

Towards Tasmania's next Mental Health Strategy.

Uniting Vic.Tas Submission

Uniting

Executive summary.

Uniting Vic.Tas (Uniting) welcomes the opportunity to contribute to the development of Tasmania's next Mental Health Strategy.

Uniting is the community services organisation of the Uniting Church in Victoria and Tasmania. We deliver services across the full spectrum of community need, from early intervention through to crisis response, supporting children, young people and families across Hobart, Launceston and regional Tasmania. This includes early learning, parenting and family services, alcohol and other drug programs, family violence services and emergency relief.

Our submission is grounded in the insights of Uniting's frontline practitioners. It reflects a consistent and deeply concerning picture, mental health outcomes in Tasmania are shaped by structural disadvantage, service fragmentation and limited access to timely, appropriate support.

A central finding is that mental health cannot be addressed in isolation from the conditions in which people live. Poverty, insecure housing, family violence and social disconnection are primary drivers of psychological distress and significant barriers to recovery. This highlights the need for a strategy that responds to the cumulative nature of disadvantage rather than treating mental health in isolation.

Barriers to accessing mental health supports remain pervasive. Cost, workforce shortages and long wait times, particularly in primary care and school-based supports, limit opportunities for early intervention. At the same time, stigma and fear of statutory involvement act as powerful deterrents to help-seeking. These dynamics mean that mental health concerns often remain hidden until they reach acute levels, with more severe consequences for individuals and families.

There are also critical gaps in developmentally appropriate supports for children and young people. Early childhood is particularly under-served, despite strong evidence that early intervention is essential to lifelong wellbeing.

Service data also points to changing patterns of need. Increasing numbers of young people are presenting to community-based services with untreated mental health and substance use issues, often outside of formal clinical settings. This reinforces the importance of embedding mental health supports in accessible, community-based environments that reduce stigma and enable earlier engagement.

Taken together, these insights point to the need for a fundamentally different approach to mental health reform in Tasmania. Mental health must be understood as inseparable from social and economic conditions. The system must shift toward early intervention, integrated service delivery and community-based responses that are accessible and responsive to lived experience. Workforce capability must be strengthened across both clinical and non-clinical settings, and services must be equipped to respond to trauma and complexity in a coordinated and person-centred way.

This submission calls for a Mental Health Strategy that recognises the structural drivers of distress, centres the voices of people with lived and living experience and invests in the conditions required for all Tasmanians to live well.

Yours sincerely,



Adrian Webber
Executive Director, Directorate of Alcohol and Other Drugs and Wellbeing Services

RECOMMENDATIONS

- 1** The Strategy explicitly recognises housing as a mental health issue and commits to integrated housing, homelessness and psychosocial support responses.
- 2** The Strategy explicitly embeds a child and family wellbeing focus by investing in place based early intervention initiatives in communities with the highest levels of social exclusion. This should include integrated child, family and mental health supports, expanded access to early childhood education and care, and coordinated service responses that strengthen family stability, connection and safety. Priority investment should be directed to communities identified through the Child Social Exclusion Index, including areas such as Ravenswood and Bridgewater–Gagebrook, to ensure resources are aligned with the scale and concentration of need.
- 3** As part of the Strategy, the Government invest in a statewide workforce capability uplift, embedding mental health literacy and trauma-informed practice across early learning, education, and community services. This includes provide greater access to accredited and affordable training, including Mental Health First Aid, as a core requirement for frontline community services roles.
- 4** Invest in the expansion and replication of integrated therapeutic programs such as Catalyst across Tasmania, including both adult and youth-specific streams, with explicit requirements for culturally-safe and linguistically accessible delivery. This should include the use of interpreters, culturally responsive practice frameworks, and partnerships with multicultural and settlement services, particularly in Northern Tasmania where service gaps are most acute.
- 5** A priority action of the strategy to invest in and scale developmentally appropriate, play-based and trauma-informed early childhood mental health programs, such as Play for Safety, to support infants and young children experiencing trauma and strengthen parent–child attachment.
- 6** Establish integrated, school-based mental health and wellbeing supports in primary schools to enable early identification, improve engagement, and respond to the social and emotional needs of children experiencing disadvantage, including the use of neuro inclusive and neuro affirming practices that recognise diversity in learning, communication, regulation and behaviour.
- 7** Fund specialist, therapeutic and family-centred programs for adolescents, including targeted responses for young people using violence in the home, to address underlying trauma, support behaviour change, and promote safe family relationships, delivered through trauma informed, culturally responsive and neuro affirming practice frameworks.
- 8** A priority action of the strategy to establish Mental Health support worker roles across priority community-based settings in Tasmania, including emergency relief, food relief, and community hubs. This could be achieved by funding an initial 12-month pilot across selected sites, to test and refine the model in the Tasmanian context, ensuring roles are equipped with strong referral pathways into mental health, AOD, housing, and family services.

What are the gaps or areas for improvement in Tasmania's current mental health system?

A critical gap in Tasmania's mental health system is its limited capacity to respond to complex, co-occurring needs. Feedback from Uniting's Family Services practitioners and leadership consistently highlights that individuals and families rarely present with a single issue. Instead, people are navigating intersecting experiences of trauma, family violence, alcohol and other drug (AOD) use, housing instability, and financial hardship. Despite this, the service system remains fragmented, requiring people to engage with multiple disconnected services, each with different eligibility criteria, thresholds, and intake processes. This results in repeated retelling of trauma, delays in support, and, ultimately, disengagement.

Primary care and mental health access remain a significant point of pressure within the system.

Practitioners consistently report limited access to general practitioners (GPs), particularly bulk-billing services, alongside long wait times and prohibitive out-of-pocket costs. The requirement to obtain a Mental Health Treatment Plan creates an additional structural barrier, delaying access to psychological support. In practice, many individuals and families are unable to secure either a GP appointment or an affordable psychologist, effectively excluding them from the mental health system. These challenges are further compounded in regional and rural areas, where workforce shortages intensify inequities in access.

The introduction of walk-in mental health clinics represents a positive step toward improving low-barrier access to care. However, practitioner feedback highlights critical limitations in current engagement models. Intake processes that rely on incoming calls from private or blocked phone numbers, limited callback attempts, and minimal follow-up are not aligned with the realities of people's lives. Practitioners working with victim-survivors of family violence report that many individuals do not answer unknown numbers, and privacy constraints prevent messages from being left, resulting in missed connections at the point of entry. Even where initial contact is made, insufficient follow-up and coordination across services mean that individuals continue to fall through gaps. These design features risk excluding those experiencing the greatest challenges and undermines the effectiveness of otherwise well-intentioned reforms.

At the intersection of mental health and alcohol and other drugs (AOD), system fragmentation becomes even more pronounced.

There is limited capacity to respond to co-occurring needs in an integrated and accessible way, with AOD and mental health supports often delivered through separate systems, referral pathways, and funding streams. This places a disproportionate burden on individuals to navigate complexity at a time of acute vulnerability. In practice, this leads to delayed access to care, unmet need, and increased disengagement, particularly for those with the most complex presentations. The absence of sufficiently resourced, community-based and non-residential treatment options further exacerbates this gap, leaving many individuals without appropriate step-down or recovery-oriented supports following withdrawal or crisis care.

Within family services, the lack of accessible, coordinated and appropriately resourced mental health supports significantly undermines families' ability to work through challenges and provide safe, stable care for their children.

Feedback from Uniting's Family Services practitioners consistently highlights that families are expected to manage complex and compounding issues, including trauma, family violence, housing instability and mental ill-health, without access to timely or adequate support. Practitioners describe working alongside parents who are doing everything within their capacity to care for their children yet are constrained by a system that is unable to respond to the level of need they are experiencing.

A critical consequence of this gap is the fear of engagement with the mental health system. In Uniting's experience, many parents, particularly those experiencing complex circumstances, are reluctant to disclose mental health concerns due to fear that doing so may trigger child safety involvement. This fear reflects lived experience and acts as a significant deterrent to help-seeking. As a result, mental health issues frequently remain hidden until they escalate to crisis point, with more severe consequences for both parent and child wellbeing.

The impacts on families are both immediate and cumulative. Without access to appropriate mental health support, parents are left to navigate trauma, stress, and instability without the therapeutic or practical assistance required to stabilise their circumstances. Practitioners report that this places unrealistic expectations on families, particularly where parents are simultaneously experiencing violence, insecure housing, and financial hardship. In these contexts, the absence of support not only limits a parent's capacity to respond to their child's needs, but also contributes to ongoing stress within the family environment, with direct consequences for children's emotional and developmental wellbeing.

Families also face significant barriers in navigating the service system itself. Limited mechanisms for voluntary, consent-based information sharing between services mean that individuals must repeatedly recount traumatic experiences and coordinate their own care across multiple providers. This places an additional cognitive and emotional burden on families already experiencing high levels of stress, and contributes to service fatigue and disengagement. Feedback from Uniting's family services practitioners further highlight that system design often assumes a level of stability and capacity that many families do not have, disproportionately disadvantaging those experiencing trauma, poverty, and family violence.

For children and young people, there are significant gaps in both recognition of their distinct mental health needs and response.

The current mental health system is not adequately equipped to respond to children as individuals, with children often treated as secondary to adult-focused service responses, particularly in mental health and family violence contexts. This occurs despite the well-established, lifelong impacts of early trauma. There is also a critical lack of investment in early intervention and prevention. Practitioners report that families are often only able to access support once issues have escalated to statutory or crisis thresholds, missing key developmental windows for therapeutic intervention.

This gap is most acute in the early years. Consultations highlight a near absence of funded, developmentally appropriate mental health supports for infants, pre-verbal children, and preschool-aged children. As a result, early experiences of trauma frequently go unaddressed, with children later presenting with behavioural challenges that are more likely to be managed through diagnosis and medication rather than trauma-informed therapeutic care. In response to this need, Uniting has developed the Play for Safety model, an evidence-informed program design targeting young children who have experienced trauma, particularly in the context of family violence. However, the model has not yet received government funding to be piloted, reflecting a broader gap in translating evidence and community-identified need into funded early intervention responses.

A significant gap identified through consultation with Uniting family services teams' is the extended wait times and limited availability of school-based psychological supports, particularly in primary school settings. Practitioners report that access to school psychologists is extremely constrained, with some primary-school aged children facing wait times of up to two years for support. This is compounded by limited workforce capacity, with psychologists often only available on-site one day per week to support large student populations, making timely and consistent intervention unachievable.

These delays have substantial and compounding impacts on children and families. The primary school years are a critical developmental window, often coinciding with the early identification of behavioural and emotional concerns, including trauma-related responses and conditions such as ADHD. However, in the absence of timely support, children are left without the therapeutic intervention required to stabilise their wellbeing and engagement. Practitioners describe this as a period where children "*need the most support to set their path for the future*", yet are instead left unsupported at a critical point in their development.

The consequences of these delays extend beyond the individual child. In Uniting's experience, unmet mental health needs contribute to increasing distress within the family environment, leading to heightened tension, breakdown in family functioning, and reduced parental capacity to respond to children's needs. Practitioners report that without early intervention, children are more likely to disengage from education, experience difficulties forming relationships, and "*veer into areas that are of great concern*", reflecting escalating risk over time.

In practice, the absence of accessible school-based mental health support shifts the burden onto families and non-clinical services. Family Services practitioners, who are not trained mental health

professionals, are often required to provide interim support while children remain on waitlists, despite recognising that this does not meet the level of need. This not only places additional strain on the workforce but reinforces inequities in access, where children's ability to receive timely support is dependent on system capacity rather than need.

Culturally safe and inclusive service design.

Tasmania's mental health and AOD systems are not consistently designed to meet the needs of people from culturally and linguistically diverse (CALD) backgrounds. Despite nearly one in ten Tasmanians speaking a language other than English at home, service models can rely on English proficiency as a prerequisite for accessⁱ. This results in systemic exclusion, poor engagement, and disrupted continuity of care.

Tasmania's Multicultural Action Plan 2025-2029 commits the Government to improving cultural safety, accessibility, and responsiveness across services, supported by targeted investment. To align with this commitment, Tasmania's next Mental Health Strategy must explicitly embed culturally-safe and culturally-informed practice across mental health and AOD services, including funded access to interpreters, culturally responsive workforce capability, and service models that recognise cultural identity, life experiences, and trauma as central to recovery.

Case study: Lack of culturally appropriate AOD services

Uniting is aware of circumstances in which the failure to provide culturally and linguistically accessible alcohol and other drug (AOD) treatment may have contributed to the death of an individual. The husband of a woman supported by Uniting had a long history of severe alcohol dependence and engaged with hospital and detoxification services, including a six-week detoxification program delivered outside his local area. Following this period of acute care, attempts were made to secure appropriate ongoing treatment and recovery supports.

Access to residential AOD care was denied due to limited English proficiency, and no culturally or linguistically appropriate residential or community-based options were available. There are also no integrated, non-residential programs to support recovery following detoxification in their region. The individual exited detoxification without continuity of care, subsequently relapsed, and later died from serious health complications associated with prolonged alcohol use.

This case highlights the systemic consequences of service models that rely on English proficiency as a condition of access and demonstrates the urgent need for culturally safe, recovery-oriented AOD pathways that ensure continuity of care following detoxification. Further, it reinforces the need for expansion of integrated, non-residential therapeutic programs such as Catalyst to ensure safe and accessible recovery supports following detoxification.

Finally, there is a notable gap in accessible, place-based and non-clinical supports.

Uniting has observed a marked shift in crisis service demand, with increasing numbers of young people presenting to food relief services. For example, at Uniting's Hobart-based 'No Bucks' café, a growing proportion of attendees are now under the age of 25, compared to just a few years ago when most people accessing the service were single older men. It has been observed that many of these young people are presenting with untreated mental health and substance use issues, often also experiencing other challenges. This reflects a broader pattern of unmet need and highlights a critical gap in the current system. These informal, community-based settings are frequently trusted points of contact for individuals who may not engage with clinical services; however, they currently lack embedded mental health capability.

Taken together, these findings point to a system that remains fragmented, crisis-oriented, and difficult to access and navigate. Addressing these gaps will require a shift toward integrated, trauma-informed, and place-based approaches that prioritise early intervention, continuity of care, and safe, accessible pathways into support.

What should the next ten years of mental health reform in Tasmania focus on?

Improving mental health and wellbeing in Tasmania requires a whole of system response that addresses the social determinants of health, strengthens early intervention, and invests in integrated, community supports.

The Discussion Paper recognises the intersecting barriers and experiences of disadvantage that contribute to the health and wellbeing of Tasmanians. Our experience strongly reinforces this, and we understand that a person's mental health cannot be improved without addressing the conditions in which they live. Experiences of insecure housing, fractured or unsafe family relationships, and financial hardship are consistently identified as central drivers of psychological distress. These same conditions also operate as barriers to recovery, limiting individuals' ability to access, engage with, and benefit from mental health supports.

Recommendation 1. Uniting recommends that the Strategy explicitly recognises housing as a mental health issue and commits to integrated housing, homelessness and psychosocial support responses.

Access inequities also persist across geography and population groups. Uniting Vic.Tas was a contributing partner to the development of the [Child Social Exclusion \(CSE\) Index](#), working alongside UnitingCare Australia and the University of Canberra to strengthen the evidence base on childhood disadvantage across Australiaⁱⁱ. The Index provides a critical lens for understanding how structural factors such as poverty, housing instability, limited access to services, and social disconnection intersect to shape children's wellbeing and life trajectories.

Our research identified that children in Tasmania experience disproportionately high levels of social exclusion, with 35 per cent living in the most excluded communities. This indicates that a significant proportion of Tasmanian children are growing up in environments where multiple forms of disadvantage compound and persist over time. The Index further identifies that two Tasmanian communities, Ravenswood and Bridgewater–Gagebrook, are among the ten most socially excluded suburbs in Australia for children.

Improving mental health and wellbeing in Tasmania therefore requires a whole of system response that addresses the social determinants of health, strengthens early intervention, and invests in integrated, community supports.

A second priority must be a sustained and targeted response to child social exclusion, recognising its long-term impact on mental health and wellbeing. The evidence demonstrates that early experiences of exclusion, driven by poverty, housing instability, limited access to services and social disconnection, are strongly associated with poorer mental health outcomes in adolescence and adulthood. Addressing these risks early is both a matter of equity and an essential component of prevention.

Recommendation 2. The Strategy explicitly embeds a child and family wellbeing focus by investing in place based early intervention initiatives in communities with the highest levels of social exclusion. This should include integrated child, family and mental health supports, expanded access to early childhood education and care, and coordinated service responses that strengthen family stability, connection and safety. Priority investment should be directed to communities identified through the Child Social Exclusion Index, including areas such as Ravenswood and Bridgewater–Gagebrook, to ensure resources are aligned with the scale and concentration of need.

What are the key system enablers that need strengthening or are currently missing?

There are critical gaps in workforce capability, particularly outside of clinical settings.

While specific mental-health workforce shortages are widely recognised, there is a need to strengthen mental health literacy and trauma-informed practice across early learning, schools, and community services. These settings are often the first point of contact for children and families, yet staff frequently lack the training and support required to respond effectively.

Feedback from Uniting practitioners indicates that in the absence of accessible and coordinated mental health responses, family services workers are increasingly required to fill gaps in the system, supporting individuals with complex mental health needs beyond the scope of their role.

This reflects a broader systemic issue in which responsibility for responding to mental health distress is increasingly shifting into non-clinical settings, without a corresponding investment in workforce capability. Workers also described the challenges of navigating complex needs without clear pathways or support, reinforcing the extent to which the current system relies on generalist staff to manage highly specialised issues.

Uniting's leadership reinforces the need to address this gap through universal capability uplift, including embedding Mental Health First Aid and trauma-informed practice as core competencies across all community services roles. This aligns directly with the Discussion Paper's recognition that a "sustainable and supported workforce" and stronger prevention and early support are essential to long-term system reform.

Recommendation 3. As part of the Strategy, the Government invest in a statewide workforce capability uplift, embedding mental health literacy and trauma-informed practice across early learning, education, and community services. This includes provide greater access to accredited and affordable training, including Mental Health First Aid, as a core requirement for frontline community services roles.

Resilience of services to maintain connection and care during times of crisis.

Tasmania's next Mental Health Strategy must be resilient to structural pressures that can undermine access to care in regional and rural communities. One such pressure is the cost and availability of transport and fuel, which represents a critical risk to access of services, workforce sustainability, and service continuity if contingency arrangements are not adequately in place.

Tasmania's geography and dispersed population require transport-supported service models, meaning that many mental health and AOD services are inherently travel dependent. In this context, rising fuel costs and localised supply disruptions would disproportionately impact regional communities, where travel distances are longer, public transport options are limited, and alternatives to face-to-face service delivery is not always appropriate or accessible.

Uniting's recent experience delivering regional mental health and wellbeing programs in Victoria illustrates how quickly these pressures can escalate. Across the Gippsland, Wimmera, and Ballarat regions, Uniting services have observed an increase in requests from consumers to shift from centre-based appointments to telehealth or in-home visits due to the current rise in fuel costs, alongside a rising demand for practical assistance such as fuel or food vouchers.

Workforce impacts have also emerged, with staff commuting long distances experiencing financial strain associated with fuel costs and requesting alternative work arrangements that are difficult to accommodate within face-to-face service models. Services have absorbed increased vehicle and travel costs within existing budgets, redirected fleet vehicles toward direct consumer transport, and coordinated travel to maximise efficiency.

What would you recommend the Tasmanian Government prioritise as the Strategy is implemented?

To achieve meaningful and sustained reform, the initial priorities of the Strategy must focus on areas where early investment will deliver the greatest impact on long-term mental health outcomes and system sustainability. Based on our service experience and the evidence outlined in this submission, Uniting has identified three priority actions that address critical gaps in early intervention, system integration and workforce capability. These actions are intended to strengthen the foundations of the mental health system, reduce escalation to crisis, and ensure that supports are accessible, coordinated and responsive to the complex realities facing Tasmanian communities

Priority action: Scale evidence-based, integrated therapeutic programs addressing co-occurring mental health and AOD needs

A critical priority for immediate investment is the expansion of evidence-based, integrated therapeutic programs that respond to co-occurring mental health and alcohol and other drug (AOD) needs, such as Uniting's Catalyst program.

There is a well-established and growing cohort of individuals presenting with intersecting challenges, including mental ill-health, substance use, trauma, housing instability, and family violence. Despite this, the current system remains fragmented, with mental health and AOD services often operating in silos. This creates significant barriers to access and continuity of care and contributes to poorer long-term outcomes.

Programs such as Catalyst demonstrate the effectiveness of integrated, structured, and person-centred models of care. Delivered as a five-week, intensive, non-residential program, Catalyst combines therapeutic interventions, peer support, psychoeducation, and service linkages to support sustained behavioural change and recovery.

The outcomes achieved through Catalyst highlight the broader system value of this approach:

- Improved psychological wellbeing and emotional regulation
- Reduced substance use and relapse risk
- Increased social connection and engagement with services
- Improved housing stability and family functioning, including increased capacity for parents to safely care for children
- Reduced interaction with the justice system

Notably, a significant proportion of participants are parents and victim-survivors of family violence, reinforcing the importance of integrated responses that address both individual recovery and family wellbeing.

This model also addresses a critical service gap. National evidence indicates substantial unmet demand for AOD treatment, with hundreds of thousands of people missing out on support each year. Without access to timely and appropriate intervention, individuals are more likely to experience escalation of mental health issues, increased service system contact, and ongoing cycles of disadvantage.

Recommendation 4. Invest in the expansion and replication of integrated therapeutic programs such as Catalyst across Tasmania, including both adult and youth-specific streams, with explicit requirements for culturally-safe and linguistically accessible delivery. This should include the use of interpreters, culturally responsive practice frameworks, and partnerships with multicultural and settlement services, particularly in Northern Tasmania where service gaps are most acute.

Priority action: Deliver a comprehensive, developmentally appropriate mental health response for all children and young people

A central reform priority for Tasmania's Mental Health Strategy is the establishment of a coherent, developmentally appropriate continuum of mental health supports for all children and young people, from infancy through to adolescence. Current system settings are fragmented and unevenly

distributed across age groups, with critical gaps evident at key developmental stages. This results in delayed intervention, escalation of need, and avoidable harm for children, families and communities.

A rights-based, prevention-focused system must recognise that children and young people experience, express, and respond to psychological distress in ways that are fundamentally shaped by their developmental stage, relationships, and environments. As such, mental health supports must be tailored accordingly, spanning early childhood, primary school years, and adolescence, and embedded within the settings where children live, learn and connect.

This need is reinforced by evidence that disadvantage in Tasmania is both widespread and cumulative. Children experiencing poverty, housing instability, family violence and limited access to services face heightened risks of developmental vulnerability and poor mental health outcomes, with impacts persisting across the life course. Early, sustained, and developmentally appropriate intervention is therefore essential.

Early childhood (0–5 years): trauma-informed, relational and play-based interventions

For infants, pre-verbal children and preschool-aged children, mental health support must be grounded in relational, non-verbal and developmentally attuned approaches. Exposure to trauma during this period, particularly family violence, can disrupt neurological development, attachment, and emotional regulation, with long-term consequences if left unaddressed.

Uniting's Play for Safety program provides a strong model for addressing this gap. Designed for children aged 0–5 years who have experienced family violence, it seeks to deliver play-based, trauma-informed therapeutic support that focuses on restoring safety, strengthening attachment with a non-offending parent, and supporting developmental recovery. The program is based on the principle that repeated, developmentally appropriate experiences can support healing in the developing brain, particularly when delivered within safe, supportive relationships.

Investing in programs of this nature is essential to ensure that the youngest children, who are often invisible within traditional mental health systems, receive timely and effective support.

Recommendation 5. Invest in and scale developmentally appropriate, play-based and trauma-informed early childhood mental health programs, such as Play for Safety, to support infants and young children experiencing trauma and strengthen parent–child attachment.

Primary school years: integrated mental health and educational engagement supports

During the primary school years, mental health needs often emerge through behavioural, social and learning challenges. Schools are a critical platform for early identification and intervention; however, current responses are limited by long wait times, insufficient specialist support, and workforce capability gaps.

There is a clear need for integrated, school-based mental health and wellbeing supports that move beyond crisis response and address the broader determinants of engagement and learning. This includes:

- Embedded wellbeing and mental health practitioners within primary schools
- Stronger links between schools, family services and community-based supports
- Targeted early intervention for children exhibiting behavioural or emotional difficulties
- Trauma-informed and inclusive classroom practices that support children affected by adversity

Educational disengagement is both a symptom and driver of poor mental health outcomes. Without appropriate support, children at risk of disengagement may experience compounding disadvantage, including reduced social connection, increased behavioural challenges, and long-term exclusion from education and employment pathways.

Recommendation 6. Establish integrated, school-based mental health and wellbeing supports in primary schools to enable early identification, improve engagement, and respond to the social and emotional needs of children experiencing disadvantage, including the use of neuro-inclusive and neuro-affirming practices that recognise diversity in learning, communication, regulation and behaviour.

Adolescence: specialist responses for complexity, including use of violence in the home

Adolescence is a critical period marked by increasing independence, identity formation, and heightened vulnerability to mental health challenges. For some young people, particularly those with histories of trauma, disadvantage or unmet needs, distress may manifest through high-risk behaviours, including the use of violence within the home.

Young people who use violence in the home represent a cohort that is frequently misunderstood and poorly served by existing systems. Responses are often crisis-driven, punitive, or siloed across youth justice, family violence and mental health systems, without addressing the underlying drivers of behaviour.

A developmentally appropriate response requires:

- Specialist, therapeutic interventions for adolescents using violence in the home
- Family-centred approaches that prioritise safety while supporting relational repair
- Integration across mental health, family violence, and youth services
- Early identification and intervention pathways to prevent escalation

Importantly, these responses must recognise that many of these young people have themselves experienced trauma, violence, or social exclusion. Addressing their needs requires a dual focus on accountability and support, grounded in an understanding of developmental context and relational dynamics.

Recommendation 7. Fund specialist, therapeutic and family-centred programs for adolescents, including targeted responses for young people using violence in the home, to address underlying trauma, support behaviour change, and promote safe family relationships, delivered through trauma-informed, culturally-responsive and neuro-affirming practice frameworks.

Priority action: Establish place-based Mental Health support roles across community settings

A critical priority for immediate investment is the establishment of place-based Mental Health support worker roles embedded within community service settings across Tasmania, to address a significant and growing gap in the current mental health system.

Across Tasmania, there is a clear mismatch between where people experience mental health distress and where support is available. Individuals, particularly those experiencing homelessness, family violence, and alcohol and other drug use, are increasingly presenting in informal, community-based settings such as emergency relief and food services. These settings are often trusted and accessible entry points into support yet are not resourced with the specialist capability required to respond safely and effectively to acute distress and crisis presentations.

This trend is becoming more pronounced among younger cohorts. As stated previously in our submission, service observations in Hobart indicate a growing proportion of young people accessing food relief services, many presenting with untreated mental health and substance use issues. Without embedded support, these presentations risk escalating, with individuals cycling between crisis services rather than receiving early, coordinated intervention.

Uniting's experience piloting the Mental Health Duty Worker model within our Prahran emergency relief and meals service site in Victoria provides a strong evidence base for this approach. The pilot was established in response to a significant increase in people presenting with complex and intersecting needs, including acute mental health distress, homelessness, family violence, and AOD use. Prior to the introduction of this role, frontline staff and volunteers, many without specialist training, were required to respond to individuals in crisis, often diverting limited resources away from core service delivery and creating safety risks within the service environment.

The introduction of a dedicated Mental Health Duty Worker enabled the provision of immediate triage, brief intervention, and crisis de-escalation, alongside active linkage to ongoing supports. This significantly strengthened service capacity, allowing support workers to engage more people accessing emergency relief while ensuring those in acute distress received appropriate, specialist responses.

Importantly, the pilot improved data capture and incident reporting, providing greater visibility of previously unmet need. Increased reporting reflected stronger identification and response to distress presentations, rather than an increase in incidents, and contributed to improved safety for staff, volunteers, and community members.

This model demonstrates the effectiveness of embedding specialist mental health capability within trusted, low-barrier community settings, enabling earlier intervention, improving engagement, and reducing reliance on crisis-driven responses. It aligns with broader evidence that place-based, integrated responses are essential to addressing the complex and intersecting drivers of mental ill-health, particularly for individuals and families experiencing disadvantage.

Recommendation 8. Establish Mental Health support worker roles across priority community-based settings in Tasmania, including emergency relief, food relief, and community hubs. This could be achieved by funding an initial 12-month pilot across selected sites, to test and refine the model in the Tasmanian context, ensuring roles are equipped with strong referral pathways into mental health, AOD, housing, and family services.

ⁱ Department of Premier and Cabinet. (2025). *Embracing Diversity, Fostering Belonging: Tasmania's Multicultural Action Plan 2025-2029*. Hobart: Tasmanian Government.

ⁱⁱ Riyana Miranti, B. F. (2024). [*Child Social Exclusion Index, Nurturing Inclusion: Paving the Way to Improved Child Wellbeing*](#). Canberra: University of Canberra.