Mental Health Council OF TASMANIA

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Productivity Commission Inquiry into Mental Health

Final Submission from the Mental Health Council of Tasmania

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About Us

The Mental Health Council of Tasmania (MHCT) is the peak body for community-managed mental health services in Tasmania. We work closely with Tasmanian Government agencies and Primary Health Tasmania to ensure sectoral input into public policies and programs. We advocate for reform and improvement within the Tasmanian mental health system. Our purpose is to improve mental health and wellbeing for all Tasmanians.

Executive Summary

This Submission is MHCT's second and final Submission to the Productivity Commission's *Inquiry on Mental Health*. It provides comment on the Commission's Draft Report and responds specifically to the 88 Draft Recommendations contained within that Report.

- MHCT supports 60 Draft Recommendations in full
- MHCT supports 25 Draft Recommendations in principle and offers comment to help inform the final wording of these Recommendations
- MHCT has no view on 2 Draft Recommendations
- MHCT recommends revision of Draft Recommendation 17.3 as described in Part 2 of this Submission.

MHCT provides this Submission with the aim of assisting the Productivity Commission to arrive at its Final Report and Recommendations in relation to its Inquiry on Mental Health.

Context: MCHT's Contributions to the Inquiry

1. On 5 February 2019 Ms Connie Digolis, CEO of MHCT, gave a verbal briefing to Commissioners Rosalyn Bell and Roger Hassan by invitation to inform initial deliberations for the Productivity Commission's Inquiry into Mental Health.
2. On 5 April 2019, MCHT lodged a formal Submission to the Inquiry that responded to the Inquiry's Briefing Paper as fully as possible, reflecting the views of MHCT members. MHCT worked with the Tasmanian Council of Social Services (TasCOSS), Flourish: Mental Health Action in Our Hands Inc. and JusTas to coordinate a broad cross-sectoral Tasmanian response covering issues both within and outside MHCT's remit. It was pleasing to see this Submission referenced in the Inquiry's Draft Report as a knowledge source in relation to:
    - the economic costs of suicide;
    - diagnostic overshadowing of physical co-morbidities for people with mental illness;
    - the distressing nature of ED presentations for people in psychological crisis; and
    - the current lack of clarity around the governance of the NMHC.
3. On 9 December 2019 Ms Digolis addressed Commissioners Julie Abramson and Harvey Whiteford at the Commission's Public Hearing in Launceston, Tasmania, to provide comment on the Inquiry's Draft Report. A summary of her presentation is included at Appendix A.

Part 1

Annotated Draft Recommendations from the Productivity Commission's *Inquiry into Mental Health* Draft Report

The following table lists all Draft Recommendations from the Draft Report and provides comment, where appropriate, with the intent to inform the final wording of the Recommendation. Where MHCT's comment on a Draft Recommendation are too detailed to fit in the table, it is provided in Part 2 of this Submission and a note to this effect appears in the 'MHCT Response' column.

MHCT's Response key is as follows:

- **SUPPORT:** MHCT supports this Draft Recommendation.
- **SUPPORT IN PRINCIPLE, NOTING THAT:** MHCT supports the Draft Recommendation in principle and provides comment to help inform its final wording.
- **RECOMMENDS REVISION, NOTING THAT:** MHCT recommends the revision of this Draft Recommendation, provides its rationale and supplies draft text for the revised Recommendation in Part 2 of this Submission.
- **NO VIEW:** MHCT does not offer any view on this Draft Recommendation.[1]

Draft Rec. No.	Topic	MHCT Response
5.1	PSYCHIATRIC ADVICE TO GPS	**SUPPORT**
5.2	ASSESSMENT AND REFERRAL PRACTICES IN LINE WITH CONSUMER TREATMENT NEEDS	**SUPPORT**
5.3	ENSURING HEADSPACE CENTRES ARE MATCHING CONSUMERS WITH THE RIGHT LEVEL OF CARE	**SUPPORT**
5.4	MBS-REBATED PSYCHOLOGICAL THERAPY	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) This Draft Recommendation aligns poorly with the Draft Report's discussion and analysis of this issue. As acknowledged in the Draft Report (Overview, p. 20), there is little evidence of efficacy for the Better Access program. It should be evaluated *against other modes of psychological therapy* (rather than against an expanded version of itself) prior to any trial expansion. (b) As MHCT has previously noted (Sub. 314, p. 52) the Better Access Program has not fulfilled its intended aim of increasing equity of access to mental health care for lower-income Australians. Take-up of the scheme is highest in relatively wealthy, inner metropolitan areas and lowest in rural and remote communities (likely due to poor access to psychologists). Equity considerations must be effectively

[1] This may be because it falls outside of MHCT's policy scope or because MHCT does not have enough information to provide an informed view.

		addressed if any expansion of the current scheme is considered. (c) Given the projected high costs of expansion of the current Program, MHCT notes the importance of undertaking a cost-benefit analysis that measures the likely equity, practical accessibility and efficacy of the Program measured against other psychological therapies.
5.5	ENCOURAGE MORE GROUP PSYCHOLOGICAL THERAPY	**SUPPORT**
5.6	PRACTITIONER ONLINE REFERRAL TREATMENT SERVICE	**NO VIEW**
5.7	PSYCHOLOGY CONSULTATIONS BY VIDEOCONFERENCE	**SUPPORT**
5.8	INCREASE CONSUMER CHOICE WITH REFERRALS	**SUPPORT**
5.9	ENSURE ACCESS TO THE RIGHT LEVEL OF CARE	**SUPPORT**
6.1	SUPPORTED ONLINE TREATMENT OPTIONS SHOULD BE INTEGRATED / EXPANDED	**SUPPORT**
6.2	INFORMATION CAMPAIGN TO PROMOTE SUPPORTED ONLINE TREATMENT	**SUPPORT IN PRINCIPLE, NOTING THAT** To avoid service failure and consumer disengagement, actions in 6.2 must be time-aligned to those in 6.1: (a) Short-term actions in 6.1 should be fully implemented prior to commencement of actions in 6.2 (b) An evaluation of service capacity v. service demand and efficacy (relating to short-term actions in 6.1) should be undertaken prior to commencement of actions in 6.2. Actions described in 6.2 should only be undertaken when service efficacy is proven and capacity is demonstrably sufficient to meet current and ongoing demand.
7.1	PLANNING REGIONAL HOSPITAL AND COMMUNITY MENTAL HEALTH SERVICES	**SUPPORT**
7.2	PSYCHIATRY CONSULTATIONS BY VIDEOCONFERENCE	**SUPPORT**
8.1	IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES	**SUPPORT**
8.2	CHILD AND ADOLESCENT MENTAL HEALTH BEDS	**SUPPORT IN PRINCIPLE, NOTING THAT** Tasmania's relatively small population base results in poor economies of scale. In this context it makes sense to create acute adolescent health care settings that cater for a range of acute care needs and include designated acute mental health beds, together with 24/7 mental health specialist staff to manage these beds. Holistic adolescent acute care settings are also advantageous because all adolescents receive care from a multi-disciplinary team that includes mental health specialists, meaning that incipient or comorbid mental illness in any adolescent acute care patient is identified and supported.

10.1	CONSUMER ASSISTANCE PHONE LINES	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) MCHT strongly supports the concept of consumer assistance phone lines, however, *Head to Health* is a national service with little capacity to provide specific advice to consumers about local services based in their communities. Therefore, MHCT questions the utility of expanding and marketing this service as contemplated in this Draft Recommendation. (b) To address this, MHCT suggests the second dot point be altered to "The Australian Government *should assist all States and Territories to develop nationally consistent consumer assistance phone lines offering one-call support and navigation of the mental health system for people with mental ill-health, their carers, families and the community.*" (c) MCHT refers Commissioners to its proposed *Centralised Mental Health Access Service* as a detailed structural exemplar for a State-based consumer assistance phone line (here, pp. 16-28, and at Appendix B).
10.2	ONLINE NAVIGATION PLATFORMS TO SUPPORT REFERRAL PATHWAYS	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) Actions in Draft Recs 10.1 and 10.2 must be integrated, so that consumer assistance phone lines (10.1) are linked to and supported by online navigation platforms to support referral pathways (10.2), rather than these two initiatives existing independently of each other. (b) Special consideration must be given to reducing the complexity of navigating an overcrowded market (both in terms of the number of navigation platforms that exist and in terms of the number of services they link to). MHCT notes that mental health sector workers report feeling overwhelmed when faced with such a large array of choices of navigational platform and service offering; consumers with no professional experience or expertise are even more poorly placed to make decisions between platforms and providers.
10.3	SINGLE CARE PLANS FOR SOME CONSUMERS	**SUPPORT**
10.4	CARE COORDINATION SERVICES	**SUPPORT**
11.1	THE NATIONAL MENTAL HEALTH WORKFORCE STRATEGY	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) The needs of specific areas and regions may not be reflected in national data and therefore may not be effectively captured in proposed national mental health workforce strategies. (b) Therefore, it is critical that state and regional mental health workforce strategies and mapping are integrated into the updated National Mental Health Workforce Strategy. (c) MHCT notes that Tasmania is well progressed on integrated state and federal regional mental health workforce planning, with this work on track for completion in 2020. (d) MHCT and the Tasmanian Government launched a *Tasmanian Peer Workforce Development Strategy* in November 2019. This is provided to Commissioners at Appendix C. MHCT requests it

		be used to inform future national mental health workforce planning.
11.2	INCREASE THE NUMBER OF PSYCHIATRISTS	**SUPPORT**
11.3	MORE SPECIALIST MENTAL HEALTH NURSES	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) The Australian Government could also consider other mechanisms to increase the number of specialist mental health and psychiatry nursing graduates (for instance, fee rebates or scholarships for students who choose to undertake a Mental Health and Psychiatric Nursing specialisation within the existing BN (Hons), Graduate Certificate in Nursing or Graduate Diploma in Nursing courses).
11.4	STRENGTHEN THE PEER WORKFORCE	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) All national work in this area should build on, be informed by and integrate any prior work by States and Territories in relation to peer work definitions, guidelines, work standards, areas of practice and appropriate qualifications systems. (b) MHCT's *Tasmanian Peer Workforce Development Strategy* was launched in November 2019 and is provided at Appendix C.
11.5	IMPROVED MENTAL HEALTH TRAINING FOR DOCTORS	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) There is a critical need for additional mental health training for general practitioners that extends far beyond information on the side effects of psychoactive medications (as contemplated in this Draft Recommendation). (b) MHCT members and their clients consistently cite GPs' lack of understanding of mental ill-health, non-trauma-informed practice approaches, and lack of knowledge in relation to the NDIS psychosocial disability stream. (c) In relation to NDIS psychosocial disability stream applications, GPs must complete part of the Access Request; if the GP does not understand the need to differentiate between diagnosis, symptoms, impacts and variability of impacts, or cannot articulate these clearly, an Access Request may fail, resulting in a consumer being deemed ineligible for the NDIS. If this issue is not addressed it has the capacity to undermine the key NDIS tenet of equity of access to appropriate psychosocial supports for all Australians. (d) Given (b) and (c) above, MHCT recommends that Draft Rec 11.5 broaden its scope by adding the following text under Dot Point 1: (e) *"Such professional development requirements should also include training on trauma-informed practice including appropriate management of patient disclosures of mental health issues (particularly in relation to young people), and training on NDIS psychosocial disability access pathways and application processes including specific guidance on how to complete an* Evidence of Psychosocial Disability *form."*

11.6	MENTAL HEALTH SPECIALISATION AS A CAREER OPTION	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) The language at Dot Point 2 "*exposing* health students and practising health professionals *to people with a mental illness*…" is stigmatising and inappropriate. (b) MHCT notes that Draft Rec 20.1 describes the same concept using non-stigmatising language: "…develop *contact interventions that involve interactions between health professionals and mental health consumers, on an equal footing* outside of a clinical setting." (c) MHCT suggests that the stigmatising wording in Draft Recommendation 11.6 be replaced with wording used in Draft Recommendation 20.1 as shown at (b) above.
11.7	ATTRACTING A RURAL HEALTH WORKFORCE	**SUPPORT**
12.1	EXTEND THE CONTRACT LENGTH FOR PSYCHOSOCIAL SUPPORTS	**SUPPORT**
12.2	GUARANTEE CONTINUITY OF PSYCHOSOCIAL SUPPORTS	**SUPPORT IN PRINCIPLE, NOTING THAT** In relation to dot point 3 of this Draft Recommendation (evaluation of barriers to the NDIS), MHCT's report on *Removing Barriers to the NDIS* is due for public release in February 2020. Please contact MHCT for further details.
12.3	NDIS SUPPORT FOR PEOPLE WITH PSYCHOSOCIAL DISABILITY	**SUPPORT**
13.1	REDUCE BARRIERS TO ACCESSING INCOME SUPPORT FOR MENTAL HEALTH CARERS	**SUPPORT**
13.2	EMPLOYMENT SUPPORT FOR MENTAL HEALTH CARERS	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) Mental health carers and their representative bodies should be enabled to participate in the contemplated evaluation of the Carers and Work program and the development of any subsequent guidelines for jobactive providers, and their views used to inform any changes to the program.
13.3	FAMILY-FOCUSED AND CARER-INCLUSIVE PRACTICE	**SUPPORT IN PRINCIPLE, NOTING THAT** (b) This Draft Recommendation should explicitly acknowledge the primacy of the mental health consumer's right to autonomy, choice, control and participation in decisions regarding their own mental health care. Consumers' views on their care may be different from that of family members or carers; additionally, consumers may not want family members or carers involved in their care decisions. In such cases the consumer's right has primacy over any rights of family members or carers, except in special circumstances that are specifically legislatively proscribed. (c) MHCT suggests this Draft Recommendation could acknowledge the above point by adding: (d) To the end of the first sentence of the Draft Recommendation:

		"… while prioritising the right of the consumer to self-advocacy, choice, autonomy and the ability to participate meaningfully in decisions affecting their care." (e) To the first item under dot point four of the Draft Recommendation: "To provide family and couple therapy, where one or more members of the family/couple is experiencing mental illness, *where this is consistent with the care recipient's right to autonomy, choice, control, and ability to participate meaningfully in decisions affecting their care. This would normally include the care recipient granting permission for others to attend such a consultation…"* (f) To the second item under dot point four of the Draft Recommendation: "For consultations with carers and family members without the care recipient present, *where this is consistent with the care recipient's right to autonomy, choice, control, and ability to participate meaningfully in decisions affecting their care. This would normally include the care recipient granting permission for such a consultation to occur…"*
14.1	EMPLOYMENT SUPPORT ASSESSMENT MEASURES	**SUPPORT**
14.2	TAILOR ONLINE EMPLOYMENT SERVICES	**SUPPORT**
14.3	STAGED ROLLOUT OF INDIVIDUAL PLACEMENT AND SUPPORT MODEL	**SUPPORT**
14.4	INCOME SUPPORT RECIPIENTS' MUTUAL OBLIGATION REQUIREMENTS	**SUPPORT**
15.1	HOUSING SECURITY FOR PEOPLE WITH MENTAL ILLNESS	**SUPPORT**
15.2	SUPPORT PEOPLE TO FIND AND MAINTAIN HOUSING	**SUPPORT**
16.1	SUPPORT FOR POLICE	**SUPPORT**
16.2	MENTAL HEALTHCARE STANDARDS IN CORRECTIONAL FACILITIES	**SUPPORT**
16.3	MENTAL HEALTHCARE IN CORRECTIONAL FACILITIES AND ON RELEASE	**SUPPORT**
16.4	INCARCERATED ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE	**SUPPORT**
16.5	DISABILITY JUSTICE STRATEGIES	**SUPPORT**
16.6	LEGAL REPRESENTATION AT MENTAL HEALTH TRIBUNALS	**SUPPORT**
16.7	NON-LEGAL INDIVIDUAL ADVOCACY SERVICES	**SUPPORT**
17.1	PERINATAL MENTAL HEALTH	**SUPPORT**

17.2	SOCIAL AND EMOTIONAL DEVELOPMENT IN PRESCHOOL CHILDREN	**SUPPORT**
17.3	SOCIAL AND EMOTIONAL LEARNING PROGRAMS IN THE EDUCATION SYSTEM	**RECOMMEND REVISION, NOTING THAT** MHCT has provided detailed comment on, and proposed alternative wording for, this Draft Recommendation in Part 2 of this Submission.
17.4	EDUCATIONAL SUPPORT FOR CHILDREN WITH MENTAL ILLNESS	**SUPPORT**
17.5	WELLBEING LEADERS IN SCHOOLS	**SUPPORT IN PRINCIPLE, NOTING THAT** MHCT has provided detailed comment on this Draft Recommendation in Part 2 of this Submission.
17.6	DATA ON CHILD SOCIAL AND EMOTIONAL WELLBEING	**SUPPORT**
18.1	TRAINING FOR EDUCATORS IN TERTIARY EDUCATION INSTITUTIONS	**SUPPORT**
18.2	STUDENT MENTAL HEALTH AND WELLBEING STRATEGY IN TERTIARY EDUCATION INSTITUTIONS	**SUPPORT**
18.3	GUIDANCE FOR TERTIARY EDUCATION PROVIDERS	**SUPPORT**
19.1	PSYCHOLOGICAL HEALTH AND SAFETY IN WORKPLACE HEALTH AND SAFETY LAWS	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) MHCT suggests the term 'psychological health and safety' be replaced with the term '*mental* health and safety' for general language consistency (b) MHCT recommends substitution of the terms 'similar' and 'similarly' with the terms *'equivalent'* and *'in an equivalent way to'* to strengthen the intent of the Draft Recommendation (c) Wording of the third sentence in Draft Recommendation 19.1 would therefore alter to "…to ensure *mental* health and safety is given *equivalent* consideration to physical health and safety" (d) Wording of the first dot point in Draft Recommendation 19.1 would therefore alter to "All WHS legislation should clearly specify the protection of *mental* health and safety as a key objective." (e) Wording of the second dot point in Draft Recommendation 19.1 would therefore alter to "Necessary amendments should be made to ensure that the relevant legislation and regulation addresses *mental* health and safety *in an equivalent way to* physical health and safety."
19.2	CODES OF PRACTICE ON EMPLOYER DUTY OF CARE	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) MHCT suggests the term 'psychological health in the workplace' be replaced with the term '*mental* health in the workplace' for general language consistency, as per comments for Draft Recommendation 19.1
19.3	LOWER PREMIUMS AND WORKPLACE INITIATIVES	**SUPPORT**

19.4	NO-LIABILITY TREATMENT FOR MENTAL HEALTH RELATED WORKERS COMPENSATION CLAIMS	**SUPPORT**
19.5	DISSEMINATING INFORMATION ON WORKPLACE INTERVENTIONS	**SUPPORT**
20.1	NATIONAL STIGMA REDUCTION STRATEGY	**SUPPORT**
20.2	AWARENESS OF MENTAL ILLNESS IN THE INSURANCE SECTOR	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) In the first item under the second Dot Point (ASIC evaluation), MHCT requests clarification of the meaning of "has removed blanket exclusions to mental illness": **Does this mean** that blanket exclusions have been removed *for the term 'mental illness'* (a broad descriptor of a category of illness that is not diagnostic of any specific mental illness)? **Does this mean** that blanket exclusions have been removed *for one, or more than one, or all, specific mental illness diagnoses* (for instance, major depressive disorder, generalised anxiety disorder, anorexia nervosa, PTSD)? (b) In the second item under the second Dot Point (ASIC evaluation), MHCT notes that determination of history, severity and prognosis of any type of mental illness is extremely complex. Mental illness symptoms and impacts are highly variable: • Between individuals with the same diagnosis; • In one person with one diagnosis over different time periods and in different circumstances. Additionally, diagnostic uncertainty is common. 43% of Australians with a diagnosed mental illness will receive more than one diagnosis. Mental illness diagnoses are 'informed opinions' (not verified facts) that rely on a single clinician's view. They are frequently subject to change over time. Therefore, the use of (generalised) prevalence, prognosis and pricing information to assess the insurance risk of *any specific individual* is highly problematic. MHCT notes that ASIC has a responsibility to ensure that consumers are not unfairly discriminated against and suggests that it incorporate a recovery-based model in all relevant advisories and regulatory frameworks. To inform its work in this area ASIC could look to NDIA's ongoing work on assessment methods for psychosocial disability situated within an insurance framework that must consider *individual* eligibility for specific claims.
20.3	TRADITIONAL HEALERS	**SUPPORT**
21.1	UNIVERSAL ACCESS TO AFTERCARE	**SUPPORT**

21.2	EMPOWER INDIGENOUS COMMUNITIES TO PREVENT SUICIDE	**SUPPORT**
21.3	APPROACH TO SUICIDE PREVENTION	**SUPPORT IN PRINCIPLE, NOTING THAT** (a) Dot point 2 suggests that the National Suicide Prevention Implementation Strategy should include direction for non-health government portfolios. MHCT suggests utilising the National Suicide Prevention Taskforce (responsible for driving a whole-of-government approach to suicide prevention) to inform any changes to the Implementation Strategy. (b) MHCT further suggests that frameworks for quality improvement and evaluation be incorporated into the Implementation Strategy.
22.1	A NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT	**SUPPORT IN PRINCIPLE, NOTING THAT** MHCT has made additional comments for this Draft Recommendation in Part 2 of this Submission.
22.2	A NEW WHOLE-OF-GOVERNMENT MENTAL HEALTH STRATEGY	**SUPPORT IN PRINCIPLE, NOTING THAT** The new whole-of-government mental health strategy should support better coordination, integration and data-sharing across and between sectors.
22.3	ENHANCING CONSUMER AND CARER PARTICIPATION	**SUPPORT IN PRINCIPLE, NOTING THAT** The separate and distinct roles, views and experiences of mental health *carers* versus mental health *consumers* should be clearly distinguished, understanding that the views and opinions of consumers and carers may differ or conflict. A carer view cannot substitute for a consumer view or vice versa.
22.4	ESTABLISHING TARGETS FOR OUTCOMES	**SUPPORT**
22.5	BUILDING A STRONGER EVALUATION CULTURE	**SUPPORT**
23.1	REVIEW PROPOSED ACTIVITY-BASED FUNDING CLASSIFICATION FOR MENTAL HEALTHCARE	**SUPPORT**
23.2	RESPONSIBILITY FOR PSYCHOSOCIAL AND CARER SUPPORT SERVICES	**NO VIEW** MCHT has insufficient information on the 'new and expanded roles of State and Territory Governments' (as per the full wording of Draft Recommendation 23.2) to express a view.
23.3	STRUCTURAL REFORM IS NECESSARY	**SUPPORT IN PRINCIPLE, NOTING THAT** MHCT has provided detailed comment in relation to this Draft Recommendation in Part 2 of this Submission.
24.1	FLEXIBLE AND POOLED FUNDING ARRANGEMENTS	**SUPPORT**
24.2	REGIONAL AUTONOMY OVER SERVICE PROVIDER FUNDING	**SUPPORT IN PRINCIPLE, NOTING THAT** MHCT has made additional comments for this Draft Recommendation in Part 2 of this Submission.
24.3	THE NATIONAL HOUSING AND HOMELESSNESS AGREEMENT	**SUPPORT**
24.4	TOWARD MORE INNOVATIVE PAYMENT MODELS	**SUPPORT IN PRINCIPLE, NOTING THAT**

		MHCT supports innovation in this area, specifically the trial of new models with appropriate governance structures that are subject to independent evaluation.
24.5	PRIVATE HEALTH INSURANCE AND FUNDING OF COMMUNITY-BASED HEALTHCARE	**SUPPORT**
24.6	LIFE INSURERS AND FUNDING OF MENTAL HEALTHCARE	**SUPPORT**
25.1	A DATA LINKAGE STRATEGY FOR MENTAL HEALTH DATA	**SUPPORT**
25.2	ROUTINE NATIONAL SURVEYS OF MENTAL HEALTH	**SUPPORT**
25.3	STRATEGIES TO FILL DATA GAPS	**SUPPORT**
25.4	STRENGTHENED MONITORING AND REPORTING	**SUPPORT**
25.5	REPORTING SERVICE PERFORMANCE DATA BY REGION	**SUPPORT**
25.6	STANDARDISED REGIONAL REPORTING REQUIREMENTS	**SUPPORT**
25.7	PRINCIPLES FOR CONDUCTING PROGRAM EVALUATIONS	**SUPPORT**
25.8	REQUIRING COST-EFFECTIVENESS CONSIDERATION	**SUPPORT IN PRINCIPLE, NOTING THAT** Greater consideration should be given to the meaning of 'cost-effectiveness' given that evidence is still emerging in relation to comparative efficacy of various therapies. MHCT notes that it is therefore important to clarify the underlying assumptions of any cost-effectiveness analysis: • Number of consumers treated per dollar spent • Amount of benefit derived per individual per dollar spent (with an explanation of how this will be measured) • Amount of benefit derived per individual per dollar spent, compared to the amount of benefit provided by other treatments per individual per dollar spent.
25.9	A CLINICAL TRIALS NETWORK SHOULD BE ESTABLISHED	**SUPPORT**

Part 2: Detailed comments on selected Draft Recommendations

Comments on Draft Recommendations 17.1, 17.2 and 17.4

MHCT was pleased to see early-in-life mental health intervention reflected as a key tenet of improved population mental health in the Draft Report. This accords with best-practice global views on the importance of mental health and wellbeing in the first 1000 days of life (from 0-3 years).

Early adverse childhood experiences (ACEs) and childhood trauma are the most significant predictors of mental illness later in life. Therefore, broad-based, early-in-life interventions that counter or prevent such experiences have the greatest potential for improving population mental health, with flow-on benefits for individuals, families, the Australian community, the public health budget and the broader economy.[2] Given the critical impact of this issue on population prevalence of mental illness and suicide, and the substantial and tangible benefits that would result if Australia were to implement effective strategies to reduce and mitigate early adverse childhood experiences, it is heartening to see the Draft Report explore this area in detail. Draft Recommendations 17.1 – 17.6 outline strengthened mental health and wellbeing initiatives for children in infancy, preschool and school age. Taken together these signal a move towards a *lifespan approach* to preventing mental illness and suicide. Emerging global evidence indicates that this approach is likely to be more effective than any other in terms of achieving significant reductions in the population prevalence of mental illness and suicide. **MHCT therefore strongly supports Draft Recommendations 17.1, 17.2 and 17.4.**

Comments on Draft Recommendation 17.3

To enable a lifespan approach (see graph on p. 24) to be fully implemented, however, MHCT believes that Draft Recommendation 17.3 requires amendment to more clearly reflect specific strategies needed for primary, early secondary and senior secondary students. The three age cohorts represent vastly different stages in social and emotional development and are discussed below.

Primary School cohort: recommended focus and aim of programs

International best-practice research in population mental health and wellbeing indicates that learning, teaching and regular practice of emotional self-regulation in children as young as 6 years is likelier than any other single mechanism to increase population mental health resilience, resulting in whole-of-life reduced risks of mental ill-health.[3]

Australian primary school students should learn and regularly practise behaviours and activities that support the development of emotional self-regulation (coping skills for difficult emotions) through distress tolerance, self-soothing, controlled breathing, meditation and bodily awareness (grounding). These skills provide foundational support for whole-of-life emotional resilience, which supports mental health and wellbeing and lowers risks of mental ill-health.

Primary school programs that encourage the development of emotional self-regulation will necessarily inform and be grounded by an educational culture that encourages open, non-stigmatising, investigative approaches to experiences of mental ill-health, and in which schools prioritise collaborative learning and open discussion around mental health and wellbeing.

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[2] "Early identification of risks in children offers the greatest potential for improving health, social and economic outcomes… identification of children at risk is simply a starting point. Schools need to be effective gateways for students and their families to access help." *Draft Report*, Vol. I: *Overview*, pp. 11-12. Also refer to RANZCP, Sub. 385, pp. 12-13.

[3] Bessel van der Kolk, a leading global expert on traumatic stress (van der Kolk 3) publicly advocates for the institution of broad-scale teaching of skills in affect regulation (including controlled breathing, grounding skills, distress tolerance and self-soothing) to every primary school student in the USA as the most effective means of protecting people from lifetime risk of mental illness (van der Kolk 1, van der Kolk 2, references at end of Submission).

Early Secondary cohort: recommended focus and aim of programs

The onset of adolescence is a significant developmental milestone for early secondary students (aged 12 – 15 years). While students have developed a more complex factual and conceptual understanding of the world, they must also contend with the equally complex experiential changes that come with psychological and emotional development. Underlying each student's emotional wellbeing is their experience of human attachment, the framework through which we communicate, bond with and understand each other.

Early secondary students should learn fundamental aspects of human psychology, including human attachment theory and how attachment affects human relationships. They should be able to apply learnings to themselves and others and have an understanding of the importance of attachment, relationships and emotional regulation to their own and others' mental health and wellbeing.

As discussed above, early secondary programs that teach students about psychology, attachment, relationships and emotional regulation and encourage them to investigate applying these learnings to their own experience must be supported by a whole-of-school culture of open, non-stigmatising and investigative approaches to experiences of mental ill-health in which open discussion, collaborative learning and engagement around student mental health and wellbeing is encouraged and facilitated.

Senior Secondary cohort: recommended focus and aim of programs

Senior secondary students (16-18 years) are rapidly progressing towards adulthood. They have significant capacity to understand and express issues relating to mental health and wellbeing. However, many senior secondary students lack:

- Knowledge about mental ill-health and how to recognise risk factors for mental ill-health in themselves and others
- Willingness or ability to ask 'adults' for advice. As late adolescence is marked by an increasing desire to individuate, students tend to distance themselves from family members and pay more attention to age peers.

To support senior secondary students' mental health and wellbeing, schools should implement programs that:

- Provide a strengths-based approach acknowledging students' relative maturity and seniority
- Provide detailed information on mental ill-health, including information on common mental illnesses, risk factors and early warning signs of mental ill-health. Discussion around these issues should be open and non-stigmatising
- Enhance students' capacity for self-guided research and reflective practice to enable autonomous learning in relation to mental ill-health and its management, and
- Support autonomy and decision-making by enabling and encouraging students' participation in age-peer mental health support programs.

Senior secondary programs that fulfil the above aims will better enable senior secondary students to understand and manage their own mental health and wellbeing as they transition into adulthood.

CASE STUDY: Senior secondary students run peer mental health support program

The Hutchins School, an independent boys' school in Hobart, Tasmania, runs a student-initiated, student-led peer mental health student support service. The model after a student survey, conducted at the School in late 2018, asked students, "If you were struggling [with a mental health issue], who would you feel most comfortable talking to?". Students overwhelmingly answered "friends" (as opposed to parents, family, or teachers).

This prompted George Scott, a School Prefect with responsibility for the Mental Health portfolio, to ask the School to provide Mental Health First Aid training for himself and other students who volunteered. The School agreed to provide this training for a small group of student volunteers. School counsellor Matt Magnus then assisted students to design and implement the program, which has the following key features:

- Mental Health Contact Officers (student volunteers who have completed Mental Health First Aid (MHFA) training) initiate, engage in, listen and actively manage conversations about mental health with other students, encouraging further help-seeking where needed. They use their MHFA training to inform decisions about whether to approach someone, why, and how. As of November 2019, there were 19 fully trained student Mental Health Contact Officers at the School.
- Students with mental health concerns can approach and speak confidentially to any Mental Health Contact Officer. Officers are easily identifiable via a green ribbon pinned to their lapels.
- In addition to being available on an *ad hoc* basis, Mental Health Contact Officers have a weekly lunchtime 'drop in' session, an engagement activity that provides a 'safe place' and counters bullying and social exclusion.
- Mental Health Contact Officers hold regular group debriefing sessions supported by the school counsellor in which they can bring up any issues and ask for advice. This is structurally equivalent to the role of clinical supervision in a mental health framework.
- A recent student survey 'tested' the program. 66% of students said they would feel comfortable to approach a Mental Health Contact Officer and over 80% of students said that Contact Officers were a good idea, showing very high support for the model.

In summary, the Hutchins Model is a successful exemplar of a peer-led, school-based mental health and wellbeing program, co-designed and run by and for senior secondary students, within a supportive structure that includes voluntary upskilling of students in mental health first aid, a degree of clinical supervision, and regular evaluation. In combining these features, the Model works to progressively transfer autonomy and decision-making power around mental health issues to senior students, assisting development of sound judgment, insight and decision-making skills, and supporting effective and empathic peer connections.

The Hutchins Model is described in MHCT's Youth Mental Health Forum Briefing Paper, pp. 18 – 19 here.

Embedding mental health learning outcomes in the National Curriculum

The National Curriculum drives and supports nationally consistent learning outcomes in Australian primary and secondary schools. It is the most effective lever the Australian Government has to implement consistent school-based learning and teaching on mental health and wellbeing.

While the National Curriculum currently references mental health, its coverage is minimal and general. It does not articulate specific learning outcomes that support better mental health and wellbeing. For instance, it requires Year 1 and 2 students to "identify and practice emotional responses that account for own and other's feelings".[4] This task of emotional recognition and expression does not address the key challenge of *regulating and managing emotion*, a critical part of emotional resilience that can be strengthened by learning skills in grounding, self-soothing and mindfulness. Likewise, the Curriculum asks Year 9 and 10 students to "investigate how empathy and ethical decision-making contribute to respectful relationships".[5] These important tasks are far less meaningful if taught in isolation. To be effective they must be situated within the context of human attachment, relationships and the importance of healthy interpersonal connection in maintaining mental health and wellbeing.

MHCT believes that the Australian Government could effectively harness the National Curriculum to drive the implementation of Recommendation 17.3 by expanding Curriculum requirements to encompass specific mental health learning and teaching tasks that:

- Are matched to the developmental stage of the student as outlined above;
- Will provide practical whole-of-life benefit in relation to increasing students' emotional resilience;
- Will enable students to understand the basis and key drivers of mental health and wellbeing, and apply these learnings to their own lives; and
- Will support students to identify risk factors and signs of mental ill-health in themselves and others.

MHCT THEREFORE RECOMMENDS that Draft Recommendation 17.3 be substantially revised as follows (please note that MHCT's suggested revisions to the Draft Recommendation appear in italics).

[REVISED] DRAFT RECOMMENDATION 17.3

BUILDING RESILIENCE FOR BETTER MENTAL HEALTH AND WELLBEING IN SCHOOLS

Governments should develop a comprehensive set of policy responses to strengthen the ability of schools *to teach effective skills that will enable students to build resilience, increase their knowledge and understanding of mental health and wellbeing, and give them greater capacity to identify and manage risk factors for mental ill-health in themselves and in others.*

In the short term (in the next 2 years):

The COAG Education Council should develop a national strategic policy on social and emotional learning in the Australian education system. This policy should include:

[4] As quoted in the *Draft Report*, Vol. II, p. 668

[5] As quoted in the *Draft Report*, Vol. II, p. 668

- A clear statement on the role of the education system in supporting mental health and wellbeing, and the role of schools in interacting with the mental health system
- *A commitment to revise the Australian National Curriculum to include additional mental health learning outcomes specifically designed for primary, early secondary and senior secondary students respectively, with reference to the following content guidelines:*
  - *Primary students (6 – 11 years): learn and regularly practise behaviours and activities that support the development of emotional self-regulation through distress tolerance, self-soothing, controlled breathing, meditation and bodily awareness, on the basis that these provide foundational support for whole-of-life emotional resilience and support improved mental health and wellbeing*
  - *Early secondary students (12 – 15 years): learn fundamental aspects of human psychology, including human attachment theory and how attachment affects human relationships; be able to apply learnings to themselves and others and demonstrate understanding of the importance of psychology, attachment, relationships and emotional regulation to their own and others' mental health and wellbeing*
  - *Senior secondary students (16 -18 years): learn about common mental illnesses; participate in non-stigmatising discussion of mental illness, risk factors and early warning signs. Demonstrate ability to undertake autonomous learning and reflection in relation to mental illness. Understand and support school-based, age-peer-led mental health support programs.*
- *A commitment to cooperate with the COAG Health Council in the implementation of mental illness prevention policy, and a clear delineation of responsibility, to prevent overlap and confusion in policy development*
- Guidelines for the accreditation of external social and emotional learning programs offered to schools. These guidelines *should have regard to the proposed mental health and wellbeing learning outcomes for primary, early secondary and senior secondary students contemplated at Dot Point 2 above*

In the medium term (over 2 – 5 years)

- State and Territory departments of education should use the national guidelines to accredit social and emotional learning programs delivered in schools.
- State and Territory teacher regulatory authorities should use the national guidelines to accredit initial teacher education programs and professional development programs for teachers. Ongoing learning on child social and emotional development and wellbeing should form part of professional development requirements for all teachers. This should include the social and emotional wellbeing of Aboriginal and Torres Strait Islander children.

In summary, given the firm basis for a 'lifespan' approach provided by Draft Recommendations 17.1, 17.2, 17.4 and 17.6, MHCT strongly supports these Recommendations as written, and further proposes that Draft Recommendation 17.3 be revised as outlined above to strengthen and complement the 'lifespan' approach contemplated by Section 17 of the Draft Report.

The aim of the suggested revisions to Draft Recommendation 17.3 is to ensure that this Recommendation will complement and strengthen Draft Recommendations 17.1, 17.2, 17.4, 17.5 and 17.6, with the aim of achieving:

- **A nationally consistent approach** in which all Australian children will have equity of access to mental health and wellbeing teaching and learning from preschool, through primary school, to early and senior secondary school
- Schools-based mental health and wellbeing programs that relate specifically to the developmental stage of the student, as per:
    - *Primary school (6 – 11 years)*
    - *Early secondary school (12-15 years)*
    - *Senior secondary school (16-18 years)*
- Program approach and content that is soundly based on **best-practice global research**
- Outcomes data is collected
- Regular evaluations are performed to create an ongoing evidence base
- Measurement and analysis of longitudinal outcomes via integrated cross-agency data collection and evaluation (for instance, through additional questions in ABS National Mental Health and Wellbeing Survey).

Comments on Draft Recommendation 17.5: Wellbeing leaders in schools

Draft Recommendation 17.5 contemplates a requirement for schools to provide a dedicated school wellbeing leader to oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access support.

MHCT notes that it is important to have an appropriately qualified mental health specialist at every school. However, the position description indicates that the wellbeing leader may be required to oversee or actively manage students with risk factors for mental illness or who are experiencing mental ill-health. While it is critical that schools provide such interventive supports, these interventions do not form part of the population-based preventive approach contemplated in Draft Recommendations 17.1, 17.2, 17.3, 17.4 and 17.6, in which all students have equitable access to teaching and learning on mental health and wellbeing.

MHCT notes concern at Dot Point 1 of Draft Recommendation 17.5:

"State and Territory Governments should review existing programs that support school wellbeing initiatives and establish which funding could be redirected toward the employment of school wellbeing leaders in schools".

This statement could result in a reduction of funding for any broad-based preventive approaches currently in place. As noted above, it is unclear whether any funding redirected toward the school wellbeing leader's employment would support preventive (as opposed to interventive) mental health and wellbeing for students. There is a risk that the funding redirection as contemplated could weaken preventive mental health and wellbeing measures currently in place.

MHCT recommends that Commissioners consider carefully the nature and purpose of the 'wellbeing leader' role, with specific regard for:

- How the school wellbeing leader role will complement and support a 'Lifespan' approach to mental health and wellbeing learning and teaching for all students, and
- Ensuring that no school need de-fund existing mental health and wellbeing teaching and learning activities aligned to a 'Lifespan' preventive model for the purposes of redirecting funding to support wellbeing leader salary costs.

Comments on Draft Recommendation 22.1: National Suicide Prevention Agreement

MHCT supports a national mental health and suicide prevention agreement that sets out a shared intention for all levels of government to work in partnership and clearly identifies the roles and responsibilities of each tier of government in funding and the delivery of mental health services.

Comments on Draft Recommendation 23.3: Structural reform

MHCT supports the Commission's aim to improve coordination and integrated delivery of funding and services across and between all levels of government.[6] MHCT believes that improvements to the coordination of funding and service delivery is a critical component to achieving greater continuity of care, an important principle of mental health care which mitigates the risk of mental health consumers 'falling through the gaps'.

Renovate v Rebuild models

MHCT notes the Commission aims to solve service gaps, duplication and discontinuities of care within the mental health system through the Rebuild model and the creation of new Regional Commissioning Authorities (RCAs)[7]. MHCT recognises the implementation of RCAs as a separate legal entity would offer greater capacity for coordination of mental health services and greater regional autonomy in relation to funding allocation.[8]

While this may be beneficial in larger states, in Tasmania such a system is effectively already in place given that Tasmania uniquely has a single PHN and LHN. In this context the implementation of an RCA may add complexity by creating another level of collaboration and planning.

It is critical that the progress made in Tasmania under the current framework should be maintained and built upon during any contemplated national structural changes. Tasmania's sole PHN, Primary Health Tasmania (PHT) has been active in undertaking intrastate planning for the diverse needs of Tasmania's regional communities. PHT has worked closely with Tasmanian Local Health Networks (LHNs) to better coordinate mental health care. Further, PHT and the Tasmanian Government are currently engaged in a joint mental health and suicide prevention planning process scheduled for completion in mid-2020. It is critical to enable this work to continue without disruption, and to allow its outcomes to inform any further mental health funding coordination between the Australian and Tasmanian governments. Therefore, MHCT urges the Commission:

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[6] *Draft Report*, Vol. I, *Overview*, p. 42

[7] *Draft Report*, Vol. II, p. 960

[8] As per Draft Recommendation 24.2 of the *Draft Report*, Vol. 1, *Overview*, p. 106

To CONSIDER:

(a) Tasmania's unique position in having a single PHN, recognising that in this context the introduction of a Regional Commissioning Authority for Tasmania may add to funding channel complexity, thereby creating the opposite effect to that intended

(b) How best to acknowledge and incorporate the ongoing collaborative work by the Australian and Tasmanian Governments toward achieving better integration of mental health funding channels and service delivery

(c) Recommending that the Australian Government work *with each state individually* to determine how best to implement or carry forward successful models of coordinated, integrated funding delivery that are aligned with the Commission's preferred structural model.[9]

Comments on Draft Recommendation 24.2: Regional autonomy

MHCT supports greater regional autonomy over service provider funding. In Tasmania, Primary Health Tasmania is best placed to identify what services are required to support the region. The joint regional planning currently being undertaken in collaboration with Tasmania's PHN and the Tasmanian Department of Health (DoH) will provide an opportunity to identify where appropriate funding is required within the state. The process intends to minimise funding duplication and fulfil service gaps throughout Tasmania with the advantage of having a single regional plan that covers the state. MHCT supports the continuation and implementation of this process and agrees with the Commission that PHNs should be able to redirect funding to better meet the needs of their local areas as they see fit.

Part 3: Additional Comments

Managing implementation: successfully transitioning to a new mental health system

MHCT notes that the Commission has considered issues in relation to successful implementation of systemic change.[10] Systemic change requires consideration of the interconnection and impact of reforms both horizontally and vertically, across all tiers of government, individuals, families and the community, along with public and private mental health sectors.

A detailed implementation plan is crucial to the success of any reforms. The interim report from the Victorian Mental Health Royal Commission has recommended the establishment of an 'Implementation Office'[11] to initially plan and action identified reforms. This may be a vital recommendation for the Productivity Commission to consider. Provision of an Implementation Office to support the rollout of systemic changes within the mental health care system could help ensure that implementation is effective, and that the demand drivers for each stage of change are mapped,

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9 Discussion of PHN-LHN integration activities as per *Draft Report*, Vol. II, p. 939

10 *Draft Report*, Vol. II, p. 1056

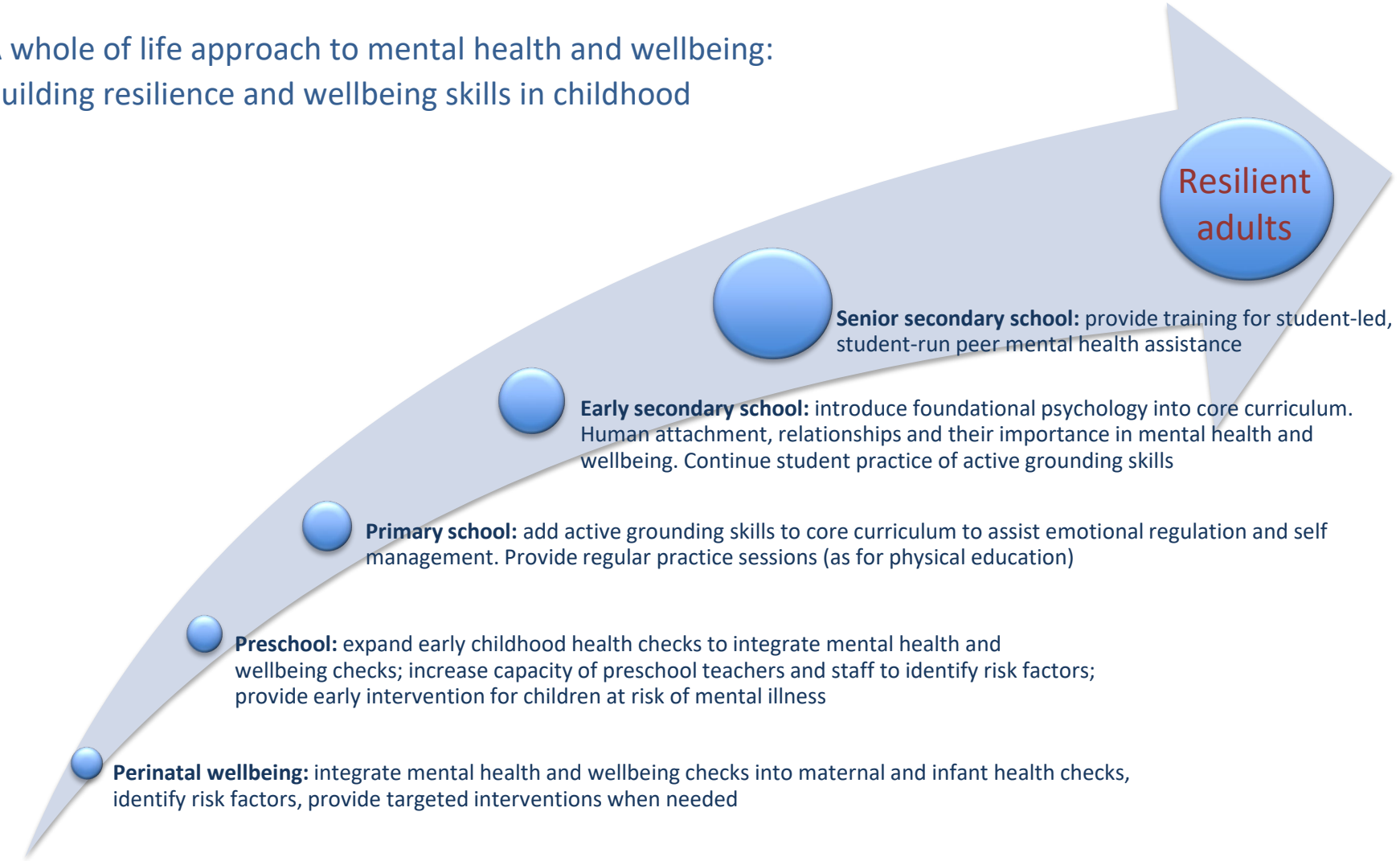
11 Royal Commission into Victoria's Mental Health System, *Interim Report*, November 2019, p. 567

in a process that ensures priority timeframes for key inputs and identifies any potential bottlenecks or points of failure.

MHCT also notes that an Implementation Office, if established, should work within recovery-focused and trauma-informed principles, widely recognised as best practice within the mental health sector. Any new reforms should be underpinned by these fundamental principles.

MHCT looks forward to the Commission's final report with detailed information on prioritising and sequencing of proposed reforms.

A whole of life approach to mental health and wellbeing: Building resilience and wellbeing skills in childhood



References

Draft Report
Productivity Commission, *Inquiry on Mental Health*: *Draft Report*, 2 vols., Canberra, October 2019

MHCT Submission to Review of Services
Mental Health Council of Tasmania, *Submission to the Tasmanian Government's Review of Services: Mental Health Services Helpline and Crisis Assessment and Treatment Teams*, Hobart, 15 October 2019

MHCT Peer Workforce Development Strategy
Mental Health Council of Tasmania, *Tasmanian Peer Workforce Development Strategy*, Hobart, November 2019

MHCT Youth Mental Health Forum Briefing Paper
Mental Health Council of Tasmania, *Youth Mental Health Forum Briefing Paper* (proceedings from the *Tasmanian Youth Mental Health Forum*), Hobart, November, 2019

RANZCP Sub. 385
Royal Australian and New Zealand College of Psychiatrists, *Submission to the Productivity Commission's Inquiry on Mental Health* (Submission No. 385).

Royal Commission Interim Report
Royal Commission in the State of Victoria, Australia, *Inquiry into Victoria's Mental Health System: Interim Report,* Melbourne, November 2019

Sydney Morning Herald, 2 Dec 19
Fowler, Michael, "School program helps teens ask their mates: 'Are you OK?' ", in the *Sydney Morning Herald*, 2 December 19

van der Kolk (1)
Van der Kolk, Bessel, *Developmental Trauma,* Conference Presentation, *Changing the Paradigm* Annual Conference, Echo Parenting and Education, Los Angeles, November 2015

van der Kolk (2)
Van der Kolk, Bessel, *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma*, New York, 2014

van der Kolk (3)
Van der Kolk, Bessel, *Effective Methods of Treating Trauma*, interview with Ing. Bernhard Trenkle, Heidelberg, Germany, 27 May 2016

Appendices

Appendix A

Dot Point Presentation by Ms Connie Digolis, CEO of MHCT, for the Launceston Hearing of the Productivity Commission *Inquiry into Mental Health*, December 2019

Introduction:

- We acknowledge and thank Commissioners for their consideration of our formal Submission to the Inquiry in May this year.

- We were pleased to note that MHCT was referenced as a knowledge source in relation to:
    - the economic costs of suicide;
    - diagnostic overshadowing of physical co-morbidities for people with mental illness;
    - the distressing nature of ED presentations for people in psychological crisis; and
    - the current lack of clarity around the governance of the NMHC

Structural reforms and governance:

- Welcome considerations on addressing continuity of care within structural reforms.
- Intergovernmental agreement and recognising roles and responsibilities across all tiers government.
- MHCT questions if the ground work currently undertaken by local PHN's and LHN's to coordinate mental health care will be undone under the rebuild system.
- MHCT questions how these major reforms will be implemented successfully.

Mental health and wellbeing in childhood:

- Applaud the Draft Report's recognition of the importance of perinatal and infant mental health and wellbeing
- Also support Draft Recs 17.3 and 17.4 (initiatives to strengthen mental health and wellbeing programs in schools) and believe that this could be developed into a "whole of life" approach with the addition of one more step – separation of primary and secondary school initiatives
- Primary children – active resilience building skills
- Secondary school children – 'how to be human' (importance of relationships/community/family) and mental health v. ill-health
- Senior secondary school children – non-clinical, strengths-based approach – consider student peer support models

National Mental Health Workforce Strategy

- Important to ensure that all existing and planned state and regional mental health workforce strategies and mapping is integrated into any update of a National Mental Health Workforce Strategy - mitigate risks of specific areas and regions being poorly reflected in national data and/or proposed strategic directions.

Appendix B

MHCT Proposal for a Centralised Mental Health Access Service for Tasmania

The Summary and Structural model of MHCT's proposed Centralised Mental Health Access Service appear below.

For full details, please refer to MHCT's *Submission to the Tasmanian Government's Review of Services: Mental Health Services Helpline and Crisis Assessment and Treatment Teams*, 15 October 2019, of which the proposal was originally part.[12]

Summary

A new **Centralised Mental Health Access Service**, co-designed and co-managed by a consortium of public, private and community providers, is proposed. This will incorporate the functions of the existing Mental Health Services Helpline and the CATTs. It will provide person-centred stepped care, foster collaborations and partnerships across the public, private and community-based mental health care sectors, and prioritise hospital avoidance and ED bypass, coupled with prevention and early intervention options for mental health consumers.

The Access Service will add frontline capacity by establishing a new, multi-disciplinary Telephone Access and Intake Team to:

- Provide comprehensive advice to service providers, allied health professionals, consumers, carers and families in relation to all mental health services available in Tasmania along the full mental health acuity spectrum;
- Act as a one-call gateway to public, private and community-managed mental health services, with direct booking capacity via an integrated data system and using warm transfer as a core telephone service principle;
- Provide immediate telephone intake to the Access Service with no need for further admission to any program that is part of the Service;
- Manage transfers between services on a 'no-discharge' model, supporting stepped care pathways and protecting consumers from the inherent risks of 'gaps' between stepped services;
- Act as a key hospital avoidance mechanism;
- Enable ED bypass for acute mental health assessments and admissions;
- Significantly increase response capability for early interventive and preventive mental health;
- Actively assist consumers to navigate mental health stepped-care pathways along the entire mental health acuity spectrum (including preventive, early interventive and interventive care) within the 'no-discharge' framework described above;
- Manage statewide mental health crisis response and outreach, coordinating complex crisis responses with other agencies; and
- Co-manage, train and coordinate mental health care staff embedded within Tasmania Police to increase the capability of the state emergency services to respond to mental health crises involving a threat to life.

[12] The Submission may be found here.

Structural Model

A structural representation of the model appears at Figure 1.

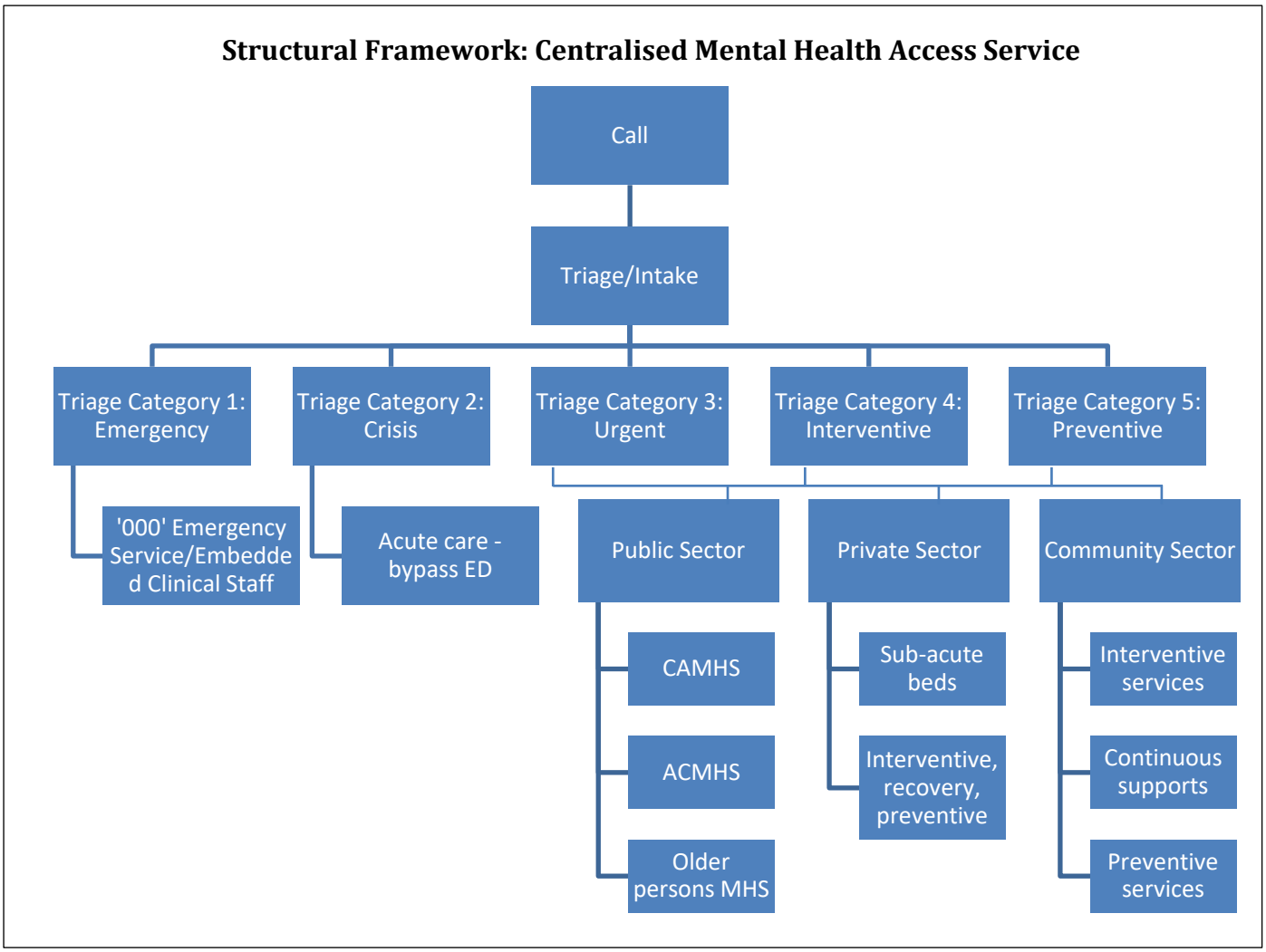


Figure 1: Structural representation of Access Service

Appendix C

Tasmanian Peer Workforce Development Strategy

Please refer to separate attachment: *Tasmanian Peer Workforce Development Strategy* (PDF file)

MHCT's *Tasmanian Peer Workforce Development Strategy* was published in November 2019. It can be found online here.