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**Mental
Health
Council**
OF TASMANIA



Hobart Digital Mental Health Roundtable 2026

Report

Closing the Distance: Digital Mental
Health as a Tool for Equity in Tasmania

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About Us

The [Mental Health Council of Tasmania](https://www.mhct.org) (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.

The Mental Health Council of Tasmania acknowledges the Palawa people of Lutruwita as the traditional and original owners, and continuing custodians of the land on which we work. We recognise and value their rich and continuing connection to country, to land, water and culture, and pay respects to Elders past and present.

We acknowledge people with lived experience of mental ill-health and recovery and we recognise our work relies upon valuing, respecting, and drawing upon the lived experience and expert knowledge of consumers, their families, carers and friends, service providers, their staff, and local communities

1. Executive Summary

On Friday 26 June 2026, the eMental Health International Collaborative (eMHIC) and the Mental Health Council of Tasmania (MHCT) co-hosted the Hobart Digital Mental Health Roundtable at St Lukes Hobart, under the theme Closing the Distance: Digital Mental Health as a Tool for Equity in Tasmania. The invitation-only, full-day event (10:00 am - 4:00 pm) brought together approximately 45 Tasmanian mental health leaders, service providers, people with lived and living experience, researchers, policymakers, First Nations representatives, and national and international digital mental health experts from Australia, Canada, New Zealand, and beyond.

The Roundtable was convened at a deliberate moment: Tasmania is finalising its next Mental Health Strategy (Rethink and Beyond), alongside the 20-Year Preventive Health Strategy, the Child and Youth Wellbeing Strategy, and in the context of the National Digital Health Strategy 2023–2028. Tasmania does not currently have a statewide Digital Mental Health Framework, and the Roundtable was explicitly designed to help close that gap by generating a practical, stakeholder-endorsed case for one. It is important to note that Tasmania is four years into implementing a 10-year Digital Health Transformation strategy (Bluegum), which encompasses mental health services and represents significant existing digital health infrastructure; any Digital Mental Health Framework could be developed in alignment with this existing strategy.

The day combined plenary presentations across three thematic sessions (the case for a framework; local and national innovation in practice; and artificial intelligence in mental health) with two structured, facilitated table-based Roundtable Exercises in which participants worked through guided discussion questions and reported back key points to the whole group. Presenters included Tasmanian, Australian, Canadian and international voices spanning government (the Australian Government Department of Health, Disability and Ageing), peak and community organisations (Beyond Blue, WellMob, eMHPrac, MHCT), international bodies (the Mental Health Commission of Canada, eMHIC), industry/innovation (PractaLuma/Luma, Dial A Mate Mental Health Australia, ORCHA), and academia (Monash University, Melbourne, University of Tasmania, University of Alberta).

Several consistent messages emerged across the day:

- Digital mental health should be embedded as core infrastructure within Tasmania's next Mental Health Strategy, not treated as a disconnected pilot program or an optional add-on.
- "Progress moves at the pace of trust" - repeated throughout the day as an organising idea - meaning that technology adoption depends less on the sophistication of a tool than on whether clinicians, communities, and consumers trust it, and trust the system that endorses it.
- Digital access is not equitable in Tasmania. Low rates of household internet connectivity and digital/health literacy, and gaps in mobile coverage in rural and remote areas, must be

treated as a foundational prerequisite for any digital mental health framework or strategy, not an afterthought.

- First Nations leadership and genuine co-design (not retrospective consultation on an already-built tool) must be embedded at every stage of design, governance, and evaluation.
- AI presents genuine opportunity (triage, system navigation, app quality assurance, multilingual support) but also genuine risk (bias, privacy, over-reliance, new forms of digital harm such as gambling-like loot boxes and companion-app misuse), and Tasmania currently has no governance framework to manage this.
- Any Tasmanian framework should integrate with, rather than duplicate, existing strategies and services, and should learn from – rather than reinvent - international best practice (Canada, Ireland, Scotland, New Zealand, Denmark, Singapore).

The Roundtable concluded with a call to formalise these discussions into a statewide Digital Mental Health Framework to inform Rethink and Beyond, an offer of continued international collaboration (particularly with the Mental Health Commission of Canada), and recognition of Krista Vanderheide (Australian Government Department of Health, Disability and Ageing) with the eMHIC Global Leadership Excellence Award for 2025 and induction into the eMental Health Hall of Fame.

This report provides a detailed, session-by-session account of the day, drawing on the concept note, the final agenda, and the full-day session transcript.

2. Event Overview

Theme	Closing the Distance: Digital Mental Health as a Tool for Equity in Tasmania
Date	Friday, 26 June 2026
Time	10:00 am – 4:00 pm
Format	In-person, invitation only
Location	St Lukes Hobart, 72 Elizabeth Street, Hobart, TAS 7000, Australia
Host organisation	eMental Health International Collaborative (eMHIC) and Mental Health Council of Tasmania (MHCT)
Facilitators	Dr M Tasdik Hasan (Australia) and Professor Andy Greenshaw (Canada)

The Roundtable followed a three-part structure across the day, each anchored by a set of plenary presentations followed by a facilitated table-based discussion exercise:

- Part A: The Case for a Tasmanian Digital Mental Health Framework: Why Tasmania needs a statewide digital mental health strategy and what it should contain.
- Part B: Digital Mental Health in Practice: local innovations and national models, including what has worked, for whom, and under what conditions.
- Part C: Artificial Intelligence in Mental Health: potential, risk and responsibility, examining AI applications, governance gaps, and safeguards.

Two structured Roundtable Exercises gave participants dedicated table discussion time against the Part A and Part C discussion questions respectively, each followed by a whole-room report-back. A shorter, more informal cross-table exchange also occurred around Part B content during the networking breaks and Q&A.

The event drew participation from Tasmanian government (Department of Health mental health reform team), Primary Health Tasmania, the University of Tasmania, community-managed organisations, First Nations representatives and organisations (including WellMob), people with lived and living experience, and international guests travelling specifically for the event from Canada and elsewhere. Both Dan Vautin (CEO, MHCT) and Dr Tasdik Hasan noted this was a larger turnout than expected, reflecting significant sector appetite for the conversation.

3. Background and Rationale

The concept note framed the case for the Roundtable around a convergence of rising demand and constrained supply. The April 2026 Psychology Supply and Demand Study found that access to psychology services in health settings is already falling short by 57.3%, projected to reach a 96.6% shortfall by 2038, a workforce crisis to which Tasmania, as Australia's most geographically dispersed and workforce-constrained jurisdiction, is disproportionately exposed.

At the same time, demand for mental health services in Tasmania has grown, driven by the enduring impacts of COVID-19, economic pressure, the mental health consequences of climate change, and structural inequities that leave rural, remote, and disadvantaged communities with less access to support. Nearly two-thirds of Tasmanians live outside Hobart; rural and remote Tasmanians experience higher rates of psychological distress and suicide than urban counterparts, and face longer waits, fewer specialists, and significant transport barriers.

. Digital technologies including telehealth, mobile health applications, digital navigation platforms, online therapy, peer support networks, and AI-assisted tools, were framed in the concept note as holding significant, largely unrealised potential to address these gaps. Participants were clear, however, that digital approaches were discussed as a complement to, rather than a replacement for, the mental health workforce and face-to-face services, most valuable where they extend the reach of existing services and connect people into human support, rather than substitute for it. However, Tasmania does not yet have a statewide Digital Mental Health Framework or strategy to guide investment, coordinate existing initiatives, set quality standards, or ensure digital tools reach those who need them most. This gap exists within an existing digital health context: Tasmania's Bluegum Digital Health Transformation, a 10-year strategy now four years into implementation, provides foundational digital health infrastructure and governance that a Digital Mental Health Framework could build on and align with rather than duplicate. The concept note was explicit that digital access itself is not equitable: Tasmania has among the lowest rates of household internet connectivity and digital literacy in Australia, a point echoed repeatedly and with specificity throughout the day (see Sections 6 and 7).

The timing was framed as deliberate: Tasmania's next Mental Health Strategy (Rethink and Beyond) is under development, alongside the 20-Year Preventive Health Strategy and the Child and Youth Wellbeing Strategy, within the broader architecture of the National Digital Health Strategy 2023–2028. The Roundtable's stated purpose was to ensure the next strategy is "digitally literate, practically grounded, and ambitious", proceeding from the premise that digital mental health is a core component of a modern, equitable mental health system, not a supplement to it.

4. Opening and Welcome

Welcome to Country and opening acknowledgements

The day opened with an Acknowledgement of Country, recognising the Palawa people as the traditional and original owners and continuing custodians of the land, alongside an acknowledgement of people with lived experience in the room and of the "dual hats" many attendees wore as both professionals and people with their own lived experience.

Dan Vautin, CEO, Mental Health Council of Tasmania

Dan Vautin formally welcomed the Roundtable, thanking international guests (some travelling from as far as Canada), interstate ("mainlander") visitors, partner organisations, members, University of Tasmania academics, and the MHCT team for their work in organising the day.

He set out MHCT's role as the peak body for psychosocial support and recovery in Tasmania, daily living supports, employment support, housing, and social prescribing, and described Tasmania's distinctive profile: a population split roughly evenly between the north and south, with the northern population notably dispersed. He identified Tasmania's "one wicked problem" as population dispersion, compounded by limited internet connectivity, transport disadvantage, long waiting lists, and cost barriers in rural areas.

On demand drivers, Mr Vautin cited adverse childhood experiences (abuse, neglect, domestic violence, parental illness, and substance use) as a significant upstream driver of adult mental ill-health, noted that around 30% of Tasmania's population sits in the lowest economic quintile, greater than any other Australian state or territory, and highlighted a high rate of substance use co-occurring with mental illness (implicated in over half of suicides in the state's most recent suicide data, per his account). He also named system-level pressures: workforce shortages, geographic dispersion, casualisation, and comparatively lower remuneration than other states, which constrains Tasmania's ability to attract and retain a professional mental health workforce.

Balancing this, he highlighted genuine Tasmanian strengths: proximity between decision-makers and community ("I can walk down the street and run into decision makers..."), making Tasmania, in his words, "a fantastic place to pilot ideas," plus a close-knit service and community sector.

"They don't care if it's digital. They don't care what it is. They need the support... am I getting what I need, when I need it, where I need it, and can I afford it?" - Dan Vautin, on centring the end user rather than the technology

He named the absence of a digital mental health framework as the reason for the day, framed the Roundtable as the start of a conversation rather than its conclusion, and flagged parallel

Tasmanian policy processes already underway - the 20-Year Preventive Health Strategy (in its first year of implementation) and the soon-to-be-released mental health plan.

Dr M Tasdik Hasan, MHCT / Roundtable Facilitator

Dr Hasan spoke to a consistent pattern he had observed across four recent MHCT policy submissions he had co-authored: submissions to the the 20-Year Preventive Health Strategy, the Disability Inclusion Plan, the Suicide Prevention Strategy implementation plan, and the forthcoming Mental Health Strategy, namely that digital mental health was consistently a "missed opportunity" in Tasmanian strategic documents, mentioned only in passing if at all, despite the sector having entered the era of artificial intelligence.

He illustrated this with lived accounts from his own research and MHCT project work, including the ACDC (Assisting Communities through Direct Connection) project interviewing Bangladeshi and Nepali communities in Tasmania. Participants reported not seeking mental health support out of fear that disclosure could jeopardise a permanent residency application, and at least one participant, a young man with a diagnosed mental illness, reported discontinuing medication because psychiatric consultation was unaffordable, despite the community having near-universal mobile phone and internet access.. He also drew on his own PhD research co-designing a Bangla sign-language mental health resource bank with Deaf communities in Bangladesh, using this as a case study of what happens when digital mental health tools are built without a specific population's access needs in mind. He noted that the situation for Tasmania's Deaf community was strikingly similar: Auslan interpreting support exists, but he could not identify any sustainable intervention directly targeting the mental health needs of the Deaf community in Tasmania specifically. He framed this as an acute version of a pattern raised elsewhere in the roundtable, that "generic" digital mental health platforms tend to assume a level of language access, digital literacy, or cultural fit that excludes particular groups by default, whether Deaf communities, CALD populations, or people in rural and regional areas. He put the Deaf mental health gap in Tasmania to the room as an open question, framed not as an isolated service gap but as a concrete test case for whether digital mental health investment can be designed inclusively from the outset, rather than retrofitted for excluded groups after the fact.

Dr Hasan reported that MHCT's most recent submission on the forthcoming Mental Health Strategy had proposed ten priority areas, one of which specifically addressed embedding digital mental health, framed as a potential hybrid/complementary model, not a replacement for traditional services, but a supplementary mechanism that, for some remote parts of Tasmania, may be the only practical way to access support. He named youth co-design, AI governance, and locally generated University of Tasmania evidence as components that could feed directly into the strategy.

"The missing piece is a statewide framework to bring digital mental health from the margin to the centre. And maybe that's the discussion we are starting today." - Dr M Tasdik Hasan

5. Session A – Global and National Perspective on Digital Mental Health

Professor Anil Thapliyal, Executive Director, eMHIC

Professor Thapliyal reframed from the day's subject: "the conversation is not about digital... it's about people. This is about trust." He argued digital mental health conversations often polarise rooms because they are misunderstood as being about technology, when they are really about meeting consumers where they already are (noting that phone calls are now the eleventh most common use of a smartphone, behind texting).

He challenged the assumption that traditional, Monday–Friday, 9–5 service models suit a population whose crises do not observe office hours, and set out eMHIC's international frame of reference: eMHIC's work is supported by the governments of Canada, the United States, Australia, New Zealand, England, Scotland, Ireland, Wales, Denmark, Sweden, Singapore, the Netherlands, and the Philippines, and collaborates with the United Nations, UNICEF, WHO, and the APEC Digital Hub for Mental Health. He described eMHIC's "GLOCAL" (Think Globally, Act Locally) philosophy of adapting international best practice to local context rather than importing it wholesale.

He set out a five-pillar model of what "good" looks like internationally, addressed to the Tasmanian context:

- Lived experience at the centre - "if it does not work for the person with the lived experience, their families and carers, then it does not work at all."
- Evidence - the role of academic partners (citing collaborations with universities globally) in establishing what is safe and effective.
- Policy and strategy - citing the Irish government's 2026–2030 digital mental health strategy (launched in the Irish Parliament with the direct, personal backing of the Minister for Mental Health) as an example of a strategy backed by ring-fenced funding, without which "it's just going to be siphoned off to something else."
- Workforce development - noting a McKinsey finding that 77% of people needing mental health care are seen by peer support workers rather than clinicians, and that 93% of the clinical workforce want to embrace innovation but do not know where to find credible tools.
- Industry and collaborative frameworks - "the only way we can create symphony is when we let each maestro play their own instrument."

He introduced the international peer-learning concept of "brag and steal" - a government-to-government knowledge exchange in which jurisdictions share proven approaches rather than duplicating development effort - and cited recent or ongoing eMHIC-facilitated collaborations spanning Ireland, Singapore, Denmark, Sri Lanka, and China as evidence this model works in practice.

Krista Vanderheide, Assistant Secretary, Mental Health and Suicide Prevention Division, Australian Government Department of Health, Disability and Ageing

Ms Vanderheide (whose portfolio covers system enablers including national data, research, system navigation, and the Medicare Mental Health Check-in service) shared two case studies from the Commonwealth's recent experience commissioning digital mental health at scale.

The Digital Mental Health Competitive Grant Program

This program consolidated many years of fragmented, individually negotiated digital mental health grants into a single competitive process; demand (~\$430 million in applications) substantially exceeded available funding. The central lesson she drew was that government initially "had no idea what it was doing" relative to the sector's own expertise, and that building trust with a sector being told "some of you may lose your funding" required sustained, honest engagement rather than a top-down announcement.

Medicare Mental Health Check-in

A fully digital, low-intensity CBT service, now offering both a practitioner-supported and a self-guided pathway. Three months into implementation, the service had received over 200 referrals and conducted over 300 appointments, with a target of serving up to 150,000 Australians a year within three years. She described running a two-stage request-for-tender process specifically to test market capability before the competitive tender, which had the secondary effect of prompting the sector to organise itself into multi-partner consortiums (combining academic, clinical, and digital delivery expertise) ahead of the formal process.

She distilled three transferable lessons for Tasmania:

- Talk to, and learn from, the sector before designing a service or program - assume the sector, not government, holds the operational expertise.
- Test feasibility and capability with the market before committing to a delivery model at scale.
- New digital services enter an existing, crowded ecosystem of variable quality; governments must be transparent about effectiveness and safety, and cannot rely on the government brand alone to earn trust - referral pathways need to run through individuals and services the community already trusts.

Professor Andy Greenshaw, University of Alberta / Roundtable Co-Facilitator

Professor Greenshaw's presentation ranged across the scale of change now underway in AI and digital health, framed around a set of provocations rather than a single argument. Key points included:

- Generative AI has moved from novelty to global infrastructure in a few years (citing ChatGPT's launch in July 2023 and 20 million users within six months). ; he G7 iss

- Data privacy in the current environment is, in practical terms, "an illusion", commercial platforms already collect and monetise vast personal data; the meaningful policy question is not whether data is collected, but who consents to its use for health benefit and under what governance.
- Health systems are frequently built on outdated infrastructure (citing concerns about legacy electronic health record vendors) that cannot support the "streaming," real-time data needed for timely digital mental health decision-making; population averages are a poor substitute for individual, real-time signals.
- Successful digital implementation is conditional on genuine co-creation and stakeholder buy-in: "you can have the highest quality things that you didn't co-create... they don't identify it, they don't want it." No single stakeholder group, clients, clinicians, policymakers, can be sidelined without undermining adoption.
- Physical and mental health must be managed jointly, not as parallel, disconnected systems.

"Care is the destination... Digital does not create distance. It closes it." - A framing echoed across several speakers during the day, including Ridhi Malhotra (PractaLuma)

6. Session B - First Nations Perspectives, Equity, and Practice-Based Innovation

Juanita Wilson, First Nations Equity and Inclusion Advisor, Beyond Blue

Ms Wilson grounded her remarks in the First Nations social and emotional wellbeing model, a holistic view of health encompassing connection to culture, community, family, and spirit, not only the individual. She reframed the day's central question: in a First Nations context, the issue with digital and AI-enabled mental health tools is not simply which platforms are available, but whether those tools strengthen connection or weaken it.

She distinguished authentic co-design from token consultation, arguing genuine co-design means First Nations peoples having a voice at every stage of design, delivery and evaluation - including employment within the organisations building the tools, not only participation as end-users consulted after a prototype is built. She warned that poorly designed digital referral pathways can "bounce" First Nations clients between services, forcing them to retell their story multiple times and adding a further layer of retraumatisation.

On Tasmania specifically, she highlighted a growing digital divide within the state: some areas cannot access the NBN and rely on Starlink, which is poorly known in community and does not function well under tree cover - meaning some residents must travel one to three hours to a community centre to access services online. She also noted the loss of 3G coverage has had a disproportionate impact in these areas, since lower-frequency signals travel further than the 4G/5G replacement (which requires denser tower infrastructure).

"Access is not the same as equity. Someone might have a phone or internet connection, but may still not have access to support that feels culturally safe or relevant, or worth engaging with." -

Juanita Wilson, Beyond Blue

She closed with a call to remunerate First Nations people for shared cultural knowledge and expertise, to invest in Aboriginal-led digital and AI innovation in Tasmania specifically, and to protect Indigenous cultural and intellectual property from misuse.

David Edwards, WellMob

Mr Edwards introduced WellMob, a digital library of culturally credible, Aboriginal and Torres Strait Islander-specific wellbeing resources (apps, websites, podcasts, videos, and positive social media content) designed around the holistic social and emotional wellbeing framework developed by Dr Clinton Schultz and Professor Pat Dudgeon and colleagues at the University of Western Australia's Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.

He reiterated the principle "nothing about us without us," calling for Aboriginal and Torres Strait Islander people to be embedded at the centre of design, delivery and evaluation, and encouraged the room to draw on local talent already present (naming Juanita Wilson and other community members at the table) to facilitate community discussions. He also highlighted SMS for Dads (and

its Aboriginal-specific adaptation, SMS for Deadly Dads), a free, text-based perinatal mental health intervention sending three messages per week from a partner's third month of pregnancy through the baby's first month - designed to reach fathers, a group he noted is frequently excluded from perinatal mental health information.

Rhiannon Hamilton, Senior Project Officer, MHCT (and an impromptu contribution from a local GP, Dr Jess Archer)

Rhiannon Hamilton, who leads MHCT's Lived Experience Training Hub, spoke about bringing a lived-experience lens into peer worker training and organisational support work, and introduced an unplanned conversation with a local general practitioner and former rural nurse (with experience on Bruny Island and in Huonville) who argued that the centrality of general practice and the family-doctor relationship in Tasmanian communities is easily overlooked in digital mental health discussions.

"Very, very rarely do I say to my clients in distress... why don't you get on an app? I say, where do you find your joy? How do you connect to your community?" - Dr Jess Archer, GP and former rural nurse, in conversation with Rhiannon Hamilton

The exchange reinforced a theme that recurred throughout the day: digital tools were consistently framed by presenters as intended to strengthen, not substitute for, human relationships - whether the family doctor, the community elder, or the peer support worker.

Heidi Sturk, Director, eMHPrac

Ms Sturk (who noted she grew up in and attended high school in Tasmania) described eMHPrac's twelve years delivering free digital mental health literacy training to health practitioners, funded continuously by the Australian Government Department of Health since 2013. eMHPrac produces printed and downloadable directories of evidence-based digital mental health programs, apps and resources, deliberately designed as a simple, desk-level reference for time-poor practitioners rather than requiring them to search online directories from scratch.

She identified five key learnings from a decade of workforce-facing practice:

- Trust operates on multiple levels simultaneously, trust in eMHPrac itself, trust in the training, trust in the resources, and (separately) the practitioner's trust in their own relationship with the client, which she described as a precondition for confidently introducing a digital tool.
- Practitioner context varies enormously: a GP's five-minute consultation differs completely from a psychologist's therapeutic hour, and "what works" must be tailored accordingly.
- Partnerships with services, communities and organisations multiply impact and uptake far beyond what training alone achieves.
- Follow-up matters, one-off training does not establish whether practitioners are actually using digital tools, or what is and is not working for them in practice.

- The workforce is wider than clinicians - paramedics, police, and teachers are increasingly seeking this information despite falling outside eMHPrac's funded remit.

She reported hearing repeated accounts in face-to-face workshops of practitioners describing tools that had, in their view, been life-saving for clients able to access support at 2am when no practitioner or family member was available. She closed by calling for digital mental health content to be embedded in tertiary curricula, so graduates enter the workforce already equipped to incorporate these tools into practice.

Liz Payne, Founder, ORCHA (recorded presentation)

Dr David Bakker (MoodMission) was unable to attend on the day; in his scheduled slot, the Roundtable played a recorded presentation from Liz Payne, founder of ORCHA (the Organisation for the Review of Care and Health Apps), one of the world's leading digital health app assurance bodies.

Ms Payne described the limitations of manual, spreadsheet-based app assurance processes, noting that even after a year of manual assessment, both the technologies assessed and the underlying standards and regulations had already changed, and outlined ORCHA's response: Atlas, a scalable assurance platform (over 40,000 assessments completed to date) built around four principles: scalability, consistency, repeatability, and governance (a full audit trail).

She presented a case study from Catalonia, where adopting the Atlas platform reduced compliance-check time by over 90% (from roughly 200 hours per product assessment) and enabled the region to assure roughly ten times as many digital health products with the same workforce, without changing the underlying assurance standard itself.

"It's not about the standard, it's about the system." - Liz Payne, ORCHA

7. Roundtable Exercise 1 - The Case for a Tasmanian Digital Mental Health Framework

Following the morning sessions, participants worked in facilitated table groups against the Part A discussion questions (see Appendix A), before each table reported back a small number of key points to the whole room. The exercise surfaced a broadly consistent set of themes across otherwise differently composed tables (mixing government, clinical, academic, First Nations, lived-experience, and community-sector perspectives):

What currently exists, and what is missing

- Multiple tables independently concluded that nobody in the room, including people whose roles would be expected to know, could confidently describe the full current landscape of digital mental health tools, platforms and initiatives operating in Tasmania. Several groups called explicitly for a current-state analysis or environmental scan as a precursor to any framework.
- One table noted there is no current road map or directory of digital mental health services available in Tasmania, meaning the public, and often practitioners themselves, do not know what already exists.
- A recurring statistic cited at the table level was that Tasmania (with Bridgewater specifically named) ranks lowest in Australia on the national Digital Inclusion Index, spanning attitudes, affordability, and access.
- Participants noted that even sitting members of professional bodies such as the Royal Australian and New Zealand College of Psychiatrists reported limited awareness of existing resources such as eMHPac, despite it operating since 2013, reinforcing that the core problem is often information flow and awareness, not absence of tools.

What a framework should contain

- A framework should give explicit "policy permission to brag and steal" to adopt and adapt proven international and interstate approaches rather than developing Tasmanian solutions from a blank page.
- Top-down strategy must meet bottom-up design: the framework may set up direction and allocate resources from the top, but implementation and solution design must be substantially informed by the state's diverse communities.
- Digital must function as an extender or helper, never a replacer, of the human element of care, across the whole continuum from prevention to crisis response.
- Several tables were sceptical of a wholly standalone digital mental health strategy, given the number of existing overlapping strategies (departmental, sector, state and federal) already competing for implementation attention; groups argued strongly that any digital mental health commitments should be integrated within - not layered alongside -

Tasmania's existing and forthcoming strategies (Rethink and Beyond, the 20-Year Preventive Health Strategy).

- A strategy "without a plan, without accountability and consequences has no teeth" - participants wanted a framework with clear implementation of accountability, not another high-level document.
- Interoperability was raised as a structural barrier: services and systems that do not "talk to each other" prevent coordinated referral, tracking, and evaluation; one group specifically linked interoperability architecture to the ability to track meaningful, funding-linked KPIs over time.
- Groups called for genuine assurance or regulatory confidence in the safety and quality of apps and platforms available to Tasmanians (echoing Liz Payne's ORCHA presentation), given the current absence of any equivalent assurance mechanism operating locally.

Rural, remote, and infrastructure-specific findings

- Community-level infrastructure - for example, functioning internet connectivity within community halls - was raised as a discrete, fundable gap that would meaningfully expand reach in isolated areas, particularly for populations without a home internet connection.
- Participants noted that only around half of Tasmanians complete Year 12, according to information shared at one table, framing general and functional literacy as a first-order barrier that any digital solution must design around, not assume away. A specific, not-yet-launched multilingual conversational AI pilot for culturally and linguistically diverse (CALD) communities was raised as a promising direction - an AI system able to interact with clients in their own language - while participants cautioned this remains in development and untested at the time of the Roundtable.
- One group specifically discussed international students as a distinct priority population, given Tasmania's university campuses attract large international cohorts who face additional language and system-navigation barriers.

What can be learned from other jurisdictions

This question was answered relatively briefly by most tables, largely because the morning's plenary sessions (Anil Thapliyal's international survey; Krista Vanderheide's Commonwealth case studies; Andy Greenshaw's global framing) had already substantially addressed it. The consistent view was that there is no shortage of transferable international and interstate models (Ireland, Singapore, Denmark, Canada, and Australia's own Commonwealth digital mental health programs); the constraint is less a knowledge gap than a translation and implementation gap specific to the Tasmanian context.

8. Session C - Artificial Intelligence in Mental Health: Potential, Risk and Responsibility

Maureen Abbott, Director of Innovation, Mental Health Commission of Canada

Ms Abbott presented findings from a February 2026 national poll conducted jointly with Mental Health Research Canada, covering every Canadian province and demographic. Headline findings included that 1 in 7 Canadians are already accessing AI for mental health support, and 76% of those who use it find it effective, set against the finding that only 14% of people trust AI for mental health purposes. She characterised this combination, high use, high perceived effectiveness, low trust - as a defining feature of the current moment.

She outlined three major workstreams from the Mental Health Commission of Canada directly relevant to Tasmania's position:

The Canadian Mental Health Strategy (launched November 2024)

Developed through an advisory committee in which half the membership had lived and living experience, informed by international review (including lessons drawn from Australia's Head to Health program), and now reportedly in use across 23 countries (English version) and 10 countries (French version). Its six priority areas were: improving perception/trust; developing resources (frameworks, evaluation standards, guidelines); reducing barriers (including for remote and Indigenous populations lacking reliable internet); embedding interoperability; embedding inclusion, diversity, equity and accessibility; and supporting the mental health workforce (noting many practitioners were forced into digital delivery during COVID-19 with no training and, consequently, little buy-in).

AI guidance for mental health and substance use health

Developed in partnership with the Canadian Centre on Substance Use and Addiction, this addresses a gap Ms Abbott identified in existing federal and healthcare-level AI guidance: none of it speaks specifically to the unique sensitivities of mental health and substance use data, or the specific stigmatising risks of its misuse. The guidance is structured around three themes and ten considerations, the first of which is trust and explainability - directly reflecting the trust gap identified in the Commission's own polling.

Mental Health App Assessment Framework

Developed with roughly 200 collaborators in Canada and internationally, and in partnership with ORCHA, this framework was used to build a government-endorsed mental health app library for the province of Newfoundland and Labrador. Distinctively, the Canadian framework incorporates cultural safety, social responsibility and equity as core (not supplementary) assessment standards, including inclusive language, plain-language accessibility (targeting a grade-five reading level), lived-experience engagement in design, and, specifically, Indigenous data sovereignty and privacy provisions reflecting Canada's history of data misuse involving Indigenous communities.

Ms Abbott noted that of the frameworks the Commission reviewed internationally during development, only one or two others incorporated lived-experience engagement in app design at all.

"Progress moves at the speed of trust." - Maureen Abbott, Mental Health Commission of Canada - a phrase invoked repeatedly throughout the day by multiple speakers

Ridhi Malhotra, Founder and CEO, PractaLuma (Luma)

Ms. Malhotra, an educational and developmental psychologist and founder of Luma, described as Australia's first AI-enabled practice management platform for mental health practitioners, reframed the Roundtable's "closing the distance" theme literally: distance, she argued, is not only geographic, but also the distance between knowing support exists and being able to access it.

She cited Australian Bureau of Statistics data that around 21.5% of Australians experienced 12 months of mental health challenges in 2020–2022, rising to 38.8% among 16–24-year-olds, framing these figures not as a scare tactic but as a design constraint: pathways to care cannot depend on people already knowing where to look, whom to call, or how to retell their story at each handoff.

She proposed three practical starting points for Tasmania's strategy work:

- Digital relationships do not replace local connections but can strengthen the quality and reach of a person's first point of contact.
- Support must be delivered in the languages and formats young people already use, rather than requiring them to translate themselves into a service model built for a different generation, with clear escalation pathways as risk increases.
- Continuity must be actively designed - follow-ups, reminders, check-ins and shared context across referrals and services, since "a lot of harm happens between visits."

She argued lived experience should be embedded in governance; evidence of review and evaluation from the outset, not consulted only at the end, and that Tasmania should adapt proven patterns from elsewhere rather than reinvent them.

Leilani Whitney, Founder and Director, Dial A Mate Mental Health Australia

Ms Whitney, a proud Aboriginal woman (whose father is a member of the Stolen Generation) and a biomedical science and psychology student, described founding Dial A Mate as a non-clinical, peer-connection service after identifying people falling through service gaps including people who had experienced incarceration, gang involvement, or crisis and needed a de-identified, judgement-free first point of contact by phone, text or SMS.

She shared several first-person accounts from her work, including a young person who called instead of committing an act that risked incarceration, and an incarcerated young person with whom she built trust over many hours of conversation. She was explicit that her work operates in a distinct, non-clinical space alongside (not in competition with) clinical care, developed organically

and, at the time of the Roundtable, without external funding or remuneration despite a year of efforts to be "seen and heard" by funding bodies.

She also presented an early-stage personal vision for an AI-supported extension of her model, though, consistent with her account of limited institutional engagement to date, this remains an individually developed concept rather than a funded or formally evaluated program.

Associate Professor Aaron Drummond, University of Tasmania

Associate Professor Drummond, a cognitive/cyberpsychology researcher, offered a deliberately counter-balancing perspective, describing Australia's mental health situation as "a very slow crisis... happening in slow motion," and cautioning that rising mental health spending in Australia has not been matched by a reduction in the population experiencing mental ill-health. He reinforced the rural-remote access disparity already established earlier in the day as central to the case for a digital mental health framework.

His core contribution was to name emerging, under-recognised forms of digital harm that a Tasmanian framework would need to contend with:

- Loot boxes - randomised, real-money in-game purchases present in roughly half of video games - which research shows function as a genuine, evidenced gateway into conventional gambling behaviour, a finding he described as new within roughly the last three years.
- AI companion/chatbot misuse - citing Replica as an example of a widely used "digital friend" platform within which some users engage in abusive or otherwise harmful relational dynamics with the AI.
- Non-consensual synthetic imagery - the proliferation of apps able to generate non-consensual sexualised images ("nudify" tools), which he flagged as a new and rapidly growing digital harm.
- A recent Lancet Commission on problematic internet use, estimating that 7–10% of people experience some form of problematic digital use (gambling, gaming, or pornography-related), often undetected by parents or services and not clearly conceptualised by affected individuals or their families as "gambling" or "addiction" at all.

He noted Australia currently lacks dedicated services for many of these behavioural/technology-related harms (strong gambling services exist; equivalent services for video-game-related or AI-companion-related harms largely do not) and argued this represents a distinct and currently unaddressed access gap that sits alongside, rather than instead of, the access opportunities presented by digital mental health tools more broadly.

9. Roundtable Exercise 2 - AI Governance and Table Report-Backs

The second Roundtable Exercise directed table groups to Part C's discussion questions on AI's potential, risks, and the governance and safeguards of Tasmania should require before endorsing or funding AI-assisted mental health tools. Given the density and technical range of the morning's AI content, facilitators reduced the exercise's allotted time on the day. Discussion at this stage was, by the nature of a live multi-table exercise, harder to capture cleanly than the earlier plenary sessions, but consistent themes were nonetheless identifiable in both the table conversations and the subsequent report-backs and closing plenary discussion:

Governance, bias, and accountability

- Participants stressed that co-design ("nothing about us without us") must extend beyond First Nations and disability contexts to any population an AI tool is intended to serve, including people who are poor, uneducated, marginalised, or who have experienced abuse but are not formally recognised as unwell.
- There was explicit concern about AI risk-alert systems that flag a person as "high risk" without being able to clearly explain the reasoning behind that determination to the clinician or support worker relying on it - reinforcing the explainability theme raised earlier by Maureen Abbott.
- Participants debated whether tighter regulation of AI mental health tools could inadvertently push people (particularly young people already reluctant to disclose distress) toward less visible, unregulated spaces such as informal AI chatbots or social media "advice" content, rather than toward safer, regulated alternatives - with no easy resolution reached.
- Several participants noted that consumer and practitioner awareness campaigns are needed alongside any regulatory response, since "regulation does not keep up" with the pace of technological change, and that debunking misinformation (rather than simply publishing correct information) needs deliberate design.

Data, privacy and consent

- A substantial exchange (led by Professor Greenshaw in response to a direct participant question) concerned how Tasmania should balance individual data ownership and consent against systemic privacy protections, noting that individuals already routinely consent to far more extensive data collection through commercial technology platforms than health systems currently permit for their own benefit.
- A clinician participant (a child and adult psychiatrist) argued that fragmented information flow between public and private systems currently forces clients to repeat their history at every handoff, causing unnecessary harm, and that privacy protections and the right to safe, informed care must be balanced rather than treated as automatically competing.

Human oversight and the role of clinicians and services

- Multiple participants reinforced that AI and digital tools should extend, not replace, clinical and community relationships, and that decisions with clinical or risk implications (for example, around suicide risk) require human judgement capable of nuance that current conversational AI cannot reliably replicate.
- Participants noted workforce trust and capability as a prerequisite: a well-regulated therapeutic AI space is only useful if clinicians are trained, resourced and confident enough to recommend it as part of a care relationship, rather than as an impersonal referral.

Report-backs from Roundtable Exercise 1 (delivered later in the day)

Note: due to time constraints, several tables' formal report-backs to the whole room (on Exercise 1, Part A) were delivered later in the afternoon program. Consolidated with Section 7 above, additional distinguishing points raised by individual tables in these later report-backs included:

- A strong consumer/lived-experience-led framing of digital tools as primarily a way to help people navigate an otherwise hard-to-navigate system, with particular attention to the compounding effect of pre-existing system mistrust among marginalised groups.
- Specific reference to Reach Out as an example of an AI-backed platform helping young people navigate care pathways and surface the right information at the right time.
- Calls for a single, live, reputable online directory of Tasmanian mental health services (echoing Heidi Sturk's and other tables' points about the absence of a current directory), alongside recognition of St Lukes' own in-house navigator model as a positive local exemplar.
- Reference to existing state initiatives already underway that any framework needs to connect with, rather than duplicate, most significantly the Bluegum Digital Health Transformation, Tasmania's 10-year digital health strategy now four years into implementation which encompasses mental health services and provides the foundational architecture within which digital mental health commitments could be embedded, alongside the Department of Health's Central Intake and Referral Service, which supports GP referrals and functions as a front door for the Medicare Mental Health Check-in phone service.
- A call for practical, principles-based guidance for embedding digital mental health solutions within existing (rather than new, parallel) strategies, alongside continued attention to equity in policy, practice, research, and implementation.

10. Wrap-Up Reflections and Way Forward

The day closed with Dan Vautin and Professor Thapliyal inviting international guests and participants to reflect on Tasmania's most useful next step. Several distinct threads emerged:

- Professor Greenshaw offered a provocative, upstream reframing, citing historical health-economics research (McMaster University) finding a 17-fold return per dollar invested in supporting single mothers with nurse-practitioner home visiting in a child's first 12 months, dramatically reducing negative mental health outcomes for both mother and child. His point was that Tasmania's investment horizon needs to extend well beyond any single electoral cycle, and that digital tools should not be expected to substitute for genuine upstream, early-intervention investment.
- An international visitor observed that Tasmania's relatively small, closely networked population and unusually direct access between community and decision-makers represent a genuine comparative advantage: Tasmania does not need to replicate what other Australian states or other countries are doing and has an unusual opportunity to build a digital mental health approach genuinely fitted to its own context from the ground up, rather than importing a model wholesale.
- A further reflection argued that with a population of only around half a million people, genuine, large-scale community co-design consultation is realistically achievable in Tasmania in a way it is not in larger jurisdictions, through town halls, structured feedback processes, and (notably) using AI itself to summarise large volumes of qualitative community feedback, provided the underlying data collection is representative.
- Professor Thapliyal closed by formally extending an open invitation for continued "brag and steal" collaboration between Tasmania and Canada specifically (building on discussions between Maureen Abbott and MHCT during the day), reiterating that "digital has no geopolitical boundaries," and reflecting on how frequently First Nations perspectives and voices had featured throughout the day's discussion, a pattern he described as personally encouraging.

The Roundtable formally closed with the acknowledgements offered throughout the day.

11. Cross- Cutting Themes

Drawing together the plenary presentations and the two Roundtable Exercises, several themes recurred across almost every session of the day, independent of speaker background or table composition:

1. Trust, not technology, is the binding constraint

The phrase "progress moves at the pace/speed of trust" (introduced by Maureen Abbott and repeated by multiple subsequent speakers) functioned as an informal organising principle for the day. Trust was discussed at several distinct levels: consumer trust in a specific tool; clinician trust sufficient to recommend a tool as part of an existing therapeutic relationship; community trust in the sponsoring institution (government, a peak body, or a private platform); and specific to Canadian polling data presented by Ms Abbott, a documented gap between usage/effectiveness and trust, where people use and benefit from AI tools they do not yet trust.

2. Equity of access is a precondition, not a downstream consideration

Multiple speakers, particularly Juanita Wilson and David Edwards, and multiple Exercise 1 table report-backs, emphasised that Tasmania's comparatively low household internet connectivity, digital literacy, and (in some communities) even basic mobile network coverage means any digital mental health strategy that assumes universal digital access will, by design, most disadvantage the communities it most needs to reach. This included specific, granular detail (Starlink's poor performance under tree cover; the loss of long-range 3G coverage; and low general literacy in some communities) not typically surfaced in higher-level strategy documents.

3. Co-design means governance and employment, not consultation

A specific distinction was drawn (explicitly, by Dr Hasan, and echoed by First Nations speakers) between authentic co-design, First Nations or community involvement from the earliest design stage, including in governance and employment, and "user-centric design," in which a already-built prototype is shown to a community for feedback. Presenters cautioned against organisations describing the latter as "co-design" without transparency about which process actually occurred.

4. Digital should extend, not replace, human relationships

This point recurred from markedly different perspectives, Ridhi Malhotra's clinical-technology lens, the GP's relationship-centred practice, David Edwards' and Juanita Wilson's cultural-connection framing, and Andy Greenshaw's technology-adoption research, converging on the same conclusion: digital tools succeed when they strengthen an existing relationship (with a GP, a family member, a peer support worker, or a community), and are far less likely to succeed, or to be trusted, when positioned as a replacement for that relationship.

5. Tasmania has evidence and appetite, but lacks a coordinating framework

Across Dr Hasan's four policy submissions, the Roundtable turnout itself, and the near-unanimous Exercise 1 finding that no single group could describe Tasmania's current digital mental health landscape, the day converged on a shared diagnosis: gaps in local evidence, innovation and

willingness may well persist, but the absence of a statewide coordinating framework compounds all three, without a shared mechanism to connect what already exists, assure its quality, and direct new investment strategically, any evidence that does exist stays fragmented, promising innovations stay isolated, and willingness across sectors has no organised channel to act on. **6. AI presents a genuinely new category of both opportunity and risk**

AI-specific content ranged from clearly beneficial applications (app quality assurance at scale via ORCHA's Atlas platform; multilingual conversational support for CALD communities; AI-assisted, low-bias summarisation of large-scale community consultation) to clearly emergent risks requiring governance Tasmania does not yet have (gambling-adjacent loot box mechanics, AI companion misuse, non-consensual synthetic imagery, and unexplainable AI risk-flagging in clinical contexts). Several participants were explicit that regulation alone is insufficient without parallel investment in consumer and practitioner awareness.

12. Recommendations

The following recommendations are synthesized directly from points made across the plenary sessions, the two Roundtable Exercises, and the closing reflections. They are presented as a thematic synthesis of what participants said during the day, not as a formal, ratified position of MHCT, eMHIC, or the Tasmanian Government.

#	Recommendation	Detail
1	Commission a current-state analysis	Map what digital mental health tools, platforms and services currently exist in Tasmania, their quality, reach, and interoperability, before finalising framework design - a gap identified independently by multiple table groups.
2	Embed digital mental health within Rethink and Beyond, not as a parallel strategy	Integrate digital mental health commitments directly into the forthcoming Mental Health Strategy (Rethink and Beyond) and the 20-Year Preventive Health Strategy, with clear accountability mechanisms, and ensure all such commitments explicitly align with and build on the Bluegum Digital Health Transformation, Tasmania's existing 10-year digital health strategy, which is four years into implementation and encompasses mental health services. New digital mental health commitments could strengthen and extend Bluegum's existing architecture rather than create parallel or duplicating structures.
3	Treat digital access and literacy as foundational infrastructure	Fund community-level internet connectivity (e.g., community halls in low-connectivity areas) and design any digital strategy assuming variable digital and general literacy, not universal access.
4	Establish an app/platform assurance mechanism for Tasmania	Draw on existing models (ORCHA/Atlas; the Mental Health Commission of Canada's app assessment framework; eMHPrac's practitioner-facing directories) rather than building assurance capability from scratch.

#	Recommendation	Detail
5	Fund and formalise authentic First Nations co-design	Embed First Nations leadership, employment, and governance - not retrospective consultation - in any digital mental health design process, with cultural knowledge and expertise appropriately remunerated.
6	Develop Tasmania-specific AI governance guidance	Adapt emerging international guidance (Mental Health Commission of Canada's AI guidance for mental health and substance use health) to the Tasmanian context, addressing explainability, bias, data sovereignty, and new digital harms (loot boxes, AI companion misuse, synthetic imagery).
7	Invest in workforce trust and capability, not just tools	Support ongoing (not one-off) digital mental health training across the mental health workforce, and embed digital mental health content in tertiary curricula, so new graduates enter practice equipped to use these tools confidently.
8	Preserve and strengthen relationship-based care as the anchor for digital tools	Position digital mental health as an extension of trusted relationships (GPs, peer workers, community and cultural connections), not a substitute for them.
9	Pursue structured international collaboration	Formalise "brag and steal" partnerships already offered during the Roundtable (particularly with the Mental Health Commission of Canada) to adapt proven frameworks rather than developing them independently.
10	Design for Tasmania's specific demographic and geographic profile	Recognise Tasmania's comparatively small, closely networked population as an asset for genuine, large-scale community consultation, rather than defaulting to models designed for larger jurisdictions

Appendix A: Final Agenda

As per the final, circulated agenda (subject to change on the day):

Time	Item
10:00–10:15	Welcome from Dan Vautin, MHCT
10:15–10:30	Dr Tasdik Hasan, MHCT
10:30–10:40	Professor Anil Thapliyal, eMHIC
10:40–10:50	Krista Vanderheide, Australian Government Department of Health, Disability and Ageing
10:50–11:00	Professor Andy Greenshaw, University of Alberta
11:00–11:10	Convenience break and networking
11:10–11:15	Juanita Wilson, Beyond Blue
11:15–11:20	David Edwards, WellMob
11:20–11:25	Rhiannon Hamilton, MHCT
11:25–11:30	Heidi Sturk, eMHPrac
11:30–12:00	Q&A and open discussion
12:00–12:45	Lunch break and networking
12:45–13:45	Roundtable Exercise 1
13:45–13:55	Maureen Abbott, Mental Health Commission of Canada
13:55–14:00	Ridhi Malhotra, PractaLuma
14:00–14:05	Leilani Whitney, Dial A Mate Mental Health Australia
14:05–14:10	Dr David Bakker, MoodMission (recorded presentation from Liz Payne, ORCHA, shown in this slot)
14:10–14:15	Associate Professor Aaron Drummond, UTAS
14:15–14:25	Convenience break and networking
14:25–14:35	Q&A and open discussion
14:35–15:35	Roundtable Exercise 2
15:35–16:00	Roundtable wrap-up, way forward, and culturally appropriate closure

Appendix B: Speakers and Contributors

Name	Affiliation / Role
Dan Vautin	CEO, Mental Health Council of Tasmania
Dr M Tasdik Hasan	Policy and Advocacy Lead, Mental Health Council of Tasmania; Roundtable Facilitator
Professor Anil Thapliyal	Executive Director, eMental Health International Collaborative (eMHIC)
Krista Vanderheide	Assistant Secretary, Mental Health and Suicide Prevention Division, Australian Government Department of Health, Disability and Ageing
Professor Andy Greenshaw	University of Alberta; Roundtable Co-Facilitator
Juanita Wilson	First Nations Equity and Inclusion Advisor, Beyond Blue
David Edwards	WellMob
Rhiannon Hamilton	Lived Experience Training Hub, Mental Health Council of Tasmania
Heidi Sturk	Director, eMHPrac
Maureen Abbott	Director of Innovation, Mental Health Commission of Canada
Ridhi Malhotra	Founder and CEO, PractaLuma (Luma)
Leilani Whitney	Founder and Director, Dial A Mate Mental Health Australia
Liz Payne	Founder, ORCHA (recorded presentation)
Associate Professor Aaron Drummond	University of Tasmania