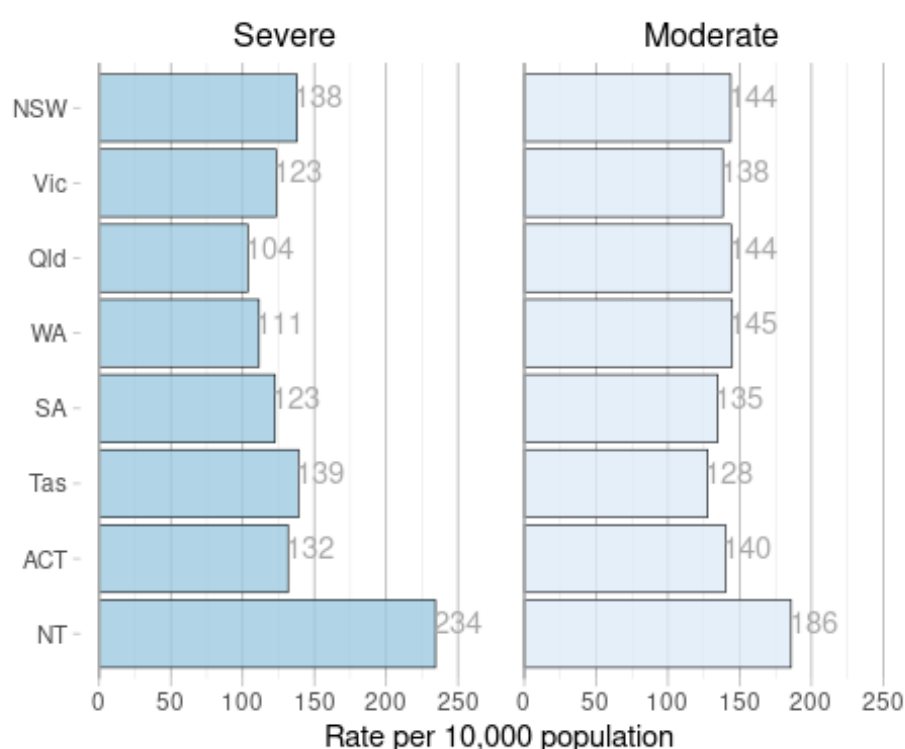
Figure 9 shows the estimate of unmet need (people with severe or moderate mental illness requiring but not receiving psychosocial support services) on a per capita basis across states and territories. On a per capita basis the number of people requiring but not receiving psychosocial support services is generally higher in the Northern Territory for both severe (234 per 10,000 population) and moderate (186 per 10,000 population) mental illness. The rates of people requiring but not receiving psychosocial supports in the other jurisdictions range from 104 to 139 per 10,000 population for

people with severe mental illness and 128 to 145 per 10,000 population for people with moderate mental illness.

The higher rate in the Northern Territory mainly reflects the higher estimated psychosocial support need in the Northern Territory population. As described in Step 2.5, there is a greater need for mental health services for First Nations people in Australia compared to non-Indigenous Australians (Diminic, Page, et al., 2023, p. 52).

Data relating to First Nations SEWB programs in all jurisdictions have also not been included due to several contextual factors. Some stakeholders in the Northern Territory were concerned that excluding SEWB programs was likely to have a major impact on the count of the provision of psychosocial services in the Northern Territory. Further information on SEWB programs can be found on p12 and in Appendix E.

Figure 9: Estimates of people aged 12–64 years requiring but not receiving psychosocial support services, per 10,000 persons aged 12–64 years, by severity and state or territory of residence\*, 2022–23



*\*Data for smaller jurisdictions should be interpreted with caution, the NT is not comparable to other jurisdictions due to the unique operating environment.*

Table 49 shows the number of people with a moderate or severe mental illness, aged 12–64 years, requiring but not receiving psychosocial support services in 2022–23 by the state or territory of residence.

Table 49: Number of people aged 12–64 years requiring but not receiving psychosocial support services by state/territory, severity and program funder, 2022–23

Jurisdiction	Severity	People requiring psychosocial support	People receiving psychosocial support:			People not receiving psychosocial support
			NDIS	State/territory	Aust Govt	
NSW	Moderate	98,880	9,360	140	4,610	84,780
	Severe	106,950	18,400	4,210	3,070	81,260
	<b>Total</b>	<b>205,830</b>	<b>27,760</b>	<b>4,350</b>	<b>7,680</b>	<b>166,040</b>
Vic	Moderate	80,970	7,460	1,760	3,050	68,710
	Severe	84,860	19,310	2,090	2,140	61,310
	<b>Total</b>	<b>165,830</b>	<b>26,770</b>	<b>3,850</b>	<b>5,190</b>	<b>130,020</b>
Qld	Moderate	64,050	5,870	990	3,680	53,510
	Severe	69,500	12,000	16,340	2,660	38,500
	<b>Total</b>	<b>133,540</b>	<b>17,870</b>	<b>17,330</b>	<b>6,340</b>	<b>92,010</b>
WA	Moderate	31,950	2,180	750	1,620	27,410
	Severe	34,900	5,240	7,480	1,080	21,090
	<b>Total</b>	<b>66,850</b>	<b>7,420</b>	<b>8,230</b>	<b>2,700</b>	<b>48,500</b>
SA	Moderate	19,880	1,900	370	1,600	16,010
	Severe	21,260	3,800	1,830	1,070	14,570
	<b>Total</b>	<b>41,140</b>	<b>5,700</b>	<b>2,200</b>	<b>2,670</b>	<b>30,580</b>
Tas	Moderate	6,050	630	770	150	4,510
	Severe	6,770	1,150	610	100	4,910
	<b>Total</b>	<b>12,820</b>	<b>1,780</b>	<b>1,380</b>	<b>250</b>	<b>9,420</b>
ACT	Moderate	5,560	480	280	200	4,610
	Severe	5,830	1,100	270	130	4,330
	<b>Total</b>	<b>11,390</b>	<b>1,580</b>	<b>540</b>	<b>330</b>	<b>8,940</b>
NT	Moderate	4,160	150	50	350	3,600
	Severe	5,740	570	390	230	4,540
	<b>Total</b>	<b>9,900</b>	<b>730</b>	<b>440</b>	<b>580</b>	<b>8,140</b>
<b>Total</b>	Moderate	311,500	28,020	5,100	15,250	263,120
	Severe	335,800	61,580	33,230	10,480	230,520
	<b>Total</b>	<b>647,300</b>	<b>89,600</b>	<b>38,330</b>	<b>25,740</b>	<b>493,640</b>

Consumer numbers are rounded to the nearest 10, which accounts for minor discrepancies in totals reported.

Table 50 provides the percentage of the number of people with a severe or moderate mental illness, aged 12–64 years, requiring but not receiving psychosocial support services in 2022–23, by the state or territory of residence.

Table 50: The percentage (%) of the number of people (n) aged 12–64 years requiring but not receiving psychosocial support services in each state/territory, by severity and program funder, 2022–23

Jurisdiction	Severity	People requiring psychosocial support (%)	People receiving psychosocial support (%):			People not receiving psychosocial support (%)
			NDIS	State/territory	Aust Govt	
NSW	Moderate	100	9.5	0.1	4.7	85.7
	Severe	100	17.2	3.9	2.9	76
	<b>Total</b>	<b>100</b>	<b>13.5</b>	<b>2.1</b>	<b>3.7</b>	<b>80.7</b>
Vic	Moderate	100	9.2	2.2	3.8	84.9
	Severe	100	22.8	2.5	2.5	72.3
	<b>Total</b>	<b>100</b>	<b>16.1</b>	<b>2.3</b>	<b>3.1</b>	<b>78.4</b>
Qld	Moderate	100	9.2	1.5	5.8	83.5
	Severe	100	17.3	23.5	3.8	55.4
	<b>Total</b>	<b>100</b>	<b>13.4</b>	<b>13</b>	<b>4.7</b>	<b>68.9</b>
WA	Moderate	100	6.8	2.3	5.1	85.8
	Severe	100	15	21.4	3.1	60.4
	<b>Total</b>	<b>100</b>	<b>11.1</b>	<b>12.3</b>	<b>4</b>	<b>72.5</b>
SA	Moderate	100	9.5	1.9	8.1	80.5
	Severe	100	17.9	8.6	5	68.5
	<b>Total</b>	<b>100</b>	<b>13.9</b>	<b>5.3</b>	<b>6.5</b>	<b>74.3</b>
Tas	Moderate	100	10.4	12.7	2.4	74.5
	Severe	100	17	9	1.5	72.5
	<b>Total</b>	<b>100</b>	<b>13.9</b>	<b>10.8</b>	<b>1.9</b>	<b>73.4</b>
ACT	Moderate	100	8.6	5	3.5	82.9
	Severe	100	18.9	4.6	2.2	74.3
	<b>Total</b>	<b>100</b>	<b>13.9</b>	<b>4.8</b>	<b>2.9</b>	<b>78.5</b>
NT	Moderate	100	3.7	1.3	8.4	86.6
	Severe	100	10	6.8	4.1	79.1
	<b>Total</b>	<b>100</b>	<b>7.3</b>	<b>4.5</b>	<b>5.9</b>	<b>82.3</b>
<b>Total</b>	Moderate	100	9	1.6	4.9	84.5
	Severe	100	18.3	9.9	3.1	68.6
	<b>Total</b>	<b>100</b>	<b>13.8</b>	<b>5.9</b>	<b>4</b>	<b>76.3</b>

The number of people aged 65 years and over who required but did not receive any psychosocial services in 2022–23 is shown in Table 51. Of the 62,420 people (aged 65 years and over) with severe mental illness who required some psychosocial support in 2022–23, 54,970 (88.1%) did not receive

any psychosocial services. Of the 82,040 people with moderate mental illness who required some psychosocial support in 2022–23, 78,290 (95.4%) did not receive psychosocial services.

Table 51: Number of people (n) and the percentage of people (%) aged 65 years and over requiring but not receiving psychosocial support services by severity and program funder, 2022–23

Severity	People requiring psychosocial support	People receiving psychosocial support			People not receiving psychosocial support
		NDIS	State/territory	Aust Govt	
<b>People</b>	n	n	n	n	n
Moderate	82,040	1,920	330	1,490	78,290
Severe	62,420	4,400	2,050	1,000	54,970
<b>Total</b>	<b>144,460</b>	<b>6,320</b>	<b>2,380</b>	<b>2,490</b>	<b>133,270</b>
<b>Percentage</b>	%	%	%	%	%
Moderate	100	2.3	0.4	1.8	95.4
Severe	100	7	3.3	1.6	88.1
<b>Total</b>	<b>100</b>	<b>4.4</b>	<b>1.6</b>	<b>1.7</b>	<b>92.3</b>

*Consumer numbers are rounded to the nearest 10, which accounts for minor discrepancies in totals reported.*

## Measure 2: Unmet need for hours of psychosocial support

The second measure of unmet need involved calculating the difference between the required and provided hours of psychosocial support. This method subtracted the hours of support provided for NDIS participants and those provided by state, territory and Australian Government programs from the total hours needed for the target cohort. These calculations were based on the requirements outlined in the NMHSPF.

Figure 10 shows the summarised method and the results of the unmet need in terms of the gap between the hours of psychosocial support recommended within the NMHSPF, and the hours of psychosocial support provided. It shows that for people with severe mental illness aged 12–64 years, the number of hours of psychosocial support required but not being provided in 2022–23 was estimated at 14.07 million, and for people with moderate mental illness it was estimated at 2.76 million.

Figure 10: Steps in estimating unmet need for psychosocial support service hours  
and results by level of severity, 2022–23

		Level of severity:	
		Severe	Moderate
<b>Step 1</b>	Estimated number of hours of psychosocial supports required (aged 12–64 years)	21,850,000	3,290,000
<b>Step 2</b>  <i>Subtract step 2 from step 1</i>	Estimated hours of psychosocial supports - <i>NDIS participants</i> (aged 12–64 years)	- 4,521,000	263,000
	Estimated hours of psychosocial supports – <i>state/territory programs</i> (aged 12–64 years)	- 3,052,000	203,000
	Estimated hours of psychosocial – <i>Australian Government programs</i> (aged 12–64 years)	- 209,000	70,000
<b>Step 3</b>	Estimated unmet need for hours of psychosocial supports (aged 12–64 years)	14,068,000	2,755,000

Hours are presented as 1,000 hours.

Table 52 presents the number of hours of psychosocial support required but not being provided in 2022-23 to people aged 12 to 64 with:

- severe mental illness (14.07 million hours), or
- moderate mental illness (2.76 million hours).

The percentage of hours required but not provided is also presented as:

- 81.2% for people with severe mental illness, and
- 91.0% for people with moderate mental illness.

Table 52: Number of hours ('000) of psychosocial support (n) and the percentage of hours (%) required but not being provided to people aged 12–64 years with a moderate or severe mental illness across Australia, by severity, age group and program funder, 2022–23

Severity	Age group	Hours ('000) of psychosocial support required total	Hours ('000) of psychosocial support required excluding NDIS participants*	Hours ('000) of psychosocial support provided through programs:		Hours ('000) of psychosocial support not being provided
				State/territory	Aust Govt	
<b>Hours</b>	-	n	n	n	n	n
Moderate	12-24	2,348	2,192	54	15	2,124
	25-64	942	835	149	55	631
	<b>Total</b>	<b>3,290</b>	<b>3,027</b>	<b>203</b>	<b>70</b>	<b>2,755</b>
Severe	12-24	5,053	4,880	630	43	4,207
	25-64	16,797	12,448	2,422	166	9,860
	<b>Total</b>	<b>21,850</b>	<b>17,328</b>	<b>3,052</b>	<b>209</b>	<b>14,068</b>
Total	12-24	7,401	7,072	683	58	6,331
	25-64	17,738	13,283	2,571	221	10,492
	<b>Total</b>	<b>25,140</b>	<b>20,356</b>	<b>3,255</b>	<b>278</b>	<b>16,823</b>
<b>Percentage</b>	-	n	%	%	%	%
Moderate	12-24	2,348	100	2.4	0.7	96.9
	25-64	942	100	17.8	6.6	75.6
	<b>Total</b>	<b>3,290</b>	<b>100</b>	<b>6.7</b>	<b>2.3</b>	<b>91</b>
Severe	12-24	5,053	100	12.9	0.9	86.2
	25-64	16,797	100	19.5	1.3	79.2
	<b>Total</b>	<b>21,850</b>	<b>100</b>	<b>17.6</b>	<b>1.2</b>	<b>81.2</b>
Total	12-24	7,401	100	9.7	0.8	89.5
	25-64	17,738	100	19.4	1.7	79
	<b>Total</b>	<b>25,140</b>	<b>100</b>	<b>16</b>	<b>1.4</b>	<b>82.6</b>

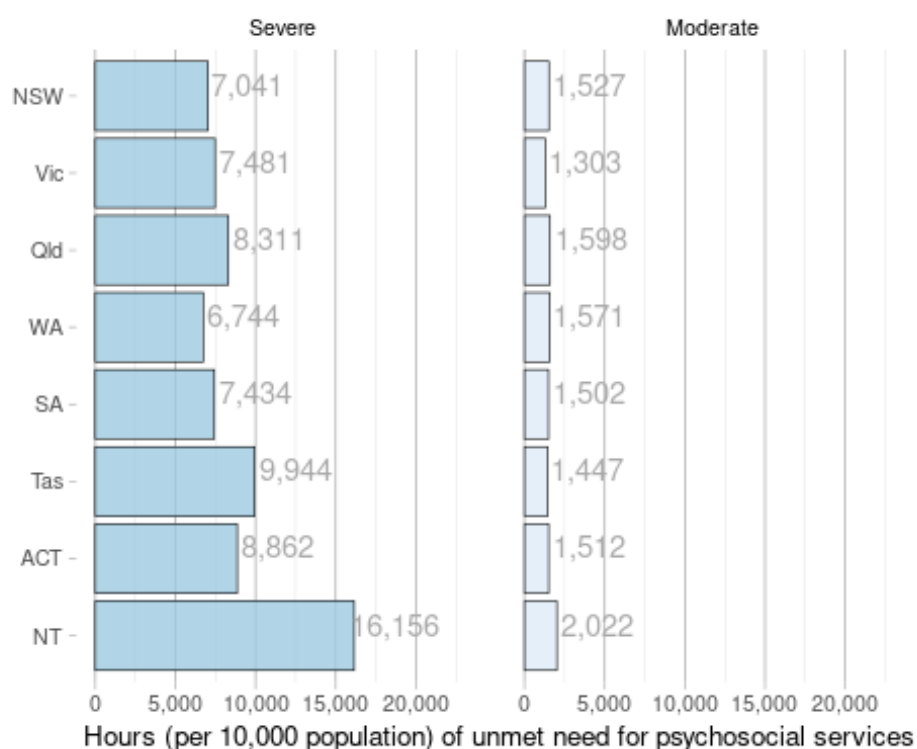
Hours are presented as 1,000 hours, which accounts for minor discrepancies in totals reported; \*Hours of psychosocial supports required excluding NDIS participants was derived by subtracting the hours of psychosocial support NDIS participants would have received (if they received on average the same number of hours as consumers in the same age and severity group who were not NDIS participants) from the total number of hours.

Figure 11 shows the estimate for the number of hours of support required but not provided to people with a moderate or severe mental illness on a per-capita basis across states and territories. Similar to the per-capita comparison of the number of people requiring but not receiving any services (Figure 9), the Northern Territory had a higher rate of hours of psychosocial services required but not provided than the other jurisdictions.

As discussed earlier, the higher rate of unmet need for hours of psychosocial services in the Northern Territory mainly reflects the higher estimated need for psychosocial supports in the

Northern Territory population, where the rate of hours of need for psychosocial services per 10,000 people is 1,974, which is much higher than other jurisdictions where it ranges from 1,117 to 1,248.

Figure 11: Number of hours of psychosocial support required but not being provided to people with a moderate or severe mental illness aged 12–64 years, per 10,000 population aged 12–64 years, by severity and state or territory of residence\*, 2022–23



*\*Data for smaller jurisdictions should be interpreted with caution, the NT is not comparable to other jurisdictions due to the unique operating environment.*

Table 53 summarises estimates for the number of hours of psychosocial required but not provided to people with a moderate or severe mental illness, aged 12–64 years, at a state and territory level in 2022–23. Table 54 provides the percentage of the hours of psychosocial supports that were required but not provided in 2022–23 by state and territory.

Table 53: Number of hours ('000) of psychosocial support required but not being provided to people aged 12–64 years with a moderate or severe mental illness across Australia by state/territory, severity and program funder, 2022–23

Jurisdiction	Severity	Hours ('000) of psychosocial support required total	Hours ('000) of psychosocial support required excluding NDIS participants*	Hours ('000) of psychosocial support provided through programs:		Hours ('000) of psychosocial support not being provided
				State/territory	Aust Govt	
NSW	Moderate	1,042	950	24	25	901
	Severe	6,975	5,631	1,417	67	4,148
	<b>Total</b>	<b>8,017</b>	<b>6,581</b>	<b>1,441</b>	<b>92</b>	<b>5,048</b>
Vic	Moderate	852	784	124	14	646
	Severe	5,543	4,118	349	46	3,722
	<b>Total</b>	<b>6,394</b>	<b>4,902</b>	<b>473</b>	<b>60</b>	<b>4,368</b>
Qld	Moderate	683	628	21	14	593
	Severe	4,482	3,601	465	52	3,085
	<b>Total</b>	<b>5,165</b>	<b>4,229</b>	<b>485</b>	<b>66</b>	<b>3,678</b>
WA	Moderate	336	315	11	7	297
	Severe	2,267	1,882	587	19	1,275
	<b>Total</b>	<b>2,602</b>	<b>2,197</b>	<b>598</b>	<b>27</b>	<b>1,572</b>
SA	Moderate	210	195	9	7	178
	Severe	1,382	1,101	200	19	883
	<b>Total</b>	<b>1,592</b>	<b>1,296</b>	<b>209</b>	<b>26</b>	<b>1,061</b>
Tas	Moderate	63	58	6	0	51
	Severe	440	357	5	1	351
	<b>Total</b>	<b>504</b>	<b>414</b>	<b>11</b>	<b>1</b>	<b>402</b>
ACT	Moderate	60	55	4	1	50
	Severe	379	299	5	2	292
	<b>Total</b>	<b>439</b>	<b>354</b>	<b>10</b>	<b>3</b>	<b>341</b>
NT	Moderate	45	43	3	1	39
	Severe	382	340	25	2	313
	<b>Total</b>	<b>427</b>	<b>383</b>	<b>28</b>	<b>3</b>	<b>352</b>
<b>Total</b>	Moderate	3,290	3,027	203	70	2,755
	Severe	21,850	17,328	3,052	209	14,068
	<b>Total</b>	<b>25,140</b>	<b>20,356</b>	<b>3,255</b>	<b>278</b>	<b>16,823</b>

Hours are presented as 1,000 hours, which accounts for minor discrepancies in totals reported; \*Hours of psychosocial supports required excluding NDIS participants was derived by subtracting the hours of psychosocial support NDIS

*participants would have received (if they received on average the same number of hours as consumers in the same age and severity group who were not NDIS participants) from the total number of hours.*

Table 54: The percentage (%) of the number of hours ('000) of psychosocial support (n) required but not being provided for people aged 12–64 years with a moderate or severe mental illness, by state/territory, severity and program funder, 2022–23

Jurisdiction	Severity	Hours ('000) of psychosocial support required total (n)	Hours of psychosocial support required excluding NDIS participants (%)*	Hours of psychosocial support provided through programs (%):		Hours of psychosocial support not being provided (%)
				State/territory	Aust Govt	
NSW	Moderate	1,042	100	2.6	2.6	94.8
	Severe	6,975	100	25.2	1.2	73.7
	<b>Total</b>	<b>8,017</b>	<b>100</b>	<b>21.9</b>	<b>1.4</b>	<b>76.7</b>
Vic	Moderate	852	100	15.8	1.8	82.4
	Severe	5,543	100	8.5	1.1	90.4
	<b>Total</b>	<b>6,394</b>	<b>100</b>	<b>9.6</b>	<b>1.2</b>	<b>89.1</b>
Qld	Moderate	683	100	3.3	2.2	94.5
	Severe	4,482	100	12.9	1.4	85.7
	<b>Total</b>	<b>5,165</b>	<b>100</b>	<b>11.5</b>	<b>1.6</b>	<b>87</b>
WA	Moderate	336	100	3.3	2.3	94.3
	Severe	2,267	100	31.2	1	67.8
	<b>Total</b>	<b>2,602</b>	<b>100</b>	<b>27.2</b>	<b>1.2</b>	<b>71.6</b>
SA	Moderate	210	100	4.8	3.6	91.6
	Severe	1,382	100	18.2	1.7	80.1
	<b>Total</b>	<b>1,592</b>	<b>100</b>	<b>16.2</b>	<b>2</b>	<b>81.9</b>
Tas	Moderate	63	100	10.7	0.6	88.8
	Severe	440	100	1.4	0.2	98.4
	<b>Total</b>	<b>504</b>	<b>100</b>	<b>2.7</b>	<b>0.3</b>	<b>97.1</b>
ACT	Moderate	60	100	8	1.6	90.3
	Severe	379	100	1.8	0.8	97.4
	<b>Total</b>	<b>439</b>	<b>100</b>	<b>2.8</b>	<b>0.9</b>	<b>96.3</b>
NT	Moderate	45	100	7.5	2.1	90.4
	Severe	382	100	7.2	0.7	92.1
	<b>Total</b>	<b>427</b>	<b>100</b>	<b>7.3</b>	<b>0.9</b>	<b>91.9</b>
<b>Total</b>	Moderate	3,290	100	6.7	2.3	91
	Severe	21,850	100	17.6	1.2	81.2
	<b>Total</b>	<b>25,140</b>	<b>100</b>	<b>16</b>	<b>1.4</b>	<b>82.6</b>

Percentages were calculated from the raw data and may be slightly different to those calculated from Table 53; \*The denominator for percentages in the table is the hours of psychosocial supports required excluding NDIS participants, which was derived by subtracting the hours of psychosocial support NDIS participants would have received (if they received on average the same number of hours as consumers in the same age and severity group who were not NDIS participants) from the total number of hours.

The number of hours and the percentage of psychosocial support required but not provided to people aged 65 years or over who have severe or moderate mental illness is shown in Table 55. For people with severe mental illness aged 65 years or over, 3.27 million hours (87.7%) of psychosocial supports were required but not provided in 2022–23 out of the 4.01 million hours needed. For people with moderate mental illness aged 65 years or over, 273,000 hours (73%) of service were required but not provided in 2022–23 out of the 382,000 hours needed.

Table 55: Number of hours ('000) of psychosocial support (n) and the percentage of hours (%) required but not being provided for people aged 65 years and over with a moderate or severe mental illness, across Australia, by severity and program funder, 2022–23

Severity	Hours ('000) of psychosocial support required total	Hours ('000) of psychosocial support required excluding NDIS participants*	Hours ('000) of psychosocial support provided through programs:		Hours ('000) of psychosocial support not being provided
			State/territory	Aust Govt	
<b>People</b>	n	n	n	n	n
Moderate	382	373	5	95	273
Severe	4,013	3,730	206	254	3,270
Total	4,395	4,103	211	349	3,543
<b>Percentage</b>	n	%	%	%	%
Moderate	382	100	1.4	25.5	73
Severe	4,013	100	5.5	6.8	87.7
Total	4,395	100	5.1	8.5	86.3

Hours are presented as 1,000 hours, which accounts for minor discrepancies in totals reported; \*Hours of psychosocial supports required excluding NDIS participants was derived by subtracting the hours of psychosocial support NDIS participants would have received (if they received on average the same number of hours as consumers in the same age and severity group who were not NDIS participants) from the total number of hours.

## 5. Sensitivity analysis

The methods used for the analysis presented in this report required various assumptions to be made, given the level of detail and nature of the data that was available for analysis. A sensitivity analysis was undertaken to explore how changes in assumptions about the data may affect the estimates of unmet need. This chapter presents these results. Key findings from the analysis include:

- The modelling and NMHSPF are underpinned by population projections that were published by the ABS in 2018. Later population estimates will have a minor effect on the results, potentially reducing the estimate of unmet need by less than 2%. This would be offset to a large extent by high immigration experience in recent years.
- The impacts of other assumptions were tested by considering a range of values that were feasible and how likely those alternative values were to occur. Combinations of these assumptions were then examined, using their probability. It was found that the range of estimates of unmet need using the first measure (people needing but not receiving psychosocial support) could fall between 212,900 people and 238,700 people, and that there can be high confidence that the estimate of unmet need lies between 214,800 and 238,700 people. This represents a range of -6.8% to +2.4% of the final estimate of 230,500 people.

The sensitivity analysis provides confidence that the level of unmet need estimated in this report and based on the NMHSPF, will not vary significantly under different assumptions.

### Population data

Population estimates and projections are central to the estimates of unmet need. For the analysis, the population data used was from the NMHSPF-PST V4.3 (Australian Bureau of Statistics, 2018a). The rationale to using the population projections from the NMHSPF-PST is that these include projections at a level of detail not available in the latest population estimates, including estimates for First Nations people at an SA3 level that were developed by the AIHW and ABS specifically for use within the NMHSPF-PST. Additional modelling was undertaken based on the 2016 Census to stratify data by "NMHSPF age groups, Indigenous status and rurality from the ABS" (Diminic, Gossip, et al., 2023, p. 26). When summed across SA3s, the total population was estimated as 27,101,404.

The most recent publication by the Australian Bureau of Statistics indicates the population of Australia on 30 June 2023 was 26,648,878.<sup>8</sup> Therefore, there were about 450,000 fewer people in Australia in 2023 than were projected in 2018 (approximately 1.7% less). The Coronavirus disease (COVID-19) pandemic had a substantial impact on the population of Australia through reduced migration although there has been some increase post COVID-19.

If the population structures are similar between the earlier projections and more recent estimates specifically in relation to the age distribution and First Nations status, then it is expected that need would be about 1.7% lower or around 5,600 fewer people with severe mental illness needing psychosocial support. A reduced level of need for psychosocial support services would in turn reduce the gap between the need for and the number of people receiving psychosocial support services.

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<sup>8</sup> Table 5 (National, state and territory population, Sep 2023)

This would result in a reduction in the number of people with severe mental illness needing but not receiving a psychosocial support in 2022–23 from 230,500 to 224,900.

## Other assumptions

The estimation of unmet need at the national level required several assumptions:

1. Among clients who receive services funded by the Australian Government (except those receiving support from either the Canefields or Kindred Clubhouses) it was assumed 40% would be assigned to the severe mental illness category. An alternative assumption is that 100% of people accessing Australian Government-funded programs were people with a severe mental illness. If this assumption applied, the overall number of people aged 12 to 64 years requiring but not receiving psychosocial support in 2022–23 would be unchanged, but the number of people with a severe mental illness requiring but not receiving psychosocial support would be reduced by around 15,260 people (from 230,520 to 215,260 people) and those with a moderate mental illness requiring but not receiving psychosocial support would increase by around 15,260 (from 263,120 to 278,380). HPA estimates range of possible values for this assumption was between 20% and 100%. This was modelled using a uniform probability density function, meaning that values between 20% and 100% were modelled with an equal probability.
2. Among clients who receive services funded through Australian Government programs, it was assumed that people whose mental illness is classified as severe, would receive 4 times as many hours of psychosocial services as those whose mental illness is classified as moderate, which is referred here to as the *Hours ratio* assumption. This assumption does not affect the number of clients requiring but not receiving psychosocial supports but does impact the distribution of hours between the severe and moderate groups. When the assumption varies between 2.1 and 5.6 hours it changes the number of hours of psychosocial supports required but not received in the severe group to between 14.09 million and 14.04 million hours.
3. It was assumed that all NDIS participants who have a psychosocial disability that is their primary disability would be allocated to the severe mental illness group. It was also assumed that 13% of NDIS participants whose psychosocial disability is a secondary disability would be allocated to the severe mental illness group, which here is referred to as the *NDIS secondary psychosocial disability percent severe* assumption. This means that 87% of NDIS participants whose psychosocial disability is a secondary disability were allocated to the moderate mental illness group. Our simulation allows the percentage of NDIS participants with a secondary diagnosis that are classified as severe to vary from 6 to 19%. When it is 6%, the number of people with a severe mental illness needing but not receiving psychosocial support services increases from 230,520 to 232,771, and when it is 19% the number drops to 228,584.
4. Implicitly the analysis presented assumed that data provided by the jurisdictions captures all psychosocial services funded and delivered by the jurisdiction, which includes the number of people who receive psychosocial support and the number of hours of services they receive. This is referred to as the *No undercount* assumption. It is quite possible that not all in-scope activity in the jurisdiction was captured in the reported data and many jurisdictions reported that not all psychosocial activity was included due to data limitations. If it is assumed that 10% of people with a severe psychosocial disability were not captured in this service provision data, then the number of people who received psychosocial services would have been underestimated and the number of people with an unmet need for psychosocial supports overestimated. Therefore, the

number of people with severe mental illness who needed but did not receive psychosocial supports would have been approximately 226,824, instead of 230,520.

5. Although the data extraction and analysis processes attempted to limit overlap of people who received services from multiple programs, it is feasible that the analysis has included people who received services from multiple sources, such as from both jurisdiction and Australian Government-funded services. It was assumed that there was no overlap between programs, which is referred to as the *Distinct* people assumption. If it is assumed that 10% of the consumers that were assumed to be distinct, were counted twice, then the analysis has overestimated the number of people who received psychosocial services and underestimated the number of people with an unmet need. The number of people with a severe mental illness who required but did not receive psychosocial supports would have been 234,887 instead of 230,520, but there would have been no effect on the hours.

HPA conducted sensitivity analysis to estimate the impact of these five assumptions on the estimate of unmet need related to people with severe mental illness not receiving psychosocial support. The sensitivity analysis was implemented by adding a parameter to the model for each of the assumptions listed above and refitting the model under the different values of the parameters. The list of the parameters is shown in Table 56, along with the values of the parameters used to derive the estimates presented in the main analysis.

HPA simulated a range of values for each parameter. For the first parameter 50 values were simulated using a uniform distribution between 20 and 100%. For the next two parameters, it was assumed that they were normally distributed with a mean equal to the value in the main analysis and standard deviation equal to 25% of the mean. The last two parameters were simulated assuming a triangular distribution between 0 and 0.1. HPA cross tabulated all possible values of the parameters and randomly selected 1,000 sets of the parameters and then fitted models with each set.

Table 56: Parameters and the range of their values used in the sensitivity analysis

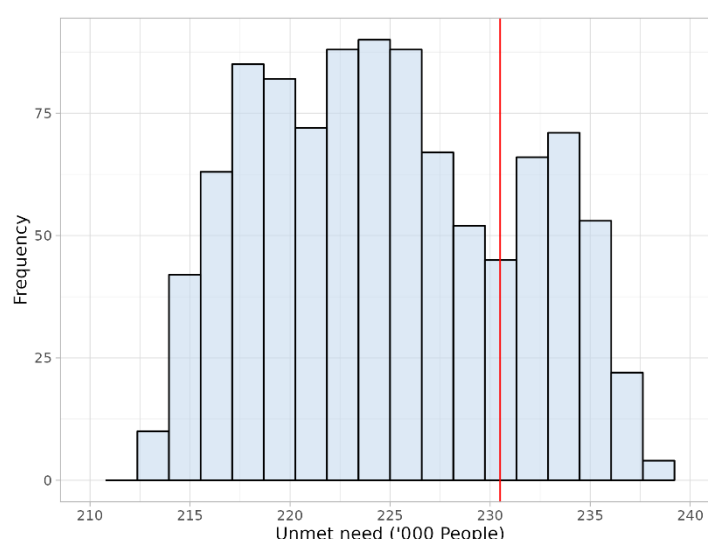
Parameter	Value used in the main analysis	Range of values used in the sensitivity analysis
Australian Government programs: Percent of people receiving support who are allocated to the severe (vs moderate) severity category	40%	20% to 100%
Australian Government programs: The ratio of hours of support provided to people allocated to the severe (vs moderate) severity category	4.00	2.11 to 5.62
NDIS: Percent of people with secondary psychosocial disability allocated to severe category (vs moderate) severity category	13%	6% to 19%.
Under count: Percent of psychosocial services not captured by the data	0%	0% to 10%
Distinct people: Percent of overlap of people receiving psychosocial services	0%	0% to 10%

The distribution of the estimates of people within the severe target cohort generated from the 1,000 simulations is shown in Figure 12. The median value of the distribution is lower than the final estimate for this measure of unmet need (224,500 vs 230,500) with the values from the simulations ranging from 212,900 to 238,700 and the 95% of the simulations falling between 214,800 and 236,100. The values are lower when all parameters are modified because of the impact of allowing the percentage of consumers who receive support from the Australian Government programs to be assigned to the severe category varying up to 100%. The ranges presented here of the number of people who require but are not receiving psychosocial services do not reflect statistical uncertainty, instead they reflect uncertainty related to the data that was collected and therefore are estimates of potential bias in the data. The aim of the sensitivity analysis is to illustrate the magnitude of the effect of these potential biases on the estimate of unmet need.

The direction of the effect on the unmet need of two of the potential biases is clear. If the number of people receiving services has been undercounted because the data was not available, then the unmet need has been over estimated. If people have been double counted, then the bias has been to underestimate the number of people not receiving psychosocial services. The other three parameters reflect the allocation of people (or hours) to the severe or moderate groups and their impact could be in either direction. It is worth noting that when the estimate of any of these three parameters is incorrect, the impact on the estimate of unmet need for people with moderate mental illness is the negative of the impact on the severe mental illness group.

Based on the information provided by stakeholders and the definition of psychosocial services used in the project, HPA believes that it is likely that the true number of people with a severe mental illness requiring but not receiving psychosocial services is between 214,800 and 236,100.

Figure 12: Distribution of the 1,000 simulated values of the number of people aged 12–64 years with severe mental illness who have an unmet need for psychosocial services, 2022–23\*

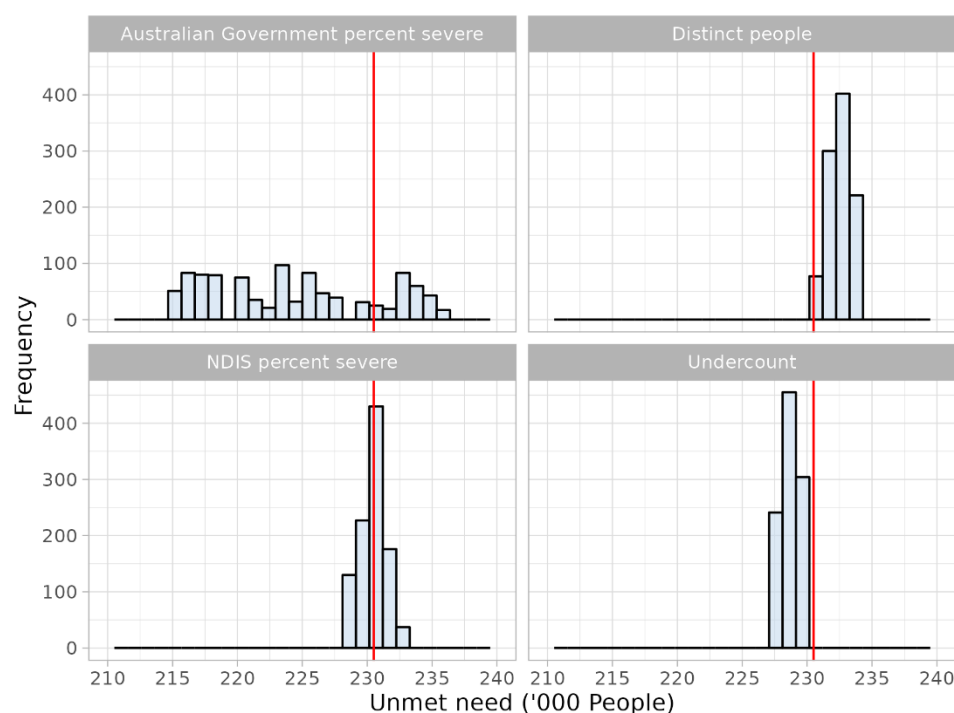


*\*The red line indicates the estimated value of unmet need by number of people*

This represents one approach to quantifying uncertainty in the estimates associated with the identified assumptions. HPA believes it captures the main areas of uncertainty related to current service provision, but it does not address uncertainty related to estimates of overall need which include the population projections and the assumptions underpinning the NMHSPF.

Figure 13 shows the variation when one parameter is changed at a time, and the summary statistics for these is shown in Table 57 – noting that the *hours ratio* parameter only affect the distribution of hours between people with severe and moderate mental illness, but not the total of hours for the Commonwealth Psychosocial Support Program. When it is assumed that there will be fewer people receiving services because people may be receiving services from multiple providers, the unmet need is higher and when it is assumed there is an undercount in the number of people receiving services the unmet need is lower.

Figure 13: Distribution of the 1,000 simulated values of the number of people aged 12–64 years with severe mental illness who have an unmet need for psychosocial services – when one parameter is modified, 2022–23\*



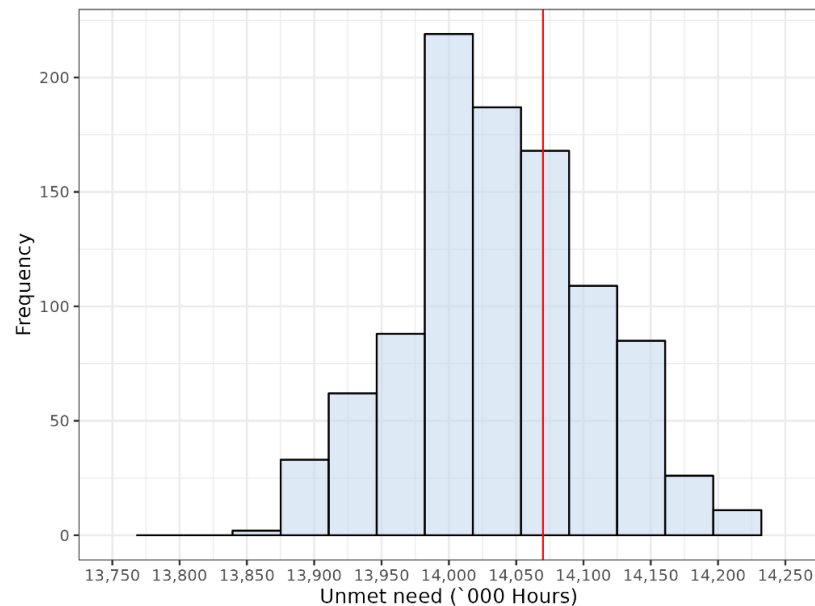
\*The red line indicates the estimated value of unmet need by number of people.

Table 57: Summary statistics of the distribution of the 1,000 simulated vales of the number of people ('000) aged 12–64 years with severe mental illness who have an unmet need for psychosocial services, 2022–23

Modified parameter	Minimum	2.5 percentile	Median	97.5 percentile	Maximum
All parameters	212.9	214.8	219.5	224.5	230.1
Australian Government percent severe	215.3	215.4	218.1	223.8	229.5
Distinct people	231	231	231.9	232.5	233.1
Hour ratio	230.5	230.5	230.5	230.5	230.5
NDIS per cent severe	228.4	228.6	230	230.5	231.2
Undercount	227.1	227.4	228.2	228.8	229.3

The distribution of the hours of unmet need for people aged 12 to 64 years with a severe mental illness is shown in Figure 14.

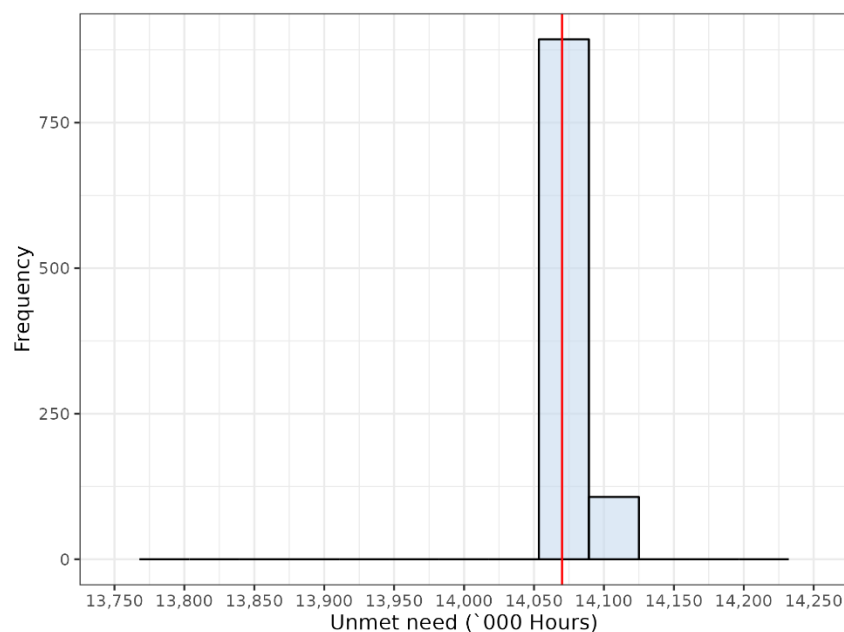
Figure 14: Distribution of the 1,000 simulated values of the number of hours of unmet need for psychosocial services for people with severe mental illness aged 12–64 years, 2022–23\*



*\*The red line indicates the estimate value of unmet need by number of hours*

Figure 15 shows the variation that occurs when the *Hour ratio* parameter (i.e. hours of psychosocial services for the severe cohort relative to the moderate cohort across the Australian Government programs) changes.

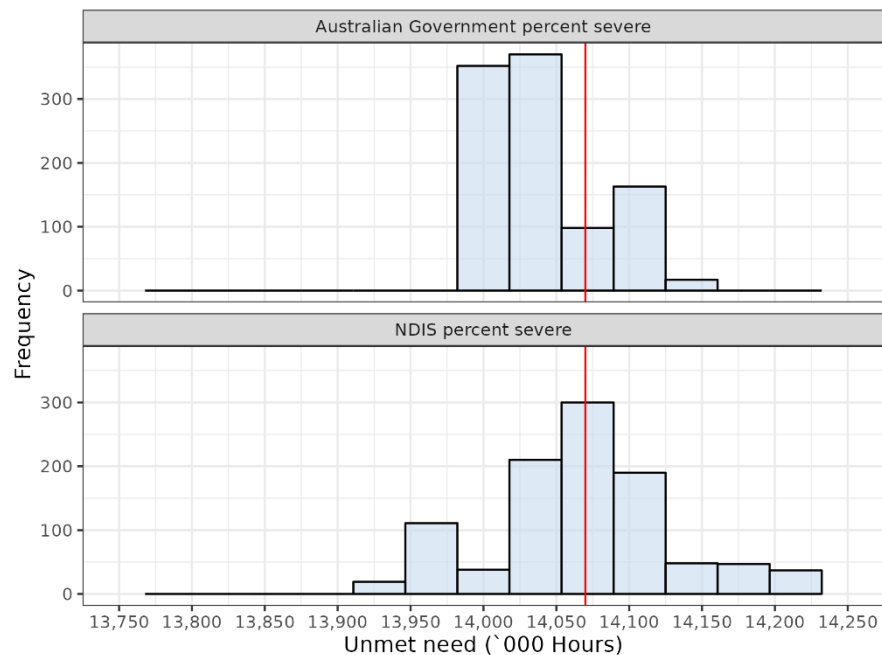
Figure 15: Distribution of the 1,000 simulated values of the number of hours of unmet need for psychosocial services for people with severe mental illness aged 12–64 years – when one parameter is modified, 2022–23\*



*\*The red line indicates the estimate value of unmet need by number of hours*

Figure 16 shows the variation in the estimate of unmet hours of need when the *Australian Government percent severe* and *NDIS percent severe* parameters are varied one at a time. There is no change in hours when the number of distinct consumers calculated from the data varies because the hours are the same. There is no assumption about the number of hours of psychosocial services that would have been received by those consumers whose data was not provided for analysis.

Figure 16: Distribution of the 1,000 simulated values of the number of hours of unmet need for psychosocial services for people aged 12–64 years – when one parameter is modified, 2022–23\*



\*The red line indicates the estimate value of unmet need by number of hours

## 6. Limitations and future requirements

This chapter describes limitations of the analysis undertaken in this project and identifies several areas in which initiatives could be taken to improve the data sources available for estimating unmet need for psychosocial support in the future. These include improving source data through classification and description of funded services and activity, service activity reporting and using consumer surveys to supplement data collection.

### Limitations

The analysis conducted for this project has several limitations, many of which stem from the defined scope of the project and the availability and quality of the data sources used.

The analysis is based on data from 2022–23 and does not account for programs newly announced but not implemented programs during or since the 2023-23 reference period. Such programs outside of the 2022-23 reference period were not included in the analysis, but are listed in Appendix E (along with other out-of-scope programs). Jurisdictions identified initiatives that will be delivering more psychosocial supports as they become established and scaled up.

The analysis focussed on psychosocial supports, a specific type of mental health service, and did not account for a broader range of services available through Australian Government and state and territory programs including Social and Emotional Wellbeing programs. More comprehensive information is available on the full range of mental health programs and expenditures through other sources, in particular the mental health services chapter of the annual Report on Government Services (Productivity Commission, 2024) and the AIHW website on mental health expenditures (Australian Institute of Health and Welfare, 2024). A range of psychosocial supports are also provided through programs managed by non-health agencies at the Australian Government, state and territory government levels. Unmet need related to these other mental health programs have impacts on the need for psychosocial services. Additionally, in planning for mental health services and related human services, a more integrated perspective is vital.

The scope of this analysis is limited to non-clinical community mental health psychosocial support, following the PPG's definition, which was aligned to the 'Specialised Mental Health Community Support Services' stream of the NMHSPF. Psychosocial components embedded and delivered as part of mental health service models addressed within other streams of the NMHSPF, such as clinical mental health multidisciplinary supports, were not analysed. This approach is broadly consistent with the Productivity Commission's analysis, which focussed on analysis of grants to non-government organisations but did not consider other services delivered directly by state and territory governments, which generally relate to other service streams within the NMHSPF. It should be acknowledged that clinical services, such as clinical community mental health teams, deliver psychosocial support along with clinical support.

As this analysis is limited to services that align with Stream 2 of the NMHSPF "Specialised Mental Health Community Support Services", there are several residential services that although were considered, were therefore not included within this analysis. Non-acute and sub-acute residential

support services best align with the 'Specialised Bed-Based Mental Health Care Services' stream in the NMHSPF. It should be recognised that many of these have significant psychosocial components of service delivery.

The data on which the analysis has been based comes from diverse sources, and is varied in its comprehensiveness, level of detail and quality. In Australia, there is no national minimum data set that has been agreed or implemented for psychosocial services. There is a Mental health non-government organisation establishments National Best Endeavours Data Set (MH NGOE NBEDS) specification that two jurisdictions have implemented. For these jurisdictions, this assisted the process of identifying relevant services. Under the National Agreement (Annex B), all states and territories have committed to implementing the MH NGOE NBEDS. However, there are key issues that impact variation in data collection across all sources, including the jurisdictions that use the MH NGOE NBEDS specification. These include:

- Other than the two jurisdictions using the MH NGOE NBEDS specifications, funded services are not assigned to a consistent taxonomy that describes psychosocial supports in a way that facilitates a common understanding of the nature of services being delivered. Additionally, there is no straightforward method of aligning funded services with the relevant components of the NMHSPF.
- Data collected on services delivered to consumers is not always collected at the level of the consumer. This creates several issues. For example, for some supplied data it is not clear whether a consumer receiving one type of psychosocial support from an organisation also receives another type of psychosocial support from the same organisation. The provision of data on the place of residence of the consumer and NDIS participation was sometimes also limited.
- There was limited capacity to identify the extent to which individual consumers received support from different programs, for example, from the Commonwealth Psychosocial Support Program and a state or territory funded program.
- For NDIS participants, there was detailed information available on individualised plans and expenditures, but not a clear basis for identifying the level of psychosocial support delivered, for example in terms of hours of support provided or occasions of service. Additionally, it was not feasible to align the components of the NDIS plans and expenditures with the service elements within the NMHSPF.

While best efforts have been made to align the types of psychosocial support programs included in the analysis to the NMHSPF, it is acknowledged that jurisdictions each have different programs and service systems, which mean that data provided by jurisdictions are not directly comparable and some programs delivering components of psychosocial supports have been excluded.

Reflecting the National Agreement, the terms of reference for this project were to analyse the needs for psychosocial support outside the NDIS. However, it is recognised that participants' needs may not be completely met through the NDIS and there are people who access both the NDIS and complementary jurisdictional psychosocial services. This issue is explored in more detail in Chapter 3. Stakeholders described in consultation throughout the analysis insufficiencies in NDIS provision, such as delivery of services in rural and remote areas, training and education and supporting complex comorbid issues.

As described earlier, the analysis of unmet needs has two estimates: the number of people who require psychosocial support, but receive no psychosocial support, and the volume of additional services required – expressed as hours of support – required to achieve the level of support that is

implied by the NMHSPF. However, this does not address the question of the extent to which the level of psychosocial support provided at an individual consumer level is adequate. Some consumers, for example, may receive some psychosocial support, but this may be inadequate compared with their needs. This limitation reflects the nature of the data available and the NMHSPF. Analysis at the individual consumer level would also require more detailed data than is available, and linkage of these data across the various sources – data that was not available for this project. Additionally, the NMHSPF is not intended to provide a prescription of services required at an individual consumer level, but to provide a basis for identifying overall levels of service provision required for the relevant care profiles.

While the estimates of need and current service availability are inclusive of people with Aboriginal and/or Torres Strait Islander background – due to data variability, the analysis is unable to support a consistent and robust analysis of service availability and unmet need specifically for Aboriginal and/or Torres Strait Islander consumers. Breakdown of data by other priority population groups and gender were also not available and thus estimates could not be represented separately for these groups.

Key limitations, raised by stakeholders, specific to the NMHSPF should also be acknowledged. The NMHSPF is a broader mental health service planning model and tool designed to provide guidance for planners to consider in estimating overall resourcing, workforce and service requirements within their geographical and population-based contexts. However, the NMHSPF is not always suitable for use in remote and very remote areas. The QCMHR outlines technical caveats of the NMHSPF at Appendix C4 Caveats and limitations.

Limitations of the NMHSPF from lived experience stakeholders' perspectives are outlined below.

- The analysis, including the definition, target cohort and demand for 'unmet needs' is determined by the NMHSPF model. However, the starting point for the NMHSPF is not psychosocial disability; the NMHSPF has a health sector lens rather than a rights-based conceptualisation preferred by many people with lived experience. It is noted the NMHSPF:
  - is a broader mental health service planning model that focuses on the healthcare and disability support service needs of populations experiencing mental illness, distress and/or associated impacts on functioning, and is built up from the population epidemiology of mental ill-health.
  - modelling of required care is based on best available evidence and consultation with experts, including some lived experience expertise.
- The NMHSPF models the amount of support and resourcing required in an ideal mental health sector service system. It does not measure the effectiveness of existing service delivery or advise on specific workforce training requirements, implementation guidance for local service models, or monitoring of quality and safety within services.
  - People with a lived experience perspective consider it is essential the next stage of service modelling and design work is aligned with the United Nations Convention on the Rights of Persons with Disabilities to ensure a human rights foundation is adopted in addressing the need.
- As the NMHSPF focuses on ideal mental health care and supports (clinical and non-clinical) rather than service deficits, the model does not address the significant impact on families when clinical services are ineffective. However, it is noted that:

- while the analysis presented in this report identifies the number of individuals with psychosocial support needs from the NMHSPF, the NMHSPF does emphasise the need for families and support networks to be actively considered, and engaged where appropriate, throughout those individuals' recovery journeys.
- the NMHSPF also models some significant services required to directly engage with and support these families/networks (outlined under 'carer' supports).

Some of these limitations have informed key lessons, described below, on how future work could improve estimates of unmet need for psychosocial support.

## Improving source data

Several steps could be taken to standardise data used to estimate unmet needs for psychosocial support, obtain greater detail for some of the measures and enhance data quality overall. These steps relate to data on services delivered by non-government organisations. It is important to acknowledge that the agencies supplying the data for this analysis made the best use of what was available.

## Classification and description of funded services and activity

States and territories collect and manage data on funded non-government services (NGOs). The total value of grants to NGOs by states and territories is reported in the Mental Health Establishments (MHE) National Minimum Data Set. However, only limited additional detail is available nationally. NGOs supported by state authorities in Queensland and Western Australia currently report data and aggregate activity through collections based on the MH NGOE NBEDS. Text Box 4 sets out the taxonomy used to describe services through the MH NGOE NBEDS. The availability of data consistent with MH NGOE NBEDS in Queensland and Western Australia significantly enhanced the ability to align funded services with the service categories and elements outlined in the NMHSPF. However, even for these states there remained a few areas in which alignment was not clear.

Ideally, all states and territories could progress implementation of the MH NGOE NBEDS categories for reporting of NGO funding and activity. This is a commitment that the Commonwealth state and territory governments have made under the National Agreement Annex B and has been included under the workplan agreed by the Mental Health and Suicide Prevention Senior Officials Forum. Additionally, reporting of funding and activity provided under Australian Government programs could be aligned to the MH NGOE NBEDS categories.

#### Text Box 4: Service taxonomy used in the MH NGOE NBEDS

- Counselling—face-to-face
- Counselling, support, information and referral:
  - o Telephone
  - o Online
- Self-help—online
- Group support activities
- Mutual support and self-help
- Personalised support:
  - o Linked to housing
  - o 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

A related development is that a team at the University of Canberra, led by Professor Luis Salvador-Carulla, has undertaken a series of studies to identify and map mental health services in several Australian regions. The team uses an approach to identifying and classifying mental health services based on the *Description and Evaluation of Services and Directories for Long-Term Care*, a classification scheme that is based on the European Service Mapping Schedule for coding adult mental health care described by Johnson et al. (2000). One feature of this approach is that it aims to capture information at a unit of analysis referred to as “Care Teams”, which is clearly defined within the framework (Johnson et al., 2000).

### Service activity reporting

There are some specific challenges in how activity data on psychosocial services is captured. This varies significantly across states and territories. Some have implemented client/service event level data collections, while others have systems through which NGOs report aggregate counts.

For some types of services, only aggregate client counts are feasible or appropriate due to the nature of the services or data collection constraints. While detailed data is beneficial, the practicalities of gathering such data must be considered, ensuring that data collection efforts remain aligned with service realities.

However, where it is possible to collect it, availability of client/service event level data could greatly enhance analysis, for example:

- The capacity to analyse the characteristics of clients receiving support (age, First Nations status, NDIS participation).
- Availability of place of residence, which is important for examining variations across regions.
- Use of services across different types of support within the same organisation.

- Analysis of service use by unique individuals receiving support from the same organisation.

Work is required on national standards for a minimum dataset on psychosocial services, similar to those reported under the Community Mental Health Care National Minimum Data Set. Developing such standards would be a long-term goal, requiring coordination through established processes led by the AIHW. This standardisation would support uniformity in data reporting, making it easier to compare and analyse data across different regions and service types.

Another potential enhancement is data linkage, which could allow for comprehensive analysis across different organisations and programs. Data linkage would enable a more holistic view of a client's journey through the mental health system, showcasing patterns of service usage and gaps in meeting psychosocial needs. Under the National Agreement Annex B, the Australian Government and state and territory governments have committed to advancing data linkage initiatives. The National Disability Data Asset provides one avenue through which analysis on the utilisation of psychosocial supports by NDIS participants could be explored in detail.

## Consumer surveys

Surveys of consumers can supplement ongoing data collection to explore particular issues, trends, or emerging needs that are not covered by standard data sets. They allow for targeted questions that delve deeper into specific areas of concern, for example:

- Insights on use of services across programs.
- Experience of receiving psychosocial services and issues in accessing support.
- Client perceptions of unmet needs for psychosocial support.
- Carer perceptions of unmet needs for psychosocial support.

National surveys generally do not appropriately represent people with severe mental illness, who may have different or more complex needs than those with milder forms of mental illness. This underrepresentation can skew perceptions of unmet needs, suggesting a need for targeted survey strategies or specialised surveys designed to include and accurately reflect this subgroup.

The National Agreement Annex B includes a commitment to improve the collection of experience measures. Experience surveys could be extended to address mental health consumer perceptions of unmet need, for example, circumstances in which the consumer needed a psychosocial support but was unable to access this support.

## Summary

Through conducting this analysis several limitations have been acknowledged, particularly those relating to data collection. Several steps could be taken to enhance data quality and standardise data used nationally to estimate unmet need for psychosocial supports in the future. The implementation across all states and territories of the MH NGOE NBEDS categories for reporting of NGO funding and activity would significantly assist with aligning funded services with service categories and elements outlined in the NMHSPF. Additionally, the collection (where possible) of client/service event level data could greatly enhance the analysis. Consumer surveys and a targeted survey strategy could also supplement data collection to better capture the service use and unmet needs and/or explore specific issues.

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# A. Consultation summary report

## Introduction

*This report summarises key themes from stakeholders' feedback received during consultations held throughout the duration of the Analysis and outlines how the Project Team addressed the feedback, in light of subsequent consultation with the inter-jurisdictional [Psychosocial Project Group](#) that is steering the analysis of unmet need.*

On behalf of the Psychosocial Project Group, the Department of Health and Aged Care (the Department) commissioned Health Policy Analysis (HPA) to quantify the level of unmet need for psychosocial supports outside the National Disability Insurance Scheme (NDIS).

The work required input from a wide range of stakeholders to ensure that the information captured and the way it is presented reflects local experiences and service delivery.

The project engaged with stakeholders through a National Methodology Workshop, as well as two rounds of consultation with jurisdictional health authorities, Australian Government departments and agencies regarding the psychosocial support services they deliver, manage, and/or commission. Section 1 of this Summary of consultation report provides a summary of feedback received at the National Methodology Workshop held in August 2023 and the approach to address this feedback.

The next phase of the project involved compiling the various data sources identified through consultation, mapping and aligning those services with the NMHSPF. Given the nature of the data, its varied sources, and completeness, the process required consultation to assist with further refinement and validation. These consultations were conducted through a series of jurisdictional workshops. The primary goals for the workshops were to present, interpret and validate results of the analysis of service provision data, discuss any assumptions made and check the extent the analysis aligns with what is understood locally, with specific questions on these matters posed to participants. At the jurisdiction workshops the general methodology adopted for the project was presented, but the primary focus was on reviewing specific questions related to the analysis for the jurisdiction. It was reported that some participants were disappointed with the narrow focus of the jurisdictional workshops.

Following these jurisdiction workshops, a National Stakeholder Session was delivered to provide national representatives an overview of the analysis, present and discuss draft estimates of need and service provision relating to the Australian Government programs, and seek further input into limitations and concerns raised at previous consultations.

Section 2 of this Summary of consultation report provides a summary of the feedback received on the draft estimates of psychosocial need, service provision and assumptions/limitations, received during the series of jurisdiction workshops held between February to March 2024 (see Attachment A: Jurisdiction Workshops 1 and 2 dates for dates) and from a National Stakeholder Session held in March 2024. The approach to address this feedback is also outlined.

Table 1 in the main body of the Final Report provides an overview of all consultations held.

# 1. Summary of consultation – National Methodology Workshop

## **Workshop purpose:**

A workshop was held 18 August 2023 to test the proposed methodology for the analysis of unmet needs for psychosocial supports outside of the National Disability Insurance Scheme (NDIS).

## **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)

Invitees including those from NGO service providers, national peak bodies and the lived experience sector were selected by the Department. An attendees list, at the organisation level, is at Attachment B: List of organisations represented in the National Methodology Workshop (18 August 2023).

## **Workshop format:**

The workshop was held virtually via Microsoft Teams. Before the workshop, a [methodology working paper](#) 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. The breakout groups ensured that all participants had opportunities to express their views and raise questions. The sessions were recorded and transcribed.

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:

- (b) Question 1: Should refinements be considered to the working definition of psychosocial supports?
- (c) 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?
- (d) 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?
- (e) 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?
- (f) 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:

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

# Key themes from National Methodology 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.

Question/stakeholder response	Handling of methodology, following feedback
<b>Question 1: Should refinements be considered to the working definition of psychosocial supports?</b>	
<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"> <li>• “Support” is potentially passive in the definition and needs to better reflect coaching and capacity-building for people to self-manage/self-regulate.</li> <li>• Related to the above, supports should be time-limited; the goal should be for people to move towards independence.</li> <li>• Supports should include connecting people to naturally occurring community resources.</li> <li>• The definitions should recognise that people’s needs change over time (they are not fixed).</li> <li>• Co-ordination and assistance with access to services should be reflected in the definition.</li> <li>• Needs of carers and families should be reflected in the definition.</li> <li>• Complexity of needs should be reflected in the definition.</li> </ul>	<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>
<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?</b>	
<ul style="list-style-type: none"> <li>• Include translational services; that is, step-up step-down services that are providing some clinical but also some psychosocial support.</li> <li>• Need to recognise that supports are not just about people’s mental health; they are about people’s whole lives.</li> <li>• Some stakeholders were not sure where residential services fit into the definition.</li> </ul> <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. What is important is that the nature of the supports provided by the ACCHSs are reflected in the definition.</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
<b>Question 3: Do you agree with the proposal to produce final estimates at the SA3, LHN and PHN levels?</b>	
<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>
<b>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?</b>	
<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"> <li>• socio-economic disadvantage</li> <li>• the distribution of refugee populations.</li> </ul>
<b>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?</b>	
<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>A suggestion made was that NDIS participants should be included in the analysis but treated as a separate group.</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"> <li>(a) NDIS participants with a primary psychosocial disability</li> <li>(b) NDIS participants with a secondary psychosocial disability and</li> <li>(c) other population groups.</li> </ul> <p>Methods to estimate the proportion of consumers, activity and hours related to NDIS participants will also be applied (within the data collated for Step 2 of the methods).</p>

Question/stakeholder response	Proposal for methodology
<b>Question 6: Are there additional data sources that reflect current level of access to psychosocial supports that should be considered?</b>	
<p>A range of potential additional data sources were suggested, including:</p> <ul style="list-style-type: none"> <li>• ABS survey of Disability, Aging and Carers</li> <li>• the Living in the Community survey</li> <li>• analysing the use of resources within NDIS plans</li> <li>• GP mental health related presentations hospital utilisation data</li> <li>• ED presentations</li> <li>• 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.</li> </ul> <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
<b>Question 7: What are your views on directly surveying NGO providers of psychosocial supports?</b>	
<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 Australian Government 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 Australian Government 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>

## 2. Summary of consultation - draft estimates of psychosocial need, service provision and assumptions/limitations

Initial consultations were held with state and territory health authorities on the development and initial analysis of service provision data. These discussions focussed on the assumptions that had been initially made to shape the data and any gaps or issues that had been encountered. Further refinement of the data then took place prior to a series of jurisdiction-level workshops, followed by a national stakeholder session.

Jurisdiction Workshop 1 aimed to present the draft estimates of psychosocial need, service provision and assumptions/limitations to internal stakeholders from the state and territory governments. The aims of Workshop 1 were to:

- (a) Consider jurisdictional level data related to service activity and the following:
  - i. Overall initial estimates for the jurisdiction.
  - ii. Review of assumptions made in interpreting data.
  - iii. Identify sensitivity analysis that may be required.
  - iv. Identify gaps in data and possible strategies to address these gaps.
- (b) Present estimates of need for psychosocial support at a regional level within the jurisdiction as estimated using the NMHSPF.
- (c) Present the data visualisation tool to obtain feedback on design and functionality.

Jurisdiction Workshop 2 consisted of broader stakeholder invitees in which the state and territory health authorities worked with HPA to establish the most appropriate attendees. Approximately 180 participants attended across 8 workshops and these included representatives from:

- Service providers
- Peak bodies
- Primary Health Networks
- State or territory government agencies
- Local health networks

Attachment C: List of organisations represented in the broader stakeholder jurisdiction workshops (Workshop 2) provides a list of organisations that were represented across all 8 of these workshops.

Jurisdiction Workshop 2 was held in a similar format to Jurisdiction Workshop 1. Key differences included the types of questions asked of stakeholders and Workshop 2 did not present the data visualisation tool. The aims of Jurisdiction Workshop 2 were to:

- (a) Consider jurisdictional level data related to service activity and the following:
  - v. Overall initial estimates for the jurisdiction.
  - vi. Review of assumptions made in interpreting data
  - vii. Identify sensitivity analysis that may be required
  - viii. Identify gaps in service provision data
- (b) Present estimates of need for psychosocial support at a regional level within the jurisdiction as estimated using the NMHSPF.

The jurisdiction workshops were structured to provide stakeholders with a general overview of the project to date, including an overview of the methods used in the analysis. The workshops had specific questions posed to stakeholders on issues that impacted the development of the analysis, particularly relevant to their jurisdiction. It was reported that at one of the Jurisdiction Workshop 2 session, some participants felt that they did not have opportunities to provide feedback on the general methodology adopted for the project and were disappointed with the narrow focus of the workshop.

The jurisdiction workshops were held either face to face or virtually via Microsoft Teams, dependent upon the state or territory's preference. Before the workshop, a project background and overview document were shared with invitees. Both Workshop 1 and Workshop 2 were held over 1–2 hour time slots.

A National Stakeholder Session was delivered online via Microsoft Teams on 22 March 2024. This workshop provided an information session to national stakeholders including representatives from peak bodies, national non-government organisations and lived experience representatives to:

- Provide an overview of the analysis.
- Present examples of draft extracts of need and service provision estimates relating to Australian Government-funded psychosocial support services.
- Discuss limitations and common issues raised in jurisdictional workshops.

Approximately 43 attendees participated in the national stakeholder session.

For the list of organisations represented, see Attachment D: List of organisations represented in the National Stakeholder Session (22 March 2024).

## Key themes from consultation on the draft estimates of psychosocial need, service provision and assumptions/limitations (feedback received in Jurisdiction Workshops 1 and 2 and the National Stakeholder Session)

Key themes	Handling of the Analysis following feedback
<b>Inclusion of programs</b>	
<p><b>Issues of inconsistency</b></p> <p>Stakeholders proposed that further consideration is required to ensure a consistent approach to programs that have been included. The issues identified included:</p> <ul style="list-style-type: none"> <li>• Residential programs including step-up and step-down</li> <li>• Individual advocacy</li> <li>• Eating disorder programs</li> <li>• Broad programs or programs that included a clinical element</li> <li>• Counselling programs</li> <li>• Inclusion of carer programs</li> <li>• Programs that may not be aimed at the target cohort (that being consumers with a moderate to severe mental illness).</li> </ul> <p><b>Alignment with the NMHSPF</b></p> <p>The alignment of residential services with the NMHSPF stream (Stream 2: Specialised Mental Health Community Support Services) and subsequent elements selected as 'in-scope', as per the Methodology paper, for this analysis was discussed.</p>	<p>Following the issues in inconsistency raised, a discussion was subsequently held on 12 March 2024 with the PPG to agree upon consistent approaches to the inclusion of services, and to assist in the finalisation of program lists. These approaches were agreed at a PPG meeting held on 18 March 2024. Table 16 outlines these agreed approaches. Following this workshop, the Australian Government, HPA and the states and territories held bilateral discussions to finalise the included program list, as well as obtain full program definitions and target cohorts including severity. The Queensland Centre for Mental Health Research (QCMHR) at the University of Queensland provided advice on the inclusion of certain programs, along with advice on the appropriate alignment with the NMHSPF streams and elements.</p> <p>Where there were gaps, and additional programs were now considered to be in-scope, further data was sourced by jurisdictions which has been included in the Interim and Final Report.</p>

Key themes	Handling of the Analysis following feedback
<p>Along with ensuring consistency with the type of residential services included within the analysis (as described above), stakeholders were keen to ensure services were also consistently aligned with the correct service stream and element. Whilst some residential services may align with the PPG definition of psychosocial supports used for this analysis, some may align better with Stream 3 (Specialised Bed Based Mental Health Care Services). These include step-up and step-down services that are delivered by a non-clinical workforce and provide mostly psychosocial support to consumers.</p> <p><b>Gaps in programs or data</b></p> <p>One comment was that consideration should be given to other state or territory agencies that may be providing psychosocial support. For example, Departments of Justice. One state noted that Local Health Networks also deliver psychosocial services not currently included in the data provided. There are also other psychosocial supports provided to consumers that may not necessarily be named as ‘psychosocial supports’, nor are they built around the funded framework. Some suggested a product of this report could be to consider a standardised core definition.</p> <p>Additionally, it was suggested there should be an acknowledgment within the report that psychosocial supports are provided within the provision of other services, such as part of multidisciplinary clinical services. For these broader programs, it was noted that either all services that have a psychosocial element should be included or none.</p> <p><b>Additional sources of funding</b></p> <p>Some participants described limited amounts of private funding for psychosocial supports, but indicated that understanding the extent to which these services meet the definition and obtaining relevant data would be difficult.</p>	<p>The Final Report will recognise other services that have not been included in the analysis, such as clinical services, also provide psychosocial supports. In addition, a list of programs there were considered, but ultimately excluded, are provided in the Report.</p>
NDIS	

Key themes	Handling of the Analysis following feedback
<p><b>Insufficiencies in NDIS provision</b></p> <p>Several workshop participants explained that the NDIS is unlikely to provide enough support for consumers with severe mental illness. Packages may also not cater for the fluctuations in need. It was heard that there is large variability in what support people with a primary psychosocial disability receive from the NDIS. Specific NDIS insufficiencies were noted and include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Funding for the right skills, training and education in psychosocial disability for complex clients</li> <li>• Transport funding</li> <li>• Independent living supports costs and subsidising rent payments</li> <li>• Wage costs</li> <li>• A lack of group services</li> <li>• Specific cohorts that are falling through the gaps, such as in regional and rural areas (psychosocial support from NGOs become crucial in this space)</li> <li>• Service coordination and coordination of packages</li> <li>• Consumers who have been in prison</li> <li>• Supporting complex co morbid issues such as drug and alcohol disorders or homelessness</li> <li>• Respite services for individuals to access locally, particularly in regional areas.</li> </ul> <p><b>NDIS funding vs utilisation</b></p> <p>One issue raised was that it may be important to consider NDIS package utilisation and relative expenditure per individual within the NDIS i.e. what is funded versus what is spent for participants. This was a particular concern for one jurisdiction where there is a greater disparity of budgeted NDIS packages compared with utilisation of packages due to rurality.</p>	<p>The terms of reference for this project, as set by the PPG and reflecting the National Mental Health and Suicide Prevention Agreement, was to estimate needs outside the NDIS.</p> <p>The Interim and Final Reports acknowledge that the recommendations of the NDIS review are being considered by governments.</p> <p>The issues on the insufficiencies of NDIS provision for psychosocial supports will be acknowledged within the Final Report. Contextual issues will be described such as a discussion of how rurality affects the utilisation of NDIS packages where relevant. Implications of the NDIS Review will be referenced within the report.</p> <p>In terms of understanding the utilisation of individual NDIS packages, HPA does not have access to granular individual NDIS participant service utilisation. HPA has been provided data on summaries of expenditures under NDIS plans, broken into the core support, capacity-building and capital categories. For each of these categories, data was provided for average annual committed support and the total payments made. These data will be analysed for the Final Report.</p> <p>Although there were mixed views on the inclusion of secondary disability, several stakeholders considered it important to include analysis of people with primary psychosocial disability and people with secondary disability</p>

Key themes	Handling of the Analysis following feedback
<p>Participants described how remoteness affects NDIS provision due to small markets and a lack of choice, or services all together, for consumers. Additionally, it is more difficult for consumers in these locations to become a NDIS participant.</p> <p><b>NDIS participants with a primary and secondary disability</b></p> <p>The inclusion of data relating to primary and secondary disability of consumers participating in the NDIS was discussed. Some expressed concerns with how reliable data on secondary disability and it was suggested this was because primary disability is the focus of data collection, so therefore secondary disability is likely to be under-reported. Others added that NDIS funding is generally geared towards primary diagnosis, therefore, if someone has a secondary diagnosis, the funding may be inadequate.</p> <p>There were mixed views as to whether secondary disability should be included as part of NDIS participation data within the analysis. It was raised that consumers may have a third or fourth diagnosis of mental illness who require psychosocial supports. Further, it was heard that it is easier to access the NDIS through another disability, such as physical disability or Autism Spectrum Disorder (ASD), rather than psychosocial needs as a primary disability. People may therefore not always identify their psychosocial disability as their primary disability, even though this may have significant impact on their lives.</p> <p>Some stakeholders were unsure as to why NDIS participants with ASD were not included as part of the analysis. However, others described that people with autism receiving supports through the NDIS are captured in a different stream by the NDIS. Someone with autism could be classed as having secondary psychosocial disability, but the assumption isn't that they all will. It was acknowledged that there are high rates of co-occurring mental ill-health in people with ASD.</p> <p><b>Severity of mental illness of consumers participating in the NDIS</b></p>	<p>in the analysis of NDIS participation data. Some stakeholders pointed out that applicants for the NDIS may not always identify their psychosocial disability as their primary disability due to the additional hurdles that may be experienced in the approval process.</p> <p>Following feedback that NDIS participants with a primary disability are more likely to have a severe mental illness and those with a secondary disability are more likely to have a moderate mental illness, HPA proposes to align NDIS participants with a primary psychosocial disability to the severe mental illness category, and 13.6% of NDIS participants with a secondary psychosocial disability registered to the severe mental illness category. The remaining (86.4%) NDIS participants with a secondary psychosocial disability will be assigned to the moderate severity category. HPA has not been provided data relating to third or fourth diagnoses.</p> <p>HPA has undertaken analysis of NDIS expenditures, but this is not required for the analyses of unmet need as agreed upon by the PPG on 18 April. This issue of how the psychosocial support within the core support components of NDIS plans is addressed in this analysis.</p> <p>In relation to the overlap of consumers receiving support from NDIS services and NGO services, for the purpose of the primary analysis, HPA proposes to make no assumption about the extent to which, if at all, consumers are receiving</p>

Key themes	Handling of the Analysis following feedback
<p>Stakeholders reported that due to the difficulty in gaining NDIS support in the first instance, it could be assumed that most NDIS participants with a primary disability of mental illness would have relatively severe mental illness. Moderate mental illness may be related more so to secondary mental illness. Participants also described that consumers may often fluctuate across the spectrum of severity.</p> <p><b>Capacity building component of expenditure</b></p> <p>Some stakeholders pointed out that the psychosocial support provided under an NDIS plan may extend beyond the capacity building categories with the plan. It was suggested that psychosocial supports may be included in core supports and/or capital supports. Others suggested that existing components of the NDIS do not necessarily match the needs of people with a psychosocial disability. We heard from other stakeholders that the psychosocial support needs from NDIS participants may therefore be underestimated.</p> <p><b>Overlap in NDIS provision and NGO psychosocial support services</b></p> <p>Some jurisdictions do not capture NDIS participation status of consumers of state/territory funded psychosocial supports. For these jurisdictions it is difficult to attribute a percentage of consumers supported by their program who were also a NDIS participant. Workshop participants described where this overlap may take place. Notably, state/territory funded psychosocial services can provide support to consumers to transition to the NDIS and support those who are waiting for their NDIS package to begin. There may therefore be an overlap of NDIS and state/territory funded services where the client cannot be without support for a particular time, and transition to the long-term service needs to be managed appropriately. Additionally, where NDIS packages are not considered to be sufficient, these consumers may have both NDIS support and state/territory funded psychosocial supports.</p>	<p>support from multiple programs. However, this issue may be considered in sensitivity analysis.</p>

Key themes	Handling of the Analysis following feedback
<p>Whilst some jurisdictions are able to provide data for this overlap in NDIS provision and NGO services, others are not. There was a concern raised to ensure that states or territories will not be disadvantaged for collecting NDIS participant data.</p> <p><b>NDIS review</b></p> <p>Some participants asked how the analysis would take into account the recent NDIS Review.</p>	
<b>Severity</b>	
<p>Overall, it was reported that most state or territory funded psychosocial programs included in this analysis are targeted to consumers with a severe mental illness. Some programs may be targeted to consumers with moderate mental illness, or both moderate to severe. At times, an estimated split of severity between moderate or severe was difficult to establish with certain programs. Participants described that consumers may often fluctuate across the spectrum of severity. Others noted that some programs are based on eligibility rather than severity.</p> <p>It was heard from stakeholders that severity and complexity is a growing issue for many providers.</p> <p><b>Initial Assessment and Referral Decision Support Tool (IAR-DST)</b></p> <p>HPA discussed using information included in the IAR-DST to understand the severity of mental illness of consumers receiving support through Australian Government funded services within the Primary Mental Health Care Minimum Data Set (PMHC MDS). This was not considered the most appropriate approach, noting:</p> <ul style="list-style-type: none"> <li>• It is relatively new tool and as such may not be consistently utilised across Australia during the years of analyses (2021/22 – 2022/23).</li> <li>• Its use has not been mandated.</li> </ul>	<p>Where unknown, target populations, including severity, will be confirmed with each jurisdiction. Where a program targets both consumers with severe or moderate mental illness severity, an assumption will be applied that consumers are allocated 50% and 50% to each severity group, unless the jurisdiction advises otherwise.</p> <p>For the Australian Government funded programs, HPA have distributed the services provided as 40% to severe and 60% to moderate. The data received for services provided from the Australian Government Psychosocial Support Program included information about the diagnoses of the consumers who received those services. Excluding those who had missing or unknown information, 20% had a diagnosis of affective mood disorder, 23.3% had anxiety disorder, 34.5% had no formal mental disorder but subsyndromal problems, 8.6% had psychotic disorder, 1.2% had substance use disorder, 2.3% had disorder with onset usually occurring in childhood, and the remaining were grouped as other. Approximately 60% had anxiety disorder or no formal mental disorder but subsyndromal problems.</p>

Key themes	Handling of the Analysis following feedback
<ul style="list-style-type: none"> <li>It is not the best tool to understand complexity.</li> <li>The IAR does not incorporate psychosocial factors.</li> </ul> <p>In general, service providers and stakeholders from PHNs generally suggested these services were predominantly provided to consumers with moderate mental illness.</p>	<p>This information, in addition to the feedback provided by stakeholders, has informed the severity of mental illness assumption for Australian Government funded programs.</p>
<b>Age distribution</b>	
<p>During consultation with state or territory health authorities, amendments to assumptions made in relation to age distribution were discussed with individual jurisdictions.</p> <p>Whilst there was general support for the age brackets presented for analysis (0-11, 12-24, 25-64 and 65+), some comments included:</p> <ul style="list-style-type: none"> <li>The Your Experience of Service – Community Managed Organisations (YES CMO) survey saw a change of age groups over 65, now have 64-75 and 76+ as these groups are affected by different things e.g. dementia.</li> <li>There may be different sets of needs across some age groups e.g. those aged 16/17 but are separate from parents may have different needs than those aged under 18 and not.</li> <li>12-24 cohort are completely different and should be treated differently. A different skillset is required for providers working with a 12 year old versus a 20 year old.</li> <li>18-35 age bracket can be very varied.</li> </ul>	<p>Assumptions tested have now been refined as per individual and specific jurisdiction feedback.</p> <p>Given the general support, no change has been made to the age brackets used for the analysis.</p>
<b>Geography</b>	
<p>Amendments to assumptions made in relation to geographic distribution were discussed with individual jurisdictions. Concerns were raised about using the current geographic distribution, and assumptions made, that this may not reflect an accurate representation of service provision across jurisdictions due to the ability to report data at the SA3 level.</p>	<p>HPA had initially proposed to report on needs, current service provision and unmet needs at the following levels of geography:</p> <ul style="list-style-type: none"> <li>State/Territory</li> </ul>

Key themes	Handling of the Analysis following feedback
<p><b>Rural and remote specific issues</b></p> <p>There were mixed views across jurisdictions as to whether it is reasonable to assume that consumers in regional or rural locations may travel to receive psychosocial services. It was discussed that in some locations, consumers may travel from remote communities for services, noting transient populations and those that may access services during certain times of the year. However, participants described the barriers that consumers may face in accessing services in these areas, such as the nature and severity of their disability, compounded by socioeconomic disadvantage, transport barriers and extensive travel requirements, housing insecurity and stress. Models of outreach are used in some jurisdictions and that staff from psychosocial services may therefore be travelling long distances to see consumers. However, workforce recruitment and retention challenges along with limited resources in regional and remote areas were discussed as a potential barrier to these models of service delivery and service delivery more generally, along with staffing skillsets. Often funding for NGO supports is greatly depleted by travel costs and time taken to access more remote locations.</p> <p><b>Borders between jurisdictions</b></p> <p>Some jurisdictions noted that occasionally services may be provided to consumers who reside across a jurisdictional border. Where this occurs, it is believed to impact only a small proportion of consumers.</p>	<ul style="list-style-type: none"> <li>• Primary Health Network (PHN)</li> <li>• Local Health Network/Local Health District (LHN/LHD)</li> <li>• Statistical Area Level 3 (SA3)</li> </ul> <p>This approach was confirmed in the Methodology Report, following the initial national workshop. Data was requested at the most disaggregated level (SA3). However, the capacity of jurisdictions to report at this level was variable. As a result, it has been concluded by HPA that it is not feasible to present an analysis of current service provision and unmet needs at the SA3 level. Presenting analysis at the PHN and LHN level remain feasible but will not be included in the final report. This was agreed at the PPG meeting held 18 March 2024.</p> <p>It remains feasible to show <u>analysis of needs</u> for psychosocial support at the SA3 level based on the NMHSPE.</p> <p>Contextual information on individual jurisdictions geographical nuances will be described where relevant within the Final Analysis Report.</p>
<b>Distinct people</b>	
<p>The extent to which there is an overlap of consumers across different NGO-delivered psychosocial services varied across jurisdictions. The majority of stakeholders thought although some overlap might be expected, this is likely to be a small number of consumers.</p>	<p>In relation to the overlap of consumers receiving support from multiple NGO providers, for the purpose of the primary analysis, HPA proposes to make no assumption about the extent to which, if at all, consumers are receiving</p>

Key themes	Handling of the Analysis following feedback
<p>Stakeholders in some jurisdictions stated a higher percentage of overlap (more than 10%) was likely. Commentary on this included that NGOs work in partnership to support consumers and a different type of service and support is provided by different NGOs. The type of support required is dependent upon a consumer's changing and complex needs and the availability of these supports. Consumers may access multiple NGOs for different types of group-based supports that are offered by different providers (such as art groups and social outings). Some consumers may use another service when one service is not operational out of hours. Some therefore believed that estimated unmet need should not be reduced if a participant is engaging with multiple service providers.</p> <p>Another jurisdiction stated there would be a 0% overlap between psychosocial services.</p>	<p>support from multiple programs. However, this issue may be considered in sensitivity analysis.</p>
<b>The role of Aboriginal Community Controlled Health Organisations (ACCHOs) in providing psychosocial supports</b>	
<p>The understanding of the provision of psychosocial services by ACCHOs was mixed across jurisdictions.</p> <p>Whilst ACCHOs may be offering psychosocial supports, these are often as part of other programs and therefore there may be difficulty disentangling data. Whilst some participants felt that this would include Social and Emotional Wellbeing (SEWB) supports, others have specified that SEWB supports are not a replacement for psychosocial supports, despite areas that are similar in practice.</p> <p>It was proposed that a discussion should be held directly with the National Aboriginal Community Controlled Health Organisation (NACCHO) and other First Nations representatives.</p>	<p>The National Indigenous Australians Agency and the NACCHO have been invited to contribute to contextual information that articulates the complexities and considerations of this SEWB area, which has been incorporated within the Interim and Final Report (p12 and Appendix E).</p>
<b>Limitations of the NMHSPF</b>	

Key themes	Handling of the Analysis following feedback
<p>Several stakeholders raised questions as to why the NMHSPF assumes that under-12-year-olds do not require psychosocial support and, therefore, why this age group are not considered within this analysis.</p> <p>Questions were also raised about the impact of socioeconomic factors on the need for psychosocial support. Additionally, whether issues faced by First Nations people and Culturally and Linguistically Diverse communities are reflected in prevalence rates. Some commented on the limitations of the NMHSPF not accounting for the diversity of psychosocial supports that are known to provide value.</p> <p>Some stakeholders raised issues around whether the NMHSPF adequately captures information on how people might change over time in the level of severity of their mental illness. This was considered important in reflecting the recovery-oriented focus of many psychosocial supports.</p> <p>Other stakeholders commented that the assumptions within the NMHSPF may not have been reviewed for a long time and that adjustments should be made in relation to recent events such as the COVID-19 pandemic.</p>	<p>HPA will provide feedback to QCMHR on these issues.</p>

## Attachment A: Jurisdiction Workshops 1 and 2 dates

Table 58: Dates of Jurisdiction Workshops 1 and 2 (February - March 2024)

<b>Jurisdiction</b>	<b>Workshop 1</b>	<b>Workshop 2</b>
NSW	26 February 2024	26 February 2024
Vic	20 February 2024	20 February 2024
Qld	12 February 2024	23 February 2024
WA	14 February 2024	29 February 2024
SA	20 February 2024	21 February 2024
Tas	15 February 2024	20 March 2024
ACT	12 February 2024	23 February 2024
NT	16 February 2024	1 March 2024

## Attachment B: List of organisations represented in the National Methodology Workshop (18 August 2023)

Table 59: A list of organisations represented at the National Methodology Workshop (18 August 2023) by stakeholder group

Stakeholder group	Organisation 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
Australian 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 (PHNs)	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 PHN
	Murray PHN
	Murrumbidgee PHN
	North Coast PHN
	North Western Melbourne PHN
	Northern Queensland PHN

Stakeholder group	Organisation represented
	PHN Cooperative (national)
	Primary Health Tasmania
	South Eastern Melbourne PHN
	South Western Sydney PHN
	Sydney North Health Network
	Western Australia Primary Health Alliance
	Western Victoria PHN
Representatives of psychosocial support consumers	Lived experience representatives
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

## Attachment C: List of organisations represented in the broader stakeholder jurisdiction workshops (Workshop 2)

Table 60: Organisations represented in Workshop 2 by jurisdiction and stakeholder group

Stakeholder group	Jurisdiction	Organisation represented
State and Territory and Australian Governments and Agencies	NSW	NSW Ministry of Health, Health and Social Policy Branch
		NSW Ministry of Health, Mental Health Branch
		NSW Ministry of Health, InforMH
	Vic	Victorian Department of Health
		Victorian Department of Families, Fairness and Housing
	Qld	Queensland Health, Mental Health Alcohol and Other Drugs Strategy and Planning Branch
	WA	Western Australia Department of Health
		Western Australia Mental Health Commission
	SA	SA Department of Health and Wellbeing (DHW), Mental Health Strategy and Planning
		SA Department of Health and Wellbeing (DHW), Mental Health Strategy Lived Experience Advisory Group
		SA Department of Health and Wellbeing (DHW), Performance and Contracts
		SA Department of Health and Wellbeing (DHW), Planning and Commissioning
		SA Mental Health Commission
		SA Department of Human Services, Strategy Policy and Reform
	Tas	Tasmanian Department of Health
	ACT	ACT Community Services Directorate
		ACT Health Directorate
	NT	Northern Territory Department of Health
		NT Government, Anti-Discrimination Commission
	Australian government	Department of Health and Aged Care
Local Health Networks (LHNs)	NSW	Northern NSW Local Health District (LHD)
		South Eastern Sydney LHD
		Sydney LHD
		Western NSW LHD

Stakeholder group	Jurisdiction	Organisation represented
	SA	Barossa Hills Fleurieu LHN
		Central Adelaide LHN
		Flinders and Upper North LHN
		Women's and Children's Health Network
		Limestone Coast LHN
		Northern Adelaide LHN
		Riverland Mallee Coorong LHN
		Southern Adelaide LHN
		Yorke and Northern LHN
PHNs	NSW	Central and Eastern Sydney PHN
	Qld	Darling Downs and West Moreton PHN
		Gold Coast PHN
		North Queensland PHN
	WA	Western Australia Primary Health Alliance
	SA	Adelaide PHN
		Country SA PHN
	ACT	Capital Health Network / ACT PHN
Peak bodies	NT	Northern Territory PHN
	NSW	BEING – Mental Health Consumers
		Mental Health Carers NSW
		Mental Health Coordinating Council
	Vic	Mental Health Victoria
		Tandem Carers
		Victorian Mental Illness Awareness Council (VMIAC)
	Qld	Mental Health Lived Experience Peak Queensland
		Queensland Alliance for Mental Health
	WA	Consumers of Mental Health WA
		Western Australian Association for Mental Health
	SA	Mental Health Coalition South Australia
		SA Lived Experience Leadership & Advocacy Network
		Lived Experience Australia
	Tas	Mental Health Council of Tasmania
	ACT	Carers ACT
		Mental Health Community Coalition ACT

Stakeholder group	Jurisdiction	Organisation represented
	NT	Aboriginal Medical Services Alliance Northern Territory
		National Disability Services
		Northern Territory Mental Health Coalition
Statutory bodies	NSW	Mental Health Commission of NSW
	Qld	Queensland Mental Health Commission
Provider organisations	NSW	Flourish Australia NSW
		New Horizons
		Neami NSW
		Open Minds NSW
		One Door Mental Health
		Stride NSW
		Uniting NSW
		Wellways NSW
	Vic	Australian Community Support Organisation
		Cohealth
		EACH
		ERMHA365 (Eastern Regions Mental Health Association)
		Mallee Family Care
		Mentis Assist
		Mind Australia Vic
		Neami Vic
		Star Health
		Uniting Vic
		Wellways Vic
	Qld	Anglicare Central Qld
		Bridges Health & Community Care
		Canefields Clubhouse Beenleigh
		Footprints Community
		Impact Community Services Limited
		Mind Australia Qld
		Neami Qld
		Open Minds
		Queensland Program of Assistance to Survivors of Torture and Trauma Limited

Stakeholder group	Jurisdiction	Organisation represented
		Selectability
		Stepping Stone Clubhouse Inc
		Wesley Mission
		World Wellness Group
	WA	Black Swan Health
		Lamp Inc
		Life Without Barriers WA
		Mental Illness Fellowship of WA
		Mind Australia WA
		Neami WA
		Richmond Wellbeing
		Ruah Community Services
		St Bart's
		Uniting WA
		360 Health
	SA	CentaCare Catholic Family Services
		Diamond Clubhouse
		Community Living Options
		Flourish Australia SA
		GROW
		KWY Aboriginal Corporation
		Life Without Barriers SA
		Mind Australia SA
		Neami SA
		Skylight
		Uniting SA
	Tas	Tas Health
	ACT	St Vincent De Paul Society Canberra/Goulburn
		Wellways ACT
		Woden Community Services
	NT	Aboriginal Medical Services Alliance Norther Territory
		Anglicare NT
		Mental Health Association of Central Australia
		Mental Illness Fellowship Australia Northern Territory

Stakeholder group	Jurisdiction	Organisation represented
		Mission Australia NT
		Miwatj Health
		Neami NT
		Salvation Army
		Sunrise Health Service
		TeamHEALTH
		Top End Mental Health Consumers Organisation (TEMHCO)
Other	NSW	David McGrath Consulting

## Attachment D: List of organisations represented in the National Stakeholder Session (22 March 2024)

Table 61: Organisations represented at the National Stakeholder Session by stakeholder group

Stakeholder group	Organisation represented
Academic organisations / technical advisors	Australian Institute of Health and Welfare
	National Mental Health Commission
	The University of Queensland/Queensland Centre for Mental Health Research
	Flinders University
Clinical sector	Occupational Therapy Australia
Commissioners of psychosocial support	Australian Government, Department of Health and Aged Care
	Australian Government, Department of Social Services
	Capital Health Network / ACT PHN
	Healthy North Coast
	National Disability Insurance Agency
	Western Australian Primary Health Alliance
Representatives of psychosocial support consumers	Lived Experience representatives from the Psychosocial Project Group and Lived Experience Group (under Mental Health and Suicide Prevention Senior Officials – part of governance structure for National Agreement)
	National Mental Health Consumers and Carers Forum (via Mental Health Australia)
Providers of psychosocial supports	Australian Psychosocial Alliance
	The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)
	Flourish
	Neami National
	Mind Australia
Peak bodies	Mental Health Australia
	Mental Health Carers Australia
	Lived Experience Australia
	Secretariat representatives of Mental Health Australia's Embrace Multicultural Mental Health Project (CALD Lived Experience group)
	Mental Illness Fellowship of Australia

## B. Prevalence estimates from the National Mental Health Services Planning Framework

Prevalence estimates for mental illness 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 2019. The NMHSPF Technical Appendices (Diminic, Page, et al., 2023) provides details of the steps used to apply the GBD estimates to the Framework:

1. Estimates of prevalence by age and mental health condition diagnosis are taken from GBD.
2. The GBD estimates are adjusted as follows:
  - (a) Adjust point prevalence estimates for major depressive condition and anxiety conditions 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 (Morgan et al., 2012).
  - (c) Adjust personality condition prevalence estimates (which in GBD represent non-comorbid personality condition 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 condition cases over the age of 18 as antisocial personality condition.
3. Use MH-CCP 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 conditions.
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 health conditions.

The prevalence of mental illness for First Nations 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 Technical Appendices for the NMHSPF V4.3. An example is the multiplier for severe disease among people aged 25 to 64 years is 3.9. That multiplier is based on 2016–2019 AIHW data on utilisation of public sector mental health services – specialised clinical mental healthcare.

Table 62: Prevalence (rate per 100,000 population) of mental illness by age group, level of severity and care profiles

Age group (years)	Severity	Care profile	Non-Indigenous	Indigenous
00–04	Mild	Mild	3,141	4,711
	Moderate	Moderate	2,152	3,228
	Severe	Severe – standard	705	2,115
	Severe	Severe – complex	705	2,115
	Top-up	Respite	165	495
05–11	Moderate	Moderate	2,435	3,653
	Severe	Severe – standard	599	1,797
	Severe	Severe – complex	599	1,797
	Top-up	Respite	165	495
12–17	Mild	Mild	7,861	15,722
	Moderate	Moderate	5,169	10,337
	Severe	Severe – standard	843	2,107
	Severe	Severe – complex	1,264	3,161
	Severe	First episode psychosis – intensive	185	464
	Severe	First episode psychosis – maintenance	35	88
	Top-up	Respite	165	412
18–24	Mild	Mild	9,576	19,247
	Moderate	Moderate	6,019	12,097
	Severe	Severe – standard	1,185	3,556
	Severe	Severe – complex	1,174	3,523
	Severe	Perinatal mental illness	71	214
	Severe	First episode psychosis – intensive	400	1,201
	Severe	First episode psychosis – maintenance	76	227
	Top-up	Intense ISR	80	240
	Top-up	Respite	165	495
25–64	Moderate	Moderate	5,411	10,876
	Severe	Severe – standard	1,925	7,509
	Severe	Severe – complex	631	2,460
	Severe	Perinatal mental illness	75	291
	Top-up	Intense ISR	80	312
	Top-up	Respite	94	368
65+	Mild	Mild	5,985	11,491
	Moderate	Moderate	3,733	7,168
	Moderate	Moderate	130	325

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

*Notes: Prevalence estimates were obtained from the Excel version of NMHSPF Care Profiles V4.3 Approximate estimates for Non-Indigenous Australians are available from Table 6 of the Technical Appendices and multipliers for the Indigenous population available in Table 20. BPSD: Behavioural and Psychological Symptoms of Dementia ISR: Individual Support and Rehabilitation.*

# C. Estimated number of people needing psychosocial supports

## C1. Aim

The aim of this analysis was to estimate the numbers of people requiring psychosocial support services nationally from the National Mental Health Service Planning Framework (NMHSPF). The NMHSPF is an epidemiological planning model for mental health services in Australia, combining estimates of population mental health needs and care requirements to estimate the numbers of people, services, workforce, and costs required to deliver adequate mental health care across the system nationally by geographic area.<sup>9</sup> The results of this NMHSPF analysis will support a national analysis of unmet need for psychosocial support services provided outside of the NDIS, as committed to by the Australian Government and state and territory governments in the National Mental Health and Suicide Prevention Agreement.

Extracting consumer counts from the NMHSPF requires manual analysis. The NMHSPF includes 'unique' estimates of consumers needing services at the care profile population level. Within each care profile, proportions of the need group are modelled as requiring different types of services, such as Individual Support and Rehabilitation, or Individual Peer Support. Each line of a care profile has a separate proportion estimate, and these generally sum to more than 100% of the group since it is expected that most people require multiple types of supports. Therefore, the NMHSPF Planning Support Tool (NMHSPF-PST) is not able to reliably calculate numbers of people requiring specific service types or groups of service types (e.g., 'psychosocial supports') due to potential double counting of people in care profiles who are expected to receive more than one type of service (or from more than one provider type).

The UQ team has previously developed a method for determining whether lines in a care profile represent the same or different people and for manual calculation of these person counts outside the NMHSPF-PST. This method incorporates information provided in NMHSPF expert group discussions, care profile notes, and general modelling rules that have often been applied for alternative service options. However, previous analyses have been done with NMHSPF V2.2; V4.3 of the NMHSPF has recently been released, which incorporates significant enhancements including updated epidemiology and specific modelling for Aboriginal and Torres Strait Islander, rural, and young adult populations. As such, a new application of the method across care profiles was required.

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<sup>9</sup> Australian Institute of Health and Welfare. (2022). National Mental Health Service Planning Framework. Available at: <https://www.aihw.gov.au/nmhspf>

This analysis therefore built on and updated previous work undertaken by the UQ team<sup>10,11,12</sup> and Department of Health and Aged Care<sup>13</sup> to analyse numbers of people needing psychosocial supports from earlier versions of the NMHSPF. These earlier estimates have been cited in various policy documents relating to psychosocial support services, such as the Productivity Commission mental health inquiry report.

## C2. NMHSPF analysis methodology

NMHSPF V4.3 care profiles and NMHSPF-PST V4.3 were used to estimate the numbers of people needing psychosocial support services in Australia and the estimated number of their carers/family members also expected to require psychosocial supports. Estimates have been broken down by age group, severity level, rurality, Indigenous status, need group, SA3 and jurisdiction.

### C1.1 Definition of psychosocial supports

People with complex mental health needs can experience a range of impacts that extend beyond the symptoms of mental illness to effects on their ability to complete day-to-day living skills, engage with employment and education, and social and community participation. Psychosocial support services are a critical component of a supportive mental health system. These are community-based services that aim to identify and work towards individuals' non-clinical recovery goals, address impacts on functioning, and help people with mental illness to live independently in the community.

The NMHSPF provides an agreed national taxonomy of the spectrum of mental health services required to meet population needs, from mental health promotion to specialised mental health services, including a variety of psychosocial support services listed under the Service Stream "Specialised Mental Health Community Support Services". In consultation with the Psychosocial Project Group, Department of Health and Aged Care and HPA, this service stream was identified as aligning with the project definition of psychosocial support services. A full list of service elements described in the NMHSPF taxonomy for Specialised Mental Health Community

Support Services is available from the NMHSPF Taxonomy and NMHSPF Service Element and Activity Descriptions documents.<sup>14</sup>

Table 63 provides summary descriptions for each of these key psychosocial support service categories and elements included in the NMHSPF.

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<sup>10</sup> Diminic, S., Gossip, K., & Whiteford, H. (2016). Mental health psychosocial support service needs from the National Mental Health Service Planning Framework (NMHSPF). Report for the Department of Social Services. Brisbane: UQ.

<sup>11</sup> Diminic, S., Gossip, K., Wright, E., Woody, C., Page, I., & Sparti, C. (2019). Mental health psychosocial support service needs from the National Mental Health Service Planning Framework (NMHSPF). Brisbane: UQ.

<sup>12</sup> Diminic, S., Sparti, C., Mundie, A. & Gossip, K. (2021). Description of consumers and carers requiring mental health psychosocial support services from the National Mental Health Service Planning Framework (NMHSPF). Report for the Department of Health. Brisbane: UQ.

<sup>13</sup> Analyses of NMHSPF psychosocial support service need conducted by the Department of Health in collaboration with the UQ NMHSPF team, 2020.

<sup>14</sup> Australian Institute of Health and Welfare (2022). NMHSPF Documentation. Available at: <https://www.aihw.gov.au/nmhspf/overview/documentation>

Table 63: Description of psychosocial support service types included in the NMHSPF

Service category	Service element	Description <sup>15</sup>
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. <sup>16</sup>  Sub-types: Individual Consumer Peer Support, Individual Carer Peer Support.
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. <sup>9</sup>  Sub-types: Group Based Consumer Peer Support, Group Based Carer Peer Support.
Family and Carer Support	Flexible Respite, Day Respite, Family Support Services, Group Carer Support Services, 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.

<sup>15</sup> 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.

<sup>16</sup> 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. Version AUS V4.3. The University of Queensland, Brisbane. <sup>9</sup> Ibid

Service category	Service element	Description <sup>15</sup>
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.

Based on the NMHSPF taxonomy and consistent with previous NMHSPF analyses of need for psychosocial supports, this analysis has defined “need for psychosocial support” separately for consumers with mental illness, and their carer(s)/family member(s), as shown in Table 64.

The number of carer/family members needing psychosocial support services has been based on the number of consumers for whom there is an identified need for carer support service types. In the absence of explicit carer estimates in the NMHSPF, a conservative estimate of one carer per consumer was used.

Table 64: Consumer vs carer/family-focused services

Consumer services	Carer/family services
Consumers needing psychosocial support services includes an identified need for any one or more of the following NMHSPF service types:	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:
<ul style="list-style-type: none"> <li>• Individual Support and Rehabilitation*</li> <li>• Individual Peer Support</li> <li>• Group Support and Rehabilitation</li> <li>• Group Based Consumer Peer Support^</li> </ul>	<ul style="list-style-type: none"> <li>• Individual Carer Support Services</li> <li>• Individual Carer Peer Support</li> <li>• Group Carer Support Services~</li> <li>• Group Based Carer Peer Support</li> <li>• Family Support Services</li> <li>• Flexible Respite</li> <li>• Day Respite</li> <li>• Residential Crisis and Respite Services</li> </ul>

\* Includes all service activities under this service element as well, e.g., “Individual Support and Rehab linked to early childhood, education and/or employment”

^ Includes the service category “Group Based Peer Work” where it has been used instead.

~ The service element “Group Support and Rehabilitation” is a consumer support service, however in the 18–24 and 25–64 years perinatal mental health care profiles, the notes indicated this was also a service targeted at partners/carers and so for these particular groups it was modelled as both a consumer and carer support service.

## C1.2 Summary of analysis methods

Building on earlier NMHSPF analyses, full NMHSPF V4.3 care profiles were used to separate out the number of consumers across all ages and severity levels requiring psychosocial support services, and separately the number of consumers who have a carer/family member(s) requiring psychosocial supports. The proportion of people was determined at the care profile level as a percentage of the total care profile population, for each of the four versions of the care profile populations (i.e.,

urban\_non-Indigenous, urban\_Indigenous, rural\_non-Indigenous, rural\_Indigenous). Rules for how these proportions were determined are included in Appendix C1. A list of the care profiles included in this analysis (i.e., care profiles including one of the in-scope psychosocial support service types) is provided in Appendix C2.

NMHSFP top-ups were included where they identified additional carers/family members with a psychosocial support need. Top-ups are additional resource estimates that apply to groups of people already quantified in the other care profile groups, so they are not unique individuals. However, in some cases there is significant psychosocial support separately identified in the Respite top-ups that indicates more numbers of carers/family members requiring psychosocial support than would otherwise be identified from the corresponding care profiles alone. In these cases, we considered the top-ups to determine the total level of support need, avoiding double counting. Further detail is provided in Appendix C1.

Percentages of each care profile population estimated as requiring psychosocial support were then multiplied through by the care profile total populations within each SA3, using Excel XLOOKUP functions to link the master care profile psychosocial service rates to each of the SA3-level care profile populations produced by the NMHSFP-PST. NMHSFP-PST generated SA3-level care profile populations for the financial years 2021–22 and 2022–23 were used. Care profile rates per 100,000 age-, rural- and Indigenous-specific population and the rates within each care profile requiring psychosocial supports have also been provided in the same format, which may allow application of rates to other area-level population data.

SA3-level estimates were calculated separately at the care profile level, with discrete estimates for each NMHSFP:

- Age group (0–4, 5–11, 12–17, 18–24, 25–64, 65+)
- severity scale (selective prevention, indicated prevention, relapse prevention, mild, moderate, severe)
- severity group (UQ-defined estimate to help identify likely NDIS-eligible versus non-NDIS target populations based on “severe (not complex)” and “severe and complex” breakdowns within the overall severe group)
- rurality (urban MM1–2 vs. rural MM3–7)
- Indigenous status (Indigenous vs. non-Indigenous)

Each of the subgroups within these categories represent separate groups of people. Therefore, the resulting estimated numbers of consumers and numbers of carers needing psychosocial supports can be rolled up to any preferred higher-level reporting categories (e.g., overall, severe across all ages, 18–64 Indigenous, etc.).

## C3. Summary of results

The estimated number of consumers needing psychosocial support services nationally in 2022–23 was 336,000 for those aged below 65 years with severe mental illness, and 1,010,000 across all age groups and severity levels.

The estimated number of carers needing support services was 155,000 for consumers with severe illness below 65 years, and 638,000 across all age and severity levels. These carer estimates assume one carer/family member per consumer.

Table 65: Estimated number of consumers and carers needing psychosocial support services from the NMHSPF V4.3, 2021–22 and 2022–23

	2021–22		2022–23	
	Consumers	Carers	Consumers	Carers
<b>Severe, 0–64 years</b>	331,523	153,043	335,860	154,748
<b>TOTAL (all severities and ages)</b>	994,004	629,850	1,009,628	638,323

These estimates are higher than previous estimates generated for earlier years from the NMHSPF V2 and used by the Productivity Commission mental health inquiry report. In addition to the increasing Australian population over time, there are a number of changes to the modelling in NMHSPF V4 that have affected these estimates, such as significantly enhanced care profile modelling of psychosocial support services for young adults, adolescents and children, and changes to the epidemiology estimates of need for mental health services, particularly for mild to moderate mental illness in adults.

Of particular note, there are a much broader range/number of consumer psychosocial support services modelled for 12–24 year olds in NMHSPF V4 compared with V2, leading to increased estimates of consumer psychosocial support need in youth age groups, especially for non-severe populations.

Likewise, estimates of the number of carers requiring support across all ages and severity levels include a significant number of carers for 12–24 year olds, which reflects the youth modelling enhancements implemented in NMHSPF V4. It should be noted that some of these carer supports reflect a one-off phone call or group psychoeducation session that is likely to be integrated as part of the consumer's multidisciplinary care within clinical settings. For example, the 12MMOD\_Moderate, 18MIND\_Low, 18MIND\_High, 18MRPV\_Relapse and 18MMLD\_Mild care profiles include the need for a proportion of the group to receive one session of 'Group Carer Support Services' representing multifamily group psychoeducation. Similarly, the 18MMOD\_Moderate, 18MSEV\_Standard and 18MSEV\_Complex care profiles include the need for 100% of the group to receive one 15-minute phone call to 'identify family/network support... check in and offer support', but the proportion modelled as likely to need further brief peer support sessions is only 30%.

## C4. Caveats and limitations

The NMHSPF only covers the “should be/ideal” estimates of need, not the “what is/on-the-ground” in terms of how many people are currently using psychosocial support services.

Estimates in this analysis were limited to community psychosocial support services and do not include 24 hour-staffed mental health residential rehabilitation or sub-acute bed-based services that may be delivered by non-government agencies. Psychosocial support services delivered by nonmental health sector funding, such as family support services provided by child protection agencies or general social services, have been excluded from the analysis (these are not comprehensively elaborated in the NMHSPF, so rows in care profiles labelled with the funder ‘non-MH’ were removed prior to this analysis).

The NMHSPF estimates of numbers of people needing services across different small/regional areas are driven by population size, age distribution, the proportion of the population catchment in rural versus urban areas, and the proportion of the population who are Indigenous. Therefore, at subnational level, regional variations in psychosocial support needs due to other factors such as socioeconomic disadvantage may need to be considered. In addition to the NMHSPF, other possible indicators of need might include service waiting lists, rates of disability support pension access for mental health, or sociodemographic predictors of psychosocial functioning from the National Survey of Mental Health and Wellbeing (NSMHWB) applied to area characteristics. However, this NMHSPF analysis does not include any consideration of or adjustment for local variation (beyond the age, rurality and Indigenous status incorporated into the NMHSPF model).

Potential impacts of the COVID-19 pandemic on need for care have not been factored into the NMHSPF V4.3 model, which uses epidemiology based on pre-2019 data, projected forward for future population changes. There may be additional support requirements in the post-COVID environment, aligned with observed increasing presentations to mental health clinical services.

## Appendix C1. Rules used to determine the number of people requiring psychosocial support services

We were guided by the following assumptions and rules to determine the proportion of people receiving psychosocial support services in each care profile, where there was more than one service type with a population which may or may not have overlapped. The rules apply in a hierarchical order.

### Rule 1 – care profile comments

In the first instance we were guided by any comments recorded against the service elements in the care profiles. If we came across a care profile with the same set of service elements but no comments, we applied the principles from care profiles with comments.

### Rule 2 – young people

For the young people age groups (i.e., 12–24 years), a review of minutes from the Youth Expert Panel revealed that Individual Support and Rehabilitation services and Individual Peer Support should not be considered mutually exclusive. Some young people may receive both supports as they are different services designed to target different psychosocial needs. When both services were included in a care profile for the 12–17 or 18–24 years age groups, they were considered to be delivered to the same group.

Minutes from the Youth Expert Panel also outlined that Group Peer Support is typically offered to individuals who are less acutely unwell. Accordingly, Individual Peer Support and Group Peer Support were considered to be delivered to separate groups. However, where the proportion of the group receiving Individual Support and Rehabilitation was greater than the proportion of the group receiving Individual Peer Support, the Individual Support and Rehabilitation and Group Peer Support were considered to be delivered to separate groups.

### Rule 3 – professional vs. peer support

For 25+ age groups, the service elements and activities in Table 66 were generally applied as being delivered to alternate groups. Therefore, if both were found in a single care profile the populations are assumed to be separate.

Table 66: Different groups for professional vs. peer support

Individual support and rehabilitation	Alternate for	Individual peer work
Group support and rehabilitation	Alternate for	Group based peer work
Individual carer support services	Alternate for	Individual carer peer work
Group carer support services	Alternate for	Group based carer peer work

## Rule 4 – individual vs group support

For 25+ age groups, not all consumers/carers will be amenable to group-based supports. The service elements and activities in Table 67 are considered to be alternatives to each other. Therefore, if both were found in a single care profile the populations are assumed to be different.

Table 67: Different groups for individual vs. group services

Individual support and rehabilitation	Alternate for	Group support and rehabilitation
Individual peer work	Alternate for	Group based peer work
Individual carer peer work	Alternate for	Group based carer peer work
Individual carer support services	Alternate for	Group carer support services

## Rule 5 – repeated service elements

When a single care profile contained a service element more than once, these populations were considered to be separate groups.

## Rule 6 – consumer-vs carer-focused services

Populations requiring psychosocial support services were examined separately for consumer versus carer-focused services according to the services outlined in Table 68. Since the level of counting for the NMHSPF is consumers with mental health needs, for simplicity we assumed that carer and family support services for a specific consumer within a need group are supplied to one carer or family member. However, this estimate is likely conservative and at the lower end of possible need.

Table 68: Consumer- vs carer-focused services

Consumer services	Carer/family services
Individual Support and Rehabilitation*	Individual Carer Support Services
Individual Peer Work	Individual Carer Peer Work
Group Support and Rehabilitation	Group Carer Support Services~
Group Based Peer Work^	Group Based Carer Peer Work
	Family Support Services
	Flexible Respite
	Day Respite
	Residential Crisis and Respite Services

\* Includes all service activities under this service element as well, e.g. "Individual Support and Rehab linked to early childhood, education and/or employment"

^ Includes the service category "Group Based Peer Work" where it has been used instead.

~ The service element "Group Support and Rehabilitation" is a consumer support service, however in the 18–24 and 25–64 years perinatal mental health care profiles, the notes indicated this was also a service targeted at partners/carers and so for these particular groups it was modelled as both a consumer and carer support service.

## Rule 7 – top-ups

Top-ups containing psychosocial supports were assumed to apply to people with severe and complex mental illness and their carers.

### Intensive ISR

Intensive Individual Support and Rehabilitation top-ups were not counted in analyses. As they are a top-up, the populations they apply to were assumed to be already counted through the severe and complex care profiles. In all age groups, the size of the estimated consumer populations requiring psychosocial support in the severe and complex group was larger than the total population for that age group's Individual Support and Rehabilitation top-up.

### Respite top-ups

Respite top-ups likely overlap with the carer supports counted in severe and complex care profiles. Accordingly, demand rates for carer supports were compared for the severe and complex care profiles and respite top-up for each age group. The larger rate was used to estimate the number of people who require carer support for each age group. In all cases except for the 12 to 17 years and 65+ years age groups, the severe and complex groups needing carer support were larger than the respite groups. For the 12 to 17 years and 65+ years age groups, the respite top-up demand rate was used to estimate the size of the population requiring carer support in place of the severe and complex group. A comparison of the demand rates across the respite top-ups and severe and complex care profiles is displayed in Table 69.

Table 69: Carer support demand comparisons (rates per 100,000 population)

Age group	Care profile/ top-up code	rural_ Indigenous	rural_non- Indigenous	urban_ Indigenous	urban_non Indigenous
0–4	00MSEV_Complex	634	211	634	211
	00MTOP_Respite	495	165	495	165
5–11	05MSEV_Complex	539	180	539	180
	05MTOP_Respite	495	165	495	165
12–17	12MSEV_Complex	285	114	285	114
	12MTOP_Respite	412	165	412	165
18–24	18MSEV_Complex	3,523	1,174	3,523	1,174
	18MTOP_Respite	495	165	495	165
25–64	25MSEV_Complex	492	126	492	126
	25MTOP_Respite	368	94	368	94
65+	65MSEV_Complex	148	87	148	87
	65MTOP_Respite	483	284	483	284

## Rule 8 – rural service modelling adjustments

The rural service modelling adjustments were found to have no impact on demand rates for psychosocial supports. All relevant modelling adjustments increase the duration of psychosocial support services for rural populations and do not increase the number of people who are expected to receive them.

## Rule 9 – Aboriginal and Torres Strait Islander service modelling adjustments

The Aboriginal and Torres Strait Islander service modelling adjustments were found to have no impact on demand rates for psychosocial supports. However, the epidemiology modelling adjustments included in V4.3 have increased the rates of Aboriginal and Torres Strait Islander people who will have a demand for psychosocial support services. These epidemiology rates have been accounted for in the calculation of the SA3 populations for each care profile as generated by the NMHSPF-PST.

## Appendix C2. Care profiles and top-ups including psychosocial support services

Table 70: Care profiles and top-ups included in the NMHSPF analysis

Age group	Severity group	Care profiles included
<b>0–4</b>	Moderate	00MMOD_Moderate
	Selective prevention	00MSEL_COPMI
	Severe and complex	00MSEV_Complex
	Severe (not complex)	00MSEV_Standard
<b>5–11</b>	Moderate	05MMOD_Moderate
	Selective prevention	05MSEL_COPMI
	Severe and complex	05MSEV_Complex
	Severe (not complex)	05MSEV_Standard
<b>12–17</b>	Indicated prevention	12MIND_Indicated
	Mild	12MMLD_Mild
	Moderate	12MMOD_Moderate
	Relapse prevention	12MRPV_Relapse
	Selective prevention	12MSEL_COPMI
	Severe and complex	12MSEV_Complex
	Severe (not complex)	12MSEV_FEP_Intensive
	Severe (not complex)	12MSEV_FEP_Maintenance
	Severe (not complex)	12MSEV_Standard
<b>18–24</b>	Indicated prevention	18MIND_High
	Indicated prevention	18MIND_Low
	Mild	18MMLD_Mild
	Moderate	18MMOD_Moderate
	Relapse prevention	18MRPV_Relapse
	Severe and complex	18MSEV_Complex
	Severe (not complex)	18MSEV_FEP_Intensive
	Severe (not complex)	18MSEV_FEP_Maintenance
	Severe (not complex)	18MSEV_Perinatal
	Severe (not complex)	18MSEV_Standard
<b>25–64</b>	Moderate	25MMOD_Moderate

	Severe and complex	25MSEV_Complex
	Severe (not complex)	25MSEV_Perinatal
	Severe (not complex)	25MSEV_Standard
<b>65+</b>	Moderate	65MMOD_Moderate
	Severe and complex	65MSEV_Complex
	Severe (not complex)	65MSEV_RACF
	Severe (not complex)	65MSEV_Standard
<b>65+ BPSD</b>	Moderate	65BMOD_Moderate
	Moderate	65BMOD_Moderate_RACF
	Severe and complex	65BSEV_Complex
	Severe and complex	65BSEV_Sub-acute_Hospital
	Severe and complex	65BSEV_Sub-acute_RACF

The following respite top-ups were included in the NMHSPF analysis. As described in rule 7 above, demand rates for the respite top-ups and severe and complex care profiles were compared. The care profile/top-up representing the larger demand for psychosocial support was used in the analysis.

Table 71: Care profiles and top-ups included in the NMHSPF analysis

Age group	Severity group	Top-ups included
<b>0–4</b>	Top-up	00MTOP_Respite
<b>5–11</b>	Top-up	05MTOP_Respite
<b>12–17</b>	Severe and complex	12MTOP_Respite
<b>18–24</b>	Top-up	18MTOP_Respite
<b>25–64</b>	Top-up	25MTOP_Respite
<b>65+</b>	Severe and complex	65MTOP_Respite

## D. Included programs

Table 72 describes each program included within the analysis.

Table 72: The description and target population of all programs included within the analysis

Government agency	Program and description	Target population
NSW	<b>Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS)</b> programs provide community based psychosocial support to people with severe mental illness throughout NSW, to live and participate in the community including helping people to achieve their own, unique goals.	Consumers Severe mental health condition NSW 16 years and over
NSW	<b>HASI Plus</b> is a transitional mental health rehabilitation and recovery program. It provides integrated high intensity clinical and psychosocial supports (16–24 hours per day, seven days per week) with stable community-based fit-for-purpose accommodation to support people transitioning from hospital or prison to the community.	Consumers transitioning from inpatient to community care. Severe mental health condition Statewide Ages all (predominantly adult)
NSW	<b>Mental Health Community Living Supports for Refugees (MH-CLSR)</b> is an enhancement of the Community Living Supports program for refugees and asylum seekers of any age who are experiencing psychological distress, mental ill health and/or impaired functioning.  Program provides trauma informed, recovery-oriented, culturally safe, and responsive psychosocial supports	Consumers (Refugee and asylum seekers) Severe and Moderate mental health condition NSW Ages all
NSW	<b>Youth Community Living Support Services (YCLSS)</b> provides community-based psychosocial support services to young people aged 16–24 years with severe and complex mental illness and their families, in areas of their life where they would like to make positive change.	Consumers Severe mental health condition NSW Ages 15–24

Government agency	Program and description	Target population
Vic	<b>Early Intervention Psycho-Social Response (EIPSR)</b> targets consumers who do not qualify for the NDIS or are waiting for an access decision and their NDIS plan to begin. The program delivers wellbeing supports for people with ongoing mental illness, unmet wellbeing needs and/or psychosocial disability. (10 Providers)	Consumers Severe, moderate mental health condition Vic Ages 16–64
Vic	<b>Youth Outreach Recovery Support (YORS)</b> program delivers wellbeing supports for young people with ongoing mental illness, unmet wellbeing needs and/or psychosocial disability. This service is delivered in community-based settings. The aim of this program is to assist the young person to learn or re-learn skills and confidence for independent living, better cope with and manage their mental illness and support them to achieve healthy, functional lives. (7 providers)	Consumers Severe, moderate mental health condition and psychosocial disability Vic Ages 16–25
Vic	<b>Youth Residential Rehabilitation/Recovery (YRR)</b> service provides psychosocial rehabilitation support to young people with a mental health condition and an emerging or existing psychosocial disability in a residential setting.  The aim of the YRR service model is to assist the young person to learn or re-learn skills and confidence for independent living, better cope with and manage their mental illness and support them to achieve healthy, functional lives. This service consists of both 24-hour and non-24-hour beds. (7 providers).  It was agreed that the twenty 24-hour beds should be excluded from this analysis; the 139 non-24-hour beds remain included.	Consumers who: <ul style="list-style-type: none"> <li>• have a disability that is attributable to a psychiatric condition and</li> <li>• have impairment or impairments that are permanent, or are likely to be permanent and</li> <li>• have an impairment or impairments that results in substantially reduced psychosocial functioning in undertaking one or more of the following activities: communication, social interaction, learning, self-care, self-management; and</li> <li>• have an impairment or impairments that affect their capacity for social and economic participation.</li> </ul> Ages 16–25 years Vic

Government agency	Program and description	Target population
Vic	<b>Mutual support and self-helps (MSSH) services</b> provide information and peer support to people with a mental illness (who are not eligible for the NDIS) and/or their carers. Operates across Victoria (9 providers). The MSSH data provided in this report only includes a portion of the Eating Disorders programs delivered by Eating Disorders Victoria (EDV). Other out-of-scope services of this program have been excluded	Consumers Moderate to severe mental health condition through Eating Disorders Victoria only (EDV). This program targets support to people with severe and enduring eating disorders. Adults 18+  Vic
Vic	<b>Continuity of Support (CoS)</b> Ongoing continuity of support to current clients of MHCSS who have been identified as ineligible for the NDIS because they do not meet age or residency requirements. All clients who were eligible have now transitioned to the NDIS. No new clients will be eligible for COS.	Moderate to severe mental health condition  Consumers 16 years and over who were transitioned to CoS during roll-out of NDIS in Victoria. They were part of the mental health community support services assessed as having a psychosocial disability. They were not eligible for NDIS.
Qld	The <b>Individual Recovery Support Program (IRSP)</b> is a non-clinical psychosocial wraparound support on a one-on-one basis, including peer to peer support in the individual's local community.	Consumers Severe mental health condition Qld Ages 18 and above Seen clinically and referred by the Hospital and Health Services (HHS)
Qld	<b>Group Based Peer Recovery Support Program (GBPRSP)</b> provides the individual with access to group-based peer led activities complementary to the supports provided through the IRSP.	Consumers Severe mental health condition Qld Ages 18 and above Referral by IRSP program.
Qld	<b>Individual Recovery Support – Transition from Correctional Facilities Program (IRS-TCFP)</b> is designed to offer a range of non-clinical psychosocial wraparound supports to an individual at least two weeks	Consumers – From corrections Severe mental health condition Qld

Government agency	Program and description	Target population
	prior to release from the correctional facility (where the date is known) and for up to 12 months post release.	Ages 18 and above Referral from correctional facility.
Qld	The <b>Individual at Risk of Homelessness Program (IRHP)</b> offers a range of nonclinical psychosocial wraparound supports that focuses on breaking the cycle of homelessness and supporting individuals to transition to secure and stable tenancy and housing	Consumers Severe mental health condition Qld Ages 18 and above living in a boarding house, crisis accommodation or hostel and seen clinically and referred by the HHS
Qld	<b>Clubhouses</b> provide support for people 18 years and over experiencing severe mental illness following the International Clubhouse model	Consumers Severe mental health condition (small element that is moderate (2%) but mostly severe) Ages 18 and above
Qld	<b>Aboriginal and Torres Strait Islander Mental Illness – Individual Recovery</b> Support for Aboriginal and Torres Strait Islander people with moderate to severe mental illness	Consumers Moderate to severe mental health condition (50/50 estimate)
Qld	<b>Consumer Operated Services</b> Peer support for individuals 18 years and over with severe mental illness. Support for individuals 18 years and over with severe mental illness	Consumers Severe mental health condition Ages 18 and above
Qld	<b>Eating Disorders</b> support for people 16 years and over who experience eating disorders and for carers and support people.	Consumers and carers Ages 16 and over Severe mental health condition

Government agency	Program and description	Target population
Qld	<b>Music and Arts Based Supports</b> Four arts-based program streams to support individuals 18 and over with mental illness.	Consumers Ages 18 and over Very Severe mental health condition
Qld	<b>Perinatal and Infant Mental Health</b> Peer support for women and their partners who have an infant or child 0–5 years, experiencing perinatal mental health problems.	Consumers 30–40% severe mental health condition.
Qld	<b>Integrated Hub</b> Stride Hub. Support for individuals over 18 years of age experiencing severe mental illness.	Consumers and carers Severe mental health condition
Qld	<b>Specialist psychosocial support program for individuals with severe mental illness from Cultural and Linguistically Diverse Communities</b> – provision of individual support and rehabilitation, may include peer work, may include group support and rehabilitation for people 18 years and above with severe mental illness.	Consumers and carers Severe mental health condition Ages 18+
Qld	<b>Transitional Recovery Service (TRS)</b> Support for individuals 18 years and over with a severe mental illness – both individual residential support and transitional outreach support	Consumers Severe mental illness Aged 18–65
Qld	<b>Mental Health Continuity of Support</b> enables people with a psychiatric disability to live in the community with stable social housing and enjoy an improved quality of life. Sustainable housing and independent living support for program participants are seen as key elements in supporting their recovery and reducing the need for hospital care.	Consumers with severe mental illness Ages 18 and above
WA	<b>Staffed Residential Short-Term Community-Based Crisis/Respite</b> accommodation for people who may be experiencing a social crisis, are homeless or at risk of becoming homeless or require respite from their	Severe mental health condition

Government agency	Program and description	Target population
	usual place of residence. Variable hours of support dependent on individual needs.	
WA	<b>Individualised Community Living Support (ICLS)</b> is an innovative and collaborative partnership approach between the Health Service Providers, Community Managed Organisations, Community Housing Organisations and the Department of Communities – Housing to provide clinical and psychosocial supports and services, in addition to appropriate housing for individuals to maximise their success in recovery and living in the community.	Severe mental health condition WA Ages 18–65 (under 18 can access a package but not housing) Referral by public mental health service Case Manager or Psychiatrist.
WA	<b>Personalised support – linked to housing</b> – includes services that provide personalised psychosocial support that is coordinated with provision of social housing or privately negotiated housing at the point of entry into the program (but not necessarily tied to such indefinitely). A mental health recovery framework through the provision of personalised individual social, recreational or prevocational activities.  <b>Personalised support – other</b> – are flexible psychosocial services tailored to a mental health consumer's individual and changing needs. They include a range of services that provide personalised support that is independent of housing arrangements (e.g. provision of social housing or privately negotiated housing) at the point of entry into the program. 'Personalised support – other' is primarily delivered in the consumer's home or own environment.	Consumers Severe mental health condition
WA	<b>Education, employment, and training</b> includes services where the principal function is to provide or support people with lived experience of mental illness, in gaining education, employment and/or training.	Consumers Ages 18–64 Moderate and severe mental health condition

Government agency	Program and description	Target population
WA	<p><b>Mutual Support and Self Help</b> includes services that provide information and peer support to people with a lived experience of mental illness. People meet to discuss shared experiences, coping strategies and to provide information and referrals.</p> <p>Self-help groups are usually formed by peers who have come together for mutual support and to accomplish a specific purpose.</p>	<p>Consumers</p> <p>Not specified (typically ages 18–65 years)</p> <p>Severe mental health condition</p>
WA	<p><b>Group Support Activities</b> services aim to improve quality of life and psychosocial functioning of people experiencing mental health and co-occurring alcohol and other drug issues through group-based social, recreational and psychoeducational activities. Psychoeducational activities include education on mental health and wellbeing, healthy lifestyle behaviours and pre-vocational activities, inclusive of services that cater to the individual needs of Aboriginal people, people from CaLD backgrounds and the LGBTIQ+ community.</p>	<p>Consumers</p> <p>Not specified (typically ages 18–65 years)</p> <p>Severe mental health condition</p>
WA	<p><b>Staffed Residential – Transitional accommodation</b> staffed between 12 to 25 hours per week at each house, dependent on beds per house, occupancy and individual need, by appropriate skilled and trained staff. Independent living skills needed.</p>	<p>Consumers</p> <p>Severe mental health condition</p> <p>Not specified (typically 18–65 years)</p>
WA	<p><b>Staffed Residential – Long stay accommodation</b> in stable, affordable housing and support to enable accommodation stability and reduce the need for hospital based care. 24/7 support of 2 to 4 hours per person per day. They are evolving to have a stronger mental health recovery focus towards transitioning people into more independent community living arrangements rather than the CSRU being permanent accommodation. They need independent living skills.</p>	<p>Consumers</p> <p>Severe and moderate mental health condition</p> <p>Not specified (typically 18–65 years)</p>
SA	<p><b>Intensive Home-Based Support Services (IHBS)</b> One on one intensive rehabilitation and support services available for up to 3 months to provide support to people with mental health conditions to live in their homes independently and prevent unnecessary hospital admissions.</p>	<p>Consumers</p> <p>Severe mental health condition and functional impairment</p> <p>SA</p> <p>Ages 16 and above</p> <p>Referral from Community Mental Health Teams.</p>

Government agency	Program and description	Target population
SA	<b>Individual Psychosocial Rehabilitation and Support Services (IPRSS)</b> One on one rehabilitation and support services delivered from 6 months to 2 years to support people with mental health conditions to live independently in the community.	Consumers Severe mental health condition and functional impairment SA Ages 16–65 Referral from Community Mental Health Teams.
SA	<b>Housing and Accommodation Support Programs, including Housing and Accommodation Support Partnership (HASP), Accommodation Support Program (ASP) and Avalon.</b> Long term or transitional individual or cluster housing with up to 24 hour 7 days one on one support (Burnside HASP 24/7 only) to support people with mental health conditions to live independently in their homes in the community.	<b>HASP:</b> Consumers Severe mental health condition and functional impairment SA Ages 18–65 Individuals with limited independent living skills and at risk of homelessness. <b>ASP:</b> Consumers – Women who have a mental illness and/or psychosocial disability or who are at risk of developing a psychiatric disability and who are homeless or at risk of becoming homeless. Moderate to severe mental health condition <b>Avalon:</b> Consumers Severe mental health condition Ages 18–65 Southern Mental Health Services At risk of homelessness
SA	<b>GP Access Program</b> One on one rehabilitation and support services for people with mental health conditions who are referred by their GP and live in the western/southern Adelaide region.	Consumers Severe mental health condition Ages 18 years and over
SA	<b>Day and Group Programs</b> Group programs for people with mental health conditions focussed on skills building and pre-vocational activities.	Consumers Severe mental health condition Ages 18 years and over

Government agency	Program and description	Target population
SA	<b>Mutual Support and Self-Help Programs</b> One on one or group programs for people with mental health conditions and their carers focussed on the provision of information, counselling, skills building and advocacy.	Consumers Ages 18 years and over Moderate to severe mental health condition
Tas	<p><b>Community Recovery Outreach Program</b> – Designed for individuals diagnosed with mental illness aged 18–65 the program provides support to individuals to assist them to live in your own home, while still enabling the individual to take advantage of the organisations care-coordination services. The aim of the program is to support clients to identify ways their mental health could be improved utilising our recovery model, to maintain their community living choices and also engage them in other services of their choice.</p> <p>The outreach mental health service is a one-on-one support program that aims to support people to live in their own homes while connecting them with relevant services in their community. This service is available on the North-West Coast (from Deloraine all the way through to Smithton).</p>	Consumers Severe, moderate mental health condition and psychosocial disability Tas Age 18–65 years of age
Tas	<p><b>Residential Rehabilitation and Recovery</b>  <b>Anglicare:</b> Non-clinical community based residential rehabilitation and recovery service for adult mental health consumers.  Anglicare is similar to the Richmond Fellowship description below  <b>The Richmond Fellowship:</b> Residential rehabilitation and recovery, support for physical and mental health and wellbeing, and psychosocial rehabilitation service for socially disadvantaged people with a mental illness. To enable residents to develop the ability to live independently in the community, have an increased level of social inclusion and to enable individual self-management for future options and opportunities.  To provide access to services for people who:</p> <ul style="list-style-type: none"> <li>• Are not eligible for, are choosing not to test or have not yet tested eligibility to access the NDIS.</li> <li>• Are accessing NDIS supports but haven't yet met the requirements for Supported Independent Living (SIL) through their NDIS plan.</li> </ul>	<p><b>Anglicare:</b>  Consumers  Severe and persistent mental health condition  Tas  16–64 years of age</p> <p><b>Richmond Fellowship:</b>  Consumers  Severe, moderate mental health condition and psychosocial disability  Tas  Age 18+ years of age</p>

Government agency	Program and description	Target population
	Have had SIL approved in their plan but require transitional support until they are able to access appropriate SIL accommodation (up to 12 weeks).	
Tas	<p><b>Packages of Care</b></p> <p><b>Anglicare:</b> Packages of care and recovery focused support for people with a mental illness who live in independent accommodation, to achieve goals across areas of life and social inclusion.</p> <p>The program provides community based, flexible and recovery focused support for people with psychiatric disabilities who live in independent accommodation. It supports participants to develop or relearn skills, confidence and motivation to pursue and achieve goals across areas of life and social inclusion.</p> <p><b>Life Without Barriers:</b> Individualised community based, flexible support through packages of care for young people with, or at risk of, severe mental illness who are clients of Public child and adolescent mental health services or Forensic mental health services and their families. Services are provided to those that may require additional therapeutic support to implement a range of strategies to assist in their recovery and/or ongoing management of their illness. These packages may include: re-engagement in education and training, access to housing and accommodation, participation in community activities including recreation and social interaction, links to other relevant supports, and home and domestic help.</p>	<p><b>Anglicare:</b></p> <p>Consumers</p> <p>Severe, moderate mental health condition and psychiatric disability</p> <p>Tas</p> <p>16–64 years of age</p> <p><b>Life Without Barriers:</b></p> <p>Consumers</p> <p>Severe and moderate mental health condition</p> <p>Tas</p> <p>12–18 years of age</p>
Tas	<p><b>Baptcare – MICare and MICare Plus – Foundations Program</b> – Intensive psychosocial recovery-based program offering tailored packages of care to people with severe and persistent mental health conditions who are case managed through public Mental Health Services.</p> <p>The program includes outreach services, working one-on-one with individuals to promote recovery, encourage progress and support life skills. the program supports individuals to have more control in their life, identifying resources that will help meet their particular needs –</p>	<p>Consumers</p> <p>Super and extremely complex</p> <p>Severe and persistent mental health condition</p> <p>Tas</p> <p>18–64 years of age</p>

Government agency	Program and description	Target population
	supporting them towards their recovery goals. The program offers wrap-around, intensive support in a range of areas including; accommodation, independent living skills, social connectedness, overall social and emotional wellbeing, connection to the community, increased independence and remaining well.	
Tas	<b>Mindset – Choices Program</b> Support packages for people with severe and complex mental illness who would benefit from psychosocial support. The mindset program utilises the Foundations Program (above) as a foundation but also delivers a further range of psychosocial programs across Tasmania that build people’s capacity to improve their mental health and make progress towards their recovery. Mental Health Practitioners and Peer Workers use evidence-informed practices and work with clients collaboratively to identify goals and remove barriers to living the life they want to lead. The program supports people public mental health services, and may include transitional accommodation when necessary, as well as providing group and short-term individual interventions for people with severe and episodic mental health issues.	Consumers Severe and complex mental health condition Tas 18–65 years of age
Tas	<b>Eureka Clubhouse</b> is a psychosocial non-clinical community mental health program which operates using The International Clubhouse Model that supports individuals by giving opportunities to explore friendships, participate in a work ordered day, recreational and educational activities and employment support.	Consumers and carers Moderate mental health condition Tas All ages
Tas	<b>Housing and Accommodation Support Initiative (HASI)</b> community based psychosocial support to people with severe mental illness throughout Tasmania at risk of homelessness, to live and recover in the community including helping people to achieve their own, unique goals.	Consumers Severe mental health condition Tas All ages
Tas	<b>Mental Health Homeless Outreach Program (MHHOP)</b> providing a daytime psychosocial outreach service to socially disadvantaged people with psychosocial concerns and/or mental ill-health accessing a homelessness/rough sleeping service in the North and South of the state. MHHOP is a mental health recovery focused program supporting Tasmanian’s who are experiencing, or at risk of homelessness focusing on	Consumers Severe, moderate mental health condition and psychosocial disability Tas Age 18+ years of age

Government agency	Program and description	Target population
	<p>identifying recovery goals, developing action plans to achieve these goals through uncovering resourcefulness and resilience, supports people as the experts in their own lives, reconnects with own capabilities and strengths</p> <p>Some of the psychosocial intervention support the MHHOP provides are:</p> <ul style="list-style-type: none"> <li>– Skills to manage daily tasks</li> <li>– Assistance to engage in work or study</li> <li>– Supports people to consider housing options</li> <li>– Alcohol and drug support</li> <li>– Managing money</li> <li>– Making connections with family and friends</li> </ul> <p>The program is offered in the South, North and North-west of the state and focuses on inclusion, building connections and increasing confidence and self-esteem. Referral in can be self-referral, from medical practitioners, family members or support workers.</p>	
Tas	<p><b>Recreation Program</b> Providing a mental health recovery service for people with psychosocial concerns and/or mental ill-health. To enable participants to develop the ability to integrate into their local community and build networks to support their physical, mental health, and wellbeing.</p> <p>TasRec creates and provides links to a diverse range of community-based recreational and social activities, events, and opportunities for skill building and creative expression, all with a focus on enjoyment and wellbeing. The TasRec philosophy is all about inclusion, building connections, increasing confidence and self-esteem, and having fun!</p> <p>Conduct of four x 11 week programs throughout the year with some activities continuing all year round while others change with the seasons, providing a broad range of ongoing favourites and fresh opportunities throughout the year. All our programs and activities are open to anyone with a living or lived experience of mental ill-health.</p>	<p>Consumers</p> <p>Severe, moderate mental health condition and psychosocial disability</p> <p>Tas</p> <p>Age 18+ years of age</p>

Government agency	Program and description	Target population
Tas	<b>Recovery and Carer Support Services</b> – through the engagement of a peer workforce to provide community-based support for people with an eating disorder and their carers and families to achieve and maintain recovery in their own community with the lowest level intensity intervention appropriate to their care.	Consumers and carers Moderate mental health condition Tas All ages
ACT	<b>Wellways DECO</b> provides psychosocial support to people with a diagnosed mental illness who are exiting or transitioning out of detention. Participants must be aged between 16 and 65 years and be clinically managed or treated by ACT public mental health services or a GP.	Consumers – out of corrections Severe, moderate mental health condition Ages 16–65
ACT	<b>Transition to Recovery Program (TRec)</b> provides services to adults living in the ACT who have subacute mental health symptoms and would benefit from psychosocial outreach supporting during a time of transition and can manage in the community with support. While not a residential Step-Up, Step-Down program, TRec similarly targets people either at risk of hospitalisation or those who need assistance with their transition from hospital back to the community.	Consumers Severe, moderate mental health condition Ages 18–65
ACT	<b>St Vincent De Paul Compeer Friendship Program</b> is a befriending program that links adults living with a diagnosed mental illness (Compeer participants) with volunteers in the community. The aim of the program is to increase participants' social connection and community participation as well as improve participants' wellbeing and quality of life through social connections.	Consumers Severe, moderate mental health condition Ages 18+
ACT	<b>Wellways Women's transitional Accommodation Program</b> provides 8 short to medium term supported accommodation places to accommodate women living with mental illness (for 3–6 months, longer on a case by case basis). It also provides transitional outreach support for participants exiting the program, and outreach to women in the community who are at risk of homelessness due to mental illness.	Consumers Severe mental health condition Ages 18+

Government agency	Program and description	Target population
ACT	<b>Youth and Wellbeing Program</b> provides home-based outreach for young people experiencing mental health difficulties, using a case-management model. The program supports young people to look at their mental health and how it affects all different parts of their life, such as: relationships, school/work, housing, family life, coping and self-esteem. The service provides therapeutic support and help to develop skills to better manage young people's mental health and wellbeing in accordance with their own recovery goals.	Consumers Moderate/severe mental health condition Ages 10–25
NT	<b>Top End Mental Health Consumers Organisation (TEMHCO)</b> – Drop-in support service provides a social and emotional support and advocacy service to consumers with a mental illness. Programs and services are focused on assisting clients to maintain and increase their independence.	Consumers Severe mental health condition
NT	<b>MiPlace</b> – Drop-in support service provides a drop-in style centre with tailored recovery focused activities for people with mental illness. Mi Place provides a psychosocial recovery focused program that promotes good mental health, recovery assistance, life skills development and psycho-education and focuses on the reduction of stigma surrounding mental health.	Consumers Severe mental health condition
NT	<b>NT Housing Support Program</b> is to support people experiencing mild, moderate to severe mental illness and related psychosocial disability who experience episodic deterioration of condition(s) to live independently in the community.	Consumers Moderate and severe mental health condition
NT	<b>Recovery Assistance Program</b> provides community access and capacity building supports to people experiencing diagnosed mental illness or undiagnosed mental ill health in the Top End and Big Rivers regions. It supports people through recovery plans, in assertive engagement with the provision of psychosocial recovery supports to achieve individualised recovery goals.	Consumers Moderate and severe mental health condition – diagnosed and undiagnosed

Government agency	Program and description	Target population
NT	<p><b>Housing and psychosocial support program (HPSP)</b> has 2 programs that provide participants with individualised recovery-oriented support to improve personal wellbeing and enhance community living. HPSP provides assistance to adults who live with a mental health condition and reside in public, community and private housing.</p>	<p>Consumers (homeless, at risk of homelessness or inappropriately housed and require intensive support to gain or sustain housing in the community)</p> <p>Diagnosed mental illness – severity unknown</p>
Australian Government Department of Health and Aged Care	<p><b>Commonwealth Psychosocial Support Program</b></p> <p>Short-term, low-intensity psychosocial support to function day-to-day (individual or group psychosocial support) and live independently in the community. Covers a range of non-clinical supports that focus on building personal capacity and stability in one or more of the following areas:</p> <ul style="list-style-type: none"> <li>• social skills, friendships and family connections</li> <li>• day-to-day living skills</li> <li>• financial management and budgeting</li> <li>• finding and maintaining a home</li> <li>• vocational skills and goals</li> <li>• maintaining physical wellbeing, including exercise</li> <li>• managing substance use issues</li> <li>• building broader life skills, including confidence and resilience; and</li> <li>• building capacity to live independently in the community.</li> </ul> <p>Commissioned through the 31 PHNs.</p>	<p>People with severe, often episodic, mental illness and associated functional impairment – who are:</p> <ul style="list-style-type: none"> <li>• not accessing similar supports through the NDIS or state/territory-based psychosocial program</li> <li>• not restricted in their ability to fully, and actively, participate in the community because of their residential setting (e.g. prison or a psychiatric facility)</li> <li>• aged 16 years and over (exceptions can be made)</li> </ul> <p>A clinical diagnosis is not required.</p>
Australian Government Department of Health and Aged Care	<p><b>Online mental health services for people with complex mental health needs</b></p> <p>Delivered by SANE Australia: Specialised digital mental health service for people with complex mental health needs who find it hard to access mainstream services. This includes people with co-occurring conditions, such as intellectual disability and autism.</p> <p>Offers a range of individual and group based digital mental health services, care coordination and service navigation.</p>	<p>Eligible participants must:</p> <ul style="list-style-type: none"> <li>• have complex mental health needs or be caring for someone who does</li> <li>• be over 18 years of age</li> <li>• live within an eligible PHN region.</li> </ul>

Government agency	Program and description	Target population
	<p>Guided service program (14 weeks) includes:</p> <ul style="list-style-type: none"> <li>• digital and telehealth mental health support</li> <li>• support planning (personalised support plan)</li> <li>• counselling or peer support 1:1 sessions</li> <li>• mental health recovery groups.</li> </ul> <p>The 1:1 sessions and mental health recovery groups assist people with goal setting, building connections and supports, and planning for the future.</p> <p><u>Note:</u> In line with the agreed scope of this analysis, counselling elements have been excluded from the analysis, as have the small number of carers that receive supports through this program.</p> <p>There is also a self-guided service that provides drop-in channels as well as resources and forums (24/7 online community) for information and support.</p> <p>Currently available to people living in 13 PHN regions.</p>	
<b>Australian Government Department of Health and Aged Care</b>	<p><b>Kindred Clubhouse</b></p> <p>Non-clinical drop-in centre in the Frankston/Mornington Peninsula area of Victoria for people with moderate to severe mental illness, who are not supported by the NDIS. The clubhouse provides opportunities for social connection, skill development, vocational employment and meaningful activities. It also assists members with referral pathways to other services and to apply for support under the NDIS.</p>	<p>Consumers, aged 16 years and over, with moderate and severe mental illness who:</p> <ul style="list-style-type: none"> <li>• live in the Frankston/Mornington Peninsula region (Victoria)</li> <li>• are not accessing similar supports through the NDIS or state programs</li> </ul>
<b>Australian Government Department of Health and Aged Care</b>	<p><b>Canefields Clubhouse</b></p> <p>Non-clinical drop-in centre in Beenleigh area of Queensland for people with severe and complex mental illness who are not funded through the NDIS. The service provides non-clinical psychosocial support that includes social events and activities as well as one-on-one individual support that provides a recovery-focused approach to enable people with severe</p>	<p>Consumers, aged 16 years and over, with severe and complex mental illness who:</p> <ul style="list-style-type: none"> <li>• live in Beenleigh and surrounding suburbs (Queensland)</li> <li>• are not accessing similar supports through the NDIS or state programs</li> </ul>

Government agency	Program and description	Target population
	<p>mental illness to live independently within the community. The clubhouse also supports clients to transition to the NDIS if they are eligible.</p>	
<b>Australian Government Department of Health and Aged Care</b>	<p><b>Disability Support for Older Australians</b></p> <p>Closed program that provides a range of specialist disability support services, including Psychosocial Recovery Coaching services, for older people with disability who were not eligible for the NDIS at roll-out.</p> <p>Psychosocial Recovery Coaching funding provides assistance for clients with psychosocial disability to build capacity and resilience. Recovery coaches work collaboratively with clients, families, carers and other services to identify, plan design and coordinate DSOA supports.</p> <p>Clients receive an Individual Support Package overseen by a DSOA service coordinator.</p> <p>There are only a small handful of participants in this program that continue to receive psychosocial supports.</p>	<p>People aged 65 years and over (and Aboriginal and Torres Strait Islander people aged 50 years and over) with disability (e.g. psychosocial disability) who were not eligible for the NDIS due to their age at the time the scheme was rolled out.</p>
<b>Australian Government Department of Health and Aged Care</b>	<p><b>Early Psychosis Youth Services (EPYS)</b></p> <p>Provides early intervention treatment and support to young people aged 12 to 25 years who are at ultra-high risk of, or actively experiencing, their first episode of psychosis. The EPYS Program aims to reduce the risk of transition to full-threshold psychosis and long-term mental ill-health through prevention, early detection, and coordinated care delivery.</p> <p>The model focusses on working towards functional recovery, increased community participation, and re-engagement with education and employment, through timely access to specialist medical, psychological, and psychosocial support, care coordination, and psychoeducation for young people and their families and care.</p>	<p>People aged 12 to 25 years who are at ultra high risk of, or actively experiencing, their first episode of psychosis.</p> <p>Moderate-severe mental illness</p>

Government agency	Program and description	Target population
	In line with the agreed scope of this analysis, only the psychosocial components are included in this analysis.	

## E. Excluded programs

Table 73 lists the programs that were considered for the analysis but have been excluded. Exclusion was based on the agreed approaches to consistency (Table 16: Proposed handling of program inclusion issues from PPG meeting on 18 March 2024), in addition to the following exclusion criteria:

- Once-off programs based around a single event or point in time.
- Programs with broad or non-specific populations not specifically targeting people with mental illness (e.g. programs involving psychosocial supports available for the general population). Persons experiencing moderate or severe mental illness may be picked incidentally and are unlikely to be identified. Further these activities would fall outside the NMHSPF.
- Programs that provide linkage/referral services only.
- Programs where services do not align with psychosocial supports as defined for this project.
- Programs that are not yet operational or were not operational during 2021–22 or 2022–23.

Table 73: Programs that were considered for the analysis but ultimately excluded

Government agency	Program	Target population	Rationale
NSW	<b>LikeMind</b> provides coordinated health and social care services in a hub setting. LikeMind provides services in four areas: mental health, primary health, drug and alcohol, vocational and social needs including linkages to employment and housing	Consumers Severity unknown Western Sydney, Orange, Wagga Wagga Ages Adult	Difficult to separate clinical and psychosocial elements
NSW	The <b>Family and Carer Mental Health Program</b> is a statewide program for carers of people with a mental health condition delivered in partnership with NSW local health districts, community managed organisations (CMOs) and the Justice Health and Forensic Mental Health Network. Districts work to enhance the skills of mental health service staff to work with families and	Carers	Does not provide support to people with a moderate or severe mental health illness (carer support service)

Government agency	Program	Target population	Rationale
	carers as partners in care, while CMOs provide training and education, one to one support, group support and advocacy services for families and carers of people with a mental illness.		
Vic	<b>Mental Health &amp; Wellbeing Local Services</b> are part of Victoria's mental health and wellbeing system reforms being rolled out. Providing psychosocial support, treatment and care for people aged 26 years and over who are experiencing mental health concerns. More than 1,000 people were supported by the new Local services in the first year of operation (2022-23). (Commencing in 2022, although data was not available for 2022–23 as this was a new program.)	Consumers  Severe, Moderate and Mild mental health condition  Ages 26 and above	Implementation started during the timeframe 2022-23
Vic	<b>Mental Health and Wellbeing Connect</b> is a new service dedicated to those who are supporting people living with mental health and substance use challenges or psychological distress. It aims to provide families, carers and supporters of all ages with the vital networks they need to keep caring for their loved one while still looking after their own wellbeing (data not available as this is a new program).	Carers	Implementation started after the timeframe 2022-23
Vic	<b>Mutual Support and Self Help</b> organisations for reference – list of organisations – to be excluded for this analysis (many of which provide helpline telehealth supports):  <ul style="list-style-type: none"> <li>• Action On Disability Within Ethnic Communities Inc</li> <li>• Eating Disorders Foundation of Victoria Inc (except for portion)</li> <li>• GROW</li> <li>• Mental Health Foundation Australia</li> <li>• Obsessive Compulsive &amp; Anxiety Disorders Foundation of Victoria Inc</li> <li>• PANDA-Perinatal Anxiety &amp; Depression Australia Inc</li> <li>• The Compassionate Friends – Victoria Inc</li> <li>• Mind Australia Limited – Helpline</li> </ul>	Consumers and carers  Severity unknown	Part of MSSH data but not in-scope for this analysis.

Government agency	Program	Target population	Rationale
Vic	<b>Supported accommodation services (SAS)</b> provide long-term residential psychosocial rehabilitation for adults with a severe mental illness and associated psychosocial disability. The four services below target people who are homeless and/or with complex health and social support needs.	Consumers Severe mental illness	24-hour residential support – aligns with stream 3.
Vic	<b>Aboriginal Mental Health Services</b> Funding is provided to Aboriginal Community Controlled Health Organisations across the state to support Aboriginal people who are experiencing, or at risk of experiencing, psychological distress and mental-ill health, as well as their carers/families and the broader community.	Consumers	Unable to separate psychosocial element or tiers of severity.
Vic	<b>Planned respite</b> supports people with a severe mental illness and associated psychosocial disability to sustain their relationship with their carers, family or significant others and reduce carer stress, through the provision of respite	Carers	Does not provide support to people with a moderate or severe mental health illness (carer support service)
Vic	<b>Carer support</b> assists carers, families and friends of people with a mental illness through the provision of information, financial assistance and general support. Can occur in the carer's home or in the community.	Carers	Does not provide support to people with a moderate or severe mental health illness (carer support service)
Qld	<b>Stride Kids</b> Early Social Emotional Wellbeing (ESEW) service providing mental health assessment and intervention to young children 0–4 years of age who have mild to moderate ranges of health needs.	Consumers	Target population is out of scope.
Qld	<b>Advocacy services</b> Advocacy for individuals 18 years and over with severe mental illness	Consumers Severe mental health condition	Advocacy services confirmed out of scope.
Qld	<b>Community bed-based care – subacute community bed-based care</b> – Gold Coast Transitional Recovery Service (TRS) and Day Program is an integrated model of service delivered by RFQ	Consumers Severity unknown	More appropriate for Stream 3 – bed-based services.

Government agency	Program	Target population	Rationale
	(psychosocial supports) in collaboration with the Gold Coast HHS (clinical supports). The model comprises of two programs of care: <b>Intensive Residential Treatment and Support</b> provided at two properties located in the same street in Robina (providing short term residential support for 7 – 14 days) and Capstone Program providing individual recovery support for up to four weeks following a consumer's stay at in the Residential program Concurrently the Capstone Program also provides a menu of evidence-based group activities up to 3 months. Community Subacute Transition and Recovery Service (CSTARS) – <b>a 10-bed subacute transitional recovery service operating 24 hours, seven days a week for up to four weeks</b> . This is an integrated model of service with the Sunshine Coast HHS providing <b>clinical services alongside Steps Group delivering non-clinical psychosocial support services</b> and operational management of the premises.	Ages 18–65 years	
Qld	<b>Family and Carers Support</b> provides support for carers of people with severe mental illness.	Carers	Does not provide support to people with a moderate or severe mental health illness (carer support service)
WA	<b>Counselling – Face to Face</b> is structured process where a counsellor works on an individual basis with the client to address and resolve specific problems, make decisions, work through feelings and inner conflicts and/or improve relationships with others. Counselling facilitates personal growth, development, self understanding and the adoption of constructive life practices.	Consumers Ages 18–64 Severity unknown	Clinically focussed counselling is not considered as psychosocial support for the purposes of the analysis. Elements of this program that were not considered counselling have been included in the Group Support Activities data.
WA	<b>Staffed Residential – Long stay accommodation and high level non-acute support of older adults</b> who cannot be supported in mainstream aged care facilities due to challenging behaviours. 24/7 hours of staffing.	Consumers Severity unknown WA	More appropriate for Stream 3 – bed-based services.

Government agency	Program	Target population	Rationale
		65 years +	
WA	<b>Staffed Residential – Residential Short term, community based crisis/respice accommodation</b> for people who may be experiencing a social crisis, are homeless or at risk of becoming homeless or require respite from their usual place of residence. Variable hours of support dependent on individual needs. Need independent living skills.	Consumers Severity unknown WA Not specified (typically 18–65 years)	More appropriate for Stream 3 – bed-based services.
WA	<b>Staffed Residential – Residential supported accommodation service for young adults who have complex needs and who are at risk of long-term homelessness.</b> The services provide transitional supported accommodation (up to approximately 12 months). 24/7 hours staffing. Strong mental health recovery focus towards transitioning towards more independent community living arrangements.	Consumers Severity unknown WA 16–24	More appropriate for Stream 3 – bed-based services.
WA	<b>Individual Advocacy</b> services work to improve the outcome for individuals and more broadly across the whole community. Peak bodies provide a voice for people with mental health, alcohol or drug problems as well as their family and carers. (includes legal information, advice and representation)	Consumers Not specified (typically ages 18–65 years)	Advocacy services confirmed out of scope.
WA	<b>Staffed Residential – Step Up Step Down</b> Short stay (maximum 28 days) for step down when a person no longer needs acute inpatient care but requires additional supports to assist re-establishing in the community. Step up support is for a person to manage deterioration in mental health that does not require admission to hospital. 24/7 staffing. Independent living units in village arrangement with shared self-catering and independent catering in own unit.	Consumers Severe moderate mental health condition not specified – typically ages 18–65	More appropriate for Stream 3 – bed-based services
WA	<b>Family and Carer Support</b> services provide comprehensive, culturally appropriate and flexible supports based upon the individual needs of families and/or carers supporting people experiencing mental health issues. This includes: information, education and skill development opportunities to fulfil their caring role while maintaining their own health and wellbeing.	Carers Ages 18-64 years	Does not provide support to people with a moderate or severe mental health illness (carer support service)

Government agency	Program	Target population	Rationale
SA	<b>Survivors of Torture and Trauma Assistance and Rehabilitation Service</b> STTARS assists people from a refugee and migrant background who have experienced torture or been traumatised prior to arrival in Australia. Services include counselling and advocacy program, community activities to foster trust and social connection, expertise in delivering cross cultural mental health services.	Consumers	Clinical focus, not specific to psychosocial supports.
SA	<b>Mental Health Shared Care Program</b> is for people aged 18-65 years who have complex mental health needs to increase their capacity to manage their physical and mental health needs to avoid onset of acute symptoms and relapse.	Consumers Ages 18-65 years	Clinical focus, not specific to psychosocial supports.
Tas	<b>Alcohol and other Drug (AOD)</b>  <b>Care Coordination</b> Care co-ordination services for Alcohol and Drug Services (ADS) clients with multiple and complex needs including at least one other bio-psychosocial complexity	Unknown	AOD focussed program.
Tas	<b>Alcohol and other Drug (AOD)</b>  <b>Alcohol and Drug Treatment Counselling and counselling</b> Alcohol and drug treatment through Holyoake's Focus Program for counselling and education.	Unknown	AOD focussed program.
Tas	<b>Alcohol and other Drug (AOD)</b>  <b>Places of Safety</b> – residential rehabilitation and recovery. Place of safety provided for people found to be intoxicated by alcohol and other drugs in a public place and at risk of harming themselves or others due to intoxication.	Unknown	AOD focussed program.
Tas	<b>Alcohol and other Drug (AOD)</b>  <b>Psychosocial and Vocational Rehabilitation</b> Psychosocial and vocational residential rehabilitation service at centres for individuals requiring support to overcome the effects of alcohol and drug dependency.	Unknown	AOD focussed program.

Government agency	Program	Target population	Rationale
Tas	<b>Alcohol and other Drug (AOD)</b>  <b>Velocity Transformations</b> Residential rehabilitation for adult men and women recovering from alcohol and other drug dependency.	Unknown	AOD focussed program.
Tas	<b>Alcohol and other Drug (AOD)</b>  <b>Salvation Army Street Teams Program</b> Support and assistance for vulnerable people who may be at risk of causing harm to others due to alcohol misuse and/or other drug use.	Unknown	AOD focussed program.
Tas	<b>Alcohol and other Drug (AOD)</b>  <b>The Bridge Program</b> Residential rehabilitation sites in the south and north west of Tasmania, for people who require short-term, intensive treatment tailored to their needs and circumstances.	Unknown	AOD focussed program.
Tas	<b>Eating disorder services</b> – Data provided represents only the case management component of the service. Of this case management component (25%) is considered to be non-clinical services offered by social workers or allied health professionals.  Services for Tasmanian’s with eating disorders including prevention, public health information, advocacy, early identification, initial response, community-based treatment, community-based Intensive treatment, inpatient treatment and recovery support.	Consumers  Moderate, Severe, Complex mental health condition  All ages	This eating disorder service is not predominantly providing psychosocial supports  Where case management is the main focus these have been excluded from the analysis.
Tas	<b>Adult community mental health services</b> – Data provided represents only the case management component of the service. Of this case management component (75%) is considered to be non-clinical services offered by social workers or allied health professionals.  Services for adults 18–65 with severe and complex mental health problems. This includes assessment, treatment, support, and education.	Consumers  Severe, Complex mental health condition  Ages 16–64	Where case management is the main focus, these have been excluded from the analysis.

Government agency	Program	Target population	Rationale
Tas	<p><b>Older persons community mental health services</b> – Data provided represents only the case management component of the service. Of this case management component (75%) is considered to be non-clinical services offered by social workers or allied health professionals.</p> <p>Service for older adults with severe and complex mental health problems. Treatment is provided through community services with support of families and carers.</p>	<p>Consumers</p> <p>Severe, Complex mental health condition</p> <p>Ages 65+</p>	Where case management is the main focus, these have been excluded from the analysis.
Tas	<p><b>Child and adolescent mental health services</b> – Data provided represents only the case management component of the service. Of this case management component (25%) is considered to be non-clinical services offered by social workers or allied health professionals.</p> <p>Work closely with families to provide support and specialist treatment. This includes assessment, education and treatment services for mental difficulties such as; anxiety disorders, attachment disorders, major depression and mood disorders, mental health concerns in pregnancy and following birth, psychosis, severe emotional trauma and adjustment problems. Suicide risk and self-harm. This service also provides community family therapy for those whose child is receiving support from the service.</p>	<p>Consumers</p> <p>Severe, Complex mental health condition</p> <p>Age up to 18 years</p>	Where case management is the main focus, these have been excluded from the analysis.
Tas	<p><b>Mental Health (MH)</b></p> <p><b>Beyond Blue</b> – Prevention and Early Intervention Services to promote mental health and wellbeing, and advocate for action on the social determinants of mental health.</p> <p>The program helps to improve people’s understanding of how to look after their mental health, help more people to access mental health support earlier, support people to feel connected, and lead and influence positive system and social change. This program includes, promotion activities, delivery of peer-to-peer forums, brief interventions, low intensity support options, and speaker programs at events, partnerships and fundraising activities.</p>	<p>Consumers and carers</p> <p>Moderate mental health condition</p> <p>All ages</p>	Primarily psychoeducation with a broad target population (not necessarily people with moderate to severe mental illness and functional impairment). Brief Interventions and Low Intensity support would fit best within NMSHPF Stream 1 (as part of structured psychological therapies).

Government agency	Program	Target population	Rationale
Tas	<p><b>Mental Health (MH)</b></p> <p><b>YouthARCH – Youth Adolescent Reachout Circular Head</b> Mental health counselling and outreach as well as suicide awareness and prevention, with a focus on young people, in the Circular Head region.</p> <p>The program involves conducting information and group sessions, enabling access to wrap-around supports for young people and their families with mild/moderate mental health presentations, providing one-to-one short term sessional based supports, development of a youth professional network and detailed escalation processes.</p>	<p>Consumers</p> <p>Moderate mental health condition</p> <p>Ages 12–25 years</p>	<p>Counselling is not considered a type of psychosocial support for the purposes of the analysis.</p>
Tas	<p><b>Mental Health (MH)</b></p> <p><b>A Tasmanian Lifeline</b> Psychosocial telephone support and information service. Tasmanian Lifeline (ATL) is a free confidential telephone support service for Tasmanians of all ages who need someone to talk things through, or need someone to listen. ATL offers one-off or ongoing support. ATL provides a dedicated service for anyone in Tasmania experiencing emotional distress, specifically focusing on building resilience and providing support in the area of mental health and wellbeing.</p> <p>A dedicated 1800 phone number that offers:</p> <ul style="list-style-type: none"> <li>– Call in – Allowing any member of the Tasmanian community to call in and receive psychosocial support from a trained support worker to discuss concerns and facilitate connections to other appropriate services, where relevant.</li> <li>– Call back – People making contact with the psychosocial telephone service can request call backs to support their social, emotional and mental health.</li> </ul> <p>The service acts as a wrap around service to assist with:</p> <ul style="list-style-type: none"> <li>– Preventing the overload of other mental health services across Tasmania.</li> <li>– Reduce the strain on the Tasmanian health system caused by non-critical mental health presentations.</li> <li>– Ensure all Tasmanians feel supported and have coping strategies for their psycho-social needs.</li> </ul>	<p>Consumers</p> <p>All levels of mental health concerns</p> <p>All ages</p>	<p>Phoneline based psychosocial supports have been excluded from the analysis.</p>

Government agency	Program	Target population	Rationale
	<ul style="list-style-type: none"> <li>– Prevent the escalation of mental health problems through access to connection, information, consultation, and support.</li> <li>– Act as a referral point to ensure, wherever possible, that Tasmanians can navigate the support systems they require – i.e. financial support/counselling, family violence services, acute mental health care, housing, medical treatment, etc.</li> </ul>		
Tas	<p><b>Mental Health (MH)</b></p> <p><b>OzHelp</b> – OzHelp Tasmania’s aim is to enhance the resilience of apprentices, workers and managers in the Tasmanian construction and building industry.</p> <p>With a primary role of social capacity building within the building and construction industry, OzHelp Tasmania has broadened its scope due to the success of the program and requests for training and support from other industries and workplaces recognising that overall workplace mental health and wellbeing was not being fully addressed.</p> <p>The program provides managers with the practical skills to help look after their employees, provide employees with an introduction to mental health to enable them to look after themselves and others, provide practical skills for young apprentices and trainees to develop resilience and coping skills (especially during their transition from school into their workplace), and provide support services to assist all employees to manage difficulties in both their personal and professional lives.</p>	<p>Consumers</p> <p>All levels of mental health concerns</p> <p>Ages 15+ years</p>	Broad or non-specific target populations not specifically targeting people with mental illness.
Tas	<p><b>Mental Health (MH)</b></p> <p><b>Phoenix Centre – Promotion, Prevention and Early Intervention</b> – Support services delivered through an early intervention program and the management of a mental health network.</p> <p>The Phoenix Centre provides therapeutic and individual mental health and wellbeing support, mental health promotion, prevention and early intervention, and capacity building activities to people from a Culturally and Linguistically Diverse (CALD) background.</p> <p>It also provides specialist support for survivors of torture and other traumatic experiences and their communities. Services are delivered in both Hobart and Launceston and include counselling, psycho educational group work, social connections programs, and community development activities.</p>	<p>Consumers</p> <p>All levels of mental health concerns</p> <p>Ages 0–25 years</p>	Broad or non-specific target populations not specifically targeting people with mental illness.

Government agency	Program	Target population	Rationale
Tas	<p><b>Mental Health (MH)</b></p> <p><b>Rural Counselling and Support Service</b></p> <p>Rural counselling, training and support service with early intervention policies and program that aims to reduce incidence of suicide and help individuals experiencing mental health issues. The program increases the number of counselling and brief intervention services for individuals and families at risk of mental health issues, increased suicide awareness and prevention through workshops and community education activities, and increased mentoring programs and community connection through community events and activities.</p> <p><b>Increased Demand for Counselling and Support Service</b></p> <p>Assistance to increase staffing capacity of the Rural Counselling and Support Service to meet the increased community. Additional funding has helped build a platform to proactively support individuals and families that are 'help-hesitant' within rural and regional communities.</p>	<p>Consumers</p> <p>All levels of mental health concerns</p> <p>Ages 14+ years</p>	<p>Broad or non-specific target populations not specifically targeting people with mental illness. Counselling is not considered a type of psychosocial support for the purposes of the analysis.</p>
Tas	<p><b>Mental Health (MH)</b></p> <p><b>Older Persons Rural Counselling and Support Service</b></p> <p>Rural counselling, training and support service with early intervention policies and program for older persons that aims to reduce the incidence of suicide and help individuals experiencing mental health and welfare issues.</p> <p>To work with older persons in rural communities to help build the resilience and capacity of, and promote help seeking avenues for, individuals, families, and communities to react to challenging life experiences including mental health and welfare issues with a focus on suicide prevention.</p>	<p>Consumers</p> <p>All levels of mental health concerns</p> <p>Older persons (age bracket not specified)</p>	<p>Broad or non-specific target populations not specifically targeting people with mental illness. Counselling is not considered a type of psychosocial support for the purposes of the analysis.</p>
Tas	<p><b>Mental Health (MH)</b></p> <p><b>Staying Afloat</b></p> <p>Program support for the mental health and wellbeing of those operating in and connected to the Tasmanian Seafood Industry.</p> <p>A range of Mental Health and Wellbeing Training and education activities are offered throughout the program. A wellbeing toolkit has been created and is continually added to, and communities have been invited to hold events and activities that foster human connection and wellbeing.</p>	<p>Consumers</p> <p>All levels of mental health concerns</p> <p>Ages 15+ years</p>	<p>Broad or non-specific target populations not specifically targeting people with mental illness.</p>

Government agency	Program	Target population	Rationale
Tas	<b>Mental Health (MH)</b> <b>Support for Individual Client</b> Residential rehabilitation and recovery support for Mental Health Services client.	Consumer Severe 65+ years of age	Excluded – 1 participant.
NT	<b>Social and Emotional Wellbeing (SEWB)</b> programs work to improve social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islanders who need support for mental health and/or alcohol and other drug-related issues.	Consumers (First Nations peoples) Severity N/A	Issues with data access, granularity (which is needed to disentangle psychosocial supports from the other services and supports provided) and data sovereignty
NT	<b>Sub-acute and longer-term psychosocial rehabilitation services</b> provide a range of non-clinical 24-hour residential programs for up to 12 months.	Consumers	More appropriate for Stream 3 – bed-based services
Australian Government Department of Health and aged Care	<b>Men's Table</b> is a community led, peer to peer, preventative men's mental health initiative. Tables comprise about a dozen men who meet once a month over dinner for peer-to-peer support in familiar social settings, such as a private room in the pub. The program aims to strengthen social connectedness.	Consumers (men) Mild mental illness Adults	Target population is broad as opposed to specifically targeting severe and moderate mental illness.

Government agency	Program	Target population	Rationale
<b>Australian Government Department of Health and Aged Care</b>	<p><b>Distress Brief Support Trial</b></p> <p>The Distress Brief Support model embeds prevention and early intervention by identifying people outside the mental health and suicide prevention system who are experiencing distress. Distress Brief Support will provide an immediate compassionate response to people experiencing distress in the community. The trial's design is based on the Distress Brief Intervention model designed and piloted in Scotland.</p> <p>People experiencing distress will be offered an option for short-term support that is non-clinical, person-centred, and connection-focused, that will provide them with the skills and supports to manage their distress and connect them to services and supports (including psychosocial supports) that are relevant to their needs.</p>	People experiencing distress in the community.	Not yet operational.
<b>Australian Government Department of Health and Aged Care</b>	<p><b>headspace Digital Work and Study (DWS) Program</b> aims to improve the education and employment of young Australians with mental health challenges, by providing work and study support via a digital platform, integrated with clinical mental health services.</p> <ul style="list-style-type: none"> <li>The headspace DWS Program is jointly funded by the Department of Social Services and the Department of Health and Aged Care.</li> <li>The Department of Health and Aged Care has provided \$7.96 million to headspace National over 2 years from 2022–23 to continue delivery of the headspace DWS Program.</li> </ul> <p><i>See also Australian Government Department of Social Services' 'Digital Work and Study Service (DWSS)' item further below.</i></p>	<p>Consumers (young Australians with mental health challenges)</p> <p>All levels of mental health concerns</p> <p>Ages 15–25</p> <p>National</p>	Target population is broad as opposed to specifically targeting severe and moderate mental illness.
<b>Australian Government Department of Health and Aged Care</b>	<p><b>Head to Health Centres</b> Head to Health adult mental health services provide a safe and welcoming place for adults to access mental health information, services and supports delivered by multidisciplinary care teams over extended hours, without needing a GP referral or paying a fee.</p> <ul style="list-style-type: none"> <li>Services offer short to medium-term care for people with moderate to severe mental health needs, and immediate support and follow-up can be provided to people presenting in crisis.</li> </ul>	Adults with moderate to severe needs	Target population is broad, given the walk-in model, as opposed to specifically targeting severe and moderate mental illness.

Government agency	Program	Target population	Rationale
	<ul style="list-style-type: none"> <li>Some of the services offered through Head to Health centres align with the psychosocial definition and target cohort – and can include peer work, potentially group peer work, and family/carer peer supports that are mainly provided onsite. Psychosocial supports currently represents the third most common service contact type (after clinical care coordination and structured psychological intervention). <i>Only the psychosocial support service contacts and clients would be included in the analysis.</i></li> <li>As at 30 June 2023, 13 sites were operational nationally.</li> </ul> <p>Note: Adelaide Urgent Mental Health Care Centre (part of the Head to Health program but operating under a different model) is currently co-funded. It provides individual peer work, but on a single session basis and not ongoing basis.</p>		
<b>Australian Government Department of Health and Aged Care</b>	<p><b>Flexible funding to PHNs for people with severe and complex mental illness</b></p> <p>PHNs are required to commission primary mental health care services through the primary mental health care funding pool for people with severe mental illness who are being supported in primary care. This includes services such as the provision of high intensity psychological services for people, and clinical care coordination, which addresses both mental health and physical health needs.</p> <p><u>Note:</u> In line with the agreed scope of this analysis, only the psychosocial components would be included in this analysis.</p> <p>PHNs are expected to:</p> <ul style="list-style-type: none"> <li>Plan for the integrated provision of services for people with severe mental illness in the region through: <ul style="list-style-type: none"> <li>Development with LHNs and other key stakeholders of joint, regional Mental Health and Suicide Prevention Plans</li> <li>Development of joined up services and referral pathways that link primary care, specialist care and community support services, including NDIS services</li> </ul> </li> </ul>	Consumers with severe mental illness who are being supported in primary care, including those with episodic mental illness.	Largely encompasses clinical services (including clinical care coordination and liaison).

Government agency	Program	Target population	Rationale
	<ul style="list-style-type: none"> <li>○ Promoting assessment and treatment of the physical health of people with severe mental illness as part of the regional plan.</li> <li>● Coordinate services for people with severe mental illness who are supported in primary health care, particularly those with complex needs, through: <ul style="list-style-type: none"> <li>○ Commissioning clinical coordination for this group, including through the use of mental health nurses and other clinical coordinators</li> <li>○ Establishing links between clinical services and psychosocial support commissioned by PHNs for this group</li> <li>○ Promoting the use of single multiagency care plans.</li> </ul> </li> <li>● Commission high intensity primary mental health services to address service gaps for people with severe mental illness who need them, including: <ul style="list-style-type: none"> <li>○ Providing services to hard to reach groups</li> <li>○ Supplementing psychological services available through the MBS</li> </ul> </li> </ul> <p>Planning for and addressing the needs of children and young people with or at risk of severe mental illness.</p>		
<b>Australian Government Department of Health and Aged Care</b>	<p><b>Commonwealth Home Support Program</b> (labelled Community and Home Support within the dataset)</p> <p>The CHSP provides small amounts of entry-level support to assist older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) to remain living at home and in their community. The CHSP funds domestic assistance, transport, meals, personal care, home maintenance, social support, nursing, and allied health. The CHSP also supports care relationships through planned respite services for older people. These respite services allow carers to take a break from their usual caring responsibilities.</p> <p>CHSP services may be short-term, intermittent or ongoing. The program places a strong focus on activities that support independence and social connectedness and take into account each person's individual goals and choices.</p>	<p>Consumers</p> <p>Aged 65+ or 50+ for Aboriginal and Torres Strait Islander people</p>	<p>Target population is broad as opposed to specifically targeting severe and moderate mental illness.</p>

Government agency	Program	Target population	Rationale
Australian Government Department of Health and Aged Care	<b>Red Dust (grant)</b> Strengths-based programs which are designed in partnership with remote First Nations communities that focus on youth mental health, suicide prevention and social and emotional wellbeing. Red Dust's programs also aim to build a skilled First Nations mental health workforce in remote communities and promote mental health pathways and careers.	Consumers (First Nations peoples) Severity N/A	Considered but excluded owing to issues with data access, granularity (which is needed to disentangle psychosocial supports from the other services and supports provided) and data sovereignty
Australian Government Department of Health and Aged Care	<b>Apunipima (grant)</b> The provision of integrated, culturally appropriate and safe mental health services through the Cape York Social and Emotional Wellbeing Centres in Aurukun, Coen, Hopevale and Mossman Gorge. Place-based arrangement where the organisation is funded directly for services that would normally be commissioned through the PHN.	Consumers (First Nations peoples) Severity N/A	Considered but excluded owing to issues with data access, granularity (which is needed to disentangle psychosocial supports from the other services and supports provided) and data sovereignty
Australian Government Department of Health and Aged Care	<b>Djanaba Centre (grant; now ceased)</b> To support the establishment and operation of a centre focused on providing tailored care to children and adolescents affected by childhood trauma in the Illawarra region of NSW.	Consumers (First Nations peoples) Severity N/A	Considered but excluded owing to issues with data access, granularity (which is needed to disentangle psychosocial supports from the other services and supports provided) and data sovereignty
Australian Government Department of	<b>Indigenous Australians Health Programme (IAHP) – Primary Health Care (PHC) Activity – Boab Health and Community Services (now ceased)</b>	Consumers (First Nations living in the serviced community)	Target population is broad as opposed to specifically targeting severe and

Government agency	Program	Target population	Rationale
<b>Health and Aged Care</b>	<p>PHC activity contributes to closing the gap in life expectancy and to halve the gap in mortality rates for Aboriginal and Torres Strait Islander children through the provision of high quality, comprehensive, culturally-appropriate primary health care.</p> <ul style="list-style-type: none"> <li>Boab is funded through IAHP for health promotion, management and prevention of chronic conditions, child and maternal services, substance use advice and mental health services in the Kimberley region.</li> <li>Primary Health Care funds: Podiatrist (2), Diabetes Educator (3), Dietician (1) and Paediatric Nutritionist (1). Boab allied health team reach over 40 sites across the Kimberley including 4 ACCHS, 17 remoted health clinics, 7 hospital outpatient, primary health and community centres, 4 dialysis centres, a youth mental health service.</li> </ul> <p>It also provides general mental health and social and emotional wellbeing counselling and crisis prevention services to the people of the Kutjungka region of Western Australia (Indigenous Primary Health Care Services (IPHCS) Kutjungka project). Boab provides a Community Development Officer (CDO) that supports the mental health and social, spiritual, cultural and emotional well-being of people living in Balgo, Bililuna and Mulan.</p>	<p>All levels of mental health concerns All age groups</p>	<p>moderate mental illness. Psychosocial elements difficult to disentangle.</p>
<b>National Indigenous Australians Agency*</b>	<p><b>Social and Emotional Wellbeing (SEWB)</b> activities, funded under Indigenous Advancement Strategy (IAS) Program 1.3 Safety and Wellbeing, recognise and work to address the adverse impacts of past trauma, dispossession, ongoing social disadvantage and racism and other historical, social and cultural issues that impact on the social and emotional wellbeing of First Nations peoples. Activities assist in the process of healing for First Nations peoples, with priority given to members of the Stolen Generations, an aim to improve SEWB outcomes.</p> <p>SEWB services funded under the IAS are typically embedded within ACCHOS that have the capability to provide culturally safe, wrap around and collaborative approaches to care, including referral pathways through active relationships and partnerships with other Providers. SEWB supports delivered as part of this Programme are therapeutic and non-clinical, delivering holistic trauma-informed and culturally safe support for First Nations individuals, families and communities. This includes, but is not limited to, counselling, case management, cultural</p>	<p>Consumers (First Nations peoples and their families) Severity N/A All ages</p>	<p>Issues with data access, granularity (which is needed to disentangle psychosocial supports from the other services and supports provided) and data sovereignty</p>

Government agency	Program	Target population	Rationale
	healing, group therapy, and community activities that reflect individual, family and community needs.		
<b>National Indigenous Australians Agency</b>	<p><b>Youth Support and diversion activities:</b> Under the Indigenous Advancement Strategy (IAS) 1.3 Safety and Wellbeing Program, youth support and diversion activities aim to address the underlying drivers of crime, supporting young First Nations people to engage in education and employment and improving wellbeing.</p> <p>Activities have a significant focus on cultural engagement and aim to increase the target group's connection to their Aboriginal family, kinship, identity and culture and will address the needs of the local Aboriginal families and communities via delivery of holistic, culturally appropriate, trauma-aware and healing-informed case management and supports.</p> <p>Providers deliver intensive case management to up to clients and have referral pathways to local organisations including police, corrections, medical/health centres, alcohol and other drug treatment, mental health, disability services, child protection Agencies and legal services etc.</p>	<p>Consumers (children and young people at risk of contact of have had contact with the justice system)</p> <p>All levels of mental health concerns</p> <p>Ages: 10–25 years</p>	Broad target population.
<b>National Indigenous Australians Agency</b>	<p><b>Supporting Healing for Families:</b> Healing initiatives, funded under Program 1.3, recognise and work to address the adverse impacts of past trauma for victims of child sexual abuse.</p> <p>The policy frame around this initiative stems out of Recommendation 9.2 of the Royal Commission into Institutional Responses to Child Sexual Abuse which identified the need for governments to improve practices and fund Aboriginal and Torres Strait Islander healing approaches to address the absence of a trauma-aware and healing-informed, culturally safe and accessible service system for Aboriginal and Torres Strait Islander people.</p> <p>The Government announced 10.9 million over four years from 2021–2025 as a measure under the National Strategy to Prevent and Respond to Child Sexual Abuse.</p> <p>The funding will be aimed at Aboriginal Community Controlled Organisations in the selected locations to provide culturally safe, wrap around and collaborative approaches to trauma recovery, including referral pathways through active relationships and partnerships with other</p>	<p>Consumers (First Nations women, children and families who have been impacted by child sexual abuse)</p> <p>All levels of mental health concern</p> <p>All ages</p> <p>Derby WA, Alice Springs NT, Adelaide SA,</p>	Not yet operational.

Government agency	Program	Target population	Rationale
	Providers. The healing activities will have a focus on culturally connected services and provide non-clinical services, delivering holistic trauma-informed and culturally safe support for First Nations individuals, families and communities. This includes, but is not limited to cultural healing and community activities that reflect individual, family and community needs as identified through the co-design process.	Townsville QLD, Gippsland VIC	
<b>National Indigenous Australians Agency</b>	<p><b>New Healing Initiative (Healing for Stronger Families):</b> Under the Indigenous Advancement Strategy (IAS) 1.3 Safety and Wellbeing Program, healing approach aims to provide support to people who have been impacted by domestic violence or the child protection system.</p> <p>The funding will be aimed at Aboriginal Community Controlled Organisations that have the capability to provide culturally safe, wrap around and collaborative approaches to trauma recovery, including referral pathways through active relationships and partnerships with other Providers. The healing activities will have a focus on culturally connected services and provide non-clinical services, delivering holistic trauma-informed and culturally safe support for First Nations individuals, families and communities. This includes, but is not limited to cultural healing other healing approaches or community activities that reflect individual, family and community needs as identified through the co-design process.</p>	<p>Consumers (First Nations women, children and families impacted by domestic violence or the child protection system)</p> <p>All levels of mental health concern</p> <p>All ages</p>	Not yet operational.
<b>Australian Government Department of Employment and Workplace Relations</b>	<b>Workforce Australia</b> supports individuals who need support to return to the workforce. Job-ready job seekers are serviced in an online platform. Those requiring more assistance are serviced by providers who deliver intensive and individualised case management. An Employment Fund (pool of funds) is available to be used by Workforce Australia Services providers to support job seekers to build experience, develop skills and prepare for work. For job seekers with a mental health condition, providers can use the Employment Fund to assist these job seekers to access professional services (including mental health and family counselling delivered by qualified psychologists or registered allied health professionals), non-vocational assistance (such as financial counselling, interpersonal skills, personal development), medical expenses and post-placement support, in addition to other categories such as training and wage subsidies.	<p>Consumers (job seekers)</p> <p>Working age population in receipt of unemployment benefits</p>	Target population is broad as opposed to specifically targeting severe and moderate mental illness.

Government agency	Program	Target population	Rationale
Australian Government Department of Social Services	<b>Disability Employment Services (DES)</b> aims to help job seekers with disability, injury or health condition to find and retain suitable work in the open labour market by addressing barriers to work and building capacity, confidence and ability.	Consumer  Working age 14 years+ and not yet qualifying Age Pension age  National	Lack of granular data on psychosocial supports available.
Australian Government Department of Social Services	<b>Information, Linkages and Capacity Building (ILC)</b>  The ILC program provides funding to organisations through one off competitive grants to deliver projects in the community that benefit all Australians with disability, their carers and families. ILC funded projects aim to increase social and community participation for people with disability. ILC funding is time-limited and ongoing funding is not available through the program. Activities which focus on people with intellectual disability, psychosocial disability and autism were highly regarded in the recent SCP and ICB grant opportunities.	All people with disability, their family and carers	Time-limited, one-off funded activities.
Australian Government Department of Social Services	<b>Community Mental Health Services – A Better Life (ABLE)</b> early intervention and other individual support for people aged 16 years and over with mental illness and experiencing drug, alcohol and gambling use problems (and their families and carers) so they can develop their capabilities, increase their wellbeing and actively participate in community and economic life (e.g. supports to build financial capability and personal capacity, confidence, self-reliance; manage daily activities; improve community participation and relationships).	Consumers (with mental illness, including Alcohol and Other Drugs and/or gambling disorders)  All levels of mental health concern  Nationally  Ages 16+  Note: Formal diagnosis of mental illness is not required	Target population is broad as opposed to specifically targeting severe and moderate mental illness.

Government agency	Program	Target population	Rationale
Australian Government Department of Social Services	<p><b>Individual Placement and Support (IPS) program and the Digital Work and Study Service (DWSS)</b></p> <p>IPS helps young people (aged 12 to 25 years) who are experiencing, or at risk of, mental ill-health achieve their employment and education goals through the support of a vocational specialist.</p> <p>The IPS Adult Mental Health (AMH) pilot is currently being trialled to adults with mental ill health in two Head to Health Adult Mental Health centres. The pilot is due to cease on 30 June 2025.</p> <p>DWSS is a unique, integrated clinical and vocational specialist work and study program providing support to young people (aged 15–25 years) with mental health challenges, via a digital platform. Priority access is given to young people in targeted regional and remote locations and First Nations people. DWSS also offers participants the opportunity to link with a volunteer mentor through partnerships with employers and industry both locally and nationally. DWSS is jointly funded by the Department of Social Services and the Department of Health and Aged Care.</p> <p><i>See also Australian Government Department of Health and Aged Care’s ‘headspace Digital Work and Study (DWS) Program’ above.</i></p>	<p>Consumer</p> <p>Mental ill-health</p> <p>National</p> <p>IPS is delivered in 50 headspace centres</p> <p>Ages 12 to 25 years</p> <p>IPS Adult Mental Health pilot is delivered in 2 Head to Health centres, Midland, WA and Darwin, NT</p> <p>Adults</p> <p>DWSS</p> <p>Ages 15 to 25 years</p> <p>Note: no formal diagnosis required</p> <p>National</p>	Target population is broad as opposed to specifically targeting severe and moderate mental illness.
Australian Government Department of Social Services	<p><b>Family Mental Health Support Services (FMHSS)</b> provide early intervention and non-clinical community mental health support for children and young people (up to 18 years) who are showing signs of, or are at risk of, developing mental illness. Three levels of support: Intensive, long term, early intervention support; short-term, immediate assistance; community outreach, mental health education and community development activities.</p>	<p>Consumers</p> <p>Mild to moderate mental health condition</p>	Target population is broad as opposed to specifically targeting severe and moderate mental illness.

Government agency	Program	Target population	Rationale
		Children and young people aged up to 18 years	
<b>Department of Veterans' Affairs</b>	<p><b>Group Programs (Education Workshops), The Open Arms – Veterans &amp; Families Counselling</b> offers a number of group treatment programs and psychoeducation workshops. Broadly, Group Programs provide education and treatment on a variety of subjects, including improving sleep, anger management and understanding anxiety.</p> <p>Group Programs provide two specific psychoeducation workshops:</p> <ul style="list-style-type: none"> <li>• Building better relationships: This program provides education on interpersonal relationships, improvement of resilience amongst individual partners and creating shared meaning and understanding between partners.</li> <li>• Stepping out: This program offers specific advice and education for ADF members transitioning to civilian life. This includes targeted education on key issues, both personal and social, commonly affecting those undergoing transition.</li> </ul>	Consumers and carers Adults	Broader program – Clinical and Psychosocial.
<b>Department of Veterans' Affairs</b>	<b>Community and Peer Program the Open Arms – Veterans &amp; Families Counselling</b> 'Lived Experience' peers (with experience from the military and mental health service system) work collaboratively with veterans, family supports, community agencies and mental health clinicians to provide and facilitate a number of supports and services. This includes community engagement, direct client services and support through the peer network. Peers can provide intensive case management as well as referrals for difficult post-service issues (e.g. finances, relationships, employment, health, mental health).	Consumers and carers Adults	Target population is broad as opposed to specifically targeting severe and moderate mental illness.
<b>Department of Veterans' Affairs</b>	<b>Kookaburra Kids – Defence Kids Program</b> Supports children (8–18 years) from serving and ex-serving Australian Defence Force families with a mental health condition – to help with the challenges of being a child of an ADF member with mental ill health. Provision of camps, activity days and age-appropriate mental health education focusing on coping skills and resilience, while allowing children to bond with peers who are facing similar challenges.	Carers Children with a parent/s who is eligible veteran	Target population is broad as opposed to specifically targeting severe and moderate mental illness.

Government agency	Program	Target population	Rationale
		with a mental health condition  Ages 8–18 years	

### **\*Further information on the First Nations Social and Emotional Wellbeing program**

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 (The Framework) guides investment and design of SEWB programs with a dedicated focus on Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health. The Framework, which is currently being refreshed, sets out a comprehensive and culturally appropriate stepped care model that is equally applicable to both Indigenous specific and mainstream health services.

The National Indigenous Australians Agency (NIAA) is also currently undertaking a broader national information gathering and mapping exercise that is targeted towards better understanding government efforts across the SEWB sector. The purpose of the mapping exercise is twofold: To map what work governments are already doing to support the implementation of The Framework; and to capture detail on the funding landscape, including who is investing in SEWB and how these services are alike or differ across each jurisdiction. Its findings are expected to identify possible funding gaps or duplication, and will support the SEWB Policy Partnership as they consider opportunities for sector reform and designing an Implementation Plan supporting the Framework. It is not intended for broader circulation at this time.

Through the Indigenous Advancement Strategy, the NIAA invests in over 100 organisations for the delivery of SEWB services. These services provide a range of supports to First Nations peoples, with the aim of assisting in the process of healing by addressing barriers to wellbeing and social connection. They recognise and work to address the adverse impacts of intergenerational trauma, dispossession, ongoing social disadvantage and racism and other historical, social and cultural issues that impact on the social and emotional wellbeing of First Nations peoples.

SEWB services funded under the Indigenous Advancement Strategy are typically embedded as part of multidisciplinary teams within Aboriginal Community Controlled Health Organisations (ACCHOs), which have the capability to provide culturally safe, trauma-informed, wrap around and collaborative approaches to care. SEWB service offerings typically include counselling, case management, cultural healing, non-clinical therapies, community engagement and outreach activities, and referral pathways through active relationships and partnerships with other providers.

## F. Severity and age group assumptions applied

Assumptions were necessary to convert the data provided by the states and territories, and by the Australian Government, into the form required to estimate the level of unmet need by severity of mental illness, age group and region. These assumptions were necessary to estimate the number of distinct consumers who received the services within each of those categories, and the estimate of the number of hours of psychosocial services provided to those consumers. These assumptions are specified below.

In relation to severity, broadly, if a jurisdiction noted a program was aimed at individuals with both moderate and severe mental illness, it was assumed consumers of those services would be equally split between the two groups, with 50% having moderate mental illness and 50% having severe mental illness, unless more specific information was provided. If a jurisdiction specified targeting only severe mental illness, it was assumed that all individuals receiving those services had a severe mental illness – unless stakeholder feedback suggested otherwise (e.g. Australian Government programs). Similarly, if the focus was solely on moderate mental illness, it was assumed that all consumers were in the moderate category.

For Australian Government programs, HPA had previously suggested using information included in the Initial Assessment and Referral Decision Support Tool (IAR-DST) to understand the severity of mental illness of consumers receiving support through Australian Government funded services commissioned via PHNs. However, consultation with stakeholders concluded that the IAR-DST was not the most appropriate approach (see Appendix A for further details). In general, stakeholders suggested these services were predominantly provided to consumers with moderate mental illness, although also served consumers with severe mental illness. To make an assumption about the split in severity between moderate and severe mental illness, HPA used information about the diagnoses of the consumers who received services from the Commonwealth Psychosocial Support Program (CPSP) that was included in the CPSP data received. Excluding those who had missing or unknown information, 20% had a diagnosis of affective mood disorder, 23.3% had anxiety disorder, 34.5% had no formal mental disorder but subsyndromal problems, 8.6% had psychotic disorder, 1.2% had substance use disorder, 2.3% had disorder with onset usually occurring in childhood, and the remaining were grouped as other. Approximately 60% had anxiety disorder (23.3%) or no formal mental disorder but subsyndromal problems (34.5%). HPA therefore distributed the services provided by the Australian Government programs as 40% to severe and 60% to moderate mental illness.

Table 74 shows the percentage of activity within each program that was allocated to the severe mental illness group.

Table 74: Assumptions about severity, by jurisdiction and program

Jurisdiction	Program	% allocated to severe mental illness category
NSW	Community Living Supports	100
	Housing and Accommodation Support Initiative	100

<b>Jurisdiction</b>	<b>Program</b>	<b>% allocated to severe mental illness category</b>
	Housing and Accommodation Support Initiative Plus	100
	Mental Health Community Living Supports for Refugees	50
	Youth Community Living Support Services	100
<b>Vic</b>	Early Intervention Psychosocial Support Response	50
	Youth Outreach Recovery Support	50
	Continuity of Support	50
	Mutual Support and Self Help (EDV)	50
	Youth Residential Rehabilitation	100
<b>Qld</b>	Aboriginal and Torres Strait Islander Mental Illness – Individual Recovery Support	50
	Clubhouses	100
	Consumer Operated Services	100
	Eating Disorders	100
	Group Based Peer Recovery Support Program	100
	Mental Health Continuity of Support	100
	Individual Recovery Support – Transition from Correctional Facilities Program	100
	Individual Recovery Support Program	100
	Individual at Risk of Homelessness Program	100
	Integrated Hub	100
	Music and Arts Based Supports	100
	Perinatal and Infant Mental Health	35
	Specialist Cultural and Linguistically Diverse Communities Mental Health Community Supports	100
	Transitional Recovery Service	100
<b>WA</b>	Education, employment & training	50
	Group support activities	100
	Mutual support & self-help	100
	Personalised support-linked to housing	100
	Personalised support-other	100
	Staffed Residential Short-Term Community-Based Crisis/Respite	100
	Staffed Residential Transitional Accommodation	100
	Staffed Residential Long Stay Accommodation	50
<b>SA</b>	Accommodation and Support Program (ASP)	50
	Avalon	100

<b>Jurisdiction</b>	<b>Program</b>	<b>% allocated to severe mental illness category</b>
	Day and Group Rehabilitation Program	100
	GP Access	100
	Housing & Accommodation Support Partnership Burnside	100
	Housing & Accommodation Support Partnership	100
	Individual Psychosocial Rehabilitation and Support Services	100
	Mutual Support and Self-Help	50
	Intensive Home Based Support Services	100
<b>Tas</b>	Community Recovery Outreach Program	50
	Mental Health: Eating Disorder Peer Workforce Partnership	50
	Mental Health: Eureka Clubhouse	0
	Mental Health: Housing and Accommodation Support Initiative	100
	Mental Health: MICare and MICare Plus	100
	Mental Health Homeless Outreach Program	50
	Mental Health: Mindset – Choices	100
	Mental Health: Packages of Care (Anglicare and Life Without Barriers)	50
	Recreation Program	50
	Mental Health: Residential Rehabilitation and Recovery	100
<b>ACT</b>	Compeer Friendship Program	50
	Detention Exit Community Outreach	50
	Transition to Recovery Program	50
	Commonwealth Psychosocial Support Program	40
	Women's Residential Program	100
	Youth and Wellbeing	50
<b>NT</b>	Housing Support Program	50
	Housing and psychosocial support program	100
	MiPLace Drop in support service	100
	Recovery Assistance Program	50
	TEMHCO – Drop in support service	100
<b>Commonwealth (Australian Government Department of Health and Aged Care)</b>	Commonwealth Psychosocial Support Program	40
	Online mental health services for people with complex mental health needs (SANE)	40
	Kindred Clubhouse	100
	Canefields Clubhouse	100
	Disability Support for Older Australians	40
	Early Psychosis Youth Services	40

The level of detail in the data provided by the jurisdictions was variable. In some jurisdictions the number of clients was provided by the age groups required to match those in the NMHSPF, but this was not always the case.

Table 75 outlines the assumptions related to the distribution of clients across the age groups within each jurisdiction.

**Table 75: Assumptions about clients and hours of psychosocial services across age groups, by jurisdiction**

<b>Jurisdiction</b>	<b>Age distribution</b>
<b>NSW</b>	Clients and the hours of services they received were provided by age group.
<b>Vic</b>	<p>EIPSR: Age group data was only available for 2022–23 and the total was larger than the sum of the age groups. HPA used the available data and assumed the distribution across age groups was the same across services for both years. Number of contacts was reported, and it was assumed each contact was of one hour duration.</p> <p>YORS: Services are only provided to people aged 16 to 25 years. HPA assumed that 10% were aged 25 and the 90% were in the 12 to 24 year age group. Number of contacts was reported, and it was assumed each contact was of one hour duration.</p> <p>Aggregate data on the total number of consumers in 2022–23 was received for the Youth Residential Rehabilitation (YRR), Continuity of Support (CoS) and Mutual Support and Self Help (MSSH) programs. Consumers were distributed proportionally across age groups based on the target population of the program. YRR was distributed the same way as YORs above. The others were distributed as 9/49ths to 12 to 24 years age group and 40/49ths to the 25 to 64 year age groups. Hours were reported for MSSH. Number of contacts was reported for CoS, which HPA assumed were one hour each. Bed days was reported for YRR and HPA assumed 5 hours of support per bed day. The aggregate data was reported by quarter so there was the potential to double count clients. For the YRR they reported new clients each quarter and therefore the total number of clients was the calculated as the number in the first quarter plus the sum of the new clients. New clients were not reported for CoS or MSSH so HPA assumed the total number of clients in 2022–23 financial years was the maximum number in any quarter multiplied by 1.25.</p>
<b>Qld</b>	<p>The data were presented in the age groups of &lt;18, 18–24, 25–34, 35–44, 45–54, 55–64, and 65+ years. These were mapped to the age groups used in the NMHSPF (12–24, 25–64 and 65+ years), assuming there were no people aged 0–11 receiving services. If the number of clients was between 1 and 4 the number was suppressed, HPA assumed it was 2. The data contained the total number of hours, but not the number of hours by age group. HPA assumed that, within each row of data, clients received the mean number of hours for that row (i.e. total hours / total clients).</p> <p>Queensland provided data in the National Best Endeavours Format (NBED), which means it was provided in separate rows of data for each service element in a program, and there was no way of identifying the clients who may have received both. When this occurs double counting of clients is highly likely. Therefore, HPA have assumed the clients counted within the service elements are likely to be the same people. To obtain the distinction number of people in that program (within a catchment area) HPA used the maximum number of clients in any service element for activity that was grouped by financial year, organisation, program, and catchment area.</p>
<b>WA</b>	The data HPA received had counts of the total number of clients. The age distribution of clients was derived from the description of the target age group. When the target age group spanned more than one of the four age groups used in the analysis (i.e., 0–11, 12–24, 25–64, and 65+), the clients were allocated assuming an even distributed across the

Jurisdiction	Age distribution
	<p>ages within the target age group. That is, clients in a program where the target age group was 18–64 years, were allocated assuming 7/47ths of them were in the 18–24 year age group, and 40/47 of them were in the 25–64 year age group. Similarly, clients in the target age group of 18–65 were distributed to the 3 age groups (12–24, 25–64, and 65+) using the ratio of 7:40:1. When the target age group was missing, it was assumed to be 18–64 years.</p> <p>The WA data also included the total number of hours of services provided and it was assumed that each client within a row of data received the same number of services (i.e. total hours/total clients). For the staffed residential services in WA it was assumed that people received 3 hours of psychosocial services per bed day.</p>
SA	<p>One of the datasets provided by SA was unit records, with unique patient identifiers, and included the age of clients. Total hours were provided for each episode of care.</p> <p>The other dataset containing aggregated data grouped into the age groups of 0–17, 18–65, and 65+ years. HPA assumed there were no clients aged 0–11 years and all of the 0–17 age group was allocated to the 12–24 year age group. The 18–65 year age group was distributed to the 12–24 years and 25–64 years using the ratio of 7:40 (i.e. HPA assumed equal distribution across the age groups). Hours were distributed across age groups assuming clients received an equal number of hours.</p> <p>The aggregated data were counts of clients per reporting period (monthly for GP access and quarterly otherwise). There was likely to be a high overlap of clients across the reporting periods, so the total number of distinct clients was calculated by multiplying the maximum in a period by 1.25.</p>
Tas	<p>Counts of clients and hours for some services were provided using the age distribution in the NMHSPF (0–11, 12–24, 25–64 and 65+). The age of clients was not provided for the other services. For some of these services, there was some information about the age distributions (e.g. it may be given as a proportion). When there was no information and the target age group excluded 0–11 year olds, HPA assumed it is 0.10, 0.80, and 0.10 for the age groups of 12–24, 25–64, and 65+, which is similar to the distributions when the data were provided. If the target age includes all ages HPA assumed (0.05, 0.1, 0.75, 0.1).</p>
ACT	<p>Clients and the hours of services they received were provided by age group for the Detention Exit Community Outreach (DECO) and Transition to Recovery Program (TRec) Programs. For the Compeer Friendship Program the number of clients were provided by age group and hours were allocated as 15 hours per client based on the average for the TRec Program. Only the total number of clients and total number of hours was provided for the Women’s residential and Youth and Wellbeing Programs. Clients were distributed to the age groups used in the analysis assuming ages within the target age range were equally likely to occur. Hours were then distributed to the clients assume age groups received the same number of hours per clients, that is the number of clients was multiplied by the total number of hours divided by the total number of clients.</p>
NT	<p>Aggregated data for services provided in the 2022–23 financial year were provided to HPA. There were five rows of data and four of them included total number of clients who received services, with a breakdown by age group (0 to 11, 12 to 24, 25 to 64, and 65+ years) for three of them. The four that included the total number of clients also included the total number of hours, with two rows of data having a breakdown of hours by age groups. There were two ‘drop-in’ services, one of which did not have a value for number of clients but had the number of hours of services provide (MiPLace Drop in support service). The other one (TEMHCO – Drop in support service) had the number of clients but not the number of hours of service. HPA assumed these services were comparable and derived the missing information using the data from the other service, but adjusting</p>

Jurisdiction	Age distribution
	<p>it by the ratio of the relative funding. Therefore, the number of clients at MiPlace was assumed to be 81% of the number at TEMHCO, and the number of hours of service at TEMHCO was assumed to be 125% the number at MiPlace.</p>
<b>Commonwealth (Australian Government Department of Health and Aged Care)</b>	<p>For the Commonwealth Psychosocial Support Program, the number of clients and number of contacts for those clients were provided by age group. The PMHC-MDS data that was provided for this analysis suppressed small numbers and totals, where these appear for PMHC-MDS data they are estimates generated by HPA. As such, when the number of clients was less than 6 the number was suppressed in the data provided to HPA, therefore an estimated value was used based on the number of contacts. A separate table with the number of contacts for a range of service durations (from 1-to-15-minute to over 120 minutes) was provided by age group and 'service contact participants' (i.e. Individual client, client group, family/client support network, other health professional or service provider, not stated and other). Minutes were assumed to be the midpoint of the range, for example 8 minutes was allocated to the 1-to-15-minute category. The over 120-minute category was allocated 120 minutes. The 'not stated' and other categories were grouped with Individual clients (but the numbers are relatively small). For each of the categories of financial year, age group and contact type HPA estimate the total number of contacts and the total time in minutes of those contacts, which provided an estimate of the mean duration of a contact for each age group and service type.</p> <p>For the two Clubhouse programs (i.e. Canefields and Kindred) HPA were only provided with a total count of clients and an estimated number of hours for those clients. HPA assumed an equal distribution of clients across the age range of 16 to 64 years. Therefore, clients were allocated to the age groups of 12–24 and 25–64 in the ratio of 9:40.</p> <p>For the Early Psychosis Youth Services program, when the number of clients was less than 5 but above 0, the number was suppressed in the data provided to HPA. Several assumptions were made to estimate the number of people and hours of service for these hidden values. If the data for number of clients was hidden and occasions of service was hidden, the number of clients was allocated 2.75. Otherwise, if the data for number of clients data was hidden, and occasions of service was known, it was allocated 4. To calculate hours, for individual service types it was assumed the average length was 20 minutes and for group service types it was assumed the average length was 97 minutes. Slightly over four occasions of service were assumed for each hidden occasions of service to calibrate to the total provided by the data custodians. Services in the Early Psychosis Youth Services were allocated to the 12–24 year age group.</p> <p>The age distribution of clients in the SANE program were provided in a table by 10 year age groups that mapped to age groups used in the NMHSPF. Additional tables were provided that include information about type of contact (Welcome call, befriending call, support planning, 1 to 1 counselling, 1 to 1 peer support, and mid program review) and appointment status (Cancelled, Completed, No show, Scheduled). From the above the completed appointments and all call contact types, except 1 to 1 counselling, were included. From these, HPA estimated the total number of contacts and assumed they were 40 minutes each, based on the Department of Health and Aged Care's understanding that 1 to 1 peer support sessions are 40 minutes long. They were distributed across clients assume average number was the same for age groups.</p> <p>All clients receiving services from the Disability Support for Older Australians programs (i.e. Psychosocial Recovery Coaching, Extended CoS Services, and Assistance in Supported Independent Living) were assumed to be aged 65+ years (or 50+ for Aboriginal and Torres Strait Islander clients). Number of hours was provided and therefore were also allocated to the 65+ age group.</p>

# G. Comparison with South Australian estimates of unmet need

The Australian Government Department of Health and Aged Care (the Department), on behalf of the PPG, engaged HPA to develop estimates of the level of unmet need for psychosocial supports in Australia outside the NDIS. This document presents a comparison of the unmet need for psychosocial support estimated in this report by HPA for SA, with the estimate reported by David McGrath Consulting (2023) in the “Unmet mental health service need in SA that could be met by the NGO sector” report (SA Report).

HPA was requested to estimate the unmet need for psychosocial services for people with moderate or severe mental illness, but the analysis in the SA Report was only for people with severe mental illness.<sup>17</sup> Table 76 shows the results of the analysis from both studies, but it is only the first two rows of the Table, which are highlighted, that are comparable. The remaining rows are included for completeness and to avoid confusion with the numbers presented in the main report, which are only for 2022–23.

The unmet need for psychosocial support services estimated in the SA Report is shown in the first row of Table 76.<sup>18</sup> HPA’s estimate of the number of people with an unmet need for psychosocial support services in 2021–22 among people aged 12 years of age or older is shown in the second row. The numbers in the severe group in 2021–22 are broadly similar between the two reports, with HPA’s analysis reporting 19,530 people have an unmet need for psychosocial services and the David McGrath Consulting reporting 19,300 (David McGrath Consulting, 2023).

Table 76: Estimates of the number of people in SA with an unmet need for psychosocial support services, by severity and age group, 2021–22.

Study: financial year	Severity	Consumers	Programs			Unmet need
			State	Cwlth	NDIS	
McGrath: 2021–22	Severe	26,810	2,775	1,714	3,200	19,300
HPA: 2021–22	Severe	26,000	2,200	710	3,550	19,530
	Moderate	26,100	470	1,060	1,940	22,660
HPA: 2022–23	Severe	26,200	2,210	1,030	4,060	18,900
	Moderate	26,400	450	1,550	2,060	22,320

<sup>†</sup> The columns of State, Cwlth and NDIS contain the values of the number of people who received some level of support funded by the South Australian Government (State), the Commonwealth and the NDIS.

<sup>17</sup> See p34 of the SA Report

<sup>18</sup> See Table 17 of the SA Report

## Consumers

In both studies the need for psychosocial support was derived from the NMHSPF. The number in the 'Consumers' column in Table 76 is the estimated number of distinct people who are likely to need some psychosocial support in the specified severity group and financial year. The number of distinct consumers is not available in any output that can be obtained from the NMHSPF Planning Support Tool, but it can be derived by making assumptions about the overlap of the people who receive different types of psychosocial services within care profiles. For people with a severe mental illness there are 26,000 consumers in the HPA analysis. This number was derived from work undertaken by the QCMHR based at the University of Queensland. The number in the SA report is 26,810 and was estimated from the service element which the report claimed had the greatest utilisation (i.e., Individual Support and Rehabilitation (ISR) linked to early childhood, education and/or employment) (David McGrath Consulting, 2023).

## State

The number in the 'state' column is the number of people estimated to be receiving support from services funded by the Department for Health and Wellbeing in South Australia (DHW). In HPAs analysis the number was estimated from data provided by DHW. HPA received two files containing data for the services provided by DHW. The first file contained aggregate data for the Day and Group Rehabilitation, GP Access, and Mutual Support and Self-Help programs. The aggregated data is counts of the number people receiving services each month for the GP Access Program and every quarter for the other two programs. These counts are not unique individuals and it's not possible to identify individuals. Therefore, to estimate the number of unique individuals who received psychosocial services from the programs, HPA multiplied the maximum number of individuals in one period by 1.25. The second file contained unit records for services provided by the Accommodation and Support Program (ASP), Avalon, Housing & Accommodation Support Partnership (HASP), HASP Burnside, Individual Psychosocial Rehabilitation and Support Services (IPRSS), and Intensive Home-Based Support Services programs (IHBSS). These data contained unique identifiers and therefore the exact number of people receiving services from these programs could be estimated. The aggregate data accounts for approximately 43% of clients.

DHW's commissioning branch provided David McGrath Consulting with information about the funding and purchased activity for each program funded by DHW (Table 8 in the SA report). The SA Report states, "There is no data on the number of clients serviced by the SA Health funding. Working on the NMHSPF figure of \$6994.34 per client per annum for ISR and dividing that into total NMHSPF dollar equivalent expenditure gives the figure in the table." (David McGrath Consulting, 2023, p. 47). That is, the estimated number of clients receiving psychosocial services funded by SADHW is 2,775 calculated by dividing \$19,406,219 by \$6994.34.

The number calculated by HPA is an estimate of the number of people who received some psychosocial service in 2021–22 from the programs funded by SADHW. It does not imply that all these people received sufficient services in that financial year to have their psychosocial needs fully met. The number calculated for the SA Report is an estimate of the number of people who could be provided with the 'ideal' number of psychosocial services, as defined by the NMHSPF, in the 2021–22 financial year. The number estimated by HPA and the number in the SA Report are highly unlikely to be the same because they are estimating two different quantities. People with severe mental illness do not necessarily need psychosocial services every financial year (according to the NMHSPF). Therefore, even if the people who were enrolled in the program in 2021–22 received the 'ideal' number of psychosocial services in a 12-month period, the numbers estimated in the two reports will still differ because most of those people will receive a portion of their services in 2021–22 and a

portion in either 2020–21 or 2022–23 because people who need these services will enroll at different points through the financial year.

It must be noted that the method used in the SA Report assumed that all people who would receive the ideal number of psychosocial services through the state programs would have severe mental illness. HPA's analysis has assumed that some programs provide services to people with severe or moderate mental illness, which has led to 560 consumers being allocated to the moderate group.

### **Commonwealth**

The number in the 'Commonwealth' column is the number of people estimated to be receiving support from services funded by the Australian Government/Commonwealth. In the HPA report the number was derived from data on services provided by Commonwealth funded programs. Most (~74%) of these services were commissioned by the Primary Health Networks through the Commonwealth Psychosocial Services Program.

The two PHNs in SA provided David McGrath Consulting with the total funding for the programs that the PHNs commissioned. Table 12 in the SA report show the data for Country SA. Total funding was \$7,441,984 and dividing that by \$6994.34 gives 1,064 clients estimated who were receiving psychosocial services funded by the PHN. The estimated number of clients who receive supports through programs commissioned by Adelaide PHN is calculated differently. The commissioned program includes streams for ISR which is allocated \$2,098,302 of funding and dividing this by \$6994.34 gives 420 individuals estimated to have received support through these streams of the program. The third stream is for Group Support and Rehabilitation, and it is estimated that 230 individuals receive services through this part of the program resulting in a total of 650 clients estimated to receive some psychosocial services (David McGrath Consulting, 2023).

The SA Report assumed all services funded by the Australian Government were provided to people with severe mental illness. The analysis conducted by HPA assumed that only 40% of people who received services funded by the Australian Government/Commonwealth had severe mental illness, the remaining 60% of people were assumed to have a moderate mental illness.

### **NDIS**

HPA requested and received a dataset containing a summary of the number of NDIS participants in June 2022 (2021–22) with a psychosocial disability recorded as their primary disability or as a secondary disability. The data were summarised by age group, disability classification (i.e. primary or secondary disability) and SA3. Counts of less than 11 were reported as '<11' to adhere to the NDIA's data sharing policy. The data also contained the dollar amount of the average annual committed support, and the total payments made. Values were imputed for counts reported as less than 11. The imputed estimates were then scaled so that the total number of participants was equal to the number in the control totals provided by the NDIA. HPA assumed that all participants with a primary psychosocial disability and 13% of those with a secondary psychosocial disability have a severe mental illness with the remainder having a moderate mental illness.

For the SA Report, data obtained from the NDIS data portal were used to estimate the number of people who were participants in the NDIS with a primary psychosocial disability. Data are available for each quarter and in March 2022 the number of people was 3,188. Examining the trend over the previous quarters it was projected there would be 3,300 in the final quarter of the 2021–22 financial year.