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Mental Health Council OF TASMANIA

Towards Tasmania's Next Mental Health Strategy

Discussion Paper Response

Mental Health Council of Tasmania Submission

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About Us

The Mental Health Council of Tasmania (MHCT) is the peak body representing the mental health and wellbeing needs of all Tasmanians, and the community organisations that work with and support them. We work closely with government to amplify the voices of our members and Tasmanian communities, to provide input into public policies and programs. We advocate for reform and improvement within the Tasmanian mental health system. Our purpose is to strengthen and advocate for our communities and service providers to support the mental health and wellbeing of all Tasmanians, and our vision is that every Tasmanian has access to the resources and support needed for good mental health and wellbeing.

Introduction

MHCT welcomes the release of the Discussion Paper for Tasmania's next Mental Health Strategy and the opportunity to provide detailed recommendations to strengthen the next five-year strategic plan. As the peak body representing community-managed mental health services in Tasmania, MHCT brings together the voices of service providers and sector leaders and considers the perspectives of people with lived and living experience, families, and carers through its membership.

This submission briefly reflects on the progress made under *Rethink 2020* and identifies several priority areas for reform. Additionally, for each principle discussed in the paper, MHCT provides an assessment of current opportunities, along with concrete recommendations and, where available, examples of good practice, including initiatives led or supported by MHCT.

The identified opportunities are informed by MHCT's ongoing research, sector consultations and member feedback, advocacy, as well as key national analyses, including the Health Policy Analysis (HPA) report commissioned by the Commonwealth (2025) and the Productivity Commission's Interim and Final Report on the National Mental Health and Suicide Prevention Agreement (2025).

In addition, MHCT provides a critical analysis of the seven guiding principles outlined in the Discussion Paper, offering recommendations to strengthen their application in the development of the new Strategy.

Reflecting on Rethink 2020

The Discussion Paper captures the progress made under Rethink 2020. From the community-managed sector's vantage point, many reforms have meaningfully improved consumer experience across the mental health Continuum of Care. Notable achievements include the opening of the Peacock Centre in North Hobart, the Medicare Mental Health Centre in Launceston, the Mental Health Hospital in the Home pilot in the Northwest, the Housing and Accommodation Support Initiative (HASI), Baptcare Choices, and the phased rollout of the Central Intake and Referral Service, among many others.

MHCT acknowledges that much of this work is still evolving, and that some initiatives remain incomplete or in various stages of implementation.

At the same time, Rethink 2020 has not resolved several structural problems that have compounded over the past six years and continue to undermine the system's capacity to meet community need. These include:

- **Demand continuing to outpace sector capacity**, particularly in community mental health. Unmet need for psychosocial supports and recovery-oriented services has grown significantly, with HPA analysis estimating that approximately 9,420 Tasmanians aged 12–64 is currently missing out on essential psychosocial supports, either because they fall outside the NDIS or because no state or federally funded services exist for them. This represents the worst combined shortfall of any Australian jurisdiction.
- **Persistent workforce shortages** characterised by ongoing difficulties in recruiting qualified staff and retaining experienced workers across both clinical and community-managed settings. Geographic dispersion, inadequate remuneration relative to other sectors, casualisation of roles, and limited professional development pathways have all contributed to a workforce under sustained pressure. These challenges are not new, but they have not been adequately addressed, and they represent a fundamental constraint on the sector's ability to grow and improve.
- **Short-term and ad hoc funding arrangements** that have produced chronic uncertainty for both providers and consumers. Annual or project-based contracts, without reliable indexation to cover rising costs including SCHADS Award increases, make it effectively impossible for community organisations to plan, invest in workforce development, or maintain the sustained relationships with consumers that recovery-oriented care requires. This uncertainty has worsened progressively over the course of Rethink 2020.

- **Contracting and commissioning practices** that have remained short-cycle, insufficiently indexed, and structured in ways that actively discourage cross-sector collaboration and long-term investment. The current model creates competitive rather than cooperative dynamics between organisations, fragments service delivery for people with complex needs, and places the administrative burden of compliance disproportionately on smaller community providers. Reform of commissioning is not a peripheral issue; it is foundational to whether the next Strategy delivers different outcomes.
- **Clinical capture and the systemic prioritisation of acute and emergency mental health services** at the expense of non-clinical psychosocial support and recovery services. Investment decisions across the decade have consistently favoured hospital and crisis-based responses over the community supports that prevent crisis in the first place. This creates a self-reinforcing cycle: underfunded community services mean more people present in crisis, which drives further investment in acute capacity, which further crowds out prevention and early intervention. Breaking this cycle requires an explicit funding commitment to community-based psychosocial supports, protected from reallocation to acute services.

For the next Mental Health Strategy to succeed, it must build upon the achievements of Rethink 2020, and address where it fell short. These structural issues must be directly named, resourced, and addressed with binding commitments, not aspirational language. Continuity matters; so, does the determination to do things differently.

MHCT welcomes the Discussion Paper's acknowledgement of the system's persistent shortcomings, including unmet psychosocial need, workforce pressures, and service fragmentation. This honesty is an important foundation for genuine reform, and MHCT's recommendations are offered in that same spirit of candour.

These structural challenges do not exist in isolation. They intersect, compound one another, and collectively define the gap between what Tasmania's mental health system currently delivers and what Tasmanians need it to deliver. They also provide the lens through which MHCT's detailed analysis of priority areas should be read.

The following section examines ten specific gaps in the current system and sets out MHCT's recommendations for each. Taken together, these recommendations are designed to address not only the surface manifestations of unmet need, but the structural conditions that produce and sustain them, and to give the next Strategy the operational architecture it needs to translate intent into measurable, lasting change for Tasmanians living with mental illness and those who support them.

Ten Priority Areas: Gaps and Recommendations

Priority Area 1: Structural and System Reform

Background and Gap

Tasmania's mental health system currently lacks a coherent statewide architecture. Roles and responsibilities across Commonwealth, state, primary health and community sectors remain poorly defined, leading to duplication in some areas and complete absence of services in others.

The Productivity Commission's interim report found that the current National Mental Health and Suicide Prevention Agreement has failed to establish the clear governance, accountability and coordination mechanisms needed for systemic reform. Fragmented commissioning, with annual, project-based contracts and no shared accountability framework, prevents the sector from planning, growing, or retaining a stable workforce.

Additionally, over the course of Rethink 2020, the decision was taken to dissolve the Mental Health, Alcohol and Drug Directorate and redistribute its functions across the Tasmanian Health Service. MHCT and the community managed mental health sector have raised concerns about the impact of this move: complicating oversight and leadership of strategy implementation, and diminishing escalation and informational pathways between the Community-managed organisations (CMOs), health as a funder and contractor, and strategic accountability.

Recommendations

- Establish a statewide mental health system architecture that clearly defines the roles and responsibilities of all funders (Commonwealth, state, PHN), service types (clinical, community-managed, psychosocial), and governance bodies.
- Explore collaborative commissioning models that bring together government, peak bodies, consumers, and service providers as genuine co-designers of service investment decisions, not merely consultees. International and national evidence demonstrates that formalised shared accountability between commissioners, providers, and communities can produce better aligned and more cost-effective outcomes.

  The Queensland Parliament's Inquiry into Delivering Quality Health Care More Efficiently (2025) provides a contemporary and relevant evidence base for exploring what such an approach might look like. MHCT notes that any collaborative commissioning model adopted in Tasmania would need to be developed and adapted to local conditions, including Tasmania's unique size, geography, and service architecture, rather than directly replicated from another jurisdiction.

- Honour the commitment to minimum five-year funding cycles with annual indexation tied to both the Social, Community, Home Care and Disability Services (SCHADS) Award and CPI, providing the stability organisations need to plan, recruit, and deliver.
- Review and strengthen existing cross-portfolio governance mechanisms, including any interagency working groups relevant to mental health, AOD, housing, and disability, to ensure sector peak bodies and lived experience representatives are formally included, and that mental health outcomes are explicitly tracked within those structures.

  MHCT recommends that a dedicated cross-portfolio integration working group be established or formalised, potentially as a sub-group of the Premier's Mental Health and Suicide Prevention Advisory Council. The group should have defined terms of reference, meet every two months, and publish biannual reports to Parliament on progress against agreed cross-portfolio outcomes.

  This embeds accountability in departmental structures rather than depending on ministerial continuity, which Tasmania's parliamentary history demonstrates cannot be assumed.

Priority Area 2: Psychosocial and Community Sector Investment

Background and Gap

Tasmania faces the worst psychosocial support shortfall in Australia.

A 2025 report by Health Policy Analysis (HPA), commissioned by the Commonwealth, found a 98.4% shortfall in hours of state and federally funded psychosocial services for Tasmanians with severe mental illness, and an 88.8% shortfall for those with moderate mental health issues. MHCT's Access and Affordability Report further documents the barriers Tasmanians face in accessing psychosocial supports, including cost, geographic distribution, and service availability, and should be read alongside the HPA analysis as a complementary evidence base for investment decisions.

Approximately 9,420 Tasmanians aged 12–64 are currently missing out on essential psychosocial supports, either because they fall outside the NDIS, or because no state or federal-funded services exist for them. The scale of this shortfall demands a substantial, phased investment response, the quantum of which should be determined through a transparent needs-based analysis conducted jointly by the Commonwealth and Tasmanian governments as a first step in developing the next Strategy.

Psychosocial supports are not adjunct services. Programs that help people manage daily activities, rebuild social connections, and participate in education and employment are foundational to preventing crisis presentations and reducing pressure on emergency

departments and acute inpatient services. Without them, Tasmania's mental health system will continue operating in permanent crisis mode.

The interface between NDIS and funded foundational psychosocial supports remains a critical unresolved issue. Many Tasmanians who are not NDIS-eligible, or who have been or will be transitioned away from the NDIS, have no clear funded pathway to community-based support, creating significant gaps in continuity of care.

The economic case for closing this gap is compelling: community-based psychosocial support is substantially less costly than the crisis presentations, emergency department attendances, and acute inpatient admissions that fill the void when it is absent.

The Productivity Commission's 2020 Mental Health Inquiry found that mental illness costs the Australian economy between $200 and $220 billion per year, representing just over one-tenth of Australia's entire economic output (Productivity Commission, 2020). A disproportionate share of this cost is driven by avoidable crisis and acute care episodes that upstream psychosocial support could prevent.

Drawing directly on the Productivity Commission's modelling, Flatau and colleagues (2026) confirmed that investing in psychosocial supports produces measurable cost offsets, including reductions in emergency and public hospital use, alongside quality of life and employment benefits.

However, they also identified a striking dearth of economic evaluation at the program level, leaving the full value of psychosocial investment systematically underestimated (Flatau et al., 2026).

Investing in psychosocial support is not a cost to the health system, it is a cost offset. Every dollar not spent on community-based recovery support is a dollar that will be spent, at far greater expense, on emergency and hospital-based care.

CMOs already deliver the bulk of psychosocial support and recovery services in Tasmania, yet their capacity to extend that reach, both into the community and into clinical settings, remains chronically under-resourced. In-reach services, in which CMO workers are embedded within or alongside clinical settings such as inpatient units, emergency departments, and community health centres, are particularly undervalued in current investment frameworks. Yet in-reach is precisely where the interface between clinical and psychosocial care is most consequential: it is the point at which people transitioning out of acute care are either connected to ongoing community support or lost to follow-up.

Well-resourced in-reach capacity strengthens the entire service continuum, amplifies the impact of clinical investment, and drives the kind of system integration that no governance structure alone can achieve.

Recommendations

- Develop a dedicated Tasmanian Psychosocial Support Strategy with defined investment targets, phased funding commitments, and coverage mapped against the known shortfall identified in the HPA report.
- Expand community-managed mental health services, recognising that the psychosocial workforce has the potential to be built more rapidly than the clinical hospital workforce, but only if the structural barriers to recruitment and retention, including casualisation, inadequate remuneration, and short-term contracts, are addressed simultaneously. This represents an immediate opportunity contingent on resolving the funding and contracting conditions that currently constrain sector growth.
- Ensure all Tasmanians who are ineligible for individual support through the NDIS are provided appropriately funded psychosocial supports outside of the NDIS.
- Recognise and resource CMOs as the primary providers of psychosocial support and recovery services in Tasmania, including through dedicated investment in both outreach and in-reach service capacity.

  Outreach services extend support to Tasmanians who cannot or do not present to services; in-reach services, in which CMO workers are embedded within clinical settings including emergency departments, inpatient units, and community health centres, strengthen care transitions, reduce re-presentation rates, and build the system integration that fragmented commissioning has historically failed to produce.

  Both functions are foundational to a recovery-oriented system and should be explicitly funded as core service types, not optional program add-ons, within the next Strategy.

  Funding models must account for the additional costs associated with outreach service provision, including travel time, transport, and worker safety infrastructure, and must be explicitly inclusive of Tasmanians living in rural and remote areas, including those on King and Flinders Islands, where geographic isolation compounds every other barrier to access and where the absence of outreach capacity is not a gap at the edges of the system but a fundamental equity failure at its centre.
- Establish an annual joint review of psychosocial service gaps, conducted by the Tasmanian Department of Health, the Australian Government Department of Health and Aged Care, and Primary Health Tasmania, with input from MHCT and the community-managed sector, with findings published publicly and defined accountability for addressing identified shortfalls within the life of the strategy.

Priority Area 3: Workforce Strategy

Background and Gap

Tasmania's mental health workforce faces acute challenges across recruitment, retention, training and geographic distribution. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has noted that Tasmania has only four full-time psychiatrists per 100,000 people in outer regional areas, with no psychiatrists in remote and very remote Tasmania, compared to a national major city average of approximately 15 per 100,000 (RANZCP, 2025; Hayter et al., 2024).

The community-managed sector faces similar pressures, compounded by casualisation, inadequate remuneration, short-term contracts, and limited professional development pathways.

The peer workforce, people employed in mental health services because of their own lived and living experience of mental illness and recovery, remains under-utilised and inconsistently embedded across the sector, despite strong and growing evidence of its value in supporting recovery-oriented care, reducing stigma in service settings, and improving consumer outcomes including carers, friends and families.

Recommendations

Comprehensive Workforce Plan

- Co-design and fund a comprehensive Tasmanian Mental Health Workforce Plan covering all sectors, clinical, community-managed, and peer, with defined growth targets, rural and remote incentives, and worker wellbeing and retention strategies including addressing casualisation and SCHADS Award increases. Tasmania does not yet have a jurisdiction-specific workforce plan of this scope.

  The National Mental Health Workforce Strategy 2022–2032, endorsed by Health Ministers in November 2022, identified a current 32% shortfall in mental health workers nationally, projected to reach 42% by 2030 if unaddressed. It sets out four pillars to guide jurisdictions: Attract and Train, Maximise and Connect, Support and Retain, and Data and Technology (Australian Government Department of Health, Disability and Ageing, 2022).

  The Strategy explicitly calls on state and territory governments to develop complementary workforce plans that address local conditions.

  A dedicated Tasmanian plan would fulfil this obligation while responding to the specific pressures of a small, geographically dispersed jurisdiction where workforce maldistribution, high casualisation rates, and below-cost indexation have compounded

national shortages to an acute degree. Without a jurisdiction-level plan with binding growth targets and funded retention strategies, Tasmania will continue to absorb the national shortfall disproportionately.

- Fund dedicated training and professional development pathways across the community sector, covering specialised practice competencies including trauma-informed care, leadership, complex and co-occurring needs, risk assessment in therapeutic relationships, data literacy and evaluation skills, system capability, and peer work.

Expand the Peer Workforce via the LEx Hub

In 2019, MHCT developed Tasmania's inaugural Peer Workforce Development Strategy, a formal commitment under the *Rethink* Mental Health Plan, identifying that Tasmania had the smallest number of lived experience workers per capita in Australia. The Strategy's development was funded by the Tasmanian Government as part of the broader Rethink reform agenda, and its subsequent implementation plan, launched in 2022, has provided the foundation for the growth of the lived experience workforce across the community-managed sector.

In November 2024, MHCT launched the Lived Experience Training Hub (LEx Hub), jointly funded by the Tasmanian Government and Primary Health Tasmania, to build the lived experience workforce across mental health, suicide prevention, and alcohol and other drugs sectors. The LEx Hub offers peer training courses including Introduction to Peer Work, Foundations of Peer Work, LEx Supervision, and LEx Leadership.

- **Fund services to embed peer workers:** Providing the LEx Hub with training infrastructure is necessary but not sufficient. Services must also be resourced to employ, support and retain peer workers. The next strategy should include dedicated funding to community organisations specifically for peer workforce growth, including supervision, mentoring and career pathway support.
- **Expand the LEx Hub's reach:** MHCT recommends building on the LEx Hub's strong foundation with sustained multi-year government investment, enabling expansion of training programs, regional delivery, and development of specialist coproduced streams (e.g., youth peer work, Aboriginal peer work, AOD peer work). Fund a staged expansion of youth peer work across Tasmania, building on the sector's implementation experience and the LEx Hub's training infrastructure, acknowledging that embedding peer workers in youth settings requires additional planning, workforce development, and cultural safety considerations beyond what has been achieved in adult settings to date.

- **Set measurable peer workforce targets:** The next strategy should include a specific, measurable target for growth in the peer workforce over five years, with progress reported publicly.

Rural Workforce

- Introduce targeted rural and remote workforce incentives including scholarship pathways, rural placements for students, and housing support for incoming workers, building on MHCT's analysis that recruitment challenges in regional areas are partly attributable to the lack of affordable housing. (MHCT submission to the Tasmanian Housing Strategy, 2024)

Priority Area 4: Data and Accountability

Background and Gap

Effective mental health reform depends on robust, shared, and transparent data. Tasmania currently lacks a consistent cross-sector data framework, meaningful performance indicators, or public reporting mechanisms that tell Tasmanians and service providers whether the system is improving. The Productivity Commission's interim report found that fragmented data systems and unclear accountability have been among the most significant barriers to reform progress under the current National Agreement.

A further critical gap is in how outcomes are measured. Current administrative metrics, hospital admissions, bed days, service contacts, capture system activity, not recovery. They measure what is convenient to count, not what matters to people. People with lived experience of mental illness consistently report that what matters to them is connection, hope, participation in life, and freedom from crisis. These outcomes are rarely measured, and almost never drive funding decisions.

Recommendations

- Establish a statewide mental health data framework with defined data standards, cross-sector data sharing arrangements (health, mental health, disability, housing, justice), and real-time monitoring capability.
- Co-design outcomes measures and a performance framework with people with lived and living experience, their families, and community sector organisations, ensuring that what gets measured reflects what matters to people, not only what is administratively convenient. This should be led by a formal co-design process, with genuine authority for lived experience participants to shape what is included.
- Define measurable, publicly reportable outcomes for the strategy, including reductions in unmet psychosocial need; changes in crisis presentations and emergency department use; growth in the peer and community workforce; improvements in consumer-reported recovery outcomes; and equity of access for priority populations.
- Commission economic evaluation of psychosocial supports and community-managed services, to build the evidence base for investment and counter the tendency to prioritise acute spending.
- Publish an annual public dashboard reporting on progress against the strategy's defined system-level outcomes. This is a mechanism for holding government accountable to its commitments, not an organisational performance or compliance tool for individual service providers.

Priority Area 5: Priority Populations

Background and Gap

The Discussion Paper references priority population groups but does not operationalise targeted strategies with specific, funded, and measurable actions for each group. Broad acknowledgement of diversity is insufficient, each population faces distinct barriers shaped by stigma, culture, systemic discrimination, and service gaps.

Recommendations

Aboriginal and Torres Strait Islander Communities

- Develop a dedicated schedule within the next strategy for Aboriginal and Torres Strait Islander social and emotional wellbeing, aligned with the Tasmanian Aboriginal community's own priorities, and consistent with the Productivity Commission's recommendation for a national agreement schedule on this issue.
- Embed cultural safety standards across all funded services, with accountability mechanisms and training requirements for the non-Aboriginal workforce.
- Ensure Aboriginal community-controlled organisations are adequately and sustainably resourced to lead the design and governance of social and emotional wellbeing services in Tasmania. Where communities determine it is appropriate, this should include direct service delivery.

  Resourcing should also support the provision of cultural training, supervision and accountability frameworks for mainstream community-managed organisations delivering services to Aboriginal Tasmanians.

  The role of Aboriginal Community-Controlled Organisations (ACCOs) in each context should be determined by Aboriginal communities themselves, not prescribed by government or sector planning processes.

CALD Communities

- Fund language-accessible mental health resources and interpreter-supported pathways across all tiers of care.
- Resource community-led mental health promotion within CALD communities, recognising that peer and community trust is often the most effective pathway to help-seeking.

LGBTQIA+ Communities

Working It Out (WIO) is Tasmania's only specialist service for LGBTIQ+ Tasmanians, providing state-wide counselling, peer group support, school-based programs, education and professional training. WIO has operated for over 22 years and has been core-funded by the Tasmanian Department of Health since 2001.

WIO is also the Tasmanian partner for the national Silver Rainbow program (for aged care), holds the co-chair position on the Whole-of-Government LGBTIQ+ Reference Group, and is a Quality Improvement Performance (QIP) Rainbow Tick accredited organisation.

LGBTIQ+ Tasmanians face significantly elevated rates of mental health distress, suicidality, and barriers to accessing culturally safe services. WIO's model, combining direct support, peer groups, school-based education, and systemic advocacy, represents a proven, community-led response that should be strengthened, not merely maintained.

- Substantially and sustainably increase core funding for specialist LGBTQIA+ mental health services in Tasmania, recognising that current resourcing across the state is vastly insufficient relative to identified need.

  Tasmania's sole specialist LGBTQIA+ community-managed service operates with approximately 3 FTE, a level of investment that cannot adequately serve a population facing significantly elevated rates of mental health distress, suicidality, and barriers to accessing culturally safe mainstream services.

  Core funding should reflect genuine population need and be indexed to enable workforce stability, statewide reach, and the delivery of both direct support and sector-wide training in LGBTQIA+ inclusive practice.

- Develop a dedicated LGBTIQA+ mental health action plan within the broader strategy, with defined targets for access, service inclusivity, and workforce cultural competency.

- Expand WIO's capacity to deliver training to the broader mental health and community sector, ensuring that LGBTIQ+ inclusive practice becomes a baseline standard, not an optional addition, for all funded services.

Young People

MHCT notes that the scale and upstream significance of youth mental health, particularly when considered through the lens of Adverse Childhood Experiences as primary determinants of adult mental illness, may warrant treatment as a cross-cutting strategic priority rather than solely as a priority population. The recommendations below reflect this view, and MHCT encourages the next Strategy to consider whether a dedicated youth mental health action plan is warranted within the broader strategy framework.

MHCT has undertaken extensive co-design work with young Tasmanians including, in collaboration with the Youth Network of Tasmania (YNOT), state-wide consultations that informed the inaugural Tasmanian Child and Youth Wellbeing Strategy (2021). Key themes consistently raised by young people include lack of awareness of available services, geographic barriers (particularly in rural and regional areas), transport constraints limiting GP access, difficulty navigating the service system, and a desire for peer support and youth-led approaches.

MHCT has also developed a Youth Peer Work model specifically tailored to young people, in which trained young people with lived experience of mental illness provide peer support to their peers, complementing (not replacing) clinical services.

- Fund an expansion of youth peer work across Tasmania, building on MHCT's implementation model and the LEx Hub's training infrastructure.
- Include young people as co-designers of youth-specific service models and outcomes measures within the next strategy, with ongoing youth advisory structures embedded in implementation governance. This requires dedicated funding for youth engagement infrastructure within community-managed organisations, including time release for young people to participate, accessible and safe meeting formats, transport support where needed, and resourcing for youth advisory structures beyond tokenistic consultation.
- Develop a clear, funded youth mental health navigation pathway to reduce system fragmentation between CYMHS, headspace, primary care, and community services.
- Embed trauma-informed practice as a minimum service standard across all funded community-managed services and invest in evidence-based early intervention programs that build protective factors for children and families at risk of Adverse Childhood Experience (ACE) exposure. Any strategy focused on young people's mental health must directly address ACEs, including abuse, neglect, domestic violence, parental mental illness, and household substance use, as primary upstream drivers of mental ill-health.

  Evidence consistently shows that exposure to multiple ACEs substantially increases the risk of depression, anxiety, PTSD, suicidality, and substance use disorders across the

lifespan, with consequences compounding with each additional adverse experience. Tasmania's high rates of socioeconomic disadvantage amplify this risk and make early, targeted investment a matter of equity as much as efficiency.

- Align the next Strategy explicitly with Tasmania's Child and Youth Wellbeing Strategy and relevant family support frameworks to ensure that mental health, child protection, and family services work toward shared prevention outcomes rather than in parallel silos. A Mental Health Strategy that does not name ACEs and childhood maltreatment as mental health determinants will be responding perpetually to the downstream consequences of upstream harms.

  Shared outcomes, joint accountability, and coordinated investment across these systems are essential to breaking the intergenerational cycle that disadvantage and adversity produce.

Example: *Community-managed organisations across Tasmania, including through the Take a minute campaign's Youth Peer Wellbeing Program, are already delivering peer-to-peer mental health education in schools and youth organisations. Scaling this sector-led model, alongside the LEx Hub's youth peer worker training, would extend reach to young Tasmanians in communities where clinical services are limited.*

People with Disabilities

MHCT notes that people with disabilities, including those with psychosocial disability arising from mental illness, represent one of the most consistently underserved populations in Tasmania's mental health system, and that the structural conditions producing this underservice have worsened rather than improved over the past decade. The transition to the NDIS created a bifurcated system in which people with psychosocial disability are frequently caught between NDIS eligibility thresholds and residual state-funded supports, neither of which adequately address the complexity and variability of their needs. The result is a population that falls through the gap between systems, often at the point of greatest vulnerability.

This underservice is compounded by the near-total absence of disability-inclusive design in how mental health services are currently commissioned, delivered, and evaluated. Services designed around neurotypical assumptions of communication and cognition frequently fail people with intellectual disabilities, sensory impairments, acquired brain injury, and autism, not through deliberate exclusion, but through the accumulated effect of not being designed with them in mind. The Victorian Royal Commission into Mental Health found that people with disability accessing mental health services consistently reported experiences of discrimination, communication failure, and inadequate care, findings that are not unique to Victoria.

MHCT recognises that genuine inclusion requires more than good intent. It requires co-design, capability investment, and accountability structures that name disability as a dimension of mental health equity rather than a specialist concern separate from the mainstream strategy. The recommendations below reflect this view.

Recommendations

- Develop clear pathways and responsibility frameworks for people whose mental health needs intersect with disability, recognising the chronic gap between NDIS and state-funded supports.
- Ensure all community-managed services funded under the next Strategy meet disability-inclusive practice standards, supported by dedicated government investment in the infrastructure required to achieve this, including funding for organisational capability assessments, subsidised training for frontline and management staff, and protected time within funding agreements for co-design with people with disabilities.
- MHCT notes that inclusive practice standards cannot be mandated without commensurate capability support: compliance requirements imposed without resourcing place disproportionate burden on smaller organisations and risk producing tick-box compliance rather than genuine inclusion.

Priority Area 6: Prevention and Early Intervention

Background and Gap

Prevention is acknowledged as a principle in the Discussion Paper but remains rhetorical rather than operationalised. There are no defined funding allocations, prioritised interventions, or measurable targets for prevention and early intervention. This is a significant gap, given the strong evidence that upstream investment reduces downstream crisis presentations, emergency department attendances and acute admissions.

Recommendations

- Allocate dedicated, protected funding for prevention and early intervention within the next strategy, with clear sub-targets for schools, workplaces, and community settings.
- Scale evidence-based programs including mental health literacy initiatives, school-based wellbeing programs, and community resilience-building efforts, building on Tasmania's mental health sector's mental health literacy model, which goes beyond awareness-raising to address protective and risk factors.
- Formally align the next mental health strategy with Tasmania's 20-Year Preventive Health Strategy, establishing shared outcomes and accountability mechanisms between the two frameworks.
- Establish measurable prevention outcomes and report publicly on progress annually, including tracking of help-seeking rates, early intervention engagement, and long-term changes in community mental health literacy

Priority Area 7: Digital Mental Health Strategy

Background and Gap

Digital mental health services, including online programs, apps, telehealth and peer support platforms, offer significant potential to improve access, particularly for Tasmania's geographically dispersed population. With emerging technologies providing both promise and potential for harm, a digital framework, navigation tools, youth-friendly access models, or a strategic risk assessment of emerging technologies including AI-driven mental health tools is essential.

MHCT has consistently noted that digital literacy and access to technology are prerequisites that must be addressed before digital services can be offered as genuine alternatives to face-to-face care. Rural and lower-socioeconomic Tasmanians face significant barriers to digital access, and the assumption that phone and online services are interchangeable with in-person support is not supported by evidence, particularly for people with severe mental illness.

Recommendations

- Develop a statewide Digital Mental Health Framework that maps existing digital offerings, identifies gaps and duplication, establishes navigation platforms to help people find appropriate digital supports, and defines quality and safety standards for publicly promoted digital mental health tools.
- Develop and fund hybrid care models that enable seamless movement between in-person and digital supports, rather than treating digital as a default or cost-saving substitute.
- Design youth-friendly access models in co-design with young people, reflecting how they actually use technology, recognising that young Tasmanians have been clear in MHCT-facilitated consultations that digital tools must be paired with accessible human support, not replace it.
- Address digital exclusion explicitly within the strategy, with investment in digital literacy and device access for priority populations, particularly those in rural and remote areas.
- Develop an approach to online harms and emerging AI-driven mental health tools, including guidelines for services and consumers on safe use, and a mechanism for monitoring and reviewing the evidence base.

Priority Area 8: Co-occurring Mental Health and Alcohol and Other Drugs (AOD)

Background and Gap

Co-occurring mental health and AOD issues are the norm rather than the exception in community mental health settings, yet Tasmania's service system remains largely siloed. People with co-occurring needs are frequently bounced between services that each require the other condition to be treated first, or that lack the workforce capability to address dual diagnosis. The Discussion Paper acknowledges this issue but does not propose integrated care pathways or workforce capability frameworks to address it.

Recommendations

- Develop integrated care pathways for co-occurring mental health and AOD, enabling seamless support across sectors with clear joint protocols, warm referral systems, and shared care arrangements.
- Establish workforce capability requirements for dual diagnosis across all funded mental health and AOD services, supported by training resources and a professional development pathway accessible via the LEx Hub and equivalent AOD sector infrastructure.
- Fund dedicated dual diagnosis training for the mental health and AOD workforce, delivered through the LEx Hub and equivalent AOD sector training infrastructure, as a minimum competency requirement for all services funded under the next Strategy.
- Commission a review of co-occurring need in Tasmania to establish the prevalence, service gaps and cost to the acute system, providing the evidence base for integrated investment.
- The next Strategy should ensure that the cross-portfolio governance mechanism recommended in Section 3.1 explicitly includes co-occurring mental health and AOD as a standing agenda item, with mental health and AOD sector peaks, including lived experience representatives, formally included as participants. MHCT notes that genuine cross-sector integration on this issue requires government to convene and resource the infrastructure – it cannot be sustained through peak body goodwill alone.

Priority Area 9: System Navigation and Access

Background and Gap

Navigating Tasmania's mental health system is genuinely difficult for many Tasmanians. Services exist across multiple funding bodies, eligibility criteria are opaque, referral pathways

are complex, and entry points remain predominantly phone-based, which is not appropriate for all people, including those in acute distress, those with communication difficulties, and many young people. People regularly present to emergency departments not because they need emergency care, but because they cannot find or access appropriate community support.

Australia has prior evidence that community-based navigation and psychosocial support can work at scale. The Personal Helpers and Mentors (PHaMs) program, which operated from 2007 until it was absorbed into the NDIS, provided recovery-oriented, community-based support to Australians with severe mental illness and demonstrated strong outcomes in connection, stability, and reduced crisis presentations.

The case for restoring an equivalent non-NDIS psychosocial support and navigation model outside the NDIS has been well-documented (Community Mental Health Australia, 2024) and is directly relevant to the navigation gaps identified in Tasmania.

Recommendations

- Establish statewide navigation hubs and navigator roles, staffed by people with both sector knowledge and lived experience, that provide clear, up-to-date service information; eligibility guidance; and active warm referral support to help people connect with the right service at the right time.
- Develop and maintain a publicly accessible, up-to-date Tasmanian mental health service directory, building on existing tools like Find Help Tas, with plain, language descriptions, entry criteria, and waiting time information.
- Establish multiple entry points to the mental health system beyond phone, based access, including online chat, text- based referral/ SMS, voice notes, walk-in options in key locations, and community-based navigator roles embedded in primary care, schools, and community organisations.
- Fund peer navigators within the navigation hub model, recognising that people with lived experience are often the most trusted and effective guides for others entering the mental health system for the first time.

Example: *MHCT supports the expansion of models like Find Help Tas, which maps LGBTIQ+, youth and general mental health services with plain, language navigation guides. A whole-of-system equivalent, actively maintained and resourced, would significantly improve access. The navigation hub model, staffed by peer navigators, has been implemented with strong results in other Australian jurisdictions and should be piloted and then scaled in Tasmania.*

Priority Area 10: Strengthening Lived Experience Leadership

Background and Gap

Lived experience leadership, the meaningful, paid and empowered participation of people with lived and living experience of mental illness, and their families and carers, in governance, commissioning, service design and evaluation, has been identified as a priority in Rethink 2020 and is acknowledged as an achievement.

However, lived experience participation remains uneven across the system. It is often tokenistic, unpaid, or limited to consultation rather than genuine decision-making authority. The breadth and diversity of the lived experience community, including Aboriginal Tasmanians, LGBTIQ+ people, people from CALD backgrounds, young people, and people with co-occurring conditions, is rarely reflected in formal lived experience representation.

Recommendations

- Embed lived experience leadership in governance structures for the next strategy, including in the Steering Committee overseeing strategy implementation, ensuring lived experience voices have genuine decision, making authority, not merely advisory roles.
- Embed lived experience in commissioning processes, including in the design of funding criteria, assessment panels, and contract review processes for community mental health services funded under the strategy.
- Embed lived experience in evaluation, including in the codesign of outcomes frameworks (as recommended under 3.4) and in the independent evaluation of the strategy at its midpoint and conclusion.
- Ensure representation of diverse populations within lived experience structures, with dedicated representation from Aboriginal communities, LGBTIQ+ people, young people, CALD communities, and people with co-occurring conditions.
- Resource lived experience participation, through proper remuneration, accessible meeting formats, peer support and preparation time, recognising that meaningful participation requires investment, not just invitation.
- Expand the LEx Hub's leadership training stream to prepare people with lived experience for senior paid roles within community-managed organisations, including team leadership, governance, and quality improvement positions, building a skilled lived experience workforce capable of influencing organisational culture and practice from within.

- Resource both MHLET and Mental Health Families and Friends Tasmania (MHFFTas) as complementary peaks representing distinct but overlapping lived experience constituencies – consumers on one hand, and families and carers on the other. Both organisations require dedicated, sustained investment to fulfil their respective mandates, and both are essential to a genuinely representative lived experience governance ecosystem within the next Strategy.

Analysis of the Seven Principles

The seven principles outlined in the Discussion Paper provide a coherent and values driven foundation for Tasmania's next Mental Health Strategy. They reflect contemporary priorities in mental health reform, continuity, prevention, partnership, lived experience, and evidence, informed practice. However, while conceptually strong, these principles remain largely aspirational. Their current framing lacks the operational clarity, governance mechanisms, and accountability structures required to translate intent into measurable system change; something the new strategy must address.

This gap between values and implementation is a recurring limitation not only in Tasmania, but across many mental health strategies internationally. MHCT's assessment of each principle, drawing on national and international evidence, follows below. For each principle, MHCT identifies the strength, the gap, and explores what operationalisation would require.

Principle 1: Building on Rethink 2020

The commitment to building on Rethink 2020 provides important continuity and acknowledges real progress made over the past decade. Tasmania has seen notable advances in community-based services, crisis response models (including the Mental Health Emergency Response Service and the Youth Mental Health Hospital in the Home pilot), and lived experience inclusion. Maintaining this momentum is essential to avoid reform fatigue and system disruption, and to honour the significant investment made by government, the sector, and communities over ten years of reform.

However, Principle 1 risks positioning the next Strategy as an extension of past reforms, rather than an opportunity for structural recalibration. The Discussion Paper itself acknowledges persistent challenges, particularly unmet psychosocial need, service fragmentation, and workforce pressures, yet the principle does not explicitly articulate how these systemic gaps will be addressed, nor what evidence from Rethink 2020's evaluation will drive material changes in direction.

Tasmania's mental health system faces challenges that incremental reform has not resolved: a 98.4% shortfall in psychosocial support hours (HPA, 2025); chronic workforce recruitment and retention difficulties; and persistent inequity of access for priority populations. These are not implementation gaps, they are structural deficits that require structural responses.

New South Wales' Collaborative Commissioning model and Scotland's Mental Health Strategy (2017–2027) both demonstrate that meaningful system reform, including new governance mechanisms, shared accountability, and cross-sector integration, can be achieved through deliberate structural redesign without a system first reaching crisis point. Where reform has

waited for crisis, as in Victoria's Royal Commission (2021), the cost, human and financial, has been substantially higher.

Tasmania has the opportunity to act structurally before crisis forces the issue. The key lesson is that continuity and transformation are not mutually exclusive: past reforms can provide the foundation without constraining the ambition (see: Royal Commission into Victoria's Mental Health System, Final Report, 2021).

Recommendation

Tasmania's Strategy would benefit from framing Principle 1 as "continuity plus transformation", explicitly committing to a critical evaluation of what worked and what did not under Rethink 2020, and identifying where structural change (not simply continuation) is required. The independent evaluation of Rethink 2020 should be published, with its findings directly shaping the commitments and resource allocations in the next Strategy.

Principle 2: Whole-of-System Approach

The emphasis on a whole-of-system approach reflects a sophisticated understanding of mental health as shaped not only by clinical services, but also by housing, education, employment, social connection and community. This framing aligns with international evidence on the social determinants of mental health and is consistent with the recommendations of the Productivity Commission's Interim Report (2025), which called for stronger cross-sector integration.

Despite its conceptual strength, the principle remains operationally undefined in two distinct but related ways.

At the broadest level, there is a need for a governance structure to facilitate cross-sector coordination across the social determinants of mental health, shared accountability mechanisms, definition of funding models for joint/collaborative commissioning, or clarity on how conflicts between sector priorities and responsibilities will be resolved. Without an appropriate mechanism, "whole-of-system" risks becoming an aspirational phrase without traction.

At a more immediate and operational level, the principle fails to articulate how community-managed mental health organisations fit within the system architecture. From MHCT's perspective, a genuine whole-of-system approach must recognise CMOs not as peripheral or supplementary to the mental health system, but as a core and distinct tier of it, with defined roles, relationships, and accountability alongside the clinical and primary health sectors.

The Discussion Paper's framing risks defaulting to a model in which "the system" means government and clinical services, with the community-managed sector acknowledged in principle but not structurally integrated in practice.

This is not a theoretical concern, it is the operational reality that MHCT's members navigate daily, and it is one of the central reasons that the whole-of-system aspiration has not translated into whole-of-system function under Rethink 2020. A whole-of-system approach that does not explicitly define the place, role, and resourcing of CMOs within the system architecture will reproduce the same fragmentation it purports to address.

A particularly urgent example: the interface between mental health, housing, and NDIS is well-established as a critical gap in Tasmania. Thousands of Tasmanians with severe mental illness lack secure housing and fall outside the NDIS, yet the principle does not commit to any mechanism to address this intersection. New South Wales has developed a collaborative commissioning model that integrates Primary Health Networks and Local Health Districts through shared planning, co-investment and accountability frameworks, providing a concrete example of how whole-of-system intent can be operationalised. (see: NSW Collaborative Commissioning).

At an international level, the UK's Integrated Care Systems (ICS) model demonstrates that system integration requires formalised structures, pooled funding and clearly defined roles, not just policy alignment (see: NHS England, Integrated Care Systems).

The Productivity Commission's Interim Report (2025) identifies the failure of the current National Agreement to drive meaningful integration as one of its most significant deficiencies and explicitly calls for clearer governance and accountability structures in any successor agreement (see: Productivity Commission Interim Report, 2025).

Recommendation

Principle 2 should be operationalised through a formal cross-portfolio governance mechanism, a senior officials' roundtable with shared accountability to the Minister, at minimum, with defined roles, joint reporting requirements, and shared outcomes for the intersections of mental health with housing, disability, justice, employment, and education. MHCT has recommended bimonthly meetings between government and peak bodies, and a roundtable involving the Ministers for Mental Health, Health, and Disability to coordinate across portfolios.

Principle 3: Prevention at Every Stage

The prioritisation of prevention and early intervention is both necessary and backed by a substantial global evidence base. Investing upstream reduces long-term demand on acute services, improves population wellbeing, and is more cost-effective than treating mental illness after it has become severe or chronic.

This principle aligns with Tasmania's Draft 20-Year Preventive Health Strategy and is consistent with national and international reform directions.

Despite its strong endorsement, prevention remains the least operationalised element of the Discussion Paper. There is no indication of how prevention will be funded, which interventions will be prioritised, or how outcomes will be measured. There are no defined allocations separating prevention expenditure from acute and clinical expenditure, which means that in resource competition, prevention will consistently lose, as has historically been the case.

This pattern has been observed across multiple Australian mental health strategies and is widely recognised as one of the most persistent structural failures of the policy environment.

Australia's National Preventive Health Strategy (2021–2030) provides a more structured model, with defined priority areas, specific targeted actions, an accompanying investment framework, and monitoring mechanisms that allow progress to be tracked publicly (see: National Preventive Health Strategy 2021–2030).

Globally, the WHO Comprehensive Mental Health Action Plan (2013–2030) links prevention to specific, measurable global targets and country-level accountability mechanisms. Each of the Plan's four objectives is linked to explicit indicators to monitor implementation, progress and impact. The plan serves as a benchmark for assessing whether national strategies are operationalising prevention with genuine accountability, not just principle (see: WHO Comprehensive Mental Health Action Plan 2013–2030).

Domestically, MHCT's own mental health literacy model, underpinning the Take a Minute campaign and the Youth Peer Wellbeing Program, demonstrates that prevention can be operationalised at community level when it is funded, implemented through trusted organisations, and evaluated rigorously.

Recommendation

Principle 3 should be operationalised through a dedicated prevention funding allocation within the next Strategy, protected from reallocation to acute services. The Strategy should specify:

a) a minimum proportion of the mental health budget allocated to prevention and early intervention;
b) a defined portfolio of evidence-based prevention programs, prioritised by population impact; and
c) measurable prevention outcomes with annual public reporting. This is consistent with MHCT's broader call for the Strategy to move from aspirational statements to operationalised commitments.

Principle 4: Partnership

The principle of partnership reflects a genuine commitment to collaboration across government, non-government and community sectors. It aligns with contemporary models of co-production, integrated care, and systems-based approaches to mental health reform. The existing relationship between the Department of Health, MHCT, Primary Health Tasmania, and community sector organisations is a genuine asset on which the next Strategy can build. The principle does not address the inherent power dynamics of partnerships between government and non-government sector bodies. Questions remain about how decision-making authority is shared, how resources are allocated across partners, and how accountability is maintained when priorities between government and the sector diverge. Without these clarifications, the risk is that "partnership" becomes consultative rather than genuinely collaborative, with government retaining substantive decision-making while the sector provides legitimacy.

This matters particularly for MHCT, as the peak body with the mandate to represent the community managed mental health sector and challenge policy positions when the evidence demands it. Meaningful partnership requires structural support for that role, including genuine responsiveness to sector advice, not just consultation processes.

What Good Practice Looks Like

The Queensland Mental Health Commission has developed models of co-design and partnership that go beyond consultation, establishing mechanisms for shared accountability in reform implementation. Critically, QLD has also recognised that partnerships require dedicated resourcing and infrastructure, they do not emerge from good intentions alone (see: Queensland Mental Health Commission).

Scotland's Mental Health Strategy (2017–2027) operationalised partnership through a formal bi-annual forum of mental health stakeholders established to guide implementation, alongside specific action items with defined sector responsibilities. A human rights-based approach, using the PANEL principles of Participation, Accountability, Non-discrimination, Empowerment and Legality, underpins the strategy's engagement model, providing a principled framework for how partnerships operate, not just that they exist.

Recommendation

Principle 4 should be operationalised by establishing formal partnership structures with defined roles, clear decision-making authority, and shared accountability. This includes: a bimonthly sector-government forum with MHCT and key peak bodies; formal co-commissioning arrangements for community-managed mental health services; and a commitment by government to structured and timely engagement with sector submissions and peak body recommendations, including providing reasons where recommendations are not adopted,

ensuring that consultation is demonstrably consequential rather than performative., including reasons where recommendations are not adopted. Partnership must be structured, not aspirational.

MHCT acknowledges the inherent tension in its dual role: as both a sector advocate, with a mandate to represent the interests of community-managed mental health organisations – and a strategic partner in the development of government policy that must serve all Tasmanians. Genuine partnership requires MHCT to hold both roles honestly and requires government to engage with sector advocacy not as lobbying to be managed but as evidence to be weighed. This tension is a feature of effective co-design, not a flaw to be resolved.

Principle 5: Lived Experience

Strength

The inclusion of lived experience as a central principle reflects one of the most important shifts in contemporary mental health reform globally. Tasmania has made meaningful progress in this area through Rethink 2020, particularly in recognising the value of lived experience in service design and establishing peer workforce roles.

The LEx Hub, launched by MHCT in November 2024, represents a significant practical step toward growing and professionalising the lived experience *workforce*, that is, people with lived and living experience employed in paid roles within community-managed services to provide peer support, supervision, and sector leadership. This is distinct from, though complementary to, lived experience *advocacy and consultation*, the participation of people with lived experience in governance, policy design, and system accountability as community representatives rather than as paid workers.

Both functions are essential to a genuinely recovery-oriented system, and both require dedicated and sustained investment. The risk in current policy settings is that progress in one area is cited as evidence of progress in the other, obscuring the significant gaps that remain in lived experience leadership at the governance and commissioning level.

Gap: Consultation Rather Than Leadership

Despite this progress, lived experience in Tasmania remains predominantly positioned as consultative rather than authoritative. The Discussion Paper does not clearly articulate how lived experience will be embedded in governance structures, commissioning decisions, or evaluation processes. The risk is that the next Strategy mirrors the pattern seen across many jurisdictions: people with lived experience are invited to provide input but do not share in decisions, and their contributions are weighed against other considerations without formal authority.

There is also a diversity gap: formal lived experience representation tends to be dominated by those who are already connected to the sector, leaving Aboriginal Tasmanians, LGBTQIA+ people, young people, CALD communities and people with co-occurring conditions under-represented.

What Good Practice Looks Like

Scotland's reforms have increasingly recognised that meaningful lived experience inclusion requires *power-sharing, not just participation*. The Scottish Government's Diverse Experiences Advisory Panel, established with Mental Health Foundation, Voices of Lived Experience and the Health and Social Care Alliance, is explicitly designed to inform and shape government mental health policy, with particular attention to diversity and intersectionality. The panel focuses on delivery of reform, review of strategy, and advising the Scottish Government on how to engage with lived experience more effectively across the system (see: Scotland Mental Health Strategy 2017–2027).

Victoria's Royal Commission (2021) went further, recommending that the new Mental Health and Wellbeing Commission include commissioners with *direct lived experience of mental illness or psychological distress and lived experience as a family member or carer*, embedding lived experience in the highest levels of system oversight and accountability (see: Royal Commission into Victoria's Mental Health System, Recommendation 46).

Recommendation

Principle 5 should be operationalised through a formal lived experience leadership framework embedded in the next Strategy, specifying:

a) paid, representative lived experience roles in strategy governance and commissioning;
b) a co-design process for outcomes measures with lived experience participants having genuine authority over what is included;
c) diversity requirements to ensure representation of Aboriginal communities, LGBTQIA+ people, young people, and CALD communities; and
d) dedicated investment in the LEx Hub's leadership training stream to build the pipeline for these roles.

Principle 6: Alignment with Other Strategies

Strength

The Strategy's acknowledgement of the broader policy ecosystem, including alignment with the Preventive Health Strategy, Suicide Prevention Strategy, Disability Strategy, and Child and Youth Wellbeing Strategy, reflects an understanding of mental health as a cross-cutting issue that cannot be addressed by one portfolio alone. This is consistent with both national and international reform thinking, and with MHCT's own advocacy for cross-portfolio integration.

Gap: Alignment as Intention, Not Mechanism

At present, alignment is described in conceptual terms without any operational model for how it will be achieved. There is no indication of how duplication will be avoided, how shared outcomes will be defined and measured, or how policy conflicts between strategies will be resolved. In the absence of formal integration mechanisms, "alignment" tends to mean that strategies are written with awareness of each other, not that they are jointly implemented, jointly governed, or jointly accountable.

A concrete example: the intersection between mental health and disability policy has been a persistent source of service gaps in Tasmania, with thousands of Tasmanians ineligible for NDIS support, and unable to access foundational psychosocial support and recovery services. The Discussion Paper acknowledges this interface but does not propose an operational mechanism to resolve it, despite it being one of the most consistently identified system failures in sector feedback.

What Good Practice Looks Like

South Australia's mental health reforms have emphasised alignment through shared planning and reporting structures across sectors-providing a model for how formal integration can move beyond policy-level acknowledgement to operational coordination (see: SA Health Mental Health).

The Victorian Royal Commission's recommendation for a Mental Health and Wellbeing Secretaries' Board, chaired by the Department of Premier and Cabinet and including Secretaries from Health, Families, Education, Justice and Treasury, demonstrates how cross-portfolio accountability can be formalised at the most senior level of government, rather than left to informal coordination between departments.

Recommendation

Principle 6 should be operationalised through a formal cross-strategy coordination mechanism with: (a) shared outcome indicators identified across strategies (e.g., housing and mental health; youth mental health and education); (b) a senior officials' body with responsibility for identifying and resolving policy conflicts; and (c) a joint public reporting requirement covering shared outcomes (d) clear articulation of how the strategy will specifically measure its performance against its stated core principles and strategic objectives. This must be a structured function of government, not a statement of intent.

Principle 7: Evidence-Informed

Strength

The commitment to evidence-informed practice is essential and reflects a broader shift toward outcomes-based policy in mental health. Tasmania has made genuine efforts in this area, including the commissioning of an independent evaluation of Rethink 2020 by the Tasmanian Centre for Mental Health Service Innovation, and the consistent use of credible analysis to inform policy submissions and budget priorities.

Gap: No Data or Evaluation Framework

Despite the principle's importance, it is not supported by a concrete data and evaluation framework. There is limited detail on what data will be collected, how outcomes will be measured across the system (beyond service activity counts), how evidence from evaluation will feed back into decision-making, and who will be responsible for independent oversight of the evidence base. Without these foundations, evidence-informed practice risks meaning "we will reference research in policy documents" rather than "the system learns and adjusts based on rigorous, ongoing evaluation of what works."

The Productivity Commission's Interim Report (2025) reinforces this concern, finding that inadequate data systems and fragmented reporting have been major barriers to accountability under the current National Agreement, and explicitly calling for integrated data frameworks and transparent public reporting as prerequisites for reform that actually delivers.

What Good Practice Looks Like

The Productivity Commission's Inquiry into Mental Health (2020) emphasised the importance of robust data systems, real-time monitoring, and accountability frameworks in driving reform, including: standardised outcome measurement tools; shared data systems across health, mental health, housing and other sectors; and independent review of system performance (see: Productivity Commission Mental Health Inquiry Report, 2020).

The WHO Comprehensive Mental Health Action Plan (2013–2030) links each of its four major objectives to specific, measurable global targets and indicators, providing a model for how a strategy's principles can be tied to accountability mechanisms that are transparent and publicly reported (see: WHO CMHAP 2013–2030).

Victoria's Royal Commission recommended a Mental Health and Wellbeing Outcomes Framework to drive collective responsibility and accountability across government, with the Cabinet subcommittee using this framework to monitor outcomes at the highest level of government.

Recommendation

Principle 7 should be operationalised through a comprehensive Tasmanian Mental Health Data and Evaluation Framework, developed jointly with the sector and with lived experience co-design, that specifies: (a) standardised outcome measures capturing what matters to people, not only service activity; (b) cross-sector data sharing protocols; (c) annual independent, publicly available performance reporting; and (d) a formal mechanism by which evaluation findings are used to adjust strategy implementation in real time.

Overall Assessment: From Aspiration to Architecture

Collectively, the seven principles articulate a compelling vision for Tasmania's mental health system. They reflect contemporary values, align with national and international reform directions, and draw on a decade of learning from Rethink 2020. On their own terms, they are well-constructed and difficult to disagree with.

However, their current formulation illustrates the most persistent challenge in mental health policy: the gap between what matters and how change happens. Principles are necessary but not sufficient. They provide direction, but not the mechanisms required for implementation.

Without clearer governance structures that support integration, defined accountability, adequate resourcing, and measurable outcomes, the next Strategy risks reiterating existing commitments without delivering substantive system transformation. Tasmania has seen this pattern before: strong statements of principle, followed by implementation that falls short of intent because the operational architecture was not built to support it.

MHCT's overarching recommendation on the principles is this: each of the seven principles should be accompanied by an operational section in the Strategy that specifies what it means in practice, who is responsible, what will be funded, how progress will be measured, and what will happen if targets are not met. Only then do principles become commitments.

Conclusion: A System That Works Across Levels

The key insight from a systems perspective is that no single intervention will resolve the challenges identified in the Strategy. Improvements at one level, such as increasing service availability, will have limited impact unless accompanied by changes across individual, community, organisational, and system levels.

The next Mental Health Strategy must therefore move beyond isolated reforms and adopt a coordinated, system-wide approach, where:

- individuals are supported and empowered
- communities are engaged and inclusive
- organisations are resourced and accountable
- the system is integrated, transparent, and responsive

Without this, there is a significant risk that existing challenges, particularly around access, navigation, and equity, will persist despite continued reform efforts.

MHCT acknowledges that this submission contains more than fifty individual recommendations spanning ten priority areas. We do not present these as a demand for simultaneous action, nor do we underestimate the resource, workforce, and governance investment that genuine system reform requires. Meaningful change in a complex system takes time, political will, and careful sequencing, and we recognise that not everything can or should happen at once.

What we are asking for is a strategy that names the right destinations, commits to the journey, and establishes the accountability structures to ensure progress is tracked and reported. Prioritisation is not a retreat from ambition; it is what makes ambition achievable.

MHCT therefore welcomes the opportunity to work alongside the Department of Health, Primary Health Tasmania, and sector partners to identify implementation priorities, sequence reform in a way that is realistic and sustainable, and ensure that the voices of people with lived experience, community-managed services, and priority populations remain central to those decisions over the life of the strategy. We do not see this submission as the end of a conversation, we see it as the beginning of one, and we are ready to be a genuine partner in what comes next.

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