Mental health continuum of care: Service model design

Summary

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1. Introduction to the Mental Health Continuum of Care Project

Primary Health Tasmania is undertaking the Mental Health Continuum of Care (MHCoC) Project to improve Tasmanians' experience of and outcomes from the mental health services we commission. The project aims to streamline the delivery of our commissioned programs to improve service access and coordination across the state.

Over time, mental health services funded by the Australian Government have been commissioned as individual services, often with different objectives and eligibility criteria. This has led to a service system that can be fragmented and difficult to navigate for consumers, providers and sector partners. Issues include:

- confusing and inconsistent referral pathways
- limited coordination between services, meaning people often have to repeat their story
- gaps and duplication across different regions and services
- limited flexibility for services to adapt to local needs.

The MHCoC Project brings these services together under a coordinated model that focuses on integration, collaboration and continuity of care across the stepped-care system. It aligns with national reform priorities under the Strengthening Medicare agenda and Australia's mental health reform directions, which emphasise better connected, person-centred care across primary and specialist services.

Why this change is needed

Feedback from people with lived experience, carers, service providers and health professionals confirmed that:

- services are often fragmented and difficult to navigate
- people can wait too long or fall through gaps between services
- providers want more flexibility to respond to local needs and workforce challenges.

The MHCoC model responds to this by creating clearer entry points, simpler referral pathways and stronger coordination between providers. It marks a shift from funding individual services to commissioning an integrated, person-centred system of care.

What we mean by a continuum of care

A mental health continuum of care approach recognises that people's mental health needs change over time.

It means having a full range of supports, from early help through to more complex care, that work together so people can step up or down as their needs change without starting over or retelling their story.

A continuum of care requires different thinking about how services are funded and delivered. Rather than commissioning separate services within programs, Primary Health Tasmania is moving toward a connected system where services collaborate to support people across different levels of need.

While Primary Health Tasmania commissions a relatively small group of services within Tasmania's wider mental health system, these services play an important part in how people access help and stay well. The new model focuses on strengthening how all parts of the system work together. Through this approach, Primary Health Tasmania aims to:

- improve integration and coordination among the services we fund and the broader mental health system
- contribute to more consistent and accessible care across Tasmania
- contribute to a sustainable and adaptable system that meets community needs
- strengthen provider capability and workforce support to deliver high-quality, person-centred care.

2. How the MHCoC service model was designed

The MHCoC service model was designed following an extensive consultation process between April and July 2025.

There was strong participation in consultation from service providers and the community, with more than 250 people participating, including people with lived and living experience of mental health issues, service users, carers, service providers, clinicians and representative organisations.

Consultation occurred in two phases:

1. Exploring the current challenges and barriers to delivering and accessing mental health services in Tasmania, to explore the potential for increased integration and to identify gaps.
2. Designing elements of the MHCoC service model based on people's experience and understanding of what works.

Consultation phase	Activities
1. Understanding current challenges and barriers	• Three workshops with people with lived and living experience of mental health services. • A workshop with family and friends of people accessing mental health services. • Interviews with Primary Health Tasmania's commissioned mental health and alcohol and other drug services. • A workshop with GPs. • Workshops with allied health clinicians. • Workshops with a range of Primary Health Tasmania's commissioned mental health services and the broader mental health sector including providers.
2. Designing elements of the MHCoC service model	• In-person community design workshops with community members, service providers, clinicians and representative groups in Hobart, Launceston and Devonport. • Two additional virtual community design workshops with community members, service providers, clinicians and representative groups, for those unable to attend in person. • Three workshops with people with lived and living experience of mental health services. • Workshops with a range of Primary Health Tasmania's commissioned mental health services and other relevant providers. • A workshop with Primary Health Tasmania's Community and Clinical Advisory Councils.

What we heard

Across these sessions, participants highlighted that referral pathways are often confusing, people can wait too long or fall through gaps, and services do not always share information effectively. Workforce shortages (particularly in rural and remote areas) and rigid program rules were also seen as limiting access and flexibility.

Participants described what good mental health care should look like and identified the features that make a positive difference for consumers and providers, including:

- clear entry points and a no-wrong-door approach
- timely and appropriate care that fits people's needs
- a skilled and connected workforce that understands the local community and what supports are available
- services that communicate and work together so people do not have to repeat their story.

This feedback directly shaped the six key elements of the new model: integrated service delivery, streamlined pathways and coordination, workforce development, equity and access, data and digital, and collaboration and partnerships.

For more information about what we heard through this process, you can read the **Mental Health Continuum of Care Community Consultation Summary Report** available on the Primary Health Tasmania website.

3. Overview of the MHCoC service model

A stepped care approach

The MHCoC service model will adopt a 'stepped care' approach to mental health. The stepped care approach recognises that needs for mental health supports vary between people, and that services should be able to respond to changing needs. The model promotes person-centred care that avoids both under- and over-servicing. Under this approach, people can move easily between levels of care as their circumstances change, without losing connection to support.

Importantly it aims to provide the right service at the right time, with lower intensity steps available to support people before they are in crisis. Consumers can move up and down the levels of care (represented in the figure below) as their needs change.

The initial implementation of the model will focus on services aligned to Levels 2-4 of the national Initial Assessment and Referral Decision Support Tool (IAR-DST). This includes low intensity, moderate and higher intensity care.

Where people need supports that sit outside these levels, such as self-management (Level 1) or specialist clinical care (Level 5), commissioned services will work collaboratively with the broader system to enable smooth handover and continuity of care.

Referral pathways into the model

People will be able to access services across the MHCoC through a range of entry points, including referral by a GP or other health professional, referral from another service, or self-referral where appropriate. The model supports a no-wrong-door approach. Regardless of where a person seeks help,

services will work together to connect them to the right support and maintain continuity of care as their needs change.

All referrals will be triaged using the Initial Assessment and Referral Decision Support Tool (IAR-DST) to determine the most suitable level of care. This nationally recognised tool assesses factors such as symptom severity, functional impact, risk and complexity to match people to the right support. More information about the IAR-DST is available on the Australian Government Department of Health, Disability and Ageing website.

Each commissioned service will apply the IAR-DST in a consistent way, ensuring equitable and transparent access across Tasmania. The triage process will include:

- initial screening and assessment to confirm urgency and suitability of service to client need
- allocation to the most appropriate level of care (IAR Level 2, 3 or 4)
- feedback to the referrer, particularly the person's GP, confirming acceptance, commencement, progress and discharge
- coordination with other parts of the system such as the Medicare Mental Health phone service, Medicare Mental Health Centres (as they are established), and public mental health services when required.

The MHCoC will complement the network of Medicare Mental Health Centres being established across Tasmania. Both aim to improve access to care and provide clearer pathways between different parts of the system. Medicare Mental Health Centres provide free, walk-in support for people experiencing moderate to severe psychological distress or in need of urgent assistance. The MHCoC focuses on coordinated, ongoing care and recovery support delivered in the community for people with low to complex needs.

Overview of interventions and supports under the MHCoC

The MHCoC is intended to provide services to consumers requiring supports across IAR-DST Levels 2-4. It is anticipated that over time, the MHCoC will be expanded to include additional services such as psychosocial and alcohol and other drug (AOD) supports where required.

An episode of care is a defined period of structured support based on a person's level of need. Each episode includes assessment, active treatment and review, with transition or re-entry as clinically appropriate. Typical interventions and durations are outlined in the overview below.

Stepped care level	Level of severity	Types of intervention	Integration with other services
Level 5: Specialist and acute services	Delivery of services at this level of severity is out of scope for the MHCoC service model. However, it is expected that services will collaborate to establish seamless pathways for consumers between Levels 4 and 5.		

Stepped care level	Level of severity	Types of intervention	Integration with other services
Level 4: High intensity interventions	Severe mental illness (persistent or episodic) without acute risk or severe symptom presentation	• Evidence-based high intensity psychological services (such as cognitive behavioural therapy (CBT) or dialectical behaviour therapy (DBT)) • Clinical coordination services that support ongoing management • Multidisciplinary, longer-term care (e.g. providing support for service users to access psychosocial interventions, rehabilitation, daily living, vocational supports, legal support, financial support, family/carer support, care coordination, physical health monitoring and lifestyle interventions) • 12-month episode of care	Partnerships and integration with: • Specialist and acute mental health services • Primary Health Tasmania's commissioned services including psychosocial supports and AOD services • Other psychosocial and lifestyle support services • GPs for ongoing monitoring and integrated physical health care
Level 3: Moderate intensity interventions	Moderate to severe symptoms and distress	• Evidence-based psychological interventions provided by a mental health clinician (e.g. CBT) • Expected to be time-limited and short to medium term • May be suitable for people with severe symptoms who do not present significant problems on other primary domains (i.e. those who are well-managed) • 6-month episode of care	• Other Primary Health Tasmania-commissioned services including psychosocial and AOD services • GPs for ongoing monitoring • Social supports (e.g. family and friends, workplaces, schools) • Neighbourhood and community centres, population-specific support services (e.g. for multicultural communities, LGBTIQA+ people)

Stepped care level	Level of severity	Types of intervention	Integration with other services
Level 2: Low intensity interventions	Mild to moderate symptoms and distress (low risk and low complexity)	• Evidence-based low intensity interventions. This may include online, telephone and face-to-face, group work, coaching support or brief psychological interventions • Services may also be available in integrated settings (e.g. within schools, workplaces and general practices) • 3-month episode of care	• Primary care and general practices • Community supports such as employment or financial support • National telehealth services such as the National Early Intervention Service • Other Primary Health Tasmania-commissioned services • Social supports (e.g. family and friends, neighbourhood and community centres, population-specific support services (e.g. People from multicultural communities, LGBTIQA+ people)
Level 1: Self-management	Delivery of services at this level of care is not part of the MHCoC service model. However, in accordance with a no-wrong-door approach, it is expected that providers refer or provide information to clients about appropriate self-management supports including online services and other services such as Medicare Mental Health and national telehealth services.		

Transition and exit from the model

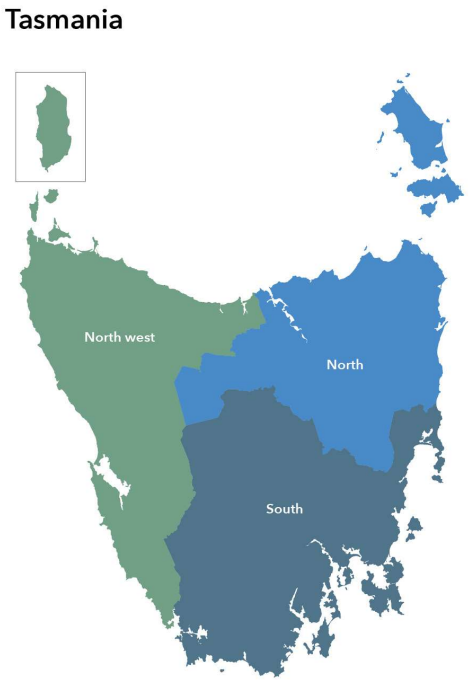
Services within the MHCoC model are designed to support people for a clinically appropriate episode of care and to plan for safe transition when care is complete. Exit planning will be part of every episode of care and developed in partnership with the person, their GP and any other relevant supports.

When needs change, people may be supported to move between levels of care or services. If symptoms return or additional support is required after discharge, a new episode of care may be started at the appropriate level. This flexible approach enables people to be connected to appropriate supports across their recovery journey.

A regional approach

The mental health continuum of care service model will be implemented across three regions: the north west, north and south. This reflects Tasmania's geography, workforce patterns and existing mental health service availability.

The regional approach is a practical way of implementing the model, rather than a means of defining or separating service areas. Each region will apply the same principles and core service elements but tailor delivery to local needs.

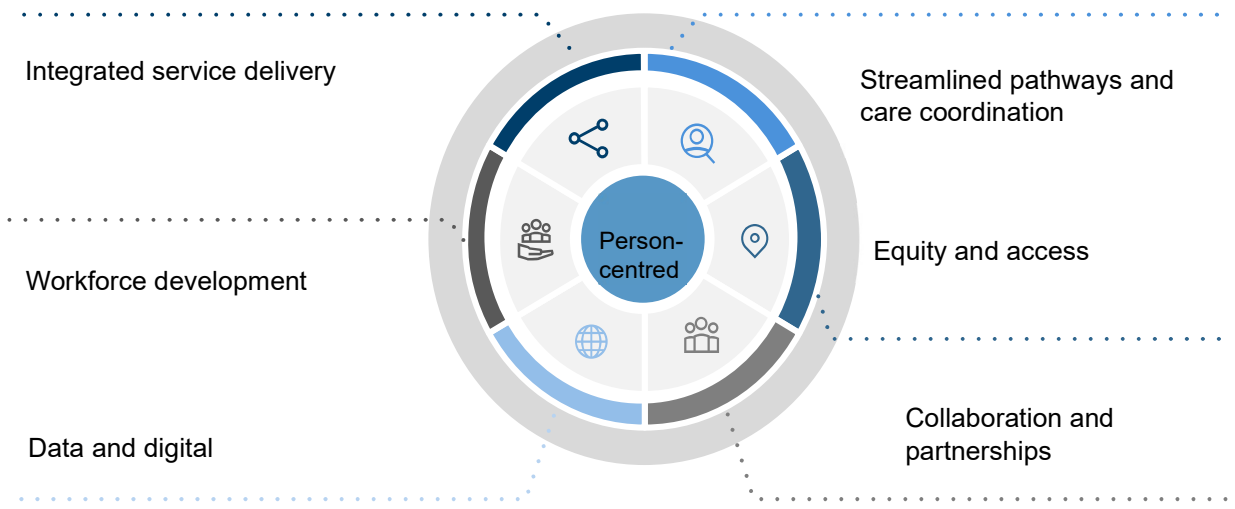


Each region will deliver services aligned with IAR Levels 2 to 4 of the stepped care model, ensuring people can access early intervention, structured therapy and complex care close to where they live. Each region will apply the same service model and quality standards while tailoring delivery to its community profile, workforce capacity and geography. Regional delivery also supports coordinated clinical governance, joint learning and consistent system coordination. Over time, Primary Health Tasmania will continue to work with providers and partners to build stronger regional and intrastate networks that support collaboration and equitable access across the state, including adjustments in delivery for areas of higher or temporarily increased need.

Regional delivery supports more targeted investment and service design, assisting resources to be directed where they can have the greatest impact. Each region can adapt how services are delivered (e.g. through outreach, local hubs, or telehealth) so that people in rural and remote communities can access appropriate supports, according to the local workforce mix and provider markets.

4. Detailed elements of the MHCoC service model

As mentioned above, extensive consultation with stakeholders across Tasmania identified six core elements that shape the MHCoC service model. Consultation explored the benefits and principles of implementing these elements to deliver services that support Tasmanians to access the right mental health services at the right time.



Further information on each of the six elements is provided in the table below. This sets out the design objectives against each, based on what we heard through consultation with consumers and community members, service providers and other stakeholders.

Element	Design objectives
1. Integrated service delivery: Consumers can access the most appropriate level of care and can transition between levels of care easily, including to services and supports that sit outside of the MHCoC service model	
1.1 Service access	• Service access should be based on the needs of consumers, with people being able to easily access the most appropriate level of care (as determined by the IAR-DST assessment) and transition smoothly between service levels.
1.2 Modes of service delivery	• Consumers have choice in how they access services. Providers have flexibility in how they deliver services to account for variations in need, location of consumers and the workforce available to them.
1.3 Seamless services connected	• Transitions are seamless across the model. The experience of accessing care should be straightforward, with no gaps in service access or care provision as their level of need changes.
1.4 Improved integration and coordination across the whole system	• Services within the MHCoC model connect with other parts of the Tasmanian mental health system to facilitate access to care. • Mental health services have increased integration with other services such as community-based and private practice as appropriate, and broader supports, including housing, employment and physical health programs.

Element	Design objectives
1.5 The role of GPs	• GPs play a vital role in ongoing mental health care and coordination. Services within the MHCoC model should maintain clear reciprocal communication and feedback loops with the person's GP to support continuity and holistic care. • Where access to a GP or a Mental Health Treatment Plan is delayed, consumers may be accepted provisionally into care, with support to obtain a Mental Health Treatment Plan within an agreed timeframe. The purpose of a care plan in the absence of cost considerations should be well-communicated to GPs.
2. Streamlined pathways and care coordination: Streamlined access to care into the service (with the MHCoC model) that supports consumers to access the right care at the right time.	
2.1 Ease of access to services	• The model should support ease of access for consumers to appropriate service/s, with a focus on a no-wrong-door approach to access.
2.2 Consistent approach to triage and assessment	• There will be a consistent intake and assessment process within the model, aligned with the IAR-DST. Each person's level of care will be reviewed as appropriate, with transitions between service levels facilitated when required.
2.3 Common branding and promotion of services commissioned under the MHCoC model	• The feasibility of developing common communication material and branding for use across services within the MHCoC model will be explored.
2.4 Enhanced information sharing and approach to consent	• Improved information sharing between providers is encouraged. Information sharing must have considered consent and privacy and be consistent with data regulation.
2.5 Care coordination support	• Care coordination support will be encouraged in the MHCoC model to improve outcomes for consumers. • Care coordination is important for consumers who have complex needs and are potentially accessing multiple services to support their needs, as well as those on waiting lists.
3. Workforce: The service model supports a multidisciplinary, collaborative workforce by building capacity and capability and supporting workforce flexibility to deliver outcomes for consumers.	
3.1 Flexible workforce mix	• Providers have flexibility to determine the most appropriate workforce mix to maximise clinical and non-clinical capacity and reflect regional needs. This would allow providers to respond to local workforce challenges and support the workforce to operate at the top of their scope.
3.2 Peer workforce	• The MHCoC service model includes a peer workforce to support consumer outcomes along multiple points of their journey. Adequate governance and support mechanisms are established to enable this workforce.

Element	Design objectives
3.3 Workforce development	• Support for professional development and capability building in Tasmania.
4. Equity and access: Optimise equity of access to services for consumers, particularly for priority populations, ensuring services are culturally safe and responsive.	
4.1 Priority populations	• Services and supports consider the needs of priority populations, and there is improved equity for identified cohorts.
4.2 Mental Health Treatment Plan (MHTP) requirements	• Reduced barriers to access for consumers who may have difficulty obtaining an MHTP. • Increased flexibility for services to accept provisional referrals while the consumer is supported to obtain an MHTP.
4.3 Capturing the voice of consumers	• Embedding consumer choice and consumer input into the service model is important to deliver enhanced experiences and outcomes for consumers.
4.4 Optimising access	• Barriers to access are removed.
4.5 Needs-based funding and regional delivery	• Mental health needs differ across Tasmania and funding needs to be flexible to address issues such as service access and coverage.
5. Data and digital: Deliver a monitoring and performance management approach with a greater focus on outcomes, integration and experience	
5.1 Strengthening data collection	• Data collection and reporting processes are strengthened. Data collection and reporting should support a continuous quality improvement cycle, the purpose and use of collected data should be transparent, data analysis should be used to inform quality improvement, Primary Health Tasmania should communicate analysis of the data collected, and there should be consistent data collection across all regions.
5.2 Consumer-focused clinical assessment tools	• Consumer-focused data collection is improved, with a focus on clinical assessment that better reflects the journey of consumers, while maintaining mandated assessment tools.
5.3 Telehealth and digital tools	• The use of telehealth and digital tools is supported, particularly for people in regional and rural areas, but face-to-face and hybrid access continues to be offered.
6. Collaboration and partnerships: Increase the capacity and capability of providers to partner and collaborate to improve integration of services under the MHCoC model and across the broader mental health system.	
6.1 Increased collaboration, integration and partnerships	• Increased collaboration between services to enable integration of delivery and improve continuity of care. • The model should support and recognise collaboration, particularly through contractual KPIs.

Element	Design objectives
6.2 Partnership arrangements	• Service providers should have opportunities to connect across the mental health and community sector and proactively work together. • Formalised partnership arrangements, where appropriate, would support the delivery of integrated services across all service levels, including intake and assessment.

4. Implementing the MHCoC service model

The MHCoC service model will be implemented in mid-late 2026 and will continue to evolve over time. Implementation will occur in stages to maintain service continuity and support a smooth transition from current commissioned services to the new model.

The first stage will replace Primary Health Tasmania's commissioned mental health services provided under the following existing programs:

- **Low Intensity Mental Health Services** (IAR Level 2)
- **Short-Term Trauma Counselling** (generally aligned with IAR Levels 2–3)
- **Short-Term Psychological Interventions (STPI)** (IAR Level 3-4)
- **Adult Complex and Severe Services** (IAR Level 4).

Together, these programs form the foundation of the MHCoC model. Later stages may extend the model to include psychosocial supports and AOD services creating a broader, more integrated continuum of care across Tasmania.

It is anticipated that a procurement process will commence in early 2026, with services to commence from mid-2026 and ramping up to full delivery from early 2027.

Primary Health Tasmania will support existing service providers during the transition to the new model and build the capabilities and capacities of providers over time.