Mind the gap

Shaping the mental health system for the people who need it most

**WORKING FOR
A JUST TASMANIA**

AnglicareTAS
Choice, support and hope

SOCIAL
ACTION &
RESEARCH
CENTRE

Contents

Published September 2025

Acknowledgement of Country

Anglicare Tasmania acknowledges and pays respect to the Tasmanian Aboriginal community as the traditional and original owners and continuing custodians of this land, Lutruwita/Tasmania, on which this project has taken place. We acknowledge Elders past and present, and Aboriginal people who have participated in and are connected with this research.

Acknowledgements

The assistance of Anglicare Tasmania's Housing Services and Community Services in the preparation of this report is gratefully acknowledged. Thank you for the important work you do, and to the people you work with for their strength and resilience.

Thank you to other Anglicare colleagues for your expertise, support and guidance.

About Anglicare Tasmania

Anglicare, in response to the Christian faith, strives to achieve social justice and to provide the opportunity for people in need to reach fullness of life.

Our values

Hope
Confidently reaching for fullness of life.

Compassion
Showing empathy and care for those in need.

Justice
Promoting the fair distribution of resources and opportunities.

Respect
Recognising the inherent value and dignity of every person.

Anglicare Tasmania's Social Action and Research Centre

The Social Action and Research Centre investigates how and why Tasmanians are affected by poverty and inequality. We use what we learn to advocate for changes that improve people's lives.

Our qualitative research centres on the lived experience of Tasmanians. It often features the voices of people who use Anglicare services and our frontline workers.

Our quantitative research uses data to demonstrate social trends.

We brief government and stakeholders on our research and create opportunities for networking and collaboration.

Executive summary

One in two Tasmanians experience a mental health condition at some stage in their lives, which is the highest rate in Australia. Compared to the general population, people with mental health conditions are more likely to experience low income, housing instability and homelessness, social isolation, and alcohol and other drug use. However, the mental health system is not yet designed to support people with complex needs who need it most.

Insights from Anglicare staff across housing and community services programs identified that:

- the service system is fragmented and difficult to navigate
- costs and waiting times are barriers to accessing care through general practitioners and psychologists for people on low incomes
- a lack of psychosocial support outside the National Disability Insurance Scheme (NDIS) and supported accommodation options for people with mental health conditions is increasing demand for crisis intervention and putting pressure on the limited mental health workforce
- people with a mental health condition who are using alcohol and/or other drugs (AOD) face barriers to accessing care due to eligibility restrictions of support services and programs.

The mental health services system needs to be designed for people who, compared to the population average, are more likely to have a low income, comorbid alcohol and/or drug use, poor physical health, fewer social supports, and/or housing insecurity. Non-health interventions that provide housing security and raise income above the poverty line are also important and feasible policy levers to improve mental health.

Acute mental health episodes that result in hospital admissions are costly both in terms of the financial cost of care and the impact on the individual. A focus on keeping people well in the community to minimise hospital admissions is paramount.

There will be a continued need for inpatient facilities for acute episodes of care and the improvements to the Launceston General Hospital (LGH), including the Emergency Department (ED), are welcome. However, complementing this work with greater investment in community-based models of care would deliver recurrent budget savings and alleviate pressure on acute care teams by reducing the frequency of admissions. Addressing the current unmet need for psychosocial supports outside of the NDIS is a critical priority.

Work to reform the mental health system, including towards an integrated system, is acknowledged. This study highlighted that governments need to maintain focus on better integrating AOD and mental health services to support people with comorbidity and addressing key enablers including the mental health workforce and the way services are funded and commissioned.

The costs of mental health care could be reduced and outcomes improved by providing adequate income and secure housing with appropriate supports to people living with mental health conditions.

Recommendations

Anglicare Tasmania recommends:

Adequate income

1. That the Australian Government increase income support payments to above the Henderson Poverty Line.

1

Affordable mental health care

2. That the Australian Government and Tasmanian Government continue work to improve the affordability of mental health care, including through:

a) expanding the number of GP bulk-billing appointments available in Tasmania; and

b) providing access to affordable and bulk-billed psychology and psychiatry, including through the Medicare Mental Health Hub.

2

Housing

3. That the Tasmanian Government and Homes Tasmania:

a) fund additional investment in transitional and long-term supported accommodation to meet the needs of people living with mental health conditions;

b) continue work with social housing and supported accommodation providers to improve allocation processes; and

c) work with the Australian Government to scale up investment in long-term social housing.

3

Progressing reforms towards an integrated system

4. That the Australian and Tasmanian Governments:

a) continue work to integrate the mental health system, including exploring funding and commissioning models of services to support a continuum of stepped care; and:

b) immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme as recommended by the Productivity Commission.

5. That the Tasmanian Government:

a) develop the next phase of the Tasmanian statewide mental health strategy following Rethink 2020, prioritising efforts to:

   i) deliver its statewide mental health workforce strategy, aimed at developing the existing workforce in Tasmania as well as attracting and retaining in-demand professions; and

   ii) progress integration of the mental health service system with other key areas including alcohol and drug services and housing;

b) support a sustainable community services sector through progressing five-year contracts with adequate indexation.

LGH Masterplan implementation

6. That the Tasmanian Government continue to implement the LGH Masterplan, prioritising:

a) an implementation plan providing detail of the delivery timelines and operational models for the precinct;

b) delivery of the LGH Mental Health Precinct including increased inpatient beds and short stay beds available to people without a discharge address; and

c) the expansion and redesign of the Emergency Department, including delivering a separate waiting area for people in acute psychological distress.

Background and context

Why we did this research

Across Anglicare's various community services and housing programs, practitioners reported that gaps in the mental health service system present barriers to clients accessing support and achieving goals. Limited access to appropriate mental health support can have significant impacts including on stable accommodation and quality of life. With work to reform the mental health service system being undertaken at the state and federal levels, it was timely to explore the current gaps in the system and their impacts on people.

This research explored experiences across programs with a focus on the North of Tasmania, due to upcoming and recent initiatives targeted in the region such as the Launceston General Hospital (LGH) mental health precinct and Medicare Mental Health Hub.

Due to the complex nature of the mental health system, the scope of this report is limited to discussing the adult mental health system (ages 18-65). Children (under 18) and older people (over 65) have additional developmental and medical needs and whilst there is some crossover between the adult, child and adolescent, and older people's mental health systems, this report does not cover the additional needs and services of children, young people and older people.

How we did this research

This research aimed to answer the following questions:

- How is the mental health service system currently operating in the North of Tasmania?
- What gaps are there in the mental health service system for Anglicare clients in the North of Tasmania?
- To what extent will mental health initiatives, such as the proposed Launceston General Hospital (LGH) mental health precinct and work towards a mental health continuum of care, address any of these gaps?
- What gaps are not expected to be addressed by proposed initiatives?

The following research tasks were completed between May and August 2025:

Quantitative and qualitative data

- Consultations with practitioners in Anglicare's Housing Services (Housing Connect, Adult Supported Accommodation Facilities, and Youth 2 Independence) to explore the current gaps in mental health services experienced by clients and their impacts.
- Consultations with practitioners in Anglicare's Community Services (Rocherlea Residential Recovery Service, Recovery (Packages of Care) Program, The Way Back Support Service, Financial Counselling, Addictions, and Child and Family Services) to explore the current gaps in mental health services experienced by clients and their impacts.
- Content analysis and thematic review of qualitative data gathered through consultations across programs.
- Analysis of deidentified service data from the Housing Connect Front Door Service in FY24-25.
- Analysis of deidentified demographic and service data from Way Back Support Service, Recovery Program, Rocherlea Rehabilitation and Recovery Service, and Financial Counselling.
- Analysis of client needs data from Adult Supported Accommodation Facilities.
- Analysis of data on mental health in Tasmania from the Australian Institute of Health and Welfare, Australian Bureau of Statistics, and Report on Government Services.

Literature review

- Literature review of relevant literature including the intersection of mental health with housing and homelessness, income, and alcohol and other drugs.

Please note that names and details of clients in stories throughout this report have been changed to protect privacy.

Content warning

Please be advised that this report includes stories and content that relate to people's experiences of mental health and navigating the mental health system. There are references throughout the report to mental health issues, including suicide. Please take care when reading this material, and if needed speak with a support person you know or call a telephone support line.

- Lifeline – 13 11 14
- Suicide Call Back Services – 1300 659 467
- 13YARN – 13 92 76
- Kids Helpline – 1800 551 800

Glossary

Different terminology can sometimes be used to express the same or similar concepts across mental health and other sectors. This report takes this into account and tries to use terminology consistently as outlined in the below glossary.

Term	Definition
Domestic and family violence	Behaviours that cause, or intend to cause, fear or harm within the context of family or intimate partner relationships. Violence can occur in the form of threat, assault, abuse, neglect or harassment and is often used by a person or people to intimidate, harm or control others. Not all forms of violence are physical (AIHW 2023).
Homelessness	When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement: • is in a dwelling that is inadequate; or • has no tenure, or if their initial tenure is short and not extendable; or • does not allow them to have control of, and access to space for social relations (Homelessness Australia n.d.).
Medicare Benefits Schedule	The Medicare Benefits Schedule (MBS) is a list of health professional services subsidised by the Australian Government (Department of Health Disability and Ageing 2025a).
Mental health condition	A broad term covering mental illness, psychosocial disability and other mental states associated with significant distress, impairment in functioning, or risk of self-harm (WHO 2022).
Mental illness	A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities (COAG Health Council 2017).
Primary Health Network	Primary Health Networks (PHNs) are independent organisations funded by the Australian Government to coordinate primary health care in their region. Primary Health Tasmania is one of 31 PHNs in Australia, which receive and distribute funding for specific mental health services such as headspace centres and for planning, integrating and commissioning other mental health services in their region in accordance with the needs of the community (Primary Health Networks 2019).
Psychosocial disability	A disability that arises from a mental health issue. Not everyone who has a mental health issue will experience psychosocial disability. Those who do can experience severe effects and social disadvantage. People with a significant disability that is likely to be permanent may qualify for NDIS support (NDIA 2024).

Term	Definition
Psychosocial supports	Non-clinical, recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community (Health Policy Analysis 2024).
Recovery	In this document, recovery means the process of creating and living a meaningful and contributing life in a community of choice with or without the presence of mental health issues (Australian Health Ministers' Advisory Council 2013). It is not just about clinical recovery (absence of symptoms) but also about an individual's overall sense of wellbeing. Recovery-oriented approaches recognise the value of lived experience of mental health issues and bring it together with the expertise, knowledge and skills of mental health practitioners, many of whom have experienced mental health issues in their own lives or in their close relationships (Australian Health Ministers' Advisory Council 2013). Most importantly, recovery-oriented care puts the needs of the person first.
Recovery College	A service based on adult education rather than clinical or therapeutic models. Offers a range of courses focused on equipping students with skills that can foster wellbeing and recovery. Peers are often involved as course teachers in co-delivery, co-design and co-production (Whitley et al. 2019).
Safe Haven	An alternative support service, other than a hospital emergency department, available to people feeling suicidal or otherwise in severe mental distress (BEING n.d.). It is staffed by both peer workers and clinicians and can be accessed without a referral.
Social housing	Government subsidised rental housing for people on very low incomes and who have often experienced homelessness, family violence or have other needs. Includes public housing owned and managed by government and community housing managed by not-for-profit organisations (AHURI 2023).
Step up step down	Clinically supported services which offer short term care in between inpatient and community settings. They provide an alternative to hospital admission (pre-acute) and provide bridging support following discharge from hospital (post-acute). Also known as 'sub-acute' (Australian Department of Health 2019).
Supported accommodation	A type of social housing, often in a communal setting, that provides a level of support for people with particular needs.

Anglicare's services

Anglicare is one of the largest providers of community services in Tasmania. It delivers community support services such as mental health, alcohol and drug support, financial counselling, Gamblers Help and housing services such as supported accommodation and Housing Connect Front Door. It is well placed to observe the intersection of mental health, low income, housing instability, and alcohol and drug use.

Anglicare's mental health services use a recovery approach.

Below is an overview of the main program areas consulted for this research.

Service type	Program or service description
Mental health services	**The Recovery program** is funded by the Tasmanian Department of Health and provides one-to-one support for up to two years for people recovering from a diagnosed mental health condition and who live in independent accommodation.
	The Way Back Support Service is funded by Primary Health Tasmania and provides personalised support for up to three months following a suicide attempt or suicidal crisis. A dedicated support coordinator works with an individual to develop and deliver a support program.
	The Rocherlea Residential Rehabilitation and Recovery Service is funded by the Tasmanian Department of Health and aids mental health recovery in a safe and calm environment. It provides therapeutic, non-clinical care to adults recovering from mental health conditions. This service has two distinct programs. • *Step-up step-down program*: This program hosts 5 self-contained rooms that provide holistic short term psychosocial support for up to 28 days. • *Residential recovery program*: This program has 10 units set up for people to stay in for up to two years as they transition towards independent living.
Addictions services	**The Alcohol and Drug Treatment Service (ADATS)** is funded by Primary Health Tasmania and delivers intensive treatment that recognises the unique biological, psychological and socio-demographic features of each client's life. As a result, each treatment approach – or combination of approaches – is unique to the individual client.
	The Care Coordination service is funded by the Tasmanian Department of Health and provides a central coordination service for people with complex needs who are referred by Tasmanian Government Alcohol and Drug Services.

Service type	Program or service description
Housing services	Anglicare Tasmania provides the **Housing Connect Front Door** service statewide, funded by Homes Tasmania. This service is the entry point to housing support in Tasmania for people experiencing, or at risk of, homelessness.
	Long-term supported accommodation facilities are funded by Homes Tasmania and provide accommodation for adults on low incomes at risk of homelessness. Tenants live in independent or separate units with communal areas and limited on-site support. Supports may include connecting residents with health and community services, connecting them with social support and assisting them to maintain a tenancy and develop their personal capability.
	Youth 2 Independence facilities are funded by Homes Tasmania and provide safe and affordable housing for young people between ages 16-24 in independent units with shared social spaces. Residents are supported to engage in education, training, and developing independent living skills.
Other community services	**Financial counselling** is a free service funded by the Australian Government and Tasmanian Government available throughout Australia and delivered statewide in Tasmania by Anglicare. This independent, non-judgemental and confidential service helps Tasmanians of all ages to organise their budgets, manage any debts and connect to other useful services.

Mental health in context

Prevalence of mental health conditions in Tasmania

Tasmania has the highest prevalence of mental health conditions in Australia:

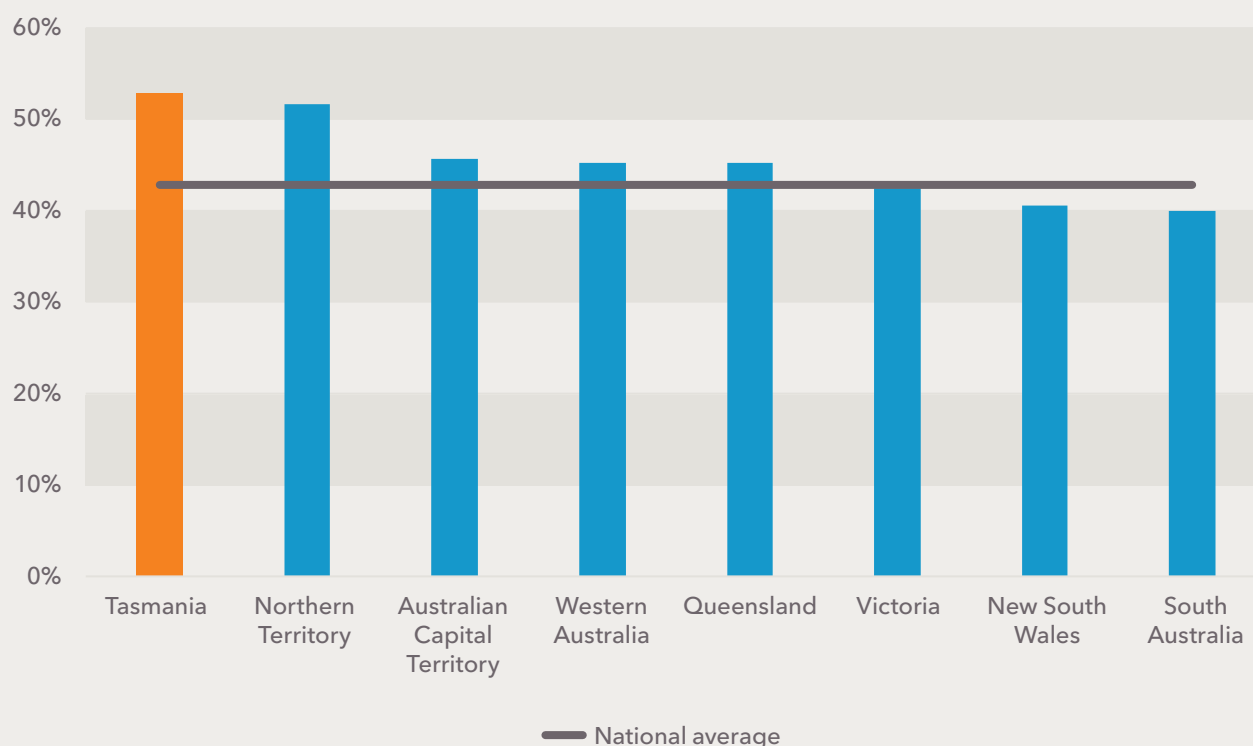**1 in every 2 Tasmanians**
aged 16-85 report experiencing a mental health condition at some time in their life (ABS 2020-2022)

At 52.9%, the rate in the Tasmanian population is the highest of all states and territories and almost 10% higher than the national average of 42.9% (ABS 2021).

Figure 1: Proportion of population who have experienced a mental health condition

Source: (ABS 2021)

In Tasmania it is estimated that:

| Over **90,000** people live day to day with a mental health condition | A further **125,000** people are at risk of developing a mental health condition |
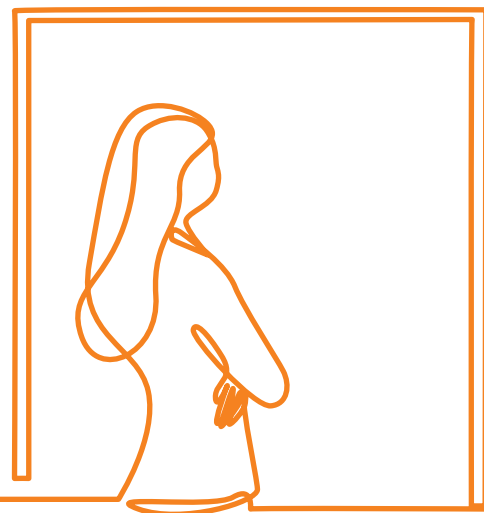
Source: (PHT n.d.-a; 2024)

Of those Tasmanians living with a mental health condition, almost 1 in 5 were living with a severe condition. Individuals living with a severe mental health condition, on average, will live for 12 to 16 years less than the general population (AIHWa 2025).

Severity is determined by the intensity and duration of symptoms, and the degree of disability (PHT n.d.-b).[1]

| **51,112** Tasmanians live with a mild mental health condition | **26,124** Tasmanians live with a moderate mental health condition | **17,605** Tasmanians live with a severe mental health condition |

Source: (PHT 2024)[2]

1. The Australian Government guidance in defining severe mental illness characterises it as a severe level of clinical symptoms and a degree of disablement to social, personal, family and occupational functioning.

2. Mild, moderate and severe mental health condition is defined using the severity measure in the Australian Bureau of Statistics National Study of Mental Health and Wellbeing which can be found here.

Suicide is the leading cause of death among Tasmanians aged 25-44 (ABS 2023) and the rate across all age groups is higher than the national average (Productivity Commission 2025b). Suicide is complex and has a significant relationship with mental health. Between 2012 and 2018, 64% of people who died by suicide in Tasmania had a prior diagnosis of mental illness (Garrett and Stojcevski 2021). Suicide is one of the greatest preventable public health and social challenges of our time (COAG Health Council 2020). Improving mental health is critical to addressing and preventing suicide, and key objectives to do so include good health, economic security and social inclusion (COAG Health Council 2020).

Analysis of mental health needs relative to access to services shows that of the three major regions of Tasmania (North West, North and South), only Northern Tasmania is rated as being of very high concern across the entire region (see Figure 2) (Mental Health Australia and University of Canberra 2023). This rating is due to the population of the region having medium mental health needs and lower service access. Launceston is the only major centre in Tasmania rated as being of very high concern.

In Launceston, it is estimated that 23.11% of people aged 18 and over have high psychological distress in the last 12 months. The estimated percentage of people in high psychological distress in low income households is 31.81% (Mental Health Australia and University of Canberra 2023). Over the same period, 26.23% of people aged 15 and over have long-term mental and behavioural conditions (Mental Health Australia and University of Canberra 2023).

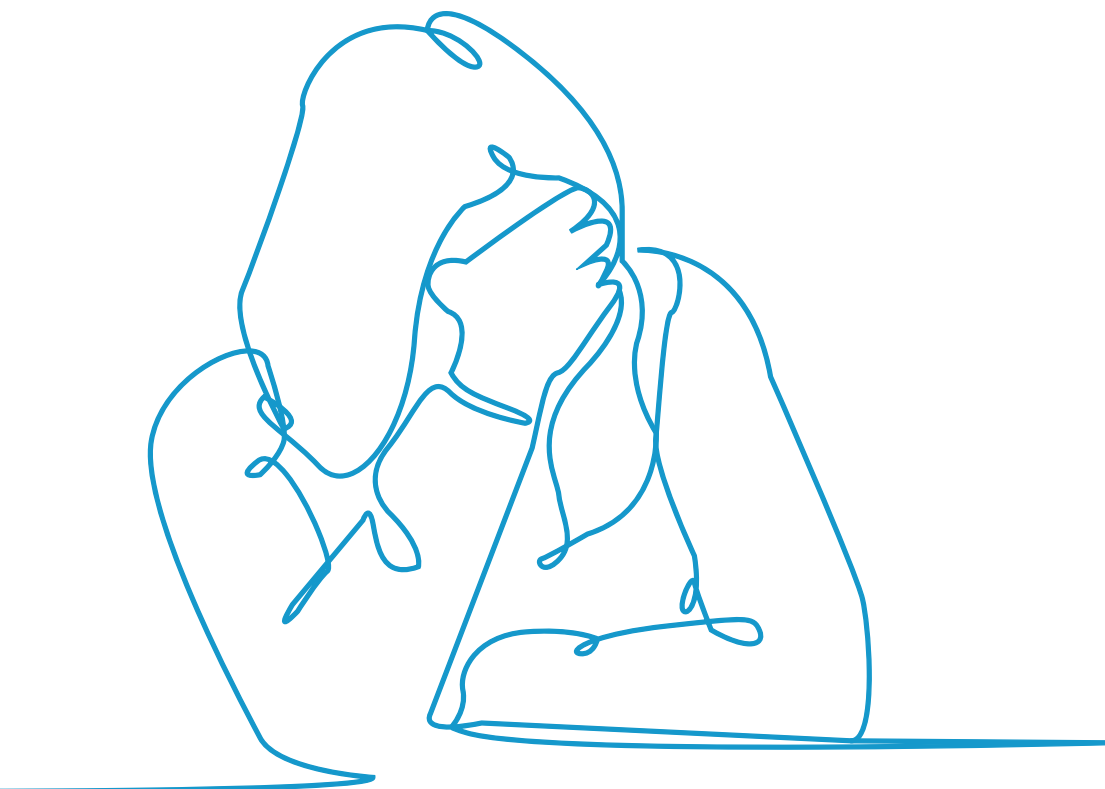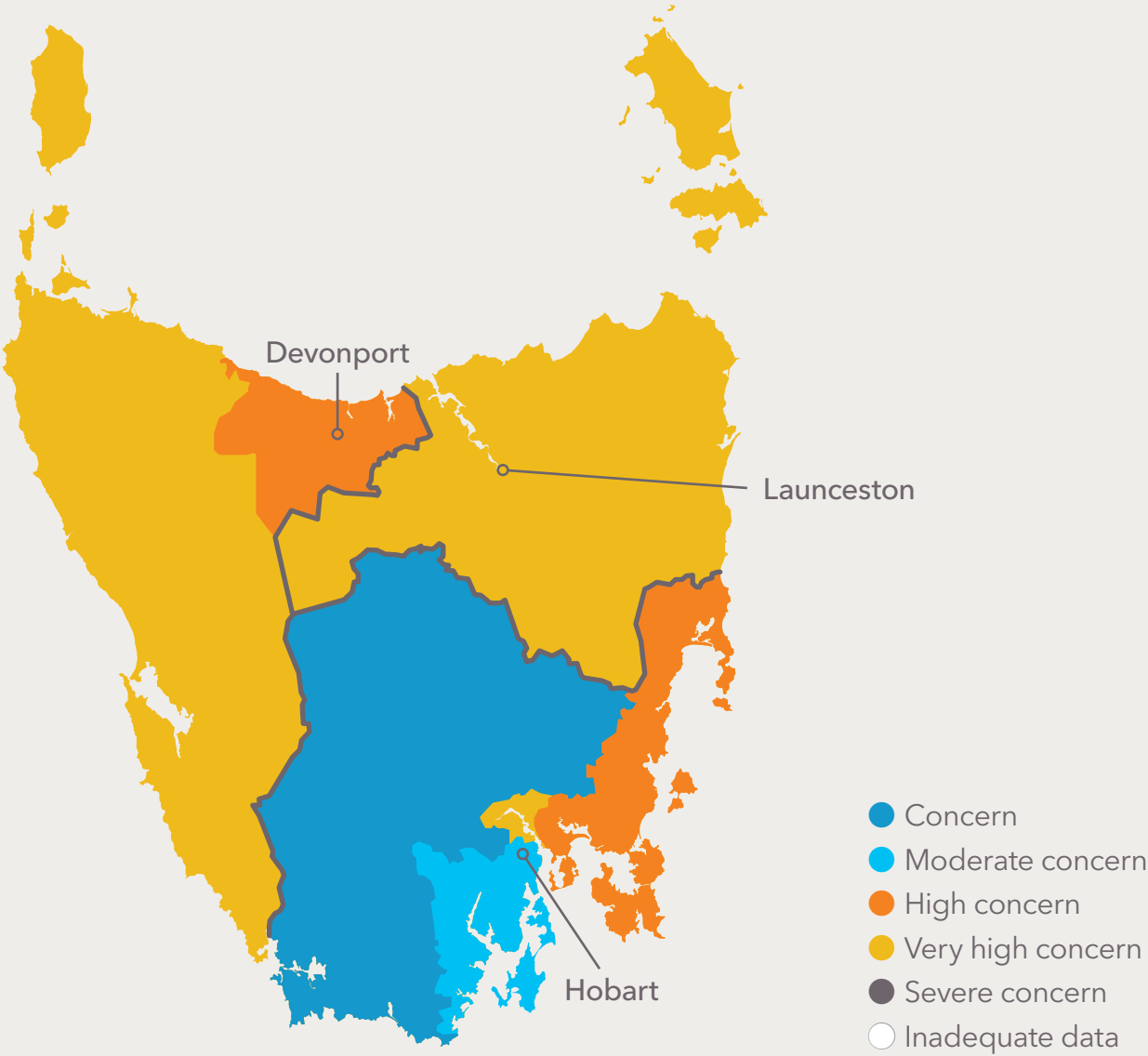**Figure 2: Rating of mental health service need-access by SA3 regions in Tasmania**

- Concern
- Moderate concern
- High concern
- Very high concern
- Severe concern
- Inadequate data

Source: (Mental Health Australia and University of Canberra 2023)

Analysis of Housing Connect Front Door service data

In 2023-24, the Housing Connect Front Door service delivered statewide by Anglicare provided 4,273 periods of housing support to individuals and their households. Deidentified data for people receiving housing support was divided into people with a mental health condition (n=1790) and people with no recorded mental health condition (n=2224).[3] For a range of characteristics, the risk or likelihood among people with a mental health condition was compared to those without a mental health condition.[4]

Reasons for seeking housing support

People seeking housing support were asked to identify all reasons that they sought support. Unsurprisingly, people with a mental health condition were 5 times (400%) more likely to nominate mental health issues as one of those reasons. They were also significantly more likely to cite one or more of the following:

- inadequate or inappropriate dwelling conditions
- previous accommodation ended
- domestic and family violence
- non-family violence
- medical issues
- harmful drug or substance use
- harmful alcohol use.

When we look at significant differences in the main reason for seeking housing support, we find that compared to people without a mental health condition, people with a mental health condition were:

1.2 x
more likely to mainly seek help due to inadequate or inappropriate dwelling conditions

22.4 x
more likely to mainly seek help due to harmful drug use

3. People with a mental health condition categorised as people with a history of inpatient treatment at a psychiatric hospital or unit in the past 12 months, a mental health diagnosis or both.

4. Significant results referred to in this paper are tabulated along with 95% confidence intervals and P statistics in appendix 1.

Likely to experience homelessness more frequently and for longer

Compared to people without a recorded mental health condition, people with a mental health condition seeking housing support were:

27% more likely to be sleeping rough or in non-conventional accommodation	**35%** more likely to be staying in short-term or emergency accommodation due to a lack of other options	**26%** less likely to say they were not homeless

In Housing Connect data, 'sleeping rough' refers to the most visible form of primary homelessness where individuals sleep in public places or makeshift shelters without any conventional housing. It does not include sleeping in a motor vehicle (another form of primary homelessness) which is recorded separately.

There were also differences between the two groups in how long they had experienced homelessness. Compared to people with a mental health condition, people without a mental health condition were significantly more likely to report that it was less than a week since their last permanent address. People with a mental health condition, on the other hand, were:

17% more likely to have been homeless for between 6 and 12 months	**30%** more likely to have been homeless for between 1 and 5 years

The Housing Connect Front Door data indicates that Tasmanians with mental health conditions who seek housing support are significantly more likely to be experiencing homelessness and they are likely to have been homeless for longer periods.[5]

5. Compared to Housing Connect clients without a mental health condition.

More likely to be living alone

Compared to people without a mental health condition, people living with a mental health condition were 31% more likely to be living alone. They were significantly less likely to be living in a household with a partner or their children.

Less likely to have employment as their main source of income

The likelihood of people with a mental health condition having employment as their main source of income was less than half that of someone without a mental health condition. However, they were 2.3 times more likely to receive a Disability Support Pension (DSP) as their main source of income.
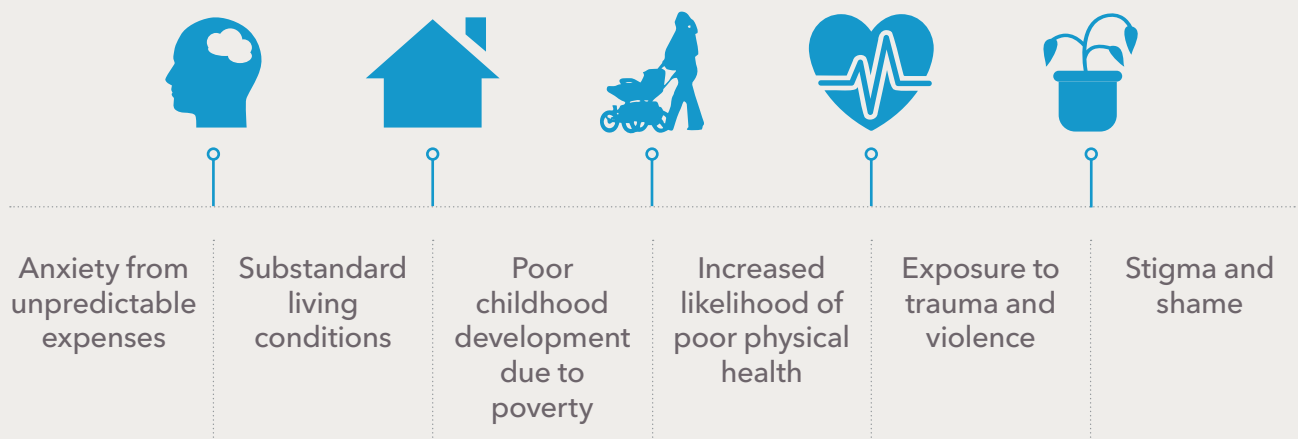
Socioeconomic determinants of mental health

The social, economic and physical environments people live in shape mental health (WHO 2014). In Australia, people experiencing socioeconomic disadvantage are more likely to report psychological distress (Enticott et al. 2024). They are also more likely to have poorer access to mental health services (Enticott et al. 2024). This is symptomatic of a system which is not designed for those who most need to use it.

Mental health and low income

Low incomes and poverty are linked with poor mental health. Four in ten Australians experiencing high levels of psychological distress are in the lowest income quintile, while less than one in ten are in the highest income quintile (Isaacs et al. 2018). Financial hardship can cause, contribute to or exacerbate poor mental health, yet mental health care is often unaffordable for people on low incomes. Recent data shows that the number of people delaying or not seeking mental health care due to cost has risen from 12% in 2020-21 to 20.4% in 2023-24 (NMHC 2025).

Reasons why poverty and financial hardship increase risks to mental ill health include:

Anxiety from unpredictable expenses	Substandard living conditions	Poor childhood development due to poverty	Increased likelihood of poor physical health	Exposure to trauma and violence	Stigma and shame

Source: (Isaacs et al. 2018)

Poor mental health can also increase the chances of experiencing poverty and financial hardship. This includes the impacts of a mental health issue on a person's ability to work in paid employment full or part time, or their capacity to manage finances (Isaacs et al. 2018).

Deborah's story below demonstrates how mental health can be affected by socioeconomic disadvantage:

Deborah's story

Following a motor vehicle accident 12 years ago, Deborah was left with chronic pain and limited mobility. She used a small payout from the accident to buy a cheap block of land in a rural area and build a basic shelter there. Deborah had limited literacy skills and found it difficult to navigate complex systems. She was unaware she might be eligible for DSP and no one suggested it might be an option.

The rising cost of fuel meant Deborah found it difficult to attend medical appointments and travel to visit family. Isolated and in constant pain that was not resolved after multiple surgeries, Deborah developed depression. Relying on JobSeeker Payment, she could not keep up with the bills. Even when her electricity was cut off, she did not seek help, partly because she didn't know where to go, and partly because her depression made her feel hopeless.

Deborah had fallen so far behind on paying her rates that the local council was preparing to seize and sell the property. The council referred her to Anglicare's financial counselling for free assistance.

The financial counsellor advised Deborah to put in an application for DSP to improve her financial situation and found there was an old superannuation account she might be able to access on compassionate grounds. These processes were not straightforward, as Deborah had never set up and used a MyGov account and needed support to do this. She also required reports from a mental health professional to support her application for the DSP, but psychiatrists and psychologists were expensive and were booked out several months in advance. The cost and delays weighed heavily on Deborah and although her situation was improving with the support of Anglicare, she began to wonder if there would ever be a resolution.
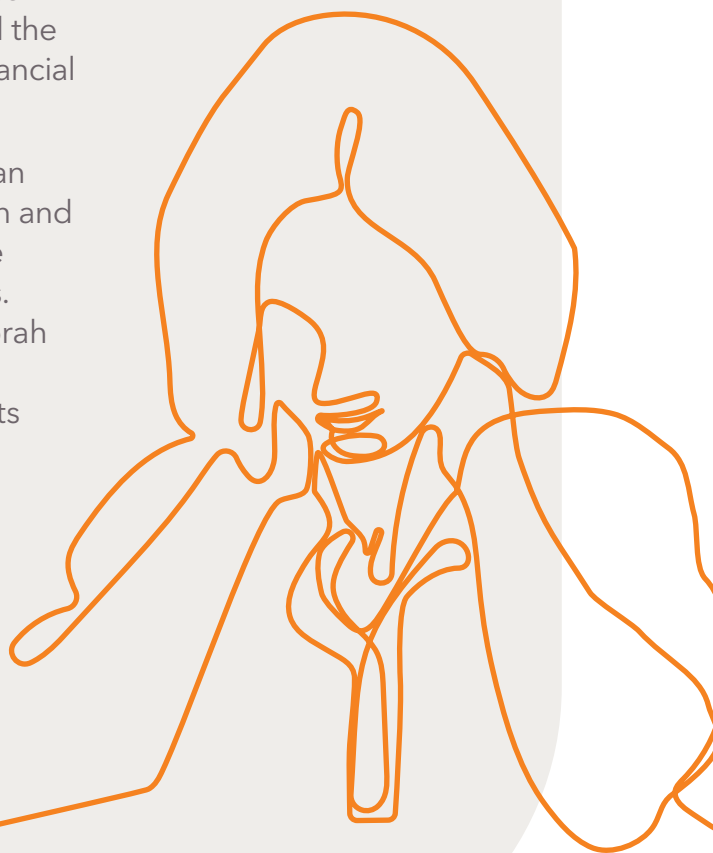
In the 2024-25 financial year, 18.3% of Anglicare's financial counselling clients self-reported having a psychiatric disability.

Observations from financial counsellors suggest the number of clients experiencing a mental health issue during a support period is close to 50%, with staff observing that as debt increases, mental health issues can either develop or worsen. This trend is reflected in research, where a correlation exists between financial hardship and experiences of depression, suicide, drug dependence and psychotic disorders (Isaacs et al. 2018).

> **When clients' finances start to get difficult, maybe because of health reasons or a loss of a job or family breakdown, their mental health starts to go down as well**
>
> – Anglicare Financial Counsellor

Importantly, research also tells us that when financial issues are addressed or disposable income increases, psychological distress declines. In 2023, the Household, Income and Labor Dynamics in Australia (HILDA) data found that for each additional $10,000 increase in household equivalised annual disposable income, the likelihood of psychological distress declines (Wilkins et al. 2024).
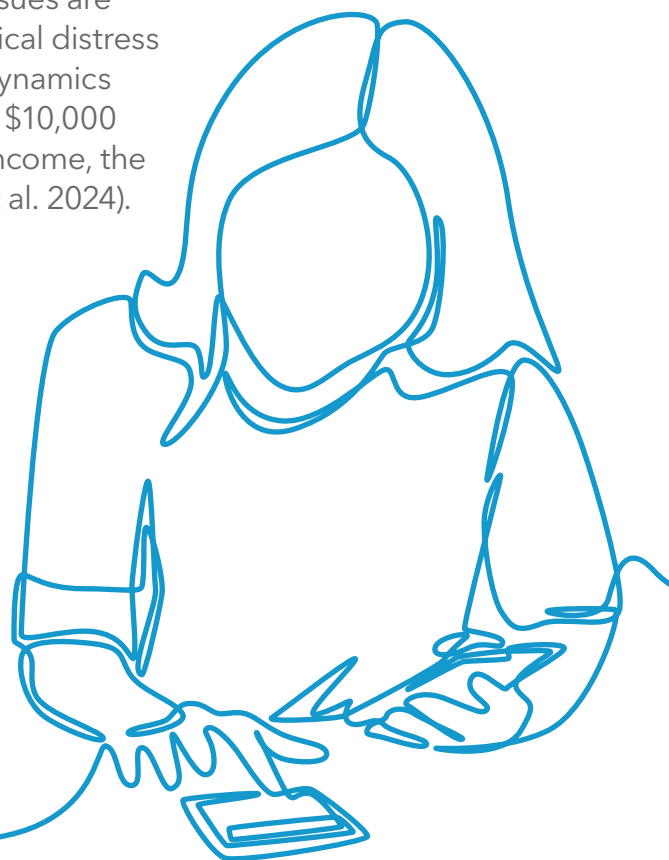
Mental health and housing and homelessness

Housing stability and mental health directly influence each other.

Housing instability and homelessness negatively impact mental health by increasing anxiety, depression and mental stress. Poor or deteriorating mental health reduces housing stability, with research finding that it increases the likelihood of financial hardship in the next 12 months by 89% and forced moves (such as eviction) by 39% (Brackertz et al. 2020).

Conversely, improved housing stability has a positive impact on mental health and well-managed mental health improves housing stability (Brackertz et al. 2020).

Analysis of 2024-25 Housing Connect data for this project shows that Tasmanians with mental health conditions are significantly more likely to experience homelessness, and they are likely to experience it for longer ().

The relationship between mental health and housing is discussed in greater detail in Anglicare's June 2025 Housing Connect Front Door Service Snapshot (Anglicare Tasmania 2025a). The Snapshot found that Tasmanians seeking housing support from the Front Door service were twice as likely to have a mental health issue as the general population (Anglicare Tasmania 2025a).

Housing Connect Front Door data reveals that of those with a mental health condition, only 69% were currently receiving mental health treatment or had received treatment in the past year (Anglicare Tasmania 2025a). This means that 3 in 10 people receiving housing support who had an identified mental health issue were not currently receiving or had not recently received mental health treatment. This suggests that when people are in housing stress, they are either unable to afford or unable to access or manage treatment for mental ill health.

The Australian Housing and Urban Research Institute (AHURI) has found that:

> Housing is a fundamental social determinant of mental health and policy interventions that are directed at reducing housing disadvantage achieve substantial mental health benefit at the population level
>
> - (valentine et al. 2024)

Housing in Tasmania remains unaffordable for those on the lowest incomes. Anglicare Tasmania's Rental Affordability Snapshot 2025 found that in Northern Tasmania only 0.04% of all rental properties advertised were affordable for single person receiving Age or Disability Support Pensions and none were affordable for those relying on JobSeeker or Youth Allowance (Anglicare Tasmania 2025b).

Mental health co-morbidities

Comorbidity refers to the co-occurrence of two or more health conditions in an individual which interact and worsen health outcomes. The conditions can occur at the same time or one may come after the other. In the context of mental health, common comorbidities include substance use disorders and chronic physical health conditions. These comorbidities can have significant impacts on the diagnosis, treatment and recovery of each condition (AIHW 2012).

Mental health and alcohol and drug use

Mental health conditions and AOD use often occur together. This is reflected in data from Anglicare's ADATS program, where 1 in every 2 referrals made by workers in the 2024-25 financial year were to a psychologist or mental health professional. National prevalence data indicates that 60% of people with a mental health condition other than substance abuse are experiencing AOD dependence (Marel et al. 2022).

The relationship between mental health conditions and substance use is bi-directional. People with mental health conditions are more likely to consume alcohol at risky levels, and are more likely to have used illicit drugs, often as an attempt to self-medicate emotional distress, psychiatric symptoms or trauma (Marel et al. 2022).

While self-medicating may provide short term relief, it often leads to cycles of dependence which worsen a person's mental health and substance use over time (see Figure 3). Stigma is also attached to both mental health and AOD use and impacts on people's ability to seek and receive treatment for their conditions (ADF n.d.).

> Often people use drugs to relieve their mental health problems or memories of trauma. They are isolated and scared. Everyone wants to be included in life.
>
> – Lived experience participant quoted in Barrett et al. (2018)

Figure 3: Cycle of dependence

Short term relief for duration of AOD effect

Experience psychological distress

Self-medicate with alcohol or other drugs
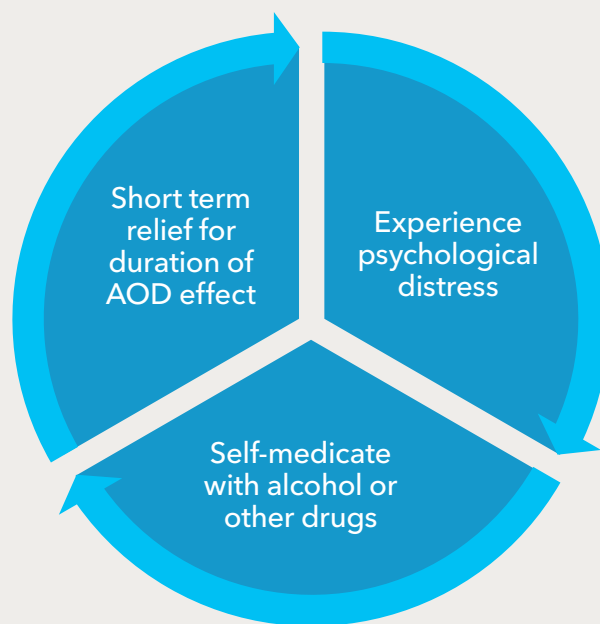
Source: Adapted from Turner et al. (2018)

When the underlying mental health condition remains untreated, substance use can intensify psychiatric symptoms, leading to more frequent or heavier use (Turner et al. 2018). People who experience this comorbidity are also more likely to face a range of poor health and social outcomes, including increased hospitalisation, homelessness, disability, unemployment and premature death (Barrett et al. 2018). The link between housing insecurity and mental ill health can also be alcohol and drug use. As demonstrated on , Anglicare clients seeking housing support who had a mental health condition were 22.4 times more likely to also report harmful drug use than those without a mental health condition.

…at least one in three people with a substance use disorder also have an anxiety or mood disorder, often resulting in poorer overall health and wellbeing and significant personal strain. Our health services need to respond effectively to comorbidity, particularly across alcohol and drug services and mental health services where there is increasing demand in non-government services, to ensure appropriate access to services.

– (Tasmanian Department of Health 2023)

Mental health and physical health

In Australia, people living with mental health conditions are more likely to experience chronic physical conditions, face preventable hospitalisations and die prematurely due to physical health issues (AIHW 2025a). Higher rates of co-occurring physical and mental health conditions can result in reduced life expectancy, increased levels of ongoing disability and reduced workforce participation (NMHC 2025).

Nearly

80%

of premature deaths of people with mental illness are due to preventable physical health conditions

1.7 million

Australians experience both a mental illness and a long-term physical health condition

Source: (AIHW 2025a)

People experiencing disadvantage are more likely to experience co-occurring physical and mental health conditions. Data shows that people with a mental health disorder living in the most disadvantaged areas were significantly more likely to have a physical health condition (48.5%) compared to those in the least disadvantaged areas (32.5%) (NMHC 2025).

The relationship between physical and mental health conditions is complex and can impact on how both conditions are diagnosed, managed and treated.

Physical health conditions can complicate mental health treatment by increasing fatigue, pain or cognitive difficulties and can reduce a person's ability to engage fully in therapy (AIHW 2025a). There can be interactions between medications which can impact the effectiveness of treatment. Chronic illness can also heighten psychological distress which can diminish the overall effectiveness of mental health interventions (Belcher et al. 2021).

Conversely, mental health conditions can cause barriers to accessing and engaging in physical health care, with individuals with mental health conditions frequently not receiving or being offered a range of preventative screenings or treatments. Diagnostic overshadowing, where physical symptoms are misattributed to a person's mental health condition, is another common occurrence (NMHCCF 2021).

People with severe mental illness are more likely to have their physical health symptoms dismissed or missed entirely in primary care settings.

– (NMHC 2022)

Figure 4: Long-term health conditions reported by persons with and without mental illness in 2021

	Persons without mental illness	Persons with mental illness
Asthma	7.8%	19.0%
Arthritis	8.2%	19.0%
Diabetes	4.8%	8.6%
Heart disease	4.0%	7.0%
Lung condition	1.6%	4.7%
Cancer	3.0%	4.7%
Stroke	0.9%	2.2%
Kidney disease	0.9%	2.0%
Any other long-term health condition(s)	7.6%	20.0%
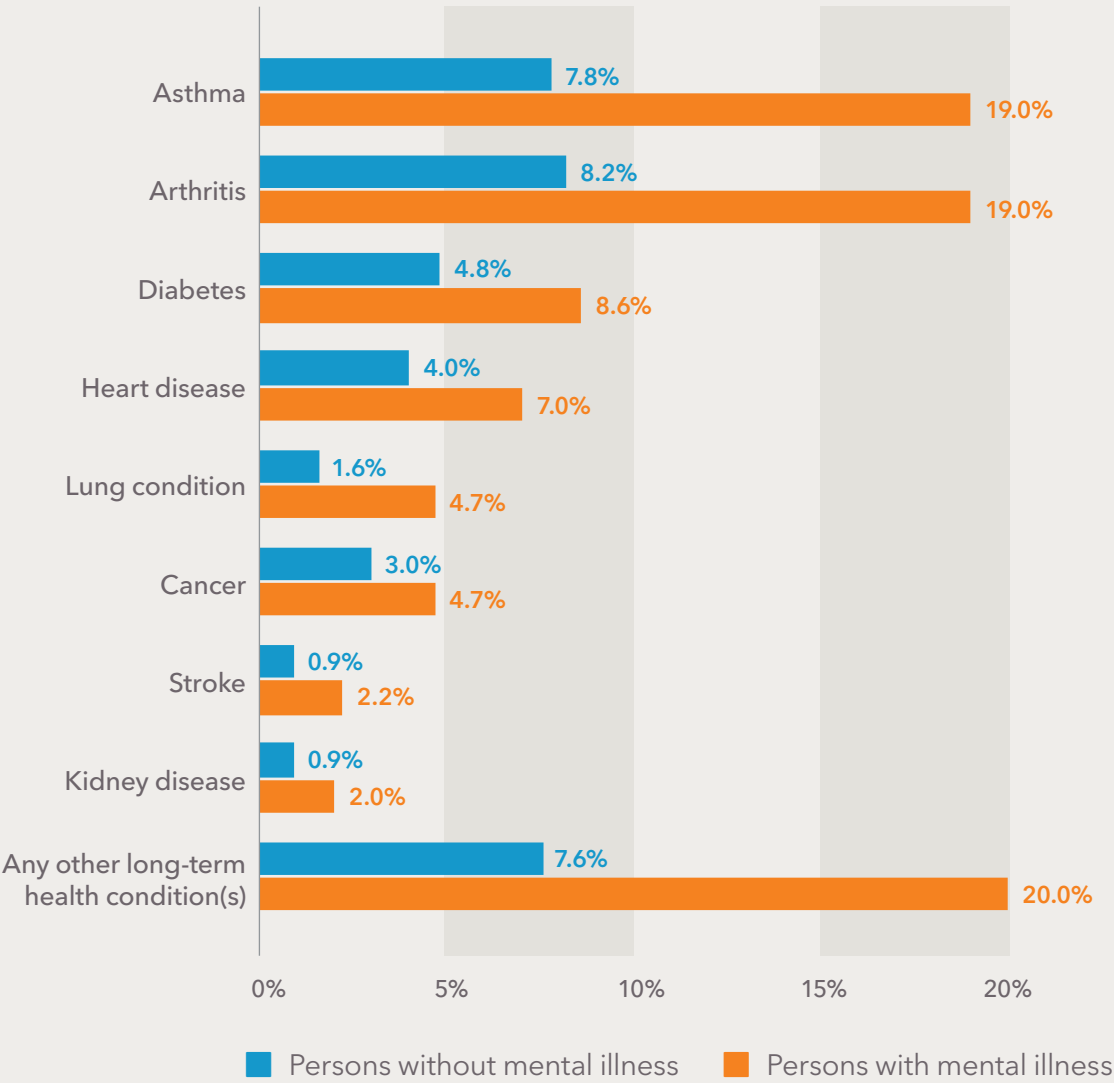
Source: (AIHW 2025a)

Figure 5: Anglicare and national prevalence data show that Tasmanians living with mental health conditions are more likely to experience other barriers and health conditions

Sources: (ADF n.d.; Isaacs et al. 2018; AHURI 2019; AIHW 2025b; Scott et al. 2012)

From these findings, there are two key policy implications:

- Non-health interventions that provide housing security and raise income above the poverty line are important and feasible policy levers to improve mental health.
- The mental health service system needs to be designed for people who, compared to the population average, are more likely to have a low income, comorbid alcohol and/or drug use, poor physical health, fewer social supports, and/or housing insecurity.

The current mental health service system

The mental health service system in Tasmania is complex, fragmented and difficult to navigate (PHT 2024). The Australian and Tasmanian governments are both responsible for funding various components of the mental health system.

For example, the Tasmanian government is primarily responsible for funding mental health care in public hospitals and community mental health care. The Australian government funds the Medicare Benefits Schedule (MBS) and Primary Health Networks. As a small state, Tasmania has one PHN, Primary Health Tasmania.

Some aspects of the mental health system are funded entirely by one level of government, and others are co-funded through mechanisms such as bilateral agreements. For example, Medicare Mental Health Hubs are co-funded by the Australian and Tasmanian governments through the Tasmanian Bilateral Agreement for Mental Health and Suicide Prevention, and centrally commissioned through Primary Health Tasmania. Joint responsibility is a potentially positive feature of the system. However, areas of shared responsibility require greater attention and investment to avoid service gaps and poor integration. Funding arrangements impact on how a service or program is administered, including its capacity, eligibility requirements and referral pathways.

Key components

Primary care

Primary care is care people first seek in their community. It is low to high intensity care provided outside of a hospital and can include diagnosis and treatment.

General practitioners (GPs) often serve as the first point of contact for individuals, providing initial support, screening for mental health conditions, and referrals to specialised services as needed (Productivity Commission 2020). GPs can create and review mental health care plans and refer patients for subsidised psychology through the Better Access initiative.

Through Better Access, the Australian Government provides MBS rebates for:

- preparation and review of mental health treatment plans and provision of mental health care consultations by GPs and other medical practitioners
- delivery of psychological therapy services by clinical psychologists
- delivery of focused psychological strategies by GPs, other medical practitioners, psychologists, social workers and occupational therapists (Pirkis et al. 2022).

People can also access mental health services through dedicated mental health centres funded by Primary Health Networks, such as headspace for young people aged 16-24 and the Medicare Mental Health Hubs for adults. A Medicare Mental Health Hub has been operating in Launceston since 2022 (formerly called Head to Health) and is a walk-in centre which requires no appointment, referral or Medicare card (Medicare Mental Health n.d.).

Specialist acute mental health care

Specialist mental health care provides the most intensive mental healthcare, including team-based assessment and intervention. It involves a range of different mental health professionals, including case managers, psychiatrists, social workers, psychologists, mental health nurses and occupational therapists.

These services are provided to a wide range of people who are experiencing complex, severe or chronic mental health conditions. They include treatment and care provided in bed-based settings such as acute psychiatric inpatient units, step-up step-down facilities and residential rehabilitation (Australian Department of Health 2020).

In the Tasmanian public system, acute mental health care is provided by Statewide Mental Health Services (SMHS) with a range of teams delivering specialised acute mental health care. These include the Crisis Assessment and Treatment Team (CATT), Adult Community Mental Health Services (ACMHS), Older Persons Mental Health Services (OPMHS), and Child and Youth Mental Health Services (CYMHS), as well as inpatient teams and Hospital in the Home. Some specialist sub-acute mental health care services are provided in partnership between SMHS and community services organisations.

National Disability Insurance Scheme

The NDIS provides funding to people with disabilities to access support services that focus on improving functional ability and participation in community life. Mental health supports through the NDIS can include:

- support with activities of daily living, social support and access to the community
- psychosocial recovery coaching
- access to allied health professionals
- specialist disability accommodation.

Community supports

A range of other services and sectors contribute to a person's mental health journey, including alcohol and drug services, disability services, acute services, emergency services, children and youth services, housing, justice, education and employment providers. A person's social supports can impact how they interact with the mental health system. Steph's story is an example of this, as her family supported her to access specialist medical care.

Overview of reforms

Significant work is ongoing at the state and federal level to reform the mental health system. Within these reform documents there are a range of initiatives, actions and priorities committed to and being progressed by governments.

Figure 6: Key mental health reform reviews, strategies and action plans

National	Tasmania
• Productivity Commission Mental Health Inquiry 2020 • National Mental Health Workforce Strategy 2022-2032 • Evaluation of Better Access 2022 and Australian Government's Response 2024 • Productivity Commission Mental Health and Suicide Prevention Agreement Review Interim Report (June 2025) • National Suicide Prevention Strategy 2025-2035	• Rethink 2020: A state plan for mental health in Tasmania 2020-2025 • Tasmanian Suicide Prevention Strategy 2023-2027 • Tasmanian Reform Agenda for Alcohol and Other Drugs 2020 • Health Workforce 2040 Strategy • Review of Tasmania's Major Emergency Departments 2023-24 • LGH Masterplan 2021
Joint reforms	
• Fifth National Mental Health and Suicide Prevention Plan 2017-2022 • National Mental Health and Suicide Prevention Agreement 2022 and Tasmanian Bilateral Agreement for Mental Health and Suicide Prevention	

The National Mental Health and Suicide Prevention Agreement sets out the shared intention of the Commonwealth and states and territories to reform the mental health system into a person-centred integrated system. It also commits both levels of government to jointly drive planning and reforms towards a stepped model of care (Commonwealth Government 2022).

Stepped care is a model of evidence-based mental healthcare delivery where the service intensity is matched to a person's severity of illness and individual needs. The model shifts the focus of system design from programmatic service provision to addressing the needs of consumers and carers (Australian Department of Health 2020).

Primary Health Networks are responsible for commissioning a range of services across the stepped care spectrum. The stepped care model to be used in regional planning describes 5 levels of care (see Figure 7).
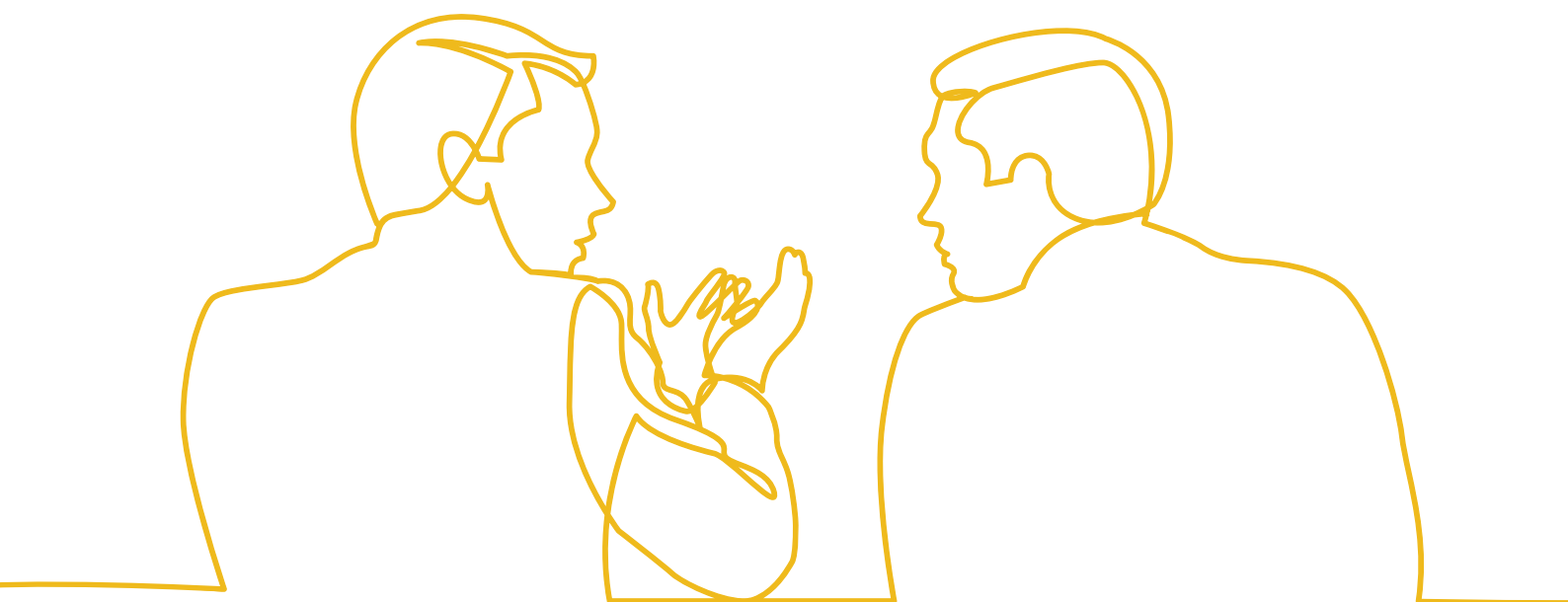
Figure 7: Mental health stepped care levels with examples of people likely to be suited to each level of care and types of care that may be provided across the continuum (adapted from Commonwealth of Australia 2025)

Level 1
Self-management

People with early, mild, previous or no symptoms

Level 2
Low intensity services

At risk groups and people with mild symptoms but without a diagnosis

Level 3
Moderate intensity services

People with diagnosable mental illness and moderate symptoms

Level 4
High intensity services

People with moderate symptoms and some complexity or severe, uncomplicated mental illness

Level 5
Acute and specialist community mental health services

People with severe and complex mental illness

Examples of clinical services				
Easily accessible resources to enable self-management of symptoms	Direct, brief engagement with an appropriately trained mental health practitioner	Structured care involving more than one service provider, such as a GP and a mental health professional	Multi-disciplinary support and care coordination, which may be managed by the GP, psychiatrist, paediatrician, or state-based community mental health team	Intensive team-based specialist assessment and service (typically state/territory mental health services) with involvement from a range of different mental health professionals

An individual's need for formal and informal psychosocial and community supports typically increases with increasing severity and complexity of their mental health

Primary care is provided across levels 1-4. While some services are associated with a single level of care, some will appear across multiple levels. For example, GP mental health care can be associated with lower levels of care when it is the only support provided but includes higher levels when it is combined with other services and interventions such as psychiatry (Australian Department of Health 2020).

Assessment of the level of care required includes consideration of the person's:

- symptom severity and distress
- risk of harm
- functioning
- co-existing conditions
- treatment and recovery history
- social and environmental stressors
- family and other supports
- understanding of the mental health condition and willingness to engage in treatment (Commonwealth of Australia 2025).

Primary Health Tasmania is currently undertaking a **Continuum of Care Project** to inform the development of a stepped care model. The project focuses on improved coordination and integration across its commissioned mental health services. This work towards a continuum of care is a promising move toward mental health system integration. However, consideration should be given to exploring and co-designing commissioning models of all mental health services including those currently funded by the Tasmanian Department of Health to support flexibility and integration across a stepped care model.

There have also been several national initiatives implemented to improve service integration and consumer navigation across the mental health system.

The **Central Intake and Referral Service (CIRS)** is a single statewide intake and assessment phone service accessed via the national Medicare Mental Health 1800 number. Currently both the CIRS and the Tasmanian Access Mental Health phone line are in operation.

The **Initial Assessment and Referral (IAR) Tool** was developed by the Australian Department of Health for use by GPs and across the mental health sector to match people with the right level of care. The tool has been embedded into Medicare Mental Health and the CIRS and is intended to be used across all state-funded services and clinical services in Tasmania. Training on the use of the IAR is available at a national level.

State-based reforms are also underway that are expected to contribute to improved service integration and consumer navigation if implemented. The **Reform Agenda for Alcohol and Other Drugs** in Tasmania includes a key action to work within Statewide Mental Health Services and with the AOD and mental health services sectors to ensure the needs of consumers with comorbidity are fully considered and addressed (Tasmanian Government 2020a). Increased investment in comorbidity support services to establish a 'no wrong door' approach for people who are seeking support for both AOD use and mental health concerns, as recommended by experts (Hilton et al. 2023; Marel et al. 2022), is a key area for government action.

In the North of Tasmania, the **LGH Masterplan** commits to the development of an **LGH Mental Health Precinct** which will increase service system capacity to the region by delivering 10 additional inpatient and 5 additional short stay mental health beds, and the establishment of a Safe Haven and a Recovery College. The LGH Masterplan also includes a commitment to redesign of the Emergency Department, which may improve the treatment of acute mental health conditions through the hospital system (Tasmanian Government 2021).

Where next?

Reform work towards an integrated mental health system is commendable, and the state and federal policy environment is fast-moving. A few significant reform documents have either lapsed or are approaching their expiry, including the *Fifth National Plan 2017-22,* Tasmania's *Rethink 2020-25,* and the National Mental Health and Suicide Prevention Agreement bilateral schedule expiring in 2026. Tasmania will need to negotiate a new bilateral agreement with the Commonwealth and progress state mental health reform following *Rethink 2020*. This presents a key opportunity for governments to evaluate the progress recent reforms have made and consolidate and align reform priorities.

As reform work progresses, it is imperative that a focus is kept on work that promises to move towards an integrated and person-centred system. This includes addressing the challenges that come from joint responsibility across state and federal governments. Two major enablers which also need to be addressed are the mental health workforce and funding and commissioning. It is likely gaps will persist in the service system while there are chronic understaffing issues and disparate state and federal funding contracts and cycles. Work towards a continuum of care may go some way to address this, however consideration of how all mental health services are commissioned and funded across both Tasmanian Department of Health and Primary Health Tasmania to support flexibility across a continuum of care is important.

In June 2025 the Productivity Commission recently released an interim report reviewing the effectiveness of the National Mental Health and Suicide Prevention Agreement with their final report to be provided to the Australian Government in October 2025. Importantly, its draft findings include that progress towards the Agreement's intent to create an integrated, person-centred mental health and suicide prevention system has been piecemeal (Productivity Commission 2025a).

They recommended that the National Mental Health Commission develop the next National Mental Health Strategy to articulate a clear vision, objective and collective priorities for long-term reform in the mental health system over the next 20-30 years (Productivity Commission 2025a). They also recommended the current National Mental Health and Suicide Prevention Agreement, including funding commitments, be extended by 12 months until June 2027, to give sufficient time to develop the foundations of the next agreement and renew the National Mental Health Strategy (Productivity Commission 2025a).

Actions recommended by the Productivity Commission **before** the expiry of the current National Agreement are:

- delivering the National Stigma Reduction Strategy and national guidelines for regional commissioning and planning of mental health and suicide prevention services.
- addressing psychosocial supports outside the NDIS (Productivity Commission 2025a).

Anglicare supports these draft findings and recommendations made by the Productivity Commission.

Current barriers, gaps and their impacts

The experiences recounted in this report demonstrate some current barriers to accessing timely and appropriate mental health care and several impacts including loss of employment and income, loss of accommodation and hospitalisation.

The major themes that emerged throughout consultations with Anglicare practitioners were:

- the fragmented service system
- accessibility and affordability of GPs and psychologists, including long wait times and limited bulk-billing options
- experiences of crisis intervention, including long wait times in the Emergency Department
- a limited mental health workforce, including under-resourcing of State Mental Health Services
- the gap in longer term psychosocial support outside the NDIS
- service barriers for people with co-occurring mental health conditions and AOD use
- limited supported housing and transitional housing options for people with mental health conditions.

Fragmented service system

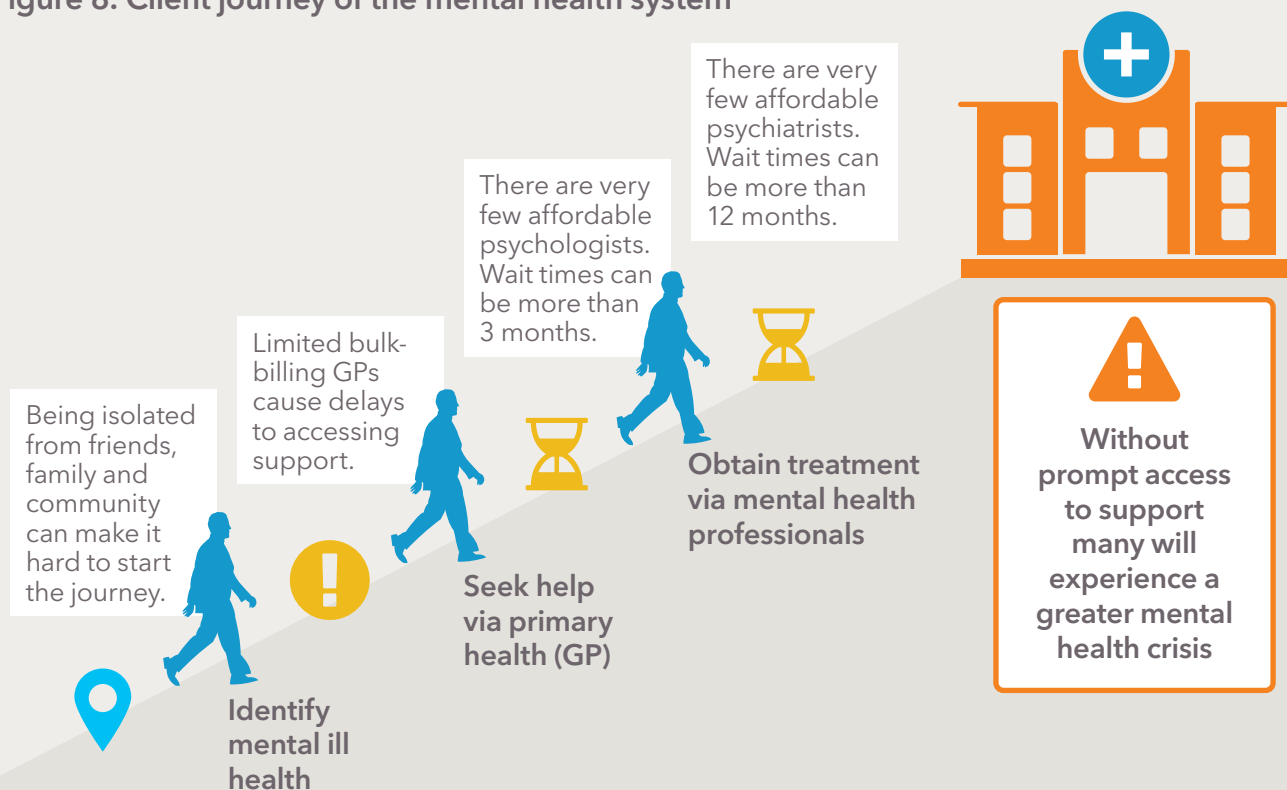> ❝ **The fragmented approach and waitlists lead to disengagement** ❞
>
> – Anglicare Housing Services worker

The mental health system is not yet designed around the needs of individuals. Ideally, people identify mental ill health early and access help they can afford with minimal wait times. Some may need ongoing support to manage their mental health conditions. However, many Tasmanians on the lowest incomes cannot access help in timely way. People can struggle to get help that meets their needs because of costs and waiting times, referral pathways are difficult to navigate, they do not meet program eligibility criteria, or they require support for longer than a service is funded to provide it. As a result, people are missing out on accessing mental health support when they need it and there are gaps in continuity of care. Reform work towards a person-centred and integrated system must continue to resolve this.

Anglicare staff across all program areas gave examples of the harmful effects to people caused by delays and difficulties in accessing appropriate mental health support. Figure 8 below demonstrates an example of this.

Figure 8: Client journey of the mental health system

Being isolated from friends, family and community can make it hard to start the journey.

Limited bulk-billing GPs cause delays to accessing support.

There are very few affordable psychologists. Wait times can be more than 3 months.

There are very few affordable psychiatrists. Wait times can be more than 12 months.

Identify mental ill health

Seek help via primary health (GP)

Obtain treatment via mental health professionals

Without prompt access to support many will experience a greater mental health crisis

People may disengage while waiting to access support, or experience a continued deterioration in their mental health, which is consistent with research into the impacts of wait times (Thomas et al. 2021). If a person's mental health deteriorates while waiting for mental health care, they may then be assessed as too high risk for the level of support they initially tried to access. Once a person is experiencing a severe mental health crisis there are limited options besides seeking support at the hospital ED. Anglicare staff reflected that if a person presents to the ED in crisis, they may be turned away from the ED due to not meeting the threshold for an inpatient admission. That person may be referred to their GP, who may be unable to accommodate an urgent appointment.

> **If they're not seeking crisis support at ED, then [they're] accessing support via GPs and referrals to psychologists and counsellors**
>
> – Anglicare Housing Services worker

Access to psychosocial support programs through community organisations may be an option and various programs are available. However, program eligibility requirements vary, and an individual may not be able to easily navigate to a service they are eligible for. GPs may also not be aware of appropriate community mental health support options to refer patients to. The Central Intake and Referral Service and Integrated Assessment and Referral Tool reforms may go some way to addressing this barrier to access but continued training and promotion of these tools is required.

> **We are not fitting services to people, we are fitting people into services**
>
> – Anglicare Community Services worker

Sammy's story (below) can be common in Anglicare's Recovery program. Clients can be left without the ongoing support they need due to program limitations, limited options, unaffordable medical care and long waitlists for public and bulk-billed services. When some clients reach the end of a Recovery support period they face the reality of having to wait for everything to get worse again before they can get access to support.

Sammy's story

Sammy started to really struggle when the COVID-19 pandemic began, as she was already living alone and socially isolated. She started experiencing severe depression and anxiety, linked to complex post-traumatic stress disorder (C-PTSD) and past trauma. Supporting herself alone in a private rental on a Disability Support Pension meant that Sammy had significant financial limitations. Her only regular support was her GP, whom she could only see when scheduling and finances allowed. Sammy felt she needed some psychological and psychiatric care as well. But this wasn't an option because the fees for private providers were beyond her budget, and she couldn't find any bulk-billing providers.

Recognising that she was struggling, Sammy contacted Anglicare's Recovery program and was able to start getting some psychosocial support which really helped her. She worked on her distress tolerance, emotional regulation and reconnecting with her community and found that slowly she started to feel better. She often had to delay her sessions because of surgeries in the public health system and would get frustrated at losing a bit of progress when this happened. After two years, she was no longer eligible to receive support through the Recovery program. In the last year of support, Sammy had been working to apply for NDIS so she could access some therapy and ongoing psychosocial supports once her time with Recovery came to an end. However, after a year she was still awaiting the outcome of her application.

After her support with the Recovery program came to an end, Sammy reflected that she was doing a lot more but was still concerned about how she would manage her complex mental health conditions without the support of her worker or any other ongoing support.

Accessibility and affordability of GPs and psychologists

People on the lowest incomes need access to bulk-billing GPs and psychologists, as they cannot afford the out-of-pocket fees. In January 2025, Cleanbill reported that in Tasmania, 0% of GPs bulk-bill new adult patients without concessions, and patients pay the highest average out-of-pocket cost in the country ($54.26) (Cleanbill 2025a). Generally people on low incomes such as income support payments are eligible for a concession, however there can still be significant wait times to access a GP that bulk-bills. For example, Anglicare staff reported that one bulk-billing GP practice in the North can have waitlists of 6 weeks or more to take on a new patient.

> **The wait for a GP can be up to 6 weeks – and in that time people can significantly decline and then it becomes an issue needing hospitalisation**
>
> – Anglicare Housing Services worker

There are also long waiting times to see a psychologist. Subsidised private psychology sessions are available through Better Access but require a mental health care plan from a GP. These subsidised visits to a psychologist often still have an out-of-pocket cost, typically of $80 or more. This is unaffordable for people on a low income, and often can't be paid without sacrificing essentials such as food. While outcomes from Better Access services are generally positive, access to subsidised services favours those on higher incomes (Pirkis et al. 2022).

In Launceston, in the 2020-2021 financial year, 8,532 people or 9.77% of the population accessed Medicare-subsidised mental health services (Mental Health Australia and University of Canberra 2023). This indicates fewer people are accessing Medicare-subsidised mental health services than those who have mental health conditions.

Wait times are even longer for the very few psychologists who offer bulk-billing. Anglicare staff report that clients can wait 6 months to see a bulk-billing psychologist. Lengthy wait times further impact mental health and increase psychological distress (Subotic-Kerry et al. 2025).

Low availability of GPs and psychologists also has a flow-on impact for clients seeking access to the DSP for income support or the NDIS for disability support services, as medical evidence is required to apply. A GP who has not seen a patient before may not be willing or able to complete the paperwork or assessments needed for these applications. Steph's story below also demonstrates an example of the cost of getting a report for a DSP application. Steph's story isn't unique. The reality is that many people with mental health conditions are on low incomes, such as Jobseeker, and not all have family members in a position to help with costs.

The Australian Government has recognised that the funding mechanisms in primary care encourage episodic care and fast throughput of appointments, which can create barriers for people to get comprehensive care and disproportionately impacts cohorts including people with mental health conditions and people on low incomes (Australian Government 2022).

Several positive measures are being taken to improve access and affordability:

• The Australian Government is expanding eligibility for bulk-billing incentives from November 2025 (Department of Health Disability and Ageing 2025b). Estimates suggest this will result in an increase of 11 bulk-billing GP practices in Tasmania from 1 November 2025 (Cleanbill 2025b).

• Services such as the Medicare Mental Health Hub may also assist to address access and affordability if able to deliver on providing free and timely access to mental health services and support, including free psychology and psychiatry (Department of Health and Aged Care 2024).

• Additional measures including a new national early intervention service and growing the availability of the mental health workforce are welcome (Department of Health and Aged Care 2024).

Steph's story

Steph had always been a hard worker and was employed for years by a company in a physically demanding job. She developed injuries from the constant strain which escalated to severe pain she couldn't ignore. The employer covered the cost of a few surgeries and after each operation doctors advised her to be placed on light duties to allow her body to heal. After a month or two of lighter work she would always be moved back to physically demanding work.

The cycle of constant pain and returning to physical tasks too soon took a toll on her mental health and led to anxiety and depression, which then required more time off work. Feeling pressured by her employer not to take further time off, Steph felt she had no choice but to resign.

With the resignation came a steep decline in her mental health, exacerbated by the weight of bills piling up. Steph visited a GP who prescribed her anti-depressants, but she felt they did not listen to her concerns or help to address the deeper issues. Her family stepped in and helped Steph to pay for visits to a psychologist. Even with subsidised visits under a mental health care plan, it was hard to keep up. At $250 a session, with over $100 out of pocket after the Medicare rebate, she could afford to see a professional only once every month or two which wasn't enough.

A friend suggested she apply for the DSP. With her application, she needed a report completed by her psychologist, which was going to cost $500. With the help of her family, they scraped together the money and the psychologist wrote a thorough report. She was able to access the DSP which improved her financial situation a little.

The financial burden placed on her loved ones added to the stress, anxiety, and guilt Steph already felt. She was also dealing with challenges such as engaging a no-win no-fee solicitor because the paperwork to access disability insurance through her superannuation was so complex.
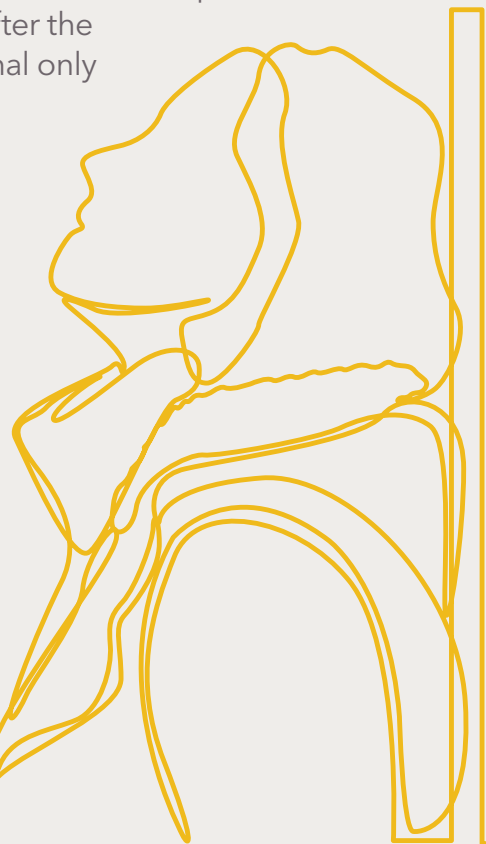
A limited mental health workforce

Anglicare staff identified workforce limitations as a contributor to current gaps between existing services (both public and private) and the limited capacity of those services. The mental health workforce comprises:

- people working exclusively in the mental health sector, such as mental health nurses, psychologists, and psychiatrists
- people working in other health settings that frequently interact with, care for and support people with mental health conditions, such as allied health, general practitioners and nurses.

There is a documented shortfall in the Australian mental health workforce that also affects Tasmania (Department of Health and Aged Care 2022), where many mental health professions have lower rates than the national average (AIHW 2024b). Northern Tasmania has a lower rate of psychiatrists, mental health nurses and psychologists than the Tasmanian and national rate (AIHW 2024b). Because new initiatives draw on the same limited pool of workers, reforms can lead to other services in the mental health system experiencing staff shortages.

The National Mental Health Workforce Strategy 2022-2023 seeks to develop a sustainable mental health workforce in Australia. However the chronic under-supply of mental health professionals, along with long training periods, means that growth of the workforce is slow (Looi, Allison, et al. 2024).

Tasmania does not yet have its own state mental health workforce strategy. Rethink 2020 identified a key reform direction to support and develop the workforce (Tasmanian Government 2020b). Under Our Health Workforce 2040 an action is to develop a statewide mental health workforce strategy and action plan to reflect international and national trends and local needs (Tasmanian Department of Health 2019). This action should be prioritised for development and release alongside the National Mental Health Workforce Strategy 2022-2032 to ensure Tasmania is able to attain and retain positions.

Resourcing constraints of Statewide Mental Health Services

It was reported that Statewide Mental Health Services (SMHS) is also impacted by the limited mental health workforce. Under-resourcing of services can lead to high case management caseloads. Anglicare staff reflected that this can impact clients requiring case management by SMHS as they may receive limited contact with case managers or have several case managers over a period. It was also observed that the frequent use of locum psychiatrists can lead to a lack of continuity of care for patients seeking diagnosis and treatment for complex and severe mental health conditions.

Anglicare staff reflected that there can be limited community mental health follow up for clients leaving Northside, the inpatient mental health unit at the LGH. These experiences are consistent with data finding Tasmania has the lowest rate in the country of community follow-up for people leaving an acute psychiatric inpatient service. Only 61.8% of people leaving an acute psychiatric inpatient service in Tasmania receive a follow up within the first seven days of discharge from hospital, in comparison to a national average of 76.2% (Productivity Commission 2025b). Furthermore, this figure is worsening. In 2022-23 Tasmania was following up with 17.4% fewer people than in 2015-16 (see Figure 9) (Productivity Commission 2025b). In contrast, every other state in Australia has experienced an improvement in follow up rates with the national average up 7.2% over the same period.

Figure 9: % of people leaving an inpatient facility with a community mental health contact recorded within seven days following separation
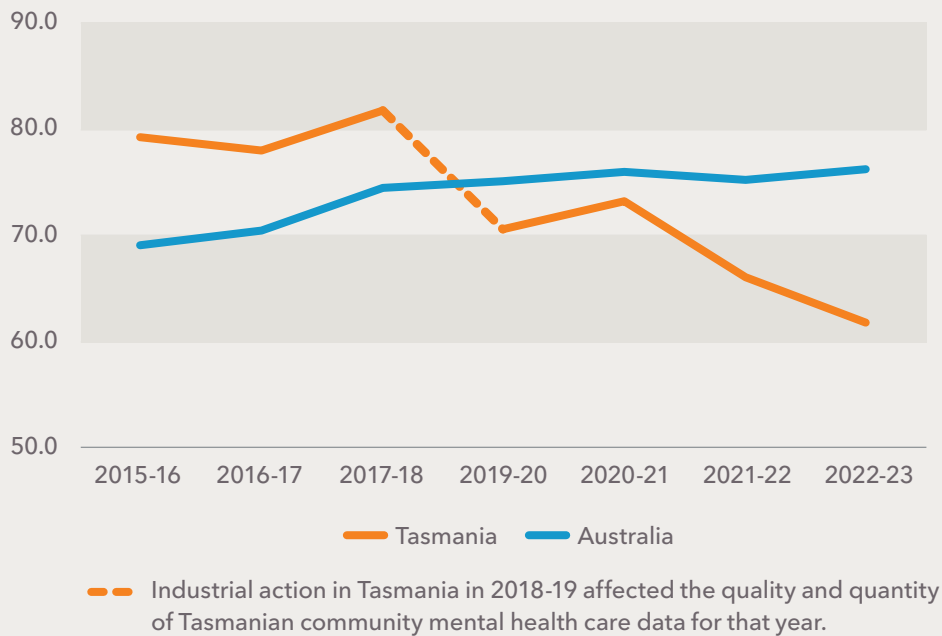
Source: Productivity Commission 2025b

People can also have trouble implementing treatment recommendations made by services such as SMHS if appropriate primary care is not available, unaffordable or difficult to access. For example, ACMHS may recommend a mental health treatment plan with psychology support but a client may be unable to access a GP to get the treatment plan, or access timely support due to psychology waiting times and gap fees.

Experiences of crisis intervention

Emergency Department and inpatient mental health

> **The very clinical approach doesn't always make someone feel validated but that's all they have, they have to go to ED if they feel unsafe and wait for days to see someone**
>
> – Anglicare Community Services worker

Anglicare staff observed that clients presenting to the Launceston General Hospital Emergency Department due to mental ill health may wait at least 7-9 hours and in some cases over 24 hours. Ash's story below highlights this. Emergency departments are not well equipped to support people experiencing psychological distress during long wait periods and waiting while in crisis can worsen mental health symptoms. Proposed improvements in the LGH Masterplan to increase the size of the ED and develop a new ED waiting room with separate areas for children, adults and people in acute psychological distress may improve patient experience (Tasmanian Government 2021). This is positive and vital in circumstances when presentation to the ED is unavoidable.

Ash's story

The first time Ash met with their Anglicare financial counsellor, they brought a supermarket bag full of unopened mail. Their mental health had deteriorated to the point where opening a letter, facing bills or notices, had become an insurmountable task. Every day, the pile grew, and every day, Ash felt the weight of it.

It hadn't always been this way. There was a time when Ash was working and going about life with a routine. But as their mental health worsened, they ended up losing their job, and the financial pressure that followed made everything feel more overwhelming. Ash's GP had been prescribing anti-depressants for some time and didn't seem to offer much else. There was no real conversation about what was going on, no investigation into the root of the problem, and no referrals to mental health services.

One day, Ash went to the Emergency Department to seek help. They sat in the waiting room for nearly 24 hours. Exhausted and still in crisis, they left before anyone could attend to them. A call from a friend who had been paying attention came just in time. The conversation, though brief, pulled Ash back from the brink.

Their financial counsellor made sure they had contact details for crisis lines and referred them to a counselling program with a community organisation. Some counselling really helped but Ash feels they still need a psychologist and psychiatric support. They are having trouble finding one they can relate to who accepts Medicare bulk-billing and doesn't have a waitlist of 6 months or longer.
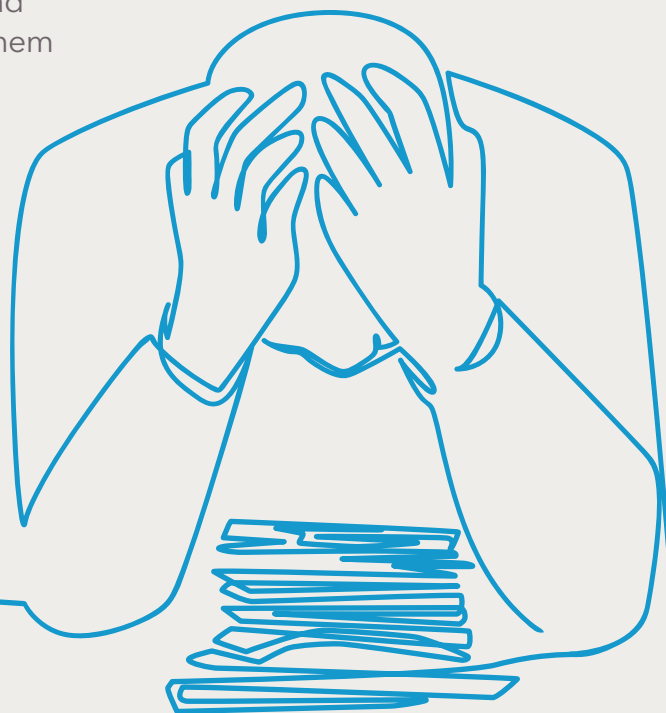
In 2022-23, there were 836 mental health patients in Tasmania who spent 24 hours or more in the ED (Picone et al. 2024). In 2023-24, the proportion of mental health patients admitted into the hospital from the LGH Emergency Department who waited in ED for less than eight hours was just 32.66% (Tasmanian Government 2024).

In Tasmania, the proportion of mental health-related ED presentations seen within clinically recommended waiting times is deteriorating, with only 42% seen within the recommended time in 2022-23, down from 57% in 2016-17 (Productivity Commission 2025b). Since 2016-17, Tasmania has underperformed in emergency department wait times when compared to other states, falling to 10% below the national average of 52.3% in 2022-23 (see Figure 10) (Productivity Commission 2025b).

Figure 10: Percentage of mental health related emergency department presentations seen within clinically recommended times
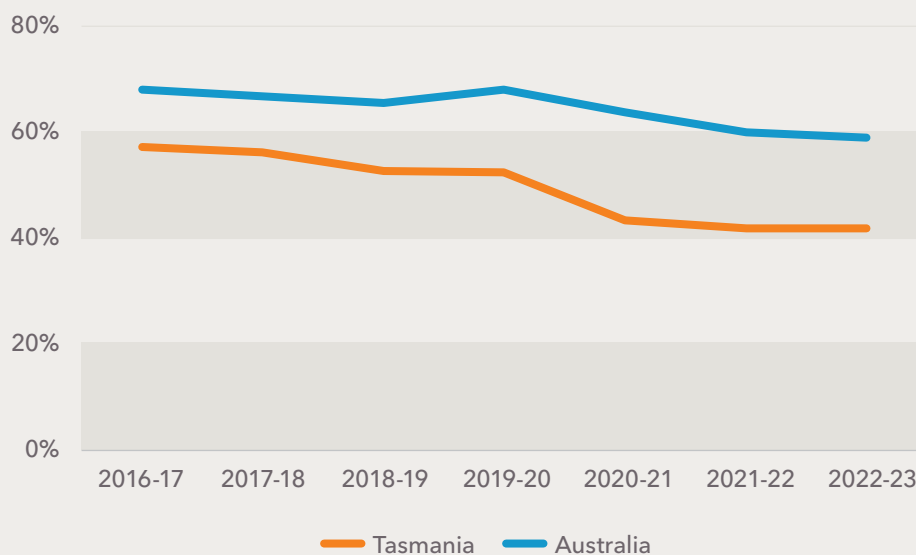
Source: Productivity Commission 2025b

> **We need to do a better job of being trauma-informed on the front line**
>
> – Anglicare Community Services worker

Anglicare staff reflected that limited beds in the inpatient mental health unit, Northside, in the LGH contributes to lengthy waits in ED for people who are too unwell to leave but are not able to be admitted due to limited beds. The proposed new LGH Mental Health Precinct includes 30 inpatient beds, 5 short-stay beds, a Safe Haven and Recovery College (Tasmanian Government 2021). The increase of 10 inpatient beds to 30 in the new LGH mental health precinct will improve the number of beds available in the region. Anglicare staff universally welcomed the plans for the Mental Health Precinct including the opportunity for people to attend the Safe Haven service when in distress.

However, questions were raised around how the precinct could be appropriately resourced with the available workforce in the region. It was also raised that the option to step-up and step-down from inpatient care are important components of stepped care. Accessing a step-up facility could prevent an inpatient admission or lengthy ED wait time and accessing step-down could prevent a readmission. Without a discharge address, a person cannot be admitted to the step-up step-down facility in the North. This means for people experiencing homelessness their only option when in distress may be to seek admission to inpatient mental health. If admitted, they may be discharged back into homelessness if suitable accommodation cannot be found.

The Tasmanian Government is encouraged to provide further information about whether the short-stay beds at the new precinct will be available to provide care to people without a discharge address and provide access to residential rehabilitation options for people experiencing homelessness. Further information about how the LGH precinct will be staffed and whether it will provide a centralised 'no wrong door' approach to access mental health support is also encouraged.

In the South, Baptcare's Choices program provides transitional accommodation for people who are unable to be discharged from mental health inpatient settings due to homelessness or who require intensive support to prevent re-admission (Baptcare n.d.). This provides an important avenue to breaking the cycle and opens safe pathways to secure housing. However, there is no comparable service in the North. There is a critical need for this gap to be filled.

Table 1 demonstrates the **current** mental health bed capacity in the North compared to the South.

Table 1: Inpatient mental health facilities in North and South Tasmania

North		South	
Facility	**Capacity**	**Facility**	**Capacity**
Launceston General Hospital	20 beds	Royal Hobart Hospital	33 beds
		Peacock House	12 beds
		Millbrook Rise	26 beds
		Mistral Place	10 beds
Total	**20 beds**	**Total**	**81 beds**

Table 2: Other mental health facilities in North and South Tasmania

North		South	
Facility	**Capacity**	**Facility**	**Capacity**
Mental health Hospital in the Home	11 beds	Mental health Hospital in the Home	12 beds
Anglicare Rocherlea (step-up step-down)	5 beds	Richmond Futures Chigwell (residential recovery)	24 beds
Anglicare Rocherlea (residential recovery)	10 beds	Baptcare Choices (residential recovery – available if person experiencing homelesness)	10 beds
Total	**26 beds**	**Total**	**46 beds**

Increasing community-based models of care to reduce inpatient admissions

There is an opportunity to enhance access to appropriate community-based services for people with mental health conditions in Northern Tasmania, which will reduce delays in assessment and treatment, and support emergency department presentation avoidance

– (Tasmanian Department of Health 2023)

Governments must maintain focus on keeping people well in the community and out of hospital where possible. The average recurrent cost per inpatient bed day in 2022-23 dollars for general acute mental health services in public hospitals in Tasmania is $1791.19. The LGH average length of stay for mental health acute overnight admissions was 20.1 days, which is longer than the statewide average of 16.5 (Tasmanian Department of Health 2023). An admission for 20.1 days at the rate of $1791.19 per day would cost $36,000, almost $6,500 (22%) more than the statewide average. The Department of Health also projects an increase in inpatient bed days in the LGH psychiatry specialty unit of 16% by 2026-27 compared to 2020-21, and a 5% increase in drug and alcohol specialty unit (Tasmanian Government 2024).

Further, the proportion of inpatient mental health readmissions within 28 days was 15.2% (Tasmanian Government 2024). This is slightly higher than the national rate of 13.7% in 2022-23 (AIHW 2024a). High readmission rates within 28 days of discharge can indicate a lack of follow up support, inadequate community care or non-effective treatment while the person was in hospital (NSW Mental Health Commission 2024). This is an indicator in the Fifth National Mental Health and Suicide Prevention Plan.

Measures such as the Mental Health Emergency Response (MHER) Team in the North of Tasmania are welcome. These teams aim to reduce demand on police and ambulance services (Tasmanian Department of Health 2025). They can be contacted to respond to mental health distress and avoid an ED presentation where appropriate. Data from the Department of Health shows that in March to May 2025 between 66 and 80 per cent of clients of the MHER North service remained in the community rather than presenting to the ED (Tasmanian Department of Health 2025). Feedback from Anglicare staff on the introduction of the unit was generally positive in terms of response time and approach. However, access to ongoing mental health support in the community after a crisis intervention can still be limited.

Whilst there will be a continued need for inpatient facilities for acute episodes of care, the cost of delivering these services is significant, and a greater investment in community-based models of care to reduce the frequency of admissions would bring savings and alleviate pressure on acute care teams. Longer term psychosocial support is an example of care that can minimise hospital admissions and is discussed in further detail below.
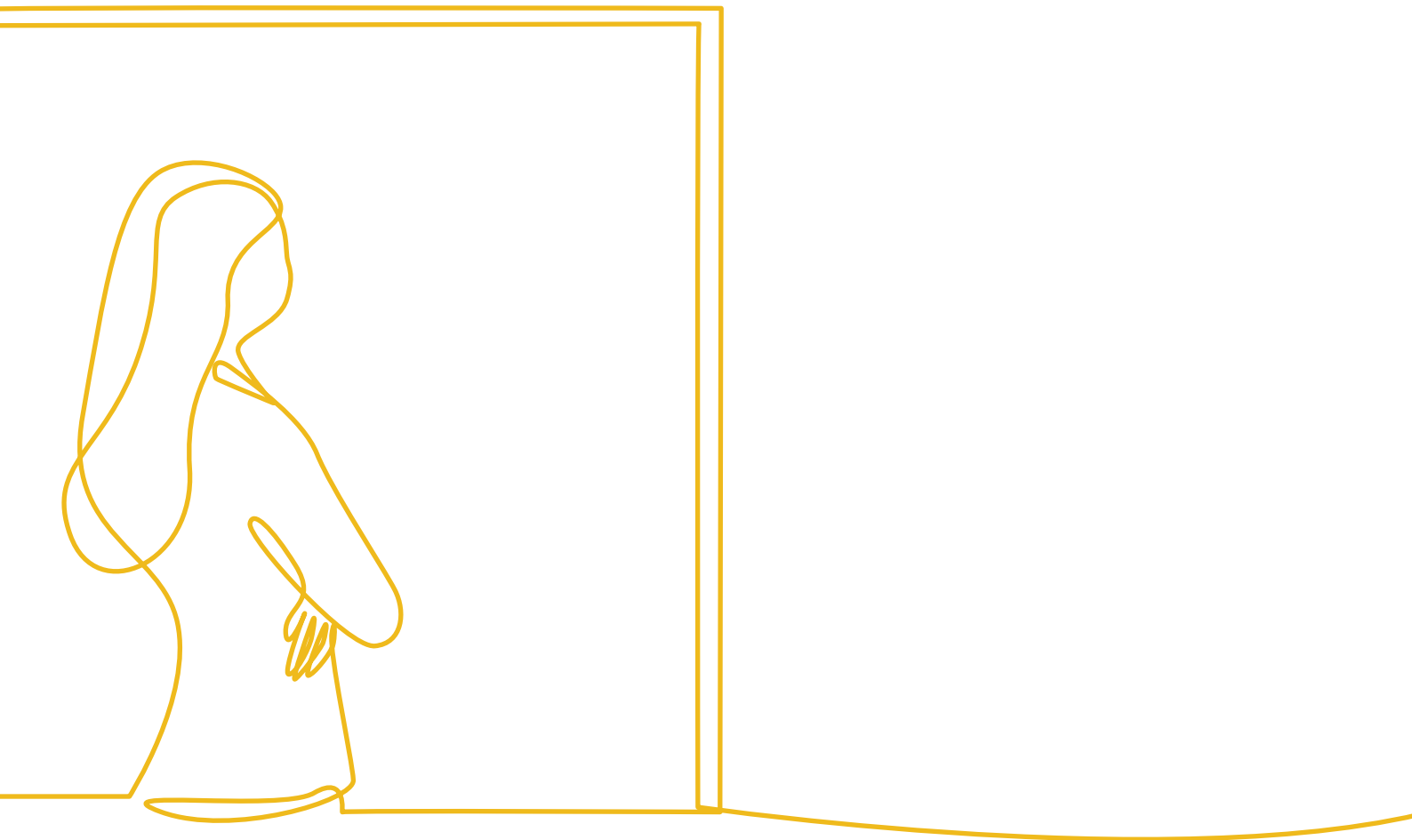
Service barriers for co-occurring mental health conditions and AOD use

A lack of integration across services to support people with both mental health and AOD issues is a barrier to accessing appropriate support. Practitioners across program areas consistently reflected that alcohol and drugs are often used as a coping mechanism for mental health issues, stressors and trauma. Yet it remains difficult to access support for both conditions due to a limited integration of services, workforce capabilities and stigma around addiction.

> **It isn't a black and white issue of what came first, but often issues with mental health lead to substance use as a coping mechanism and in turn that makes your mental health worse**
>
> – Anglicare Community Services worker

People seeking access to mental health services may be referred to AOD services to address their use before being able to commence mental health treatment. Anglicare staff provide an example of a person who presented to LGH ED to seek an inpatient mental health admission as part of the safety plan developed with their AOD worker. Due to alcohol usage they were advised detox was required first, and they travelled to Hobart to attend the only inpatient withdrawal unit in the state. Travelling was difficult while in suicidal distress, but they were determined to get help. When they returned after detox challenges remained in accessing support and they felt there was nothing more they could do.

> **There is too much focus on whether the mental [health condition] or alcohol and drug use came first, which is the primary and which to treat first… when the priority should be providing support for the person**
>
> – Anglicare Community Services worker

Conversely, people may be told to seek mental health treatment before being able to engage in AOD treatment. This can lead to people feeling they are 'too difficult' for the system or passed back and forth between services. AOD workers may not have the capability to manage acute mental health conditions and vice versa. It is important for mental health services to understand addiction and prioritise supporting the whole person rather than discriminating based on comorbidity, and vice versa for AOD services.

In my experience it is difficult to see which one came first, but sitting in my shoes, it does not matter, it needs to be treated together, not sending me from mental health services to AOD services, back and forth. It needs to be treated holistically, and people need not give up on me because I have not ceased my drug use, or I relapse.

– Lived experience participant quoted in Barrett et al. (2018)
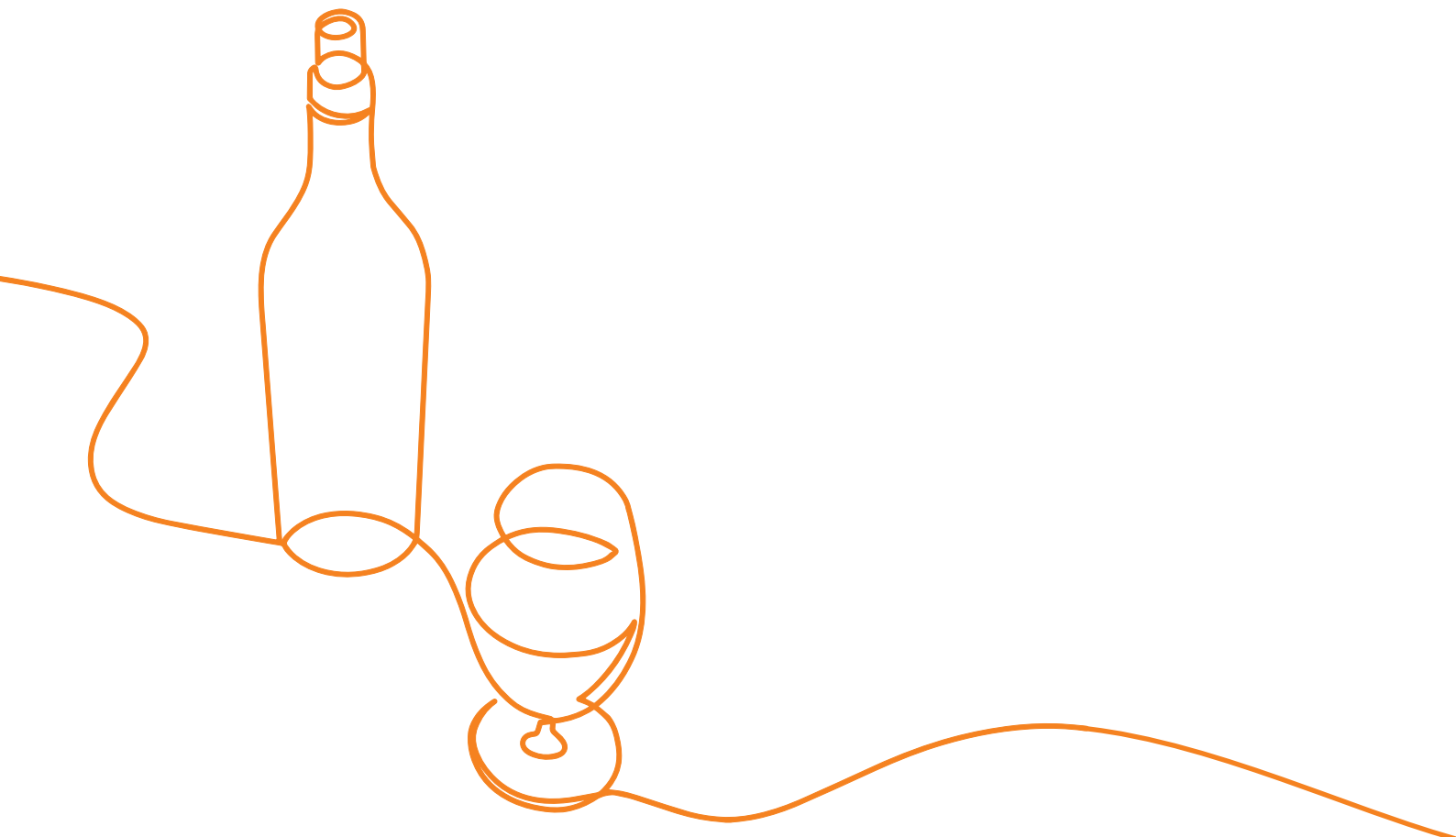
Jemima's story

Jemima was a long-term client of Statewide Mental Health Services (SMHS) and had a case worker and regular appointments with a psychologist and psychiatrist. She was engaged with an AOD treatment program and had recently quit substance use due to becoming pregnant. As her pregnancy progressed, her mental health began to deteriorate noticeably. Her AOD worker observed troubling signs that were early indicators of psychosis – her speech became erratic and rapid, and she began expressing thoughts that were disconnected from reality.

Jemima's AOD worker advocated strongly to SMHS, urging them to take her mental health decline seriously. They highlighted the heightened risk of psychosis during pregnancy, especially given her mental health diagnosis and recent cessation of substance use. SMHS concluded she was doing better than she had in the past and decided to close her case. She also presented to the LGH Emergency Department on multiple occasions seeking help, but was not assessed as needing an inpatient admission.

Only a few weeks after SMHS closed her case, she was arrested following an incident and incarcerated. She also lost her housing. Her child was born and removed from her care, and she has been trying ever since to advocate for reunification with them. The cumulative impact of these events has been devastating for Jemima who felt she did all she could to seek help and was dismissed.
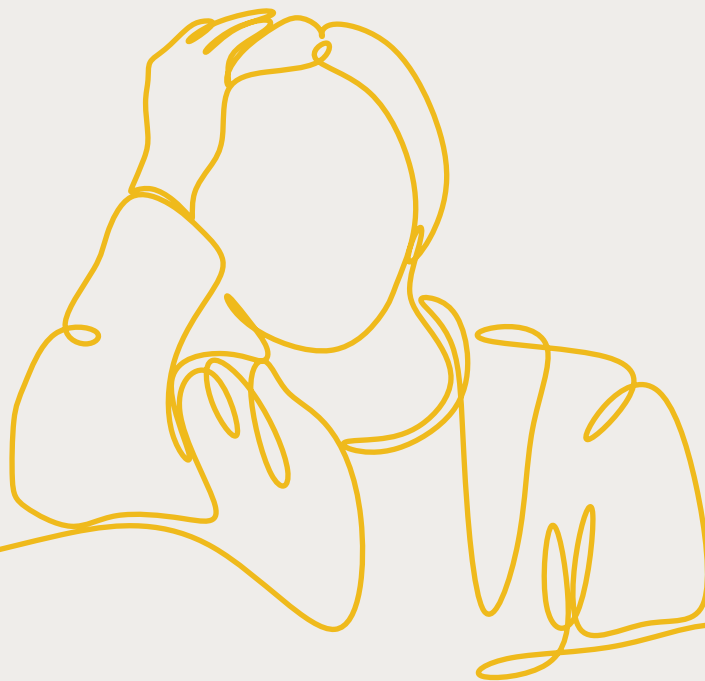
The outcome for Jemima was not inevitable. With appropriate mental health support and intervention – such as admission to LGH when needed and close monitoring – the decline could have been mitigated. Her trauma history and diagnoses should have prompted a more cautious and informed response. The interactions between her diagnosis, pregnancy, and substance cessation should have been well-known and considered.

Jemima's story demonstrates the need for integrated and compassionate care. The need for integration across mental health and AOD services has been recognised by experts, (Marel et al. 2022) and continued work towards this is a key area for continued government action. The Productivity Commission recommended a 'no wrong door' approach for mental health and AOD services as well as investing in more dual diagnosis services providing integrated and targeted care, developing the mental health and AOD workforces so they can better respond to comorbidities, and further integrating mental health and substance use at the policy, planning and commissioning levels (Productivity Commission 2020).

Sven's story below outlines the positive effects of services providing support for both mental health and alcohol and drug use.

Sven's story

Sven has struggled with mental health issues for a long time due to significant trauma. Sven started to self-medicate with drugs and alcohol and their dependence started interfering with almost every aspect of their life. Sven reached out to Anglicare's ADATS program and started receiving assistance to manage their AOD usage.

When Sven first started their AOD recovery journey, their mental health began to deteriorate, and they struggled with significant cravings, social isolation and unemployment. ADATS helped to organise mental health support for Sven. After several sessions with both their mental health provider and ADATS, Sven's mood and cravings improved and subsequently so did other aspects of their life such as their housing and employment. They regularly implement strategies from ADATS sessions and their mental health provider and have been achieving a key goal in relation to their AOD use for 9 months.

Sven's ADATS worker reflects on how important it is to have ongoing support for both AOD and mental health conditions, and to integrate strategies from a range of modalities to properly support clients with both AOD and long-term mental health conditions, often linked to trauma.
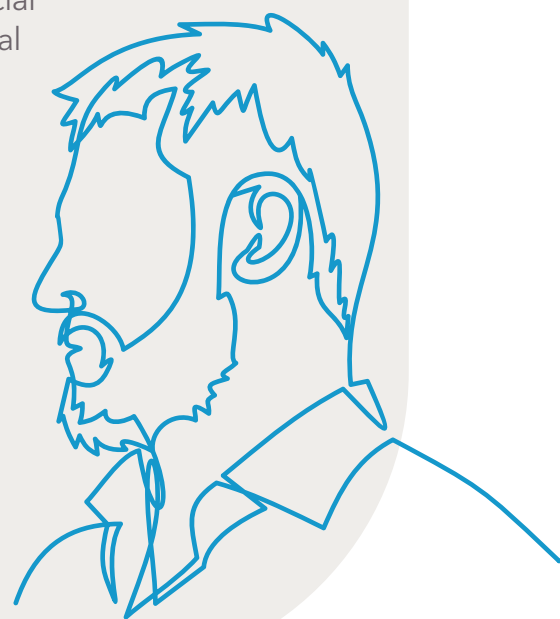
The need for longer-term psychosocial support outside the NDIS

Under the National Mental Health and Suicide Prevention Agreement (2022-2026), Australian, State and Territory governments agreed to work together to address gaps in the system. Psychosocial support for people outside of the NDIS is a significant service gap, identified in June 2025 by the Productivity Commission to be urgently addressed before the end of the current Agreement:

> Governments should immediately work to resolve the commissioning and funding responsibilities for psychosocial supports outside the National Disability Insurance Scheme – a service gap affecting 500,000 people
>
> – (Productivity Commission 2025a)

Gaps created by the NDIS for people with psychosocial disability

While some people are well supported through the NDIS, difficulties gaining access to the NDIS, securing and maintaining a suitable support package, and the defunding of previous psychosocial programs leave a significant gap in the service system for people with complex and chronic mental health conditions.

Difficulties gaining access to the NDIS for people with psychosocial disability

Access to the NDIS can be a significant barrier for people with psychosocial disability due to difficulty meeting eligibility criteria and securing a support package. To be eligible to access the NDIS, a person must have a disability caused by a permanent impairment (NDIA 2025). People with psychosocial disability are found eligible at far lower rates than people with other disabilities, as the permanency criteria are not applied as consistently (Bennett et al. 2025). This is because of the episodic and fluctuating nature of psychosocial disability and the lack of agreement among medical professionals and the community about when and if they should be considered permanent (Tune 2019). People may be declined NDIS support even after several reviews and detailed clinical evidence. This process itself can be very difficult for people to go through. Anglicare staff report that some participants get near their 2-year tenure with the Recovery program and are not through the access request process to obtain NDIS funding by that time.

When people with psychosocial disability can gain access to the NDIS, challenges can continue with implementing suitable supports. A person's NDIS funding package is reviewed regularly and sometimes reduced or ceased depending on internal decisions made or on the quality and detail of reporting by medical professionals and support workers, which can result in an inability to continue previously accessed supports. Other people might have adequate funding available but be unable to implement supports as there are not enough available providers. The NDIS Review stated 'we have heard that approaches to eligibility, planning and plan reviews are traumatising, and that the NDIA and partners do not have a good understanding of psychosocial disability' (Commonwealth of Australia 2023).

Defunding of previous psychosocial programs

Previous psychosocial programs such as the Commonwealth-funded Personal Helpers and Mentors Service (PhaMS) were phased out due to the transition to the NDIS. Anglicare practitioners across program areas continually raised the gap that the defunding of programs like PHaMS has left for people needing psychosocial support.

> **The NDIS has created gaps … psychosocial programs that were working well were ended due to the introduction of the NDIS, and they did not require eligibility like the NDIS does**
>
> – Anglicare Community Services worker

While the NDIS was expected to be responsible for functional supports for a person's psychiatric condition where it impacts a person's functional capacity (Australian Government 2015), eligibility rules have not been applied as consistently for people with psychosocial disability to access the scheme and implement supports. Further, the approach of the NDIS is fundamentally different to a program like PHaMS, which did not have the eligibility requirements that the NDIS does, and could support people with a range of mental health conditions, including mood and anxiety disorders. PHaMS was strengths-based and recovery focused, and provided holistic support including links to other services such as housing support and drug and alcohol support (AIHW 2016). The NDIS requirement for permanent disability can conflict with a recovery approach to mental health conditions. For some previous clients of Anglicare's mental health programs, the NDIS process was discouragingly deficit focused. This approach led them not to continue pursuing NDIS access, coupled with experiencing rejection of their applications, including for people with treatment-resistant schizophrenia and significant impacts on ability to maintain work and social interactions.

The need for long term psychosocial support outside the NDIS

Psychosocial support programs are uniquely placed to 'sit with risk' and provide support before it becomes clinical. While clinical oversight of a person's treatment may still be needed, psychosocial practitioners can support the person to work through their psychosocial stressors at a deeper level, which can avoid moving into the acute phase requiring a hospital admission. Anglicare's Recovery Program is an example of an existing psychosocial support program. People recovering from a diagnosed mental illness can receive support through the program for a period of up to two years. The opportunity exists to scale up such programs to meet the needs of people requiring longer term support outside of the NDIS. This is especially required in the context of limited resourcing of state mental health services as outlined above.

> **What is needed is psychosocial support for those who need it longer term – meaningful interventions, case management, medication overview and the scope to…prevent outcomes like readmissions to hospital**
>
> – Anglicare Community Services worker

A longer period of psychosocial support is needed for some people with complex mental health conditions, such as Emilia below. Such supports can:

- provide a non-judgemental, person-centred and trauma informed practice
- intervene early when signs of decline appear, using the professional relationship to avoid hospitalisation (relapse prevention)
- manage symptoms and maintain skills
- maintain consistency of care
- work through psychosocial stressors using effective therapies
- assist to access and engage or re-engage with family and community connections
- offer ongoing self-advocacy and support with clinical appointments
- support a healthy environment for progressing individual recovery.

Emilia's story

Emilia's mental health concerns started when she was a teenager. She experienced regular hospitalisation for over a decade, with several changes in diagnosis and treatment. Every time she went to hospital she felt traumatised by the experience. She was eventually diagnosed with Bipolar Disorder.

Emilia was referred to the Recovery program and received support for several years. Over her one hour a week session with a Recovery worker, she worked on her coping strategies and talked over stressors. Her Recovery worker also helped her to develop and work toward goals including supporting communication and repair with family, and advocacy with her clinical team at ACMHS.

There were some challenges with inconsistent clinical care due to locum doctors and treatment issues. A medication change led to Emilia being hospitalised for 4 weeks and eventually returning to her former medication regime. Otherwise, for the period of support the Recovery program was able to recognise when early intervention was needed and provide appropriate support which avoided further admissions and traumatisation.

Since Emilia transitioned to the NDIS and was no longer eligible for the Recovery program, she has had a lengthy period of inpatient care with 2 weeks of Hospital in the Home followed by a 3 week admission to hospital. Emilia had a degree of psychosis which was quite extreme and different from previous periods of being acutely unwell. Her family had to strongly advocate for medication reviews so Emilia could get back to living her life.

Emilia was able to get access to NDIS for core supports and funding for a combined Psychosocial Recovery Coach/Support Coordinator, but almost all their time is taken up coordinating supports and documents for plan funding reviews. Because of these constraints, the NDIS supports she can access do not meet her needs and she and her family miss the support of the Recovery program.

Trust and rapport with a consistent support person is important. This is especially the case if the person's GP and/or case manager changes frequently in the context of limited resourcing of state mental health services. A person might see multiple psychiatrists and clinical case managers over a relatively short period of time and may receive varied diagnoses and treatment. If someone has a consistent support person or key worker from a psychosocial support program, they can communicate and advocate more effectively with treating clinical practitioners.

Anglicare staff observe that some clients of the Recovery program who were able to access NDIS supports could not appropriately connect or build rapport with NDIS workers in the time allocated. The amount of time to build appropriate trust and rapport is not necessarily considered in NDIS funding decisions. Other issues observed were that some NDIS Recovery Coaches were not available or suitably qualified and that sometimes not enough funding was allocated to appropriately support participants.

> **The cohort with complex trauma are unable to establish trusting and effective relationships with the way the NDIS is funded**
>
> – Anglicare Community Services worker

For people with long-term persistent mental health conditions, often associated with trauma histories, their personal, social, financial and psycho-emotional capital has often been reduced. To regain a sense of self-efficacy, they require support to achieve goals such as obtaining a home, overcoming a major barrier, engaging in study or achieving a pass in a subject, securing employment, or reconnecting with family or the community. These may require a substantial period with support. Sue's journey below highlights an example:

Sue's goal is to return to full time employment after suffering from PTSD from workplace bullying and domestic and family violence.

It takes her three years to secure fulltime employment:

1.5 years
to secure part-time entry level employment

+

0.5 years
to secure professional employment

+

1 year
to negotiate full time work

Meeting the unmet need for psychosocial supports outside the NDIS

The Productivity Commission in June 2025 recommended that governments should immediately work to resolve the commissioning and funding responsibilities for psychosocial supports outside the NDIS (Productivity Commission 2025a). They stated that 'PHNs currently commission some psychosocial supports and have experience and existing relationships; they are well placed to work with state and territory governments and providers to support this expansion and transition' (Productivity Commission 2025a). This must be a priority for governments.

Health Policy Analysis estimated that the number of people aged 12-64 in Tasmania requiring but not receiving psychosocial support services in 2022-23 was 9,420 (Health Policy Analysis 2024). These estimates were based on the definition of psychosocial supports as defined by the Psychosocial Project Group as 'non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community' (Health Policy Analysis 2024).

The Mental Health Council of Tasmania estimated roughly $200 million is needed annually to support 4,910 Tasmanians (aged 12-64) with severe mental illness and 4,510 with moderate mental health issues who are either outside the NDIS or don't get any state or federal-funded psychosocial services (MHCT 2025). In May 2025, mental health peak bodies called on Health and Mental Health Ministers 'to recommend to National Cabinet that a funding envelope for a 50:50 cost share arrangement between the Commonwealth Government and State and Territory Governments be allocated to increase investment in psychosocial supports to meet need over a five-year funding period' (QAMH et al. 2015).

Housing options for people with mental health conditions

Stable housing is key to mental health and recovery, demonstrated by Peter's story below.

Peter's story

Peter started drinking too much after he and his partner broke up. No longer able to stay in the family home, he struggled to find a place to live. Alcohol helped him cope with his growing depression.

His family urged him to try a residential rehab program for alcohol use, but it wasn't a good fit. Peter had trouble with the program's rules and after several attempts he was eventually asked to leave. By now Peter was spending much of his time sleeping rough, which was so stressful alcohol was the only way he could get through it. During a stint in crisis accommodation, he contacted an AOD service and told them he wanted to work on his drinking, but he couldn't do it when he didn't have a safe place to sleep.

Peter found the counselling sessions the service offered to be useful and he managed to make some progress with his addiction. The real change came after he received a social housing unit. After a downwards spiral lasting three years, Peter finally had a place where he felt safe. Best of all, he had a home where his children could visit.

Limited supported housing options for people with mental health conditions

Supported accommodation with mental health support can prevent people from becoming homeless or re-entering homelessness. Private rental properties may not be safe for people with complex support needs including chronic mental health conditions as they may not have the resources to maintain a shared tenancy without intensive support. They are also unaffordable for people on the lowest incomes, as found in Anglicare's Rental Affordability Snapshot.

An increased number of supported housing options need to be available statewide, including in the North. Existing adult supported accommodation facilities managed by Anglicare in the North are intended to provide support for people on a low income at risk of homelessness. A high proportion of residents experience mental health issues, due to experiences of disadvantage and the lack of mental health specific supported accommodation. A point-in-time sample showed that 63.63% of residents in Anglicare's adult supported accommodation facilities in the North had mental health issues.

These facilities are not resourced to provide intensive or overnight support and are not staffed by mental health clinicians. When a resident requires more mental health support than can be provided, the main option is to apply through the NDIS for supported independent living with 24/7 support. There can be significant wait times when seeking increased funding for a supported independent living property, even if the person has an existing NDIS package. While a person is waiting for increased NDIS support, their quality of life can decrease significantly.

A range of supported accommodation options is required. This includes crisis and transitional accommodation that is suitable for people with mental health conditions, supported accommodation facilities and programs to support people to stay well at home. For example, when a person is acutely unwell they may not be able to access emergency accommodation if they are displaying behaviours suggesting extreme distress or a risk to themselves or others. The only option may be to contact police or ambulance.

If supported accommodation options were available in the community, including crisis accommodation options that are suitable for people with mental health conditions, the expense of emergency call-outs and hospital admissions could be reduced.

Increased supported housing could alleviate some of the other issues in relation to acute facilities and workforce:

- 'Estimates suggest that the total shortfall in mental health workforce is approximately 8200 FTE and of drug and alcohol workforce of approximately 840 FTE annually, representing over 9000 FTE in total. However, if supported housing was available for every Australian with a severe chronic mental health condition who needed it, the requirement for community mental health services is estimated to reduce by approximately 74% for patients settled in long term supported accommodation. This would, again, reduce the need for additional workforce over and above those employed in – and budgeted for – in supported accommodation' (Looi, Robinson, et al. 2024).

- 'Supported housing has been shown to be cost-effective through rigorous economic analysis in Australian settings. Data from contemporaneous Australian supported housing models shows that persons with chronic severe mental health conditions managed in such settings have an up to 74% reduction in the need for community mental health services, reductions of more than 70% in the need for hospitalisation, and – if hospitalisation is required – reductions of more than 75% in length of stay' (Looi, Robinson, et al. 2024).

Supported accommodation options include support to maintain social housing tenancies. The Housing Accommodation and Support Initiative (HASI) is a program that supports social housing tenants experiencing mental ill health to maintain stable housing in Southern Tasmania. Shelter Tas recommended expansion of the HASI program to all regions of the state, encouraging 'the State Government to prioritise HASI or a similar response becoming a statewide initiative, expanding to the north and northwest. This would include people who are transitioning from acute care into the community. This investment not only benefits tenants, who are able to maintain housing security and receive the mental health care they need but also saves money through the decreased need for acute care and for additional housing and homelessness services that are needed if a tenancy is not sustained' (Shelter Tas 2023).

HASI programs exist in some other jurisdictions.

The University of NSW evaluated their HASI program in 2022 and found:

- It **reduced hospitalisations**, both the number of instances and length of stay.
- **Hospital admissions due to mental health dropped** by 44.8% in the first year of the program, and a further 29.2% decrease in the second year, a total decrease of 74% (from an average of 1.5 to 0.4 admissions per year) following entry to the program.
- **Average days in hospital decreased** by 74.8% over 2 years (from an average of 49.4 days to 12.4 days after 2 years) and a similar drop happened with involuntary hospital days.
- **Participants with a new charge in the criminal justice system and community corrections orders dropped** to almost none in the year after entering the program. Both types of events increased slightly in the second year but remained low.
- The economic modelling results for the 5-year timeframe found **the program is highly cost effective**, showing a net cost saving per person of about $86,000 and a positive outcome of about 0.25 Quality Adjusted Life Years. The economic modelling shows that it is not likely that CLS-HASI is cost effective in a very conservative 1-year scenario (43% probability that it is cost effective). The likelihood of cost effectiveness increases to 67% over 2 years and to 95.3% over 5 years (Purcal et al. 2022).

Recommendations

Anglicare Tasmania recommends:

Adequate income

1. That the Australian Government increase income support payments to above the Henderson Poverty Line.

1

Affordable mental health care

2. That the Australian Government and Tasmanian Government continue work to improve the affordability of mental health care, including through:

a) expanding the number of GP bulk-billing appointments available in Tasmania; and

b) providing access to affordable and bulk-billed psychology and psychiatry, including through the Medicare Mental Health Hub.

2

Housing

3. That the Tasmanian Government and Homes Tasmania:

a) fund additional investment in transitional and long-term supported accommodation to meet the needs of people living with mental health conditions;

b) continue work with social housing and supported accommodation providers to improve allocation processes; and

c) work with the Australian Government to scale up investment in long-term social housing.

3

Progressing reforms towards an integrated system

4. That the Australian and Tasmanian Governments:

a) continue work to integrate the mental health system, including exploring funding and commissioning models of services to support a continuum of stepped care; and

b) immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme as recommended by the Productivity Commission.

5. That the Tasmanian Government:

a) develop the next phase of the Tasmanian statewide mental health strategy following Rethink 2020, prioritising efforts to:

i) deliver its statewide mental health workforce strategy, aimed at developing the existing workforce in Tasmania as well as attracting and retaining in-demand professions;

ii) progress integration of the mental health service system with other key areas including alcohol and drug services and housing; and

b) support a sustainable community services sector through progressing five-year contracts with adequate indexation.

LGH Masterplan implementation

6. That the Tasmanian Government continue to implement the LGH Masterplan, prioritising:

a) an implementation plan providing detail of the delivery timelines and operational models for the precinct;

b) delivery of the LGH Mental Health Precinct including increased inpatient beds and short stay beds available to people without a discharge address; and

c) the expansion and redesign of the Emergency Department, including delivering a separate waiting area for people in acute psychological distress.

Appendix 1: Housing Connect data analysis

De-identified unit record data was analysed using stata statistical software.

Records with an admission to a psychiatric hospital or unit in the past 12 months, a prior mental health diagnosis (yes response), or both were classified as having a mental health condition. The remaining records were classified as having no recorded mental health condition (for the purposes of this analysis).

The significant results that have been referenced in this report are provided in Table A1.1 below, including the risk in each population (group), relative risk, upper and lower bounds of the 95% confidence interval for the relative risk and the 2-sided P value.

A relative risk greater than one indicates that a characteristic (such as harmful drug use) is more likely to be recorded for people with a mental health condition than for people without a mental health condition. A relative risk below one means that an outcome is less likely for people with a mental health condition than for people with no mental health condition.

Table A1.1 Relative risk of selected presenting reasons in Housing Connect clients with a mental health condition (MHC) compared to clients without a recorded mental health condition (No MHC)

	MHC	No MHC	Relative risk	95% confidence interval		P value
	Risk	Risk		Lower bound	Upper bound	
Presenting reasons (all)						
Inadequate or inappropriate dwelling conditions	0.4184	0.3367	**1.2425**	1.1470	1.3458	<0.0001
Previous accommodation ended	0.2408	0.1830	**1.3157**	1.1666	1.4840	<0.0001
Domestic and family violence	0.2173	0.1646	**1.3205**	1.1614	1.5015	<0.0001
Non-family violence	0.0559	0.0288	**1.9413**	1.4274	2.6403	<0.0001
Mental health issues	0.3698	0.0612	**6.0478**	5.0834	7.1952	<0.0001
Medical issues	0.1324	0.0926	**1.4294**	1.1987	1.7045	0.0001
Harmful drug or substance use	0.0575	0.0171	**3.3677**	2.3337	4.8598	<0.0001
Harmful alcohol use	0.0302	0.0085	**3.5312**	2.1013	5.9342	<0.0001
Main presenting reason						
Inadequate or inappropriate dwelling conditions	0.2190	0.1763	**1.2425**	1.096	1.4085	0.0007
Mental health issues	0.0464	0.0009	**51.562**	12.701	209.33	<0.0001
Harmful drug or substance use	0.0101	0.0004	**22.364**	2.9883	167.37	0.0025

Table A1.2 Relative risk of selected housing and income factors in Housing Connect clients with a mental health condition compared to clients without a recorded mental health condition

	MHC	No MHC	Relative risk	95% confidence interval		P value
	Risk	Risk		Lower bound	Upper bound	
Time since last permanent address						
Sleeping rough or in non-conventional accommodation	0.2615	0.2059	1.2696	1.1342	1.4212	<0.0001
Short-term or emergency accommodation, due to a lack of other options	0.3793	0.2810	1.3498	1.2348	1.4755	<0.0001
Not homeless	0.4034	0.5454	0.7395	0.691	0.7915	<0.0001
Time since last permanent address (if not permanent address)						
Less than 1 week ago	0.2978	0.3889	0.7656	0.7010	0.8362	<0.0001
More than 6 months, to 1 year ago	0.0978	0.0679	1.4399	1.1688	1.774	0.0006
More than 1 year, to 5 years ago	0.1374	0.0886	1.5515	1.3001	1.8515	<0.0001
Living arrangements one week before presenting						
Lone person	0.5788	0.4155	1.3931	1.3078	1.4839	<0.0001
One parent with child(ren)	0.1743	0.2756	0.6324	0.5602	0.7139	<0.0001
Couple with child(ren)	0.0324	0.0796	0.4071	0.3047	0.5441	<0.0001
Couple without child(ren)	0.0352	0.0625	0.5631	0.4209	0.7534	0.0001
Dwelling one week before presenting						
House/townhouse/flat	0.6670	0.7320	0.9112	0.8744	0.9496	<0.0001
No dwelling/street/park/in the open	0.0391	0.0202	1.9327	1.3359	2.7961	0.0005
Emergency accommodation	0.0777	0.0531	1.4636	1.1544	1.8556	0.0017
Main source of income						
Employee income	0.0408	0.1030	0.3961	0.3066	0.5116	<0.0001

MHC = has mental health condition, No MHC = no recorded mental health condition.

References

ABS (Australian Bureau of Statistics) (2020-2022) *National study of mental health and wellbeing*, accessed August 2025.

--- (2021) Census data [TableBuilder].

--- (2023) *Causes of death, Australia*, accessed August 2025.

ADF (Alcohol and Drug Foundation) (n.d.) *Alcohol and other drugs and mental health*, accessed August 2025.

AHURI (Australian Housing and Urban Research Institute) (2019) *Understanding the links between mental health, housing and homelessness*, accessed August 2025.

--- (2023) *What is the difference between social housing and affordable housing - and why do they matter?*, accessed August 2025.

AIHW (Australian Institute of Health and Welfare) (2012) *Comorbidity of mental disorders and physical conditions 2007*, accessed August 2025.

--- (2016) *Personal helpers and mentors*, accessed August 2025.

--- (2023) *Family and domestic violence*, accessed August 2025.

--- (2024a) *Mental health monitoring: performance indicators*, accessed August 2025.

--- (2024b) *Mental health: workforce*, accessed August 2025.

--- (2025a) *Physical health of people with mental illness*, accessed August 2025.

--- (2025b) *Social isolation and loneliness*, accessed August 2025.

Anglicare Tasmania (2025a) *Housing Connect Snapshot June 2025*, accessed August 2025.

--- (2025b) *Rental Affordability Snapshot*, accessed August 2025.

Australian Department of Health (2019) *PHN primary mental health care flexible funding pool programme guidance: Stepped care*, accessed August 2025.

--- (2020) *National PHN guidance: initial assessment and referral for mental healthcare*, accessed August 2025.

Australian Government (2015) *Principles to determine the responsibilities of the NDIS and other services*, accessed August 2025.

--- (2022) *Strengthening Medicare taskforce report*, accessed August 2025.

Australian Health Ministers' Advisory Council (2013) *A national framework for recovery-oriented mental health services: policy and theory*, Commonwealth of Australia.

Baptcare (n.d.) *Support for people exiting hospital or mental health inpatient settings: Choices*, accessed August 2025.

Barrett E, Dudley L, Conroy C, Kay-Lambkin F, Kelly P, Mills K and Teesson M (2018) 'Lived experiences of Australians with mental health and AOD comorbidity and their perspectives on integrated treatment', *Newparadigm*, Summer 2018-19.

BEING mental health consumers (n.d.) *Safe havens finder*, accessed August 2025.

Belcher J, Myton R, Yoo J, Boville C and Chidwick K (2021) 'Exploring the physical health of patients with severe or long-term mental illness using routinely collected general practice data from MedicineInsight ', *Australian Journal of General Practice*, 10.31128/ajgp-08-20-5563.

Bennett S, Jessarun M and Orban H (2025) *Saving the NDIS: how to rebalance disability services to get better results*, Grattan Institute.

Brackertz N, Borrowman L, Roggenbuck C, Pollock S and Davis E (2020) *Trajectories: the interplay between mental health and housing pathways*, AHURI and Mind Australia.

Cleanbill (2025a) *Blue report: national general practitioner listings*, accessed July 2025.

--- (2025b) *GP pricing analysis bulk billing incentive changes*, accessed August 2025.

COAG Health Council (2017) *Fifth national mental health and suicide prevention plan*, Commonwealth of Australia.

--- (2020) *National suicide prevention strategy for Australia's health system: 2020–2023*, National Suicide Prevention Project Reference Group.

Commonwealth Government (2022) *National mental health and suicide prevention agreement*, accessed August 2025.

Commonwealth of Australia (2023) *Working together to deliver the NDIS: independent review into the National Disability Insurance Scheme*, final report, Commonwealth of Australia.

--- (2025) *Initial Assessment and Referral Decision Support Tool (IAR-DST)*, accessed August 2025.

Department of Health and Aged Care (2022) *National Mental Health Workforce Strategy 2022-23*, Commonwealth of Australia.

--- (2024) *Australian Government response to the Better Access evaluation*, Commonwealth of Australia.

Department of Health Disability and Ageing (2025a) *About the MBS Review*, accessed August 2025.

--- (2025b) *Bulk Billing Practice Incentive Program: frequently asked questions for practices and providers*, accessed August 2025.

Enticott J, Meadows G and Rosenberg S (2024) *'For richer, but not for poorer: how Australia's mental health system fails those most in need'*, The Conversation, 2 December, accessed August 2025.

Garrett A and Stojcevski V (2021) *Report to the Tasmanian Government on suicide in Tasmania*, Tasmanian Government.

Health Policy Analysis (2024) *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme*, accessed August 2025.

Hilton T, Davies A and Lee N (2023) *Investment in the alcohol and other drugs sector in Tasmania*, 360edge for the Tasmanian Government.

Homelessness Australia (n.d.) *About homelessness*, accessed August 2025.

Isaacs AN, Enticott J and Inder B (2018) 'Lower income levels in Australia are strongly associated with elevated psychological distress: implications for healthcare and other policy areas', *Frontiers in Psychology*, 10.3389/fpsyt.2018.00536.

Looi J, Allison S, Bastiampillai T, Hensher M, Kisely S and Robson SJ (2024) 'Australian specialised mental healthcare labour shortages: potential interventions for consideration and further research', *Australasian Psychiatry,* 10.1177/10398562241267138.

Looi J, Robinson N and Robson S (2024) *Don't walk by: unmet need in chronic severe mental health conditions,* Australian National University and The Australia.

Marel C, Siedlecka E, Fisher A, Gournay K, Deady M, Baker A, Kay-Lambkin F, Teesson M, Baillie A and Mills K (2022) *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (3rd edition)*, Matilda Centre for Research in Mental Health and Substance Use, University of Sydney.

Medicare Mental Health (n.d.) *Launceston Medicare Mental Health Centre*, accessed August 2025.

Mental Health Australia and University of Canberra (2023) *Mapping mental health care*, accessed August 2025.

MHCT (Mental Health Council of Tasmania) (2025) *A plan for funding psychosocial supports for Tasmanians with severe and moderate mental illness*, accessed August 2025.

NDIA (National Disability Insurance Agency) (2024) *Psychosocial disability access factsheet 3: Lifetime support and recovery for psychosocial disability in the NDIS*, accessed August 2025.

--- (2025) *Am I eligible*, accessed August 2025.

NMHC (National Mental Health Commission) (2022) *National report 2022: reflections on a journey of change*, accessed August 2025.

--- (2025) *National report card 2024*, accessed August 2025.

NMHCCF (National Mental Health Consumer and Carer Forum) (2021) *Physical health impacts of mental illness and its treatments*, accessed August 2025.

NSW Mental Health Commission (2024) *Living well indicators: mental health readmission*, accessed August 2025.

PHT (Primary Health Tasmania) (2024) *Health in Tasmania: Health needs assessment 2025-28*, accessed August 2025.

--- (n.d.-a) *For professionals: mental health*, accessed August 2025.

--- (n.d.-b) *Mental health - complex and severe (adults)*, accessed August 2025.

Picone D, Keenan A, Walker T and Small N (2024) *Independent review of Tasmania's major hospital emergency departments*, accessed August 2025.

Pirkis J, Currier D, Harris M and Mihalopoulos (2022) *Evaluation of Better Access*, University of Melbourne.

Primary Health Networks (2019) Submission No. 377 to Productivity Commission, *Inquiry into the Social and Economic Benefits of Improving Mental Health Primary Health Networks*.

Productivity Commission (2020) *Inquiry into mental health*, accessed August 2025.

--- (2025a) *Mental health and suicide prevention agreement review: interim report*, accessed August 2025.

--- (2025b) *Report on government services: services for mental health*, accessed August 2025.

Purcal C, O'Shea P, Giuntoli G, Zmudzki F and Fisher K (2022) *Evaluation of NSW community-based mental health programs: community living supports and housing and accommodation support initiative*, prepared for NSW Department of Health by Social Policy Research Centre, UNSW Sydney.

QAMH (Queensland Alliance for Mental Health), Mental Health Community Coalition ACT, Mental Health Australia, Mental Health Coordinating Council New South Wales, Northern Territory Mental Health Coalition, Mental Health Coalition of South Australia, Mental Health Council of Tasmania, Mental Health Victoria and Western Australian Association for Mental Health (2025) *Joint Open letter to Health Ministers*, accessed August 2025.

Scott D, Burke K, Williams S, Happell B, Canoy D and Ronan K (2012) 'Increased prevalence of chronic physical health disorders in Australians with diagnosed mental illness', *Australian and New Zealand Journal of Public Health*, doi: 10.1111/j.1753-6405.2012.00916.x.

Shelter Tas (2023) *Tasmanian State Budget Submission 2024-25*, accessed August 2025.

Subotic-Kerry M, Borchard T, Parker B, Li SH, Choi J, Long EV, Batterham PJ, Whitton A, Gockiert A, Spencer L and O'Dea B (2025) 'While they wait: a cross-sectional survey on wait times for mental health treatment for anxiety and depression for adolescents in Australia', *British Medical Journal*, 10.1136/bmjopen-2024-087342.

Tasmanian Department of Health (2019) *Health workforce 2040 strategy*, Tasmanian Government, Hobart.

--- (2023) *2023-2027 Clinical Services Profile North*, accessed August 2025.

--- (2025) *Health system dashboard: mental health*, accessed August 2025.

Tasmanian Government (2020a) *Reform agenda for the alcohol and other drugs sector in Tasmania*, accessed August 2025.

--- (2020b) *Rethink 2020: A state plan for mental health in Tasmania 2020-2025*, accessed August 2025.

--- (2021) *Launceston General Hospital precinct masterplan*, accessed August 2025.

--- (2024) *Department of Health annual report 2023-24*, accessed August 2025.

Thomas KA, Schroder AM and Rickwood DJ (2021) 'A systematic review of current approaches to managing demand and waitlists for mental health services', *Mental Health Review Journal*, 10.1108/MHRJ-05-2020-0025.

Tune D (2019) *Review of the National Disability Insurance Scheme Act 2013*, accessed August 2025.

Turner S, Mota N, Bolton J and Sareen J (2018) 'Self-medication with alcohol or drugs for mood and anxiety disorders: a narrative review of the epidemiological literature', *Depression and Anxiety*, 10.1002/da.22771.

valentine k, Liu E, Veeroja P, Harris P, Blunden H and Horton E (2024) *The role of housing providers in supporting clients with complex needs*, AHURI Final Report No. 428, Australian Housing and Urban Research Institute, Melbourne, doi: 10.18408/ahuri7131301.

Whitley R, Shepherd G and Slade M (2019) 'Recovery colleges as a mental health innovation', *World Psychiatry*, 18(2):141-142, doi: 10.1002/wps.20620.

Wilkins R, Botha F, Lass I and Peyton K (2024) *The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 22*, Melbourne Institute of Applied Economic and Social Research, University of Melbourne.

WHO (World Health Organization) (2014) *Social determinants of mental health*, accessed August 2025.

--- (2022) *World mental health report: transforming mental health for all*, accessed August 2025.