



Rethink Mental Health – review report – stakeholder feedback

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Contents

Introduction	5
Summary – a contemporary mental health system that works.....	6
Consultation scope and method.....	9
Consultation feedback	10
Putting consumers, their families and carers at the centre of the system	10
Consumers.....	10
Young people	13
Carers and families.....	14
Improving access and streamlining referral pathways	17
Access	17
Mental Health Helpline	17
Referral and client pathways.....	17
Further integrating our mental health service system.....	18
Partnerships	18
Mental Health Services	18
Clients and their needs	18
Current services and service gaps	19
Future service system structures/models.....	20
Other important considerations.....	21
Promotion, prevention and early intervention and suicide prevention	21
Whole of government/whole of community approach	21
Physical and mental health	21
Supporting infrastructure.....	21
Workforce	22
Supported accommodation options	24
Mental health needs of older people	24
Population groups	25
Balancing investment in mental health and mental health services	28
ATTACHMENT A – Consultation method and participation	29

We would like to acknowledge the work of 3P & Associates, the Mental Health Council of Tasmania and the organisations who hosted consultation sessions.

We would also like to acknowledge the individuals and organisations that provided feedback throughout the consultation period. It is only with the input of people who are using, working with

and involved in the system every day that we will be able to design a truly effective long-term plan for mental health in Tasmania, so we thank you for your contribution to this process.

Introduction

The Rethink Mental Health Project is a key part of the government's election commitment – *A long-term plan for mental health.*

The Mental Health Council of Tasmania is a key partner in the Rethink Project, working with the Mental Health, Alcohol and Drug Directorate.

This is a commitment to develop an integrated Tasmanian mental health system that provides support in the right place, at the right time and with clear signposts about where and how to get help.

The focus is on achieving better outcomes for consumers, their families and carers from existing mental health expenditure and directing resources onto frontline services and support.

The Rethink Mental Health Project will deliver a long-term plan (the Plan) for mental health in Tasmania that guides investment into the next decade, establishes priorities and identifies strategies to enable changes to be realised. The Plan will be released in October 2015.

Stakeholder feedback will help inform the development of the Plan. A significant consultation process seeking views from consumers, their families and carers, clinicians, service providers and other key stakeholders, spanning nearly six months has been completed.

This report provides a summary of the information provided by stakeholders during the consultation process and highlights key themes. The purpose of this report is not to test the accuracy of the information but to present the views, opinions and perceptions of these important stakeholders.

Feedback from consumers and carers and the key organisations that work to ensure their voices are heard (Flourish – Mental Health Action in Our Hands, Mental Health Carers Tasmania, Carers Tasmania and the Mental Health Council of Tasmania), and the people that provide services including clinicians of public mental health services, GPs, primary health providers, private practitioners/providers, and community sector organisations is included.

This report will help to inform the development of the long-term plan for mental health in Tasmania. Along with the literature review and summary report of relevant local, national and international mental health policy and related research completed in September 2014 (available at www.dhhs.tas.gov.au/rethink), and relevant data and planning frameworks.

Development of the Plan will also consider state and national initiatives including (but not limited to):

- establishment of Primary Health Networks
- the National Review of Mental Health Programmes and Services – *Contributing lives, thriving communities* - by the National Mental Health Commission
- the *One State, One Health System, Better Outcomes* reform of health service delivery and creation of a single Tasmanian Health Service
- the Government's election commitments to deliver targeted and proactive suicide prevention strategies and to develop a Joined Up Human Service System
- the Caring Voices Project (Mental Health Carers Tasmania in partnership with COTA Tasmania, Carers Tasmania and Tasmania Medical Local)
- UTAS Health Services Innovation - Tasmanian clinical re-design project

Summary – a contemporary mental health system that works

In summary stakeholders thought that a mental health system that is contemporary and working well would not feel like a system and it would:

Put the person first

- Consumers would be seen as people and individuals and not simply as a diagnosis. They would be seen as the whole person and not just their illness. Support would include other areas such as accommodation, relationships, employment and other life domains
- There would be a focus on meeting the needs of consumers
- Consumers would be listened to
- Consumers would have choice and control and would have the information they need to make informed decisions
- Consumers rights would be protected

Be family friendly and inclusive of families and carers

- There would be recognition of the central role that carers and families played and they would be included in their family members care
- It would include and listen to carers who are negotiating on behalf of their family member
- It would provide support to carers
- Carers would be able to get help for their family members'

Be based on the 'lived experience' and include peer support models and a peer workforce

- Consumers would be able to interact and share experiences with other consumers in a variety of ways to support recovery
- The 'lived experience' would be recognised as a specialist area and people with a lived experience would be employed as peer workers within the system

Be welcoming and friendly, respectful and compassionate

- Respectful of all individuals in the system (consumers, carers, service providers and staff) and compassionate toward consumers and their families and carers
- Acknowledge the courage that it takes to ask for help
- Have a compassionate and appropriately skilled workforce

Be non-judgemental

- People would get help regardless of their issues and it wouldn't matter if people had alcohol and drug use issues or a personality disorder; they would not be judged and would get the help they need

Be easy to find, easy to access, easy to navigate and easy to exit

- Services would be easy to find and easy to access
- People would know how to get help and where to go to get help
- Support would be available
- Information could be accessed about mental health and mental health services more broadly not just specialist clinical mental health services
- Services and support would be easy to access and it would be easy to move within the system and in and out of the system - "Easy in and easy out"

- People would get the support they need when they are discharged from hospital settings
- Client pathways would be clear to everyone and it would be easy for people to move through the system to get the services and support they need

Be responsive and consistent

- People would be able to get help as soon as they needed it and they would be able to get the particular support they need
- People would be able to get the ongoing support they need when they are discharged from the system or when they move within the system
- There would be access to specialists when needed
- Available technology would be used to enhance service response

Be safe

- Consumers, carers, service providers and staff would all feel safe

Support the workforce

- The workforce would be supported to meet the needs of consumers and their families and carers

Take a lifespan approach

- It would support consumers across the lifespan of their illness with a structured approach to the stages from diagnosis and across the continuum of care

Be focussed on care in the community, recovery, wellness and not illness

- There would be case management, care coordination, follow up and support
- There would be a greater focus on recovery focusing on a person's strengths and not their pathology
- There would be a move away from hospital focussed care to care in the community
- There would be appropriate long-term supported accommodation options
- There would be a stepped model of care
 - People could step-up and get more support when they needed it and step-down from support when they felt ready
 - There would be 'in-between services' available when needed, well before people get to their "worst point"
- The importance of physical health and the links between physical health and mental health would be acknowledged and addressed

Be focussed on promotion, prevention and early intervention

- There would be a greater focus on promotion and prevention across the lifespan and at all levels of service
- Early intervention would be prioritised
- There would be more education in schools and increased community awareness about mental health and mental illness

Reduce stigma

- There would be compassion and a greater awareness of mental health and mental ill-health

Be coordinated and integrated

- All the different parts of the system would talk to each other and work together
- Shared data and records
- Enable public-private integration of service delivery facilitating increased linkages with the private sector to maximise consumer choice
- A statewide gateway-type entry point for the whole system as a means for providing a more seamless and statewide consistent model of care and service delivery
- The gap between alcohol and drug services and mental health services would be bridged
- Consultation liaison models of care to facilitate access to specialist mental health services for GPs, private providers and or across specific areas of e.g. diagnosis eating disorders, specialist dual disability

Consultation scope and method

Consultation is a key component of the Rethink Mental Health Project. To facilitate the feedback process, a range of options have been available for stakeholders to participate and have their say. This has included stakeholder consultation forums, an online feedback form, feedback via phone, email or in writing and submissions in response to the discussion paper.

As part of the stakeholder consultation process pre-determined questions were developed to enable consistency of themes across all stakeholders and in alignment with the discussion paper and online survey.

The consultation period commenced on 10 October 2014 and closed on 28 February 2015; however targeted consultation continued in March 2015. A small number of submissions from individual consumers and family members/carers and individual clinicians were received after this time. This feedback has been included in this report.

38 stakeholder consultation forums were held around the state and with varying stakeholder groups including consumers, carers/families, clinicians, community sector organisations and specific population groups.

100 responses were received through the online feedback form; a small number of verbal submissions and written submissions were received from individual consumers and carers and 18 submissions were received from organisations.

A process was also undertaken to receive specific feedback from consumers who at the time of the consultations were receiving mental health inpatient or community care through clinical mental health services. This included consultation sessions for consumers in inpatient units across the state conducted by the Senior Consumer and Carer Liaison Consultant and the opportunity for consumers to complete a feedback form which had been designed in consultation with consumers and Flourish - Mental Health Action in our Hands (Flourish).

The consultation process was led by the Mental Health Council of Tasmania (the Council) and the Mental Health, Alcohol and Drug Directorate (the Directorate). An independent facilitator, 3P & Associates, undertook the majority of stakeholder consultations with support from the Council, the Directorate and other key stakeholder organisations. The Council and the Directorate also conducted stakeholder consultations.

All information provided through stakeholder consultation forums, the online feedback form, via phone, email or in writing and submissions in response to the discussion paper was brought together and analysed to identify key themes.

Further detail about the consultation process is provided in Attachment A.

Consultation feedback

To reflect the consumer journey through the mental health service system and the journey of those who care for and support them, separate sections for feedback from consumers and carers and families are outlined in this report. Feedback from service providers is interwoven with considerations of the broader mental health service system and is featured further on in the report.

Putting consumers, their families and carers at the centre of the system

Consumers

The experiences of consumers have been front and centre in driving the Rethink Mental Health Project consultation. Including the voices of consumers is essential to developing an understanding of services from their perspective and how the system can be responsive to their needs. It also provides insight into where there are gaps, either in services available and/or the clinical or community approach to delivering services. In addition, the 'culture' of service delivery through the lens of consumers is an important element to capture.

The consumers who took part in the consultations have accessed a variety of services offered by multiple service providers both in the government and community sectors. They ranged in age from 16 through to individuals in their late 60s and early 70s who had long-term experiences across the mental health system. This section brings together their experiences and identifies a number of key themes that were common among consumers.

Many consumers want a culture that enforces that while they may (or may not) have a particular diagnosis, they are still an individual; their needs, and their responses to treatment, medication etc., are about who they are as individuals.

Some consumers talked about the need to go back to basics, the need for positive change and thought that over the years not much had really changed and the issues identified in the Burdekin Report¹ were still issues some 20 years later.

The conversations with consumers validated views expressed by other stakeholder groups – that is, the difficulty individuals have when interacting and navigating the mental health service system.

Key themes highlighted by the feedback from consumers are outlined below.

Accessing timely support (including diagnosis, admission and discharge)

The timeliness, responsiveness and appropriateness of the system relating to admission and discharge together formed a strongly discussed theme of the consultation.

Responses to the online feedback form emphasise the importance of being able to access the care and support needed in a timely manner in order to minimise the impact of an episode of illness.

Access to timely specialist input, particularly psychiatry was raised as an issue, mostly in relation to diagnosis and/or changing diagnosis. The result of these time delays was considered to generally result in a worsening state of mental health.

¹ Burdekin Report - *National Inquiry into the Human Rights of People with Mental Illness (1993)*

Much discussion was focused around the initial diagnosis, various hospital admissions and discharge. Overall, it was agreed that what happened next for a consumer often depended on the source of the diagnosis (GP versus hospital). For those who were diagnosed through a GP, generally there was a higher level of satisfaction with the timeliness and type of support that was accessed. For those who had entered the system after an episode requiring them to present to Emergency Departments (EDs), the experience relating to responsiveness and timeliness of service was often less positive.

Consumers also raised concerns that individuals with high-level suicidal risk/ideation are not always admitted to hospital. In particular, consumers were concerned that there were no alternative options for support available if a person in these circumstances was refused admission.

When considering access to timely support many consumers also raised consistency of clinician/service provider. Many consumers raised the issue of having to retell their story, having medication changes made due to different professional opinions, not being treated consistently, resulting in an escalation in illness. For some consumers, the constant changes in clinician resulted in reactions to medication that previous clinicians had known but were not picked up in file notes by a new clinician.

Discharge planning and follow up was also highlighted. On a positive note North West consumers advised that the 'discharge group' held regularly by Spencer Clinic is very helpful. Across the state however consumers said it is common for people to be discharged without being allocated a case manager, with no or inappropriate accommodation and/or support options. Consumers said there is a lack of follow up with them once they are discharged from hospital and often care and care planning for consumers after discharge is left to their families. Consumers also highlighted the lack of availability of psychiatrists once discharged from hospital.

Approach to care

Many consumers described a system that would support them across the lifespan of their illness and recognise the need for ongoing, active assessment and management to provide a wellness approach. Consumers provided feedback about the need for individual and group support and the ability for them to access extra support at times when this was needed.

Case management

The majority of consumers had a very positive experience of the case management models and considered case management a priority in a redesigned system. Their feedback described their experience in accessing case management as hit or miss, but when they had good support models it was mainly through community sector organisations. Broadly, comments indicated that case management took a proactive approach and provided a more holistic/whole-of-person focus including looking at the broader issues such as employment, relationships and accommodation that can impact on their mental health.

Support in the community

Some consumers raised concerns about not being able to access support and after care in the community following discharge from an inpatient unit. The issue of advanced care planning for mental health consumers was also raised as an option to be further pursued in the mental health context to enable consumers to make decisions about their care when they are feeling well and able to make informed choices.

Some consumers also discussed care in the community through their GP, medications being changed unilaterally and an over reliance on medication with little information provided to patients about

how medications work and their side effects. Consumers thought more education regarding illness and medication is needed.

Peer support

Consumers reported that they highly valued interacting in various ways with other consumers. The feedback was an overwhelmingly strong support for Flourish as an organisation that gave consumers the opportunity to have a voice, be heard, be supported in peer mentor roles and receive the encouragement required to take on challenges they may have previously not undertaken.

Wellbeing, not illness

Consumers expressed a strong desire for a cultural shift in thinking away from illness to a focus on wellness. Many participants wanted a system that considered their illness in similar terms to physical illness and highlighted diabetes as an example, that it would most likely be with them long-term, but their treatment plan should be focused around their capacity to be well, rather than treating the illness only. This would involve a broader focus on life domains such as relationships, employment and leisure, and not just on medical needs.

Fragmented service system

Consumers, like all stakeholder groups, consistently raised as an issue the complications of the service system and how to navigate it. The starting point of knowing where to go when you first know something is not right is one of the most critical points for individuals. Many consumers said this was their GP, and there was usually a positive outcome. Decisions consumers made about the first entry point into the system were driven by a range of factors including:

- Severity of the episode;
- Economic circumstances (ability to access a GP or private hospital);
- Previous/current knowledge of the health and human services system (e.g. through a family member or own engagement with other services);
- Access to and ability to use general and publically available information (e.g. beyondblue or other websites).

The other area of fragmentation raised was the lack of flexibility and holistic support. Many consumers with a range of needs saw the categorisation of services into programs as a barrier.

Consumer Choice, Control and Rights

Consumers reported that wherever possible they wanted to be given a choice about the services they accessed. Consumers (and service providers) also talked about the importance of consumers being provided with information to make an informed decision about service options they have available to them including service options available if they do have private insurance.

Some consumers and carers from CALD backgrounds reported that they were not given information regarding their rights in a language they could understand.

Ensuring consumer rights are protected when police are involved was also raised by some consumers. Generally feedback in relation to involvement of police was positive, although some consumers felt that police could be a bit heavy handed and didn't always understand how to treat people with mental illness. These consumers thought that police may need more education or they may need someone who understands the consumer and what they need to attend situations involving people with mental illness.

Employment

Consumers raised employment as an important issue for them and talked about the challenges of gaining and maintaining employment.

Consumers who had experienced mental illness since their teens, talked about the impacts this had had on their participation in education and their opportunities for employment.

Consumers talked about the pressure and stress of applying for jobs and attending interviews as well as keeping jobs once they had obtained them. High levels of support, guidance, coaching and mentoring were needs commonly raised by consumers who either wanted or were in employment. There was also a level of frustration expressed by consumers that they did not think Job Network Providers and Centrelink staff were well informed about the needs of people with mental illness.

Consumer experience of services and/or programs

Issues were raised in relation to the culture of inpatient services, where some consumers identified issues such as a lack of respect from staff, lack of empathy and compassion from staff as being concerning. However consumers receiving inpatient care at the time of the consultation generally provided positive comments about their inpatient experience and the nursing care they received.

Disability access to some inpatient rooms and a lack of call bells which had created distress for one consumer who, due to disability required assistance with transfers to and from their bed and wheelchair but had to contact staff using a personal mobile phone.

They also expressed frustration regarding limitations to smoking and did not seem aware that legislation mandated these requirements and instead seemed to hold the view that that nursing staff are not compassionate towards smokers.

Young people

The consultation included separate discussions with young people. These were young people who were members of Council run youth groups and also a small group of young people with a lived experience and who accessed a range of support services that related to their mental health needs.

Feedback from young people generally focussed on where they and their friends go to access support for mental health issues, what good service looks like to them and young people had a particular focus on protecting their privacy and the importance of confidentiality.

Overall, most young people said that more could be done to raise awareness of where to get help for mental health issues, but there is plenty of information out there.

Young people also talked about the need for easy and timely access to help and support because many young people leave things until it is at crisis or emergency level.

In accessing help, support and information, young people reported that websites are important for research however they emphasised that for actual services/support/counselling, they preferred a face-to-face interaction. They did acknowledge that living in a more rural area might make online support more practical, but their preference was face-to-face. In a similar theme, they also reported they would like to see more helplines.

Young people also reported that school counsellors are a valuable resource but they are often not sure how to approach them. This was because they tend to be in a back room at school

somewhere and students often don't know much about them, and don't have the confidence to knock on their door. Most don't realise there is a difference between school psychologist and counsellor/social worker and students would like to see these issues promoted more to students. They also noted going to a school counsellor makes it obvious to other that there is 'something wrong with you' and this leads to the potential of bullying. A more discreet system for seeking counselling would be better.

Confidentiality, choices and control over what is happening were all raised by young people as important aspects of service.

A summary of the key messages from young people is:

- Do not assume young people want everything online, face-to-face is really important
- School counsellors are an important first point of call for young people and they would like to know more about them; how it works and how to access them
- Having control, choice, feeling understood, respected and included are all important aspects of service
- The ease of access makes young people more likely to seek help
- Protecting the privacy of young people and confidentiality of services is very important

Carers and families

There was strong alignment between the issues raised by consumers and those articulated by carers and family members in their consultations. The experiences of carers were often told through the lens of the consumer for whom they were caring. Overwhelmingly, the carer voice was that of a parent, with a smaller number of carers who were siblings, spouse/partner or a child who had a parent with a mental illness participating in the consultations. This section highlights the areas consistently raised by carers that are additional and not specific to those already captured in the consumer section.

Participation and inclusion

One of the key messages from carers was the desire for a more respectful and compassionate system that acknowledged and accepted the important role they played in the consumer's life and ongoing treatment.

Carers consistently raised what they described as inappropriate attitudes and a culture of dismissiveness and "shutting out" family members. The descriptions generally relate to the clinical system, and particularly when their family member is an inpatient.

Carers frequently highlighted their experience of Child and Adolescent Mental Health Services (CAMHS) as a more positive and inclusive experience of working with mental health services. Carers (particularly those who were parents) spoke of their experiences with CAMHS as being collaborative, supportive, compassionate, caring, respectful, knowledgeable and inclusive. The most highly valued component of the CAMHS model of care was in relation to the family-inclusive approach.

Caring for the carers

While it was clear from the consultation feedback that the priority for carers is meeting the needs of the person they care for, carers also shared their individual journeys and talked about their battles,

illness and the stress in providing a caring role to their loved one. Predominantly there were two themes to this:

- The need for respite and a break from the stress
- The fear of what will happen to the person they are caring for if/when they are not able to

Mental Health Helpline and after-hours support

The Mental Health Helpline was a point of focus for many carers. The main issue carers raised was their expectations versus their experiences in reality. Overall, the expectation from carers was the helpline would provide them with support, information and advice when they were in crisis. Their reality was that it was unlikely they could get the required response. Many carers were concerned at the lack of after-hours support available, particularly in times of distress.

Suicide risk and admissions/discharge

Potentially the most frustrating, frightening and emotional experiences that carers shared during the consultation related to their family member either not being admitted, or discharged as an inpatient, despite articulating suicidal intentions/thoughts or suicide attempt.

Support after discharge

Many carers raised the issue of supporting their family member after discharge and their need to be better informed. This issue links closely with the theme of inclusion and participation. For many carers, the discharge of a family member is a significant event to deal with, particularly if the family member is reluctantly returning to the family home.

Overall, the key messages from carers related to a system that provided structured, planned and inclusive models of discharge that ensured there were appropriate strategies and support in place for the consumer and their carer/s.

Stigma

Attitude and culture relating to stigma in the mental health system and broader community also formed a common theme. Many felt that although there was a greater awareness of mental illness and mental health across the community, a high level of stigma and negative attitudes still persisted with many people they dealt with, both in and out of the system.

Legal frameworks

Carers raised issues relating to the legal frameworks relative to the mental health system, including legislation (particularly in relation to the *Mental Health Act 2013*), police response to mental health-related incidents and use of advance care directives.

Many carers expressed their concerns about the need to call police and many spoke highly of the police they had interacted with and empathised with the role police often had to carry out; this was echoed in a number of online responses from carers. They did, however, express the desire to see all police undertake basic mental health training to enable them to understand more deeply what behaviours related to a person's mental illness and what strategies are most likely to provide the best outcome.

Tasmania Police also raised their concern at the perceived increase in demand on police to deal with people experiencing mental illness.

Carer experience of services and/or programs

When talking about positive experiences carers highlighted aspects of service delivery as well as naming specific programs or organisations. These included: case management and coordination, support from GPs and the development of a mental health plan, Mental Health First Aid Training the Partners In Recovery Program, carer and peer support programs, carer organisations including Carers Tasmania and Mental Health Carers Tasmania, the MICare program, Personal Helpers and Mentors Service (PHaMs), the mental health nurses located in the ED at the Royal Hobart Hospital (PEN nurses), Well-ways program, Hobart City Mission and Forensic Mental Health Services (including the Wilfred Lopes Centre).

Carers were also asked to list any other supports they need or have needed previously that would have assisted them in their role as a carer. The following list captures their responses:

- More psycho-social interventions
- Greater focus on recovery/wellness
- Positive cultural change in the acute system
- Mental health training for all hospital staff on wards – reception, nurses, cleaners
- To be around other carers/ access group support programs
- Access to the latest information to improve personal knowledge of mental illness and caring
- Increase level of information and support available at/in acute units
- Opportunities for time out, respite
- Encouragement to take care of myself
- Opportunities to share personal stories
- Peer support
- Involvement in discharge planning
- On-call service to get support after hours
- Hospital-based mental health advocate
- Support for first-time carers
- Service providers demonstrate compassion, they listen and care
- Help with the court system
- Protection and safety

Improving access and streamlining referral pathways

The need to improve access and streamline referral pathways was a prominent feature in feedback from consumers, their families and carers.

Consumers, carers and service providers described accessing and navigating the mental health service system as a complex and ever-changing process. All stakeholders thought that the consumer pathway needed to be clear and explicit and expressed the importance of being able to know when, where and how to access support, from the initial stage of knowing something is not right through to the ongoing interaction with the service system.

Access

Stakeholders often raised not knowing how to get help or where to get help and the need for a single point where people can go to get all the information they need.

Service access issues for people living remotely or out of urban areas without easy access to transport options was identified as a challenge to client pathways and access to services.

Mental Health Helpline

Some service providers raised issues in relation to the Mental Health Helpline and its role as an entry point to public sector clinical mental health services. In particular, that it is a triage service for specialist clinical mental health services and as such is generally only able to support people with very serious mental illness. It is not a helpline in the sense that it provides information about mental health more broadly and referral to mental health services outside of the public mental health system. GPs, private providers and CSOs noted inconsistency of response from the Helpline. GPs and private providers noted that not all referrals they make are always followed up and at times there is a lack of communication with the referrer to let them know what has happened to their client.

There was consensus among stakeholders that the actual function of the Helpline needed to be clearly identified and communicated so that consumers, carers and service providers were clear about the role of the Helpline.

Referral and client pathways

When considering referral and client pathways service providers spoke about the challenges of not knowing referral criteria and processes for services, varying referral process and criteria across services and not knowing what services were available. GPs and private practitioners/providers spoke about the challenging referral process into public mental health services and difficulties of getting a client into these services. Private providers also spoke about the challenges of getting public mental health services to refer to them and more broadly to recognise the role of the private sector in the Tasmanian mental health service system.

Further integrating our mental health service system

Consultation with stakeholders looked at the opportunities for integration and partnership with the goal of providing a more comprehensive, joined-up service system. Stakeholders noted that working towards a system that provides a more joined-up approach had the potential to achieve improved outcomes for clients in conjunction with potentially greater efficiencies at an operational level.

Overall, there was a high level of support for exploring and developing a more integrated approach to meeting the needs of consumers. Reference was also made to the unique opportunities that exist to achieving better integration in the Tasmanian context given the small population base.

Partnerships

Consultation feedback regarding further integrating the mental health service system considered partnerships in some detail. Many of the submissions received from organisations focused on the need and value of working in partnership and building stronger relationships both within the mental health sector and more broadly. One of the most successful partnership models identified in mental health care (between clinical and non-clinical services) was the Adult Prevention and Recovery Care (PARC) model from Victoria. This provides short-term residential treatment services which have a recovery focus and are located in the community.

There was a major emphasis on communication as being an essential component to strengthen partnerships and increase integration of services. Communication was considered to include timely and effective communication with consumers and carers as well as communication between services and service providers involved in the care of consumers.

Mental Health Services

During the consultation process stakeholders discussed the range of services that should be provided around the state, the gaps and opportunities for the future and considered how mental health services could best be organised. Other relevant information about the range of services is also contained throughout this report.

Clients and their needs

When providing feedback service providers considered who their clients were, what their needs were, and whether or not from a service provider perspective this had changed over the last 5 – 10 years. Across the consultation groups, service providers identified that clients could be anyone and could be of any age.

Service providers generally thought that client needs hadn't necessarily changed over the years, but thought that the complexity of needs has increased. For example, they talked about increased numbers of clients with long-term and complex illness; increased number of older people 80–90 with complex medical needs; increased number of clients with substance use issues; increased number of clients with intellectual disorders and co-morbid mental health conditions; increased number of clients with physical health issues; and increased number of clients with Huntington's disease.

Service providers spoke about the changes in client expectations and those of their carers and families over the past five to ten years and highlighted an increased focus on wellness, not illness, a shift from clients being a passive recipient of care to becoming active participants in their care,

clients were better informed because of greater access to information, clients expected more than just treatment and wanted to be seen and treated as a whole person not their illness.

Service providers also spoke about broader community and system changes that had occurred over the past five to ten years including increased community awareness with more empowered service users with increased expectations and demands of providers, a growth in the non-government mental health sector, increased number of services on the ground compared to ten years ago including CSOs, ATAPS, Better Access initiative, headspace, increased complexity in the service system making it difficult to navigate, a change in access points for people into the mental health service system, improved assessment processes (although more work was needed in this area), improved collaboration (although further improvement was needed), more demands from nursing homes for behaviour management/placements for clients, increasing referral from rural and remote areas and increasing expectation of service delivery to these areas.

Current services and service gaps

When considering current services, staff from community sector organisations were generally more likely to describe services that ranged across the government and non-government sectors and included services outside of the mental health sector but that were common need areas for consumers, such as housing. Staff from public mental health services focussed more on services that were available within government agencies and some indicated that, although they did do it, they were less likely to refer out to external programs for a range of reasons.

Very few participants talked about duplication of services, which can be common in these types of consultation discussions. Rather, the discussion focused on the alignment or conflict in criteria for entry, and program or service funding roles and target groups. This was reiterated by other providers such as GPs, who identified knowing which service was right for which patients as a key challenge to managing mental health patients needing additional support in the community.

A strong theme in the feedback relating to a gap in the system is the availability of a 'step-up, step-down' model of care and support. Stakeholders described a stepped model of care as a range of services that allow people to 'step-up' to more intense health care if they are becoming unwell and 'step-down' to other support services as they get better.

Stakeholders considered a stepped model would enable people to have access to the appropriate level of support when they need it. It provides more alternatives and support to people in the first stages of an episode of mental ill health before it gets to the stage where they need to go to hospital.

Consumers and carers in particular talked about currently being able to get help from their GP but if they need more than this there is only the hospital and there is nothing in between. Consumers talked about models of care which enabled a higher level of support and referred to it as not needing to be admitted as an inpatient but requiring a higher than average level of support and structured time out from their situation. Consumers also talked about the need for an in-between stage of support through a transitional care model, which provides 'step-down' support while still being able to have freedom and independence. This is described in much of the feedback as the gap between acute care and recovery.

This type of care and the identified gap in services was not seen as a 'housing' issue. It may require accommodation, but the needs are more around the level of support, care and mentoring that might be required to enable a person to 'step-up' into a more supported environment or 'step-down' from an acute-care environment. It could be described as transitional care that may have a specific accommodation component if this is required.

Future service system structures/models

A key theme was the need to increase the amount and level of care offered through community based services and away from a hospital focussed system of mental health care. Several models and programs from other areas were also provided as examples of what could be possible in the Tasmanian system. These included Trieste Model (Italy)², the Lille Model (France)³ and the Andalucía model (Spain)⁴ these models all focus on community based mental health, social inclusion and a reorientation of the mental health service system to community and away from hospital care.

The system needs to be able to better support the needs of consumers across the continuum of care and across their lifespan. This included ensuring clients are aware of their options and choices, increasing the focus and valuing the important role of natural supports/networks for people experiencing a mental health issue and the need to increase access for clients to broader health promoting activities and opportunities consistent with a focus on wellbeing and not just illness.

Discussion also highlighted that the practice of mental health treatment and care has been shaped largely by the medical model where the focus has been on solving problems and controlling the symptoms of mental illnesses. Service providers thought there needed to be a move away from this to a focus on wellness and recovery models that enable consumers to take control of their life. Identified models that some services use to deliver recovery-oriented services include the Strengths Model⁵, the Tidal Model⁶ and the Wellness Recovery Action Plan (WRAP)⁷.

When considering future service system structures/models the areas that were commonly named up by stakeholders broadly outlined the need for promotion, prevention and early intervention approaches and a framework of primary, secondary and tertiary levels services with easy step up and step down between services.

² http://www.triestesalutementale.it/english/mhd_department.htm

³ Jean Luc Roelandt et al (2014), Community Mental Health Service: An Experience from the East Lille, Journal of Mental Health and Human Behaviour, Vol. 19, no. 1, p. 12 <http://www.salutmental.org/wpcontent/uploads/2014/11/Community-Mental-Health-Service.pdf>

⁴ <http://www.faisem.es/index.php/en/>

⁵ The strengths model or strengths based approach focuses on individual strengths rather than pathology.

⁶ The Tidal Model is defined as a philosophical approach to the discovery of mental health. It emphasises helping people reclaim the personal story of mental distress, by recovering their voice. By using their own language, metaphors and personal stories people begin to express something of the meaning of their lives. (www.tidal-model.com/)

⁷ www.scottishrecovery.net/WRAP/wellness-recovery-actions-planning.html

Other important considerations

Promotion, prevention and early intervention and suicide prevention

The need for a focus on promotion, prevention and early intervention was identified. Prevention and early intervention was generally considered in terms of investing in the early years and was part of the broader focus on the need for greater investment in child and adolescent mental health and supporting the important role of GPs and primary health more broadly in this area.

Whole of government/whole of community approach

Feedback in relation to developing a whole of government and whole of community approach to mental health focussed on the key areas of integration and collaboration across sectors and in a systematic way that addresses the continuum of care. Responses emphasised the importance of increased integration between acute care and primary health care.

It was suggested an overall commitment to policy supporting whole of government approaches, reducing the silos and facilitating better pathways in the mental health service system could produce positive results for Tasmanians.

Physical and mental health

All stakeholders spoke about the need to consider health holistically. Consumers talked about this in terms of being seen as the whole person and not as a 'diagnosis' so that all of their needs would be considered including their physical health needs. Stakeholders also talked about the connection between physical health and mental health and stakeholders suggested GPs and the primary health sector had an important role to play in this area.

Supporting infrastructure

Contemporary system for records and delivery

Consultation has identified that the current system provides multiple barriers to person-centred care, collaborative models of care and integration of services. Areas most discussed in this regard include:

- The need to scope and resource the development of an integrated IT system across the government and community sector that incorporates e-health records;
- A common client e-record system incorporating case management and record keeping;
- An agreed case management model and software system to support the delivery of the model to enable integration across all parts of the sector. This model would require a software package that enabled all practitioners working with an individual to access the record (with consumer permission) but some areas would be "locked off" depending on the practitioner and the needs; and
- A single-entry-point referral system for individuals and therefore a single point for data collection.

Building infrastructure

Purpose-built facilities in the community and also inpatient services were discussed by consumers, carers, and community sector and government staff including:

- Integrated community facilities incorporating primary health, mental health and human services (including child protection, youth justice, housing);
- Purpose-built inpatient facilities to facilitate contemporary care and to meet the needs of client groups e.g. young people, adults, older people; and
- Common reception – CAMHS, Adult services, Alcohol and Drug Services.

Workforce

The specialist and community mental health workforce was a priority area of focus throughout the consultations. This section outlines the focus of feedback and input on the current workforce in conjunction with identified opportunities for the next 10 years.

Consumers and carers saw that a change in culture and attitude was the area of highest need for the workforce. They also raised more issues with their experiences of clinical/government staff, while they were more likely to speak positively of their experiences with community sector staff.

Conversely, many clinicians in the government system saw the community sector staff as requiring an increase in their skills and knowledge to support the clinical needs of consumers. This said, many also had very positive experiences with a range of community sector organisations.

Community sector organisations generally provided feedback more closely aligned with consumers. They wanted to see a workforce that had a deeper understanding and focus on the needs of the whole person rather than just the presenting need relating to a mental illness. They were also more likely to raise workforce needs that were about areas such as shared workforce values regardless of what system you worked in, and more flexibility to provide individualised support.

Consumers and carers and the workforce

Consumers most consistently expressed a desire for the workforce to have a deeper understanding of contemporary approaches to person-centred care and a culture change in attitudes and approaches to consumers. For consumers and carers, there was more emphasis on the people side of care and less on issues relating to clinical skills. Specifically, the words like compassion, empathy, listening, believing and understanding were most often used by consumers and carers when discussing workforce needs and issues. When asked what a mental health system would look like if it were working well, many of the initial consumer and carer responses related to the workforce. This nearly always focused on workforce attitude, not skills and knowledge.

Peer workforce

Peer-worker models for individuals with a lived experience working across all areas of the mental health system were discussed in many of the consultation sessions. Most participants felt this would contribute to breaking down the culture and attitude issues that were raised consistently in the consultations.

Education and training for individuals working in the mental health sector should not just be in mental health, but rather in holistic, wellness-focused, person-centred care. This requires training and support for clinicians who can then understand, be connected and engaged in the sector.

Many participants shared the view that there is a need for a higher level of expertise and specialisations, and these need to be integrated so they are available based on a patient's needs wherever they are presenting – for example into EDs or a community sector organisation.

Strategic and structured linkages with the University of Tasmania (UTAS) were discussed as an opportunity to influence curriculum and the skillset and knowledge of graduates. This linked with discussion about UTAS also providing mental health research that encompassed workforce planning.

Participants identified clinical supervision as an emerging workforce issue, and they highlighted the importance of workforce planning, training and structures to support clinical supervision.

Peer support for clinicians, government and community sector staff was perceived as a tangible and immediate option that would support increased knowledge, networks and the ability to think about systemic planning issues for the mental health workforce. Models such as establishing communities of practice in regions or across areas of specialisation were discussed as a means of increasing knowledge within the workforce.

Increasing the clinical and general capacity of the community sector to work with low, medium and high-need clients was raised consistently. As discussed previously in this section, consumers and carers did not share this view and articulated a greater level of satisfaction with staff working in the community sector.

Leadership and governance in the sector were also raised as a workforce development issue. While the emphasis of feedback was more consistently on the skills and attitudes of clinicians and staff in community organisations, there was recognition of the need for succession planning and leadership development to ensure the future mental health sector would be led by individuals with high-level strategic skills.

Workforce development was also a focus of the workforce integration and collaboration discussions. This aligned with concerns expressed by consumers and carers regarding the need for structured and targeted training and development for important roles that work closely with shared clients; examples ranged from Child Health and Parenting nurses, school social workers and guidance officers through to GPs. In addition, there were suggestions made to increase the overall mental health allied health workforce through the development of specific mental health career pathways as a way of engaging and retaining novice practitioners. Some staff considered this would also assist in attracting and retaining more senior and highly skilled practitioners. Some participants suggested speech pathology should be an allied health speciality included in the mental health workforce, this is not currently the case in Tasmania, but is in some other jurisdictions.

From the perspective of the public allied health workforce, there is no doubt the introduction of the Better Access to Mental Health Initiative has changed that psychology workforce dramatically, moving many from the public sector into private practice. The Better Access Initiative has however, improved access to psychology services for many experiencing high prevalence mental health disorders.

Consultation with clinical practitioners in the private sector also highlighted the limitations the clear split between public and private sectors creates for the system. Private practitioners indicated there are numerous opportunities to enhance the psychiatry workforce in Tasmania through the creation of joint appointments that work across both public and private mental health sectors.

Ultimately, the overwhelming agreement from a range of practitioners working in the mental health sector was that increased collaboration across sectors and services is the most efficient and achievable way to maximise the capacity of the current and future mental health workforce.

Supported accommodation options

In addition to the consumer experiences relating to housing agencies discussed earlier, stakeholders reiterated the importance of appropriate housing and accommodation as an acknowledged determinant of health and as an essential component in recovery for mental health consumers.

A number of specific issues were raised in relation to the need for increased options for supported accommodation including various levels of support and types of accommodation. Supported accommodation for specific population groups was outlined, particularly in relation to the lack of supports for people under 18 years and for people who have co-existing disabilities/ mental illness and or behavioural issues. Concerns were also raised around the number of restrictions and criteria required in order to access existing supported accommodation options and the time limitations around access, stakeholders also considered there was a service gap around longer-term options for people with chronic disability.

In the consultations, accommodation was a regularly raised area, particularly by consumers and carers. There was recognition that there is a lack of referral points by clinicians and community sector participants. There is general consensus that recovery and maintenance of recovery is based on having safe and secure housing. There was also a high level of agreement that the linkages between homelessness and mental illness are strongly evidenced and further emphasise the critical nature of ensuring housing is considered as part of the overall mental health service system.

There was an overall consistency in the two main areas of need as they related to:

- Long-term sustainable accommodation options
- Discharge into temporary accommodation and the support required

Finding long-term, supported accommodation was a consistent issue and was more often raised by carers than consumers. Many consumers and carers talked about the challenges of maintaining long-term unsupported accommodation. While wanting to maintain a predominantly independent life, due to the need for episodic care and contributing factors, many recognised this was not always possible. For consumers with alcohol and drug issues contributing to their mental illness, this was compounded.

In a similar area, the need for short-term, safe-discharge accommodation options was also a dominant issue. There were many examples given by carers of their family member being discharged either as an inpatient or from ED with no viable accommodation option. Carers reported sometimes finding this out by accident and often getting desperate phone calls after hours and not always with the capacity to respond due to distance, transport limitations or other commitments.

Mental health needs of older people

The discussion around the mental health needs of older people was a dominant theme. With an ageing population that is set to increase as a proportion of the overall population, many raised this need both now and in terms of strategic planning for the next 10 years.

Issues were raised relating to significant time delays in diagnosis of dementia by geriatricians that sit within geriatric services, not mental health services, and patients with delirium not being properly assessed and treated and being incorrectly referred to public sector services.

Private providers raised concerns about a lack of collaboration between public sector older persons mental health services and the private sector providing the example of an organisation that operates dedicated aged psychiatry programs including inpatient and day therapy services, yet the service has little engagement with public sector services despite its significant efforts to develop partnership arrangements.

Private sector providers further noted that collaboration across public and private sectors was very important with an ageing population in Tasmania and the relatively high rates of private health insurance in this age cohort meaning a significant percentage of people over 65 years could be supported in the private sector.

Issues relating to limited supports and services to be able to support older people to stay at home longer, long wait lists for Home and Community Care (HACC) funded packages and criteria around mental health packages of care funded through the state only for people aged up to 65 years were identified.

A lack of support in identifying, diagnosing and treating mental illness in older people was a common theme. The consultation heard that for many older people, their GP will be their main entry point. Many consumers and carers perceive GPs are not always skilled and knowledgeable in the diagnosis and treatment of mental illness in older people. They also reported a lack of knowledge on referral points, or a lack of referral options available. However it was noted by service providers that GPs could be upskilled in these areas and some GPs already have a strong knowledge base in this area. Opportunities to consider how GPs can provide input into nursing homes and residential aged care facilities, particularly those GPs with an interest and knowledge base in older persons mental health could be increased.

Stigma, ageism and ignorance of the needs of older people and their mental illness were also discussed. Service providers also expressed concern about the lack of knowledge in the primary health and aged-care sectors about the prevalence of mental illness in older people. Some participants mentioned the importance of ensuring the elderly were a priority in information and education campaigns that may be run as part of a prevention and promotion strategy. The need to help the community and health professionals have an awareness and deeper understanding of the prevalence and types of mental illness common in older people was raised.

Consumers, carers and clinicians also raised a lack of integration and collaboration between mental health, primary health and aged-care services as an issue. While fragmented services comprised a theme of the Rethink Project consultation as a whole, it was particularly evident in conversations about the needs of older people. A specific strategy that linked these parts of the health and ageing system together is an opportunity to address this issue. For consumers and carers, there was a strong sense of disconnect between the level of specialist knowledge and support required compared to the availability of clinicians with that specialist knowledge. Their personal need, or that of a family member, was often left to a GP or residential aged-care facility without the availability of a specialist to consult and provide the care needed. This often related to the prescribing of medications.

Population groups

In addition to the information provided earlier in the report the consultation provided a range of discussion and a focus on specific population groups including:

- Children, adolescents and young people
- Aboriginal people
- Culturally and Linguistically Diverse people
- Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) People
- People with multiple co-morbidities
- People with alcohol and substance misuse disorders
- People with borderline personality disorders

Children, adolescents and young people

The importance of child and adolescent mental health specific services was a prevailing issue throughout the consultation process. Overall, while there were many areas of focus in discussions relating to children and adolescents, there were four dominant themes that emerged:

1. Resourcing that is representative of the proportion of the population that is impacted and presenting
2. Dedicated inpatient facility for adolescents
3. A more integrated, co-located partnership approach across government and community sector organisations
4. Reorganisation of current CAMHS with either an age or developmental approach.

Resourcing and reorganisation

The issue of resourcing was raised consistently and was linked to a 'reorganisation' of the current CAMHS with either an age or developmental approach. This has been suggested as a way of being able to provide more needs-based and targeted funding across the lifespan, with a specific focus on children and adolescents.

Two options were put forward in various forums as suggested ways of organising this age range:

- Age based
 - Perinatal
 - 0–5
 - 6–12
 - 13–18
 - 19–25
- Developmental based
 - Perinatal
 - Early years/pre-school
 - Lower primary
 - Upper primary
 - Secondary
 - Senior secondary
 - Uni/workforce/not engaged

Children

The increasing number of children presenting with mental health needs and, specifically, with trauma-related mental illness was a strong theme in the consultation. Many consumers and carers reflected on how things might have been different for them or their family member had there been identification of the trauma, a trauma informed response and trauma specific services available during

their childhood. Many of the adult consumers shared their stories of various forms of childhood trauma and their experience of how this may have influenced the onset of a range of mental illness.

Adolescents

While the impact of trauma was also linked with much of the work in the adolescent age group, the more complex range of presentations was a common theme. The growing need in all areas was raised, and there were common themes around behavioural disorders, self-harm, suicide, eating disorders and dual-diagnosis with disability.

In the adolescent population group, the need for improved adolescent inpatient services was raised as critical across all consultations, including consumers, carers, government and non-government clinicians and the broader mental health workforce. The discussion around transition from CAMHS to adult MHS raised a range of issues and, for carers, the lack of any structured transition process limited their active engaged in the discussions and care planning of their child as they moved through the service.

Aboriginal and Torres Strait Islander People

Consultation with the Tasmanian Aboriginal Centre (TAC) indicated that there needed to be greater cultural understanding for consumers who identify as Aboriginal. Cultural barriers were raised as an issue particularly in relation to services in the ED, however it is an issue that extends beyond emergency services. Some of the barriers articulated were around language and communication techniques.

Issues were also raised in relation to meaningful participation and engagement of the Aboriginal community when developing services and the rigid and time-limited funding models that target the Tasmanian Aboriginal community.

Culturally and Linguistically Diverse (CALD) People

Consultation indicated issues in relation to the use of interpreters in the hospital setting, with some involuntary patients waiting lengthy periods of time for an interpreter. This was also an issue in relation to community services where appropriate access to interpreters is not provided for CALD clients.

Discharge processes were again identified as problematic for this population group with individuals often discharged into the community with inadequate support and unsuitable levels of care available.

In terms of strengths, the service model of the Personal Helpers and Mentors Service (PHaMS) program was identified as extremely valuable for CALD clients, the more gradual and community focused approach to providing support was seen as a more suitable and acceptable model for CALD individuals, however there was concern that the pending inclusion of this program in the NDIS would exclude CALD people.

There was concern that referral of CALD people to places such as the Phoenix Centre was often seen as addressing the mental health needs of the person and at times there was not recognition that the person may also need support from specialist clinical mental health services.

Feedback suggested that a shared care approach and improved communication between organisations such as the Phoenix Centre and specialist mental health services could enhance the service response to CALD people.

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) People

Consultation with LGBTI groups identified similar themes as other stakeholder groups including access to services and/or lack of services with an appropriate understanding of their needs. It was suggested that health services and professionals could be educated on these issues to reduce stigma and discrimination within the service system.

Education regarding LGBTI issues more broadly was also identified as a strategy to increase community understanding and reduce stigma.

People with multiple co-morbidities, alcohol and substance misuse disorders and personality disorders

Throughout the consultation there was significant discussion about people with multiple co-morbidities and how the system currently struggles to support these consumers, and how people with mental illness and alcohol and substance misuse disorders and people with personality disorders do not receive the support and care they often need.

Balancing investment in mental health and mental health services

Resourcing of the service system was consistently raised as the overarching area of need. In particular stakeholders highlighted the need for increased investment in services and supports for children and young people, older people and community care.

Participants favoured funding models that recognise the diversity of the clients and their needs which are flexible enough to be responsive to the individual. The individualised funding package model such as the NDIS was raised by many as a potential new approach for funding for those individuals who have medium to long-term needs. This resourcing approach was described as providing consumer choice and control and responding to the whole-of-person needs including clinical, social and accommodation.

Stakeholders thought there was a need to balance investment across the mental health service system and the need to consider mental health more broadly. Stakeholders highlighted the need to move away from a system that was hospital focussed with a balance of investment across clinical bed based services, community teams, community sector organisations, mental health and mental ill-health.

ATTACHMENT A – Consultation method and participation

Consumers and carers

The structure and focus questions for the consumer and carer consultations were the same. Pre-prepared documents were used to allow individuals to map their journey across various points of interaction with the service system. The sessions encouraged consumers and carers to consider their journeys in three distinct phases:

- Diagnosis – when I knew something was wrong and was looking for a diagnosis
- Treatment – initial diagnosis and development of a treatment plan
- Ongoing – ongoing interaction with the system

Sessions started with asking participants to visualise what the mental health service system would look like if it were working well. The following question was workshopped with participants as a starting point:

What would the ideal service system look and feel like if it was effectively supporting you and/or the people you care for to be active, independent, self-reliant members of the community?

At the conclusion of the workshopping of the opening question, participants were asked to work on their journey document and choose three examples of their interaction with the system; they looked at when and where these happened (for example, year and region), what were positives from the experience and what were negatives.

Participants shared with the group some of the highest priority areas for change they would like to see achieved through the Rethink Mental Health Project.

Mental Health Services clinicians and Community Sector Organisations (CSOs)

Regional consultations were conducted with community sector organisations to gain feedback from the perspective of community-based mental health services and support. Forums were also conducted with mental health services clinicians and staff from across Tasmania. Questions developed for these forums are provided here.

Who are we working with? – Environmental scan of our clients and their needs

Clients – who are they, what are their needs, has that changed over the last 5–10 years? If so, how?

How are they accessing the system – what is working, what isn't?

Services – Environmental scan of our services and how they do or do not match with our clients and their needs

What services do we have, how does it work and what is working well?

What would we like to do differently?

What are the gaps?

Are there opportunities for integration of any of our services?

Partnerships

Who are our current partners in service delivery?

Who do we need to work with to provide the services and support that our clients need?

Are there current or required partnerships that will make it more seamless for clients and address service gaps?

What would a contemporary mental health system look like?

If you were given the task of redesigning the system, what would it look like?

What would you keep, what would you do differently, why?

Participants from each stakeholder group were asked the following questions:

- If the mental health system was working well, what would it look like?
- What would be the key characteristics of a contemporary mental health system?

Participation

Consultations took place across Tasmania with stakeholder group participation summarised in the table below.

Rethink Mental Health Project – Stakeholder Consultation Forums

Date	Location	Stakeholder group
20 November 2014	South 64 Burnett Street, North Hobart	Carers
21 November 2014	South Level 2, Meeting Room Carruthers Building, St Johns Park New Town	Clinical services (Mental Health and Statewide Services Executive)
24 November 2014	South Tom Dempsey Room, Glenorchy Civic Centre, Cooper Street, Glenorchy	Consumers
27 November 2014	North West: Burnie Yacht Club South Burnie Esp Burnie	Clinical services MHS North West
1 December 2014	South Glenorchy LINC (Elwick Room)	Consumers
3 December 2014	North Anglicare meeting room 116 Elizabeth Street Launceston	Consumers
3 December 2014	North CSO Meeting Anglicare meeting room 116 Elizabeth Street Launceston	CSO Service Providers
4 December 2014	North West CSO Meeting Toyota meeting room 41 Best Street, Devonport TAS 7310	CSO Service Providers
4 December 2014	North West Community Health Centre 23 Steele Street, Devonport TAS 7310	Consumers
10 December 2014	Campbell Town The Grange	MH-SPAG Clinical services – Managers and Clinical Directors
15 December 2014	South CSO service providers/CEO network Hockey Function Centre, 19 Bell Street, New Town	CSO service providers
16 December 2014	Glenorchy Youth Advisory Group	Young people
18 December 2014	North Launceston General Main Lecture Theatre, Level 2	Clinical Services MHS North
8 January 2015	Tasmanian Aboriginal Centre	Tasmanian Aboriginal

		Community
14 January 2015	St Marys Community Health Centre	Rural Consumers
19 January 2015	Grand Chancellor, Launceston	Service Clubs (Rotary)
20 January 2015	South Mental Health Carers Tasmania Meeting Room 1 St John's Avenue, New Town	Mental Health Carers Tasmania
20 January 2015	South Staff Amenities Room Level 2/99 Bathurst Street, Hobart	Clinical services MHS South
20 January 2015	Phoenix Centre	Culturally and Linguistically Diverse (CALD) community
21 January 2015	North Anglicare Meeting Room 116 Elizabeth Street Launceston	Mental Health Carers Tasmania
21 January 2015	Launceston	LGBTI
22 January 2015	North West Civic Centre Isandula Room Kind Edward St Ulverstone	Mental Health Carers Tasmania
23 January 2015	South, Clarence	Young people
30 January 2015	South, Hobart	LGTBI
29 January 2015	South	Older people
2 February 2015	South	Older people
4 February 2015	South	Older people
4 February 2015	South Risdon Prison	Tasmanian Prison Service – Therapeutic services team, case management team and offender management program team
4 February 2015	South Risdon Prison	Correctional Primary Health Services
26 February 2015	Hobart Clinic	Providers of the private mental health facilities and key clinical staff
10 March 2015	Launceston	GPs
10 March 2015	North	Community Forensic Mental Health Services
10 March 2015	North	Older Persons Mental Health Clinicians
11 March 2015	Ulverstone	GPs
12 March 2015	Burnie	Older Persons Mental Health clinicians
12 March 2015	Hobart	GPs
10 March 2015	North	Community Forensic Mental Health Services
17 March 2015	Statewide	CAMHS Clinical Advisory Group

Mental Health, Alcohol and Drug Directorate

Department of Health and Human Services

Email: rethink@dhhs.tas.gov.au

Visit: www.dhhs.tas.gov.au/rethink

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