Sector led advice on new and/or refined models of youth mental health care

FINAL ADVICE

The Consortium acknowledges the Traditional Owners of the lands across Australia and pays respect to their Elders past and present. We recognise and respect their cultural heritage, beliefs and connection to Country, which continue to be important to First Nations people living today.

This advice was developed by a Consortium of leading youth mental health organisations, subject matter experts, and project management consultants who joined together to deliver sector-led advice on youth mental health models of care to the Commonwealth Department of Health, Disability and Ageing. As the project lead, Orygen would like to thank its consortium partners: dandolopartners, batyr (including the seven young co-researchers and advisors), Indigenous Professional Services, headspace, ReachOut, The Brain and Mind Centre (University of Sydney), Mission Australia, SANE Australia, yourtown (Kids Helpline), Youth Focus, Monash University's Health Economics Group, and University of Melbourne's Department of General Practice and Primary Care for their passion, dedication and contributions throughout this project.

We would like to thank the many young people, parents, carers, supporters, organisations, professionals and workforce from around Australia who contributed to this advice by sharing their experiences and expertise through workshops, interviews, consultations and written submissions. These collective insights have deeply enriched this advice to the Department of Health, Disability and Ageing to more effectively meet the needs of all young people experiencing mental ill-health in Australia, and their families, kin, carers and supporters.

Throughout this document the term First Nations has been used interchangeably with the term Aboriginal and/or Torres Strait Islander. We respect and recognise the diversity of the over 250 distinct groups and approximately 984,000 people that make up Australia's Aboriginal and Torres Strait Islander population today.

Contents

Executive summary

The mental health and wellbeing of young Australians (aged 12–25) has been rapidly declining over recent years. Most mental health conditions first onset before the age of 25 and according to data from the National Study of Mental Health and Wellbeing, there has been a 50 per cent increase in the 12-month prevalence of mental disorders among young people aged 16–25 years since 2007. It is a trend that is mirrored in many other parts of the world. Unsurprisingly, young people's help-seeking rates and access to mental health care in Australia has also increased significantly over this time.

Australia's global leadership in advancing the field of youth mental health, combined with recent investments in essential service infrastructure, has delivered an increase in youth mental health and social care services available across the country. However, differences exist in the equity of access, and the gaps in services, particularly for young people with more severe and persistent mental health conditions, has widened.

20 years since Australia began building this field, there is a need to redesign and strengthen models of youth mental health care. To do this we need to understand: what service gaps still exist, who is missing out, and what are the essential components of care and approaches to service delivery that will deliver better clinical and functional outcomes in youth mental health.

This project, commissioned by the Australian Government, Department of Health, Disability and Ageing, aims to provide sector-led advice on new and/or refined models of youth mental health care. This has been informed by:

- mapping of the current system to understand areas of fragmentation, duplication, and gaps in the current service landscape
- broad sector, youth and family consultations with 544 individuals engaged
- the global evidence-base for best practice models of youth mental health care
- the expertise and experience of a consortium of youth mental health partners and youth co-researchers involved in the project.

Youth mental health care today

There are many aspects of youth mental health care that are working well in Australia. Young people, families, carers and supporters and broader stakeholders all recognised the importance of:

- youth specific models, such as headspace
- engagement of young people in design and delivery
- integration, including colocation and partnerships with other services
- provision and integration of digital offerings
- locally co-designed/adapted approaches.

What we heard through the consultations and derived from a review of the recent and available evidence all provides endorsement to the progress that has already been made.

However, consultations and the service mapping for this project also highlighted:

- There are many services providing mental health care to young people nationally. These are (with some exceptions) often fragmented, disconnected and not always available in the locations where they are most needed.
- Significant barriers to accessing care including: cost; wait times; not meeting eligibility criteria (level of severity and age, including for those under 12); a 'missing middle' of services to respond to presentations with greater complexity and severity; broken referral pathways; and difficulties finding information on what is available.

- Poor experiences of care described by young people and their families, including in some instances: a lack of family engagement; inconvenient operating hours; limited outreach into community and home environments; and being bounced around between different services and clinicians, resulting in repeated assessments and resharing of personal and clinical histories.
- Issues regarding culturally safe, appropriate and accessible care in some mainstream services and a lack of funding for Aboriginal-led and controlled responses for young mob.
- Processes and systems, including screening and assessments, that exclude particular groups of young people, particularly those with greater complexity and need, from services.
- Significant workforce challenges, short term commissioning and contracting cycles, insufficient funding and a lack of resources to meet demand, support integration and provide seamless care pathways for young people.

Future opportunities to refine and strengthen the system

The advice presents three models of youth mental health care, enhanced headspace, Youth Specialist Services and Community Youth Wellbeing Hubs, which respond to what has been heard and learned throughout the project. However, these models exist within a broader youth mental health system which, as highlighted above, includes broader challenges and opportunities for successful implementation.

As such, the advice also describes a range of structural, workforce, governance, data and funding enablers that are needed to implement all three models, along with suggestions for how youth mental health can be responded to outside of the models proposed, for example through education settings and a stronger focus on promotion and prevention.

Proposed models

Enhanced headspace

The national network of over 170 headspace centres is a core part of Australia's youth mental health infrastructure, particularly as an entry point for young people into services and support. However, the level of demand has grown – across both numbers of young people presenting for care and the complexity of their needs – creating challenges for centres to deliver the necessary level of access and support.

headspace already has a defined model of care for young people with mild to moderate mental health issues. This includes 10 service components (youth participation, family and friends participation, community awareness, enhanced access, early intervention, appropriate care, evidence-informed practice, four core streams of physical health, mental health, drug and alcohol and vocational recovery, service integration, supported transitions) and six enabling components (national network, lead agency governance, local consortia, multidisciplinary workforce, blended funding, monitoring and evaluation).

An enhanced headspace model would continue to provide this level of support. However, it will also have greater capacity to respond to the missing middle of the system and support young people presenting with more complex and serious mental health needs. This includes assessment, delivery of medical and psychological interventions and a broader range of integrated psychosocial supports.

Key delivery features of an enhanced model would include (but is not limited to):

- no referral
- extended hours
- expanded outreach efforts,
- offering flexible care options like drop-in services and Single Session Therapy (SST).

Family inclusion in the enhanced model would be strengthened, with the employment of family peer workers, family support sessions, along with the capacity to provide support for young people from multicultural backgrounds and culturally safe care for Aboriginal and/or Torres Strait Islander young people.

Key to implementing the model would be a new salaried funding model with less reliance on private practitioners and MBS funding. The direct employment of diverse and skilled clinical staff, including General Practitioners (GPs), psychiatrists, and multidisciplinary teams such as mental health nurses, peer workers, and youth workers, will enable this level of enhanced service.

The enhanced headspace service could support transition into, or coordinate care with, the Youth Specialist Services (described below).

Youth Specialist Service

Even within a strong primary and enhanced primary care system, delivered by GPs, psychologists, headspace, and the proposed enhanced headspace model, there will be a significant number of young people with a range of complex social and specific clinical needs that require longer term specialised clinical and social care. To more comprehensively address the 'missing middle' of the system, i.e. secondary care, the Youth Specialist Service model is proposed.

These services would provide multidisciplinary care for the upper end of moderate to severe, persistent and complex clinical presentations (across all diagnoses) and intensive case management to support social and functional recovery.

While referral would be required, the service would prioritise access for young people not 'unwell enough' to access acute tertiary care and those who are often considered too high risk to support; this includes risk of harm to themselves and/or others or concurrent substance use issues.

Key features of the Youth Specialist Service would include:

- Early detection through diagnostic and functional assessments across clinical, social, educational, vocational, and physical domains.
- Provision of secure long-term tenure of care, with the ability to refer to and coordinate with other services as needed, and for the young people to be referred back to the service if they experience a relapse in recovery.
- Access to specialist care streams for specific mental health conditions e.g. eating disorders, mood disorders, personality disorders, early psychosis, PTSD, and substance use disorders.
- Comprehensive and fully integrated psychosocial support and multidisciplinary case management teams.
- Assertive outreach teams and strong partnerships with external services (e.g. housing, legal aid and community legal centres, education, family violence, justice, translation services) to ensure coordinated, wrap-around care.

Central to the model is strong integration with existing primary/enhanced primary care and state/territory services and local planning and partnerships to ensure that the services build on what exists and do not add further fragmentation.

Community-based Youth Wellbeing Hubs

The third proposed model of youth wellbeing hubs responds to feedback across the consultation streams on the need for complementary non-clinical models of support that focus on wellbeing, community care, community capacity building and cultural safety and appropriateness.

This model was seen as more appropriate and accessible to rural and remote communities, Aboriginal and/or Torres Strait Islander communities, multicultural communities and other young people who need a softer, non-clinical entry into holistic support, including those experiencing homelessness or other types of social exclusion. However, it could be delivered within any community. The key features include:

- Holistic, non-clinical approach with a focus on overall wellbeing.
- Peer workers and community mentors as the core workforce, providing a safe and inclusive environment and then linking young people to other support when and where needed.
- No referral, open predominantly after school and regular business hours and offers general counselling, creative and nature-based programs, social groups, and family support.
- Practical support such as access to everyday essentials (food, Wi-Fi, safe spaces) and support for employment, education, and functional recovery.

These hubs need to be designed with, and for, the communities they will support and have dedicated roles to focus on maintaining strong partnerships and links into local communities and available clinical and other services where required.

Key to these hubs are appropriate funding arrangements which must include longevity, and have resourcing built in for genuine codesign, relationship building, and learning.

Further considerations

To deliver these models, and to address gaps into the future, the consortium identified additional considerations regarding system, funding, workforce, and integration. These include:

Commissioning

- Piecemeal and short-term commissioning/ contracting of youth mental health services and programs has been disruptive to delivering youth mental health care. Services should be commissioned for a minimum of three to five years, provided with adequate resources to address the level of need.
- Recommissioning/retendering services should be undertaken where service underperformance is the primary driver/ concern, not for the purpose of testing the market.
- Consideration should also be given to embedding national oversight, expertise and consistency in commissioning, particularly of the new Youth Specialist Services.

Build and retain the workforce

- Salary-based funding for youth mental health models should be prioritised to enable the direct and secure employment of workforces including GPs, psychiatrists, psychologists, allied health that may otherwise rely on MBS claims.
- Funding for models should also provide for competitive salaries for professionals employed in youth mental health (particularly in areas of low workforce supply).
- Incentives and education sector initiatives are needed to support clinical placements, training and early career pathways.
- New and diverse workforces are needed to complement health and clinical workers and support the better integration and development of psychosocial support. This includes peer workers (including youth and family peer workers – as well as those with intersectional experiences), youth workers, Social and Emotional Wellbeing (SEWB) workers and other community mentors and leaders.
- Building rural and remote workforces requires greater investment in upskilling new and existing workers based in communities (including building youth mental health competencies in community members) and retaining these workforces by providing them access to learning and development and networking opportunities such as communities of practice.

Enhance integration

- Integrated youth mental health care has the strongest evidence base for improving outcomes for young people, but there remain several structural, governance and funding barriers to achieving this e.g. the lack of harmonisation of age range across jurisdictions to deliver youth mental health systems and services for 12–25-year-olds.
- Integration requires resourcing. Funding provided to deliver the youth mental health models needs to recognize the true cost involved with supporting integration and collaboration of mental health service providers, education, community and social support at a local and regional level.
- Psychosocial support needs to be fully integrated into the models of youth mental health care. Breaking down existing silos between clinical, psychosocial and peer-based approaches will require dedicated resources, systems and organisational policies to integrate these areas.
- Dedicated roles and/or digital tools are needed within services that are responsible for supporting service navigation.

Responsive to the needs of young people and their families

- Resourcing co-design with young people and their families, carers and supporters is required for all youth mental health models to ensure they meet the needs of those they are providing support to. An intersectional approach to engagement is also needed to ensure services are inclusive.
- To deliver the proposed models of youth mental health care funding and service design needs to support longer service hours, outreach, and flexibility to accept young people for support at different ends of the age range where appropriate.
- Family inclusion (where appropriate) is critically important. There is a need to increase capacity and capabilities for family inclusive practice and provide structures for families to engage in care and receive support for themselves.
- Providing culturally safe care is imperative for mainstream youth mental health services. Acknowledging there are areas where this is being done well, youth mental health models need to be resourced to build all staff competencies, employ identified roles and build links and relationships with local community.

Leverage digital

- Across the youth mental health system there is a need to support: digital infrastructure, evidence-based online supports, innovation, technology-based service delivery (e.g. telehealth) and ongoing evaluation.
- Digital solutions are also key to supporting young people and their families to find the care and support they need. A national directory of services which would standardise information on services, linking in with the multiple directories that exist, would address system navigation issues.
- The integration of digital mental health tools, platforms and services with face-to-face youth mental health services, i.e. blended care, is recognised as best practice and should be a key attribute of new and/or refined models of youth mental health care.

System monitoring and learning

- Continuous improvement in youth mental health care should be enabled through a learning youth mental health system supported by a national data framework, centralised infrastructure, and robust research, evaluation, and quality improvement capabilities.
- Introducing new models of care, such as the specialist service and youth wellbeing hubs necessitate a stronger data driven and needs-based approach to regional and national service planning. To support this standardised tools and capabilities for service mapping (e.g. definitions, data extraction methods) are required.
- Monitor and respond to service demand by tracking waitlists and using this data to guide the placement of new services, implement demand management strategies, and provide interim support to young people and their families while they wait for care.

Recognise social determinants

- Raised consistently through the consultations was the lack of response both in youth mental health policies and systems, along with many other government policies, to address the known determinants of mental ill-health among young people. This includes (but is not limited to) child maltreatment, experiences of poverty, homelessness, family violence, and justice involvement.
- However, the rise in mental health conditions also suggests new factors driving distress among young people including climate change, housing unaffordability, social media and job precarity. There is an urgent need for implementable and funded actions that deliver outcomes related to mental health prevention in future government policies.

This advice, informed by the input from stakeholders across Australia, presents the existing youth mental health service and system issues identified by young people, families, carers and supporters, service providers, planners and policy makers and highlights the need for new models of youth mental health care.

The Australian youth mental health system, as it currently stands, is no longer sufficient to address the growing complexity, scale, and early onset of mental health challenges faced by young people. Enhancing established and evidence-based models to be fit for purpose in this time of rising mental health issues for young people, as well as, developing new innovative, integrated, and youth-centered approaches that prioritise early intervention, accessibility, cultural relevance, and community involvement are essential. Investing in these new models is not only a moral imperative but also a strategic necessity for building a healthier, more resilient future generation.

1. INTRODUCTION

1.1 Project purpose

Australia has led the way in youth mental health service design and delivery, establishing youth-specific prevention and early intervention services and models over two decades. These include enhanced primary care models, digital and blended (e.g., combined in-person and digital services) support and the development of youth-focused tertiary care models, creating youth-friendly residential step-up, step-down and inpatient services.

However, there has simultaneously been an increase in the prevalence and complexity of youth mental health needs. Over the past decade, a 50 per cent rise in youth mental health conditions has strained existing youth service models and exacerbated barriers to accessing or receiving appropriate mental health care, including long wait times and insufficient capacity to address increasingly complex cases and embed a consistent approach to culturally safe and appropriate care.

To understand the challenges, gaps and needs of the current youth mental health system and determine what actions are needed to respond effectively, the Australian Government's Department of Health and Aged Care engaged a consortium of organisations led by Orygen to deliver advice to the Australian Government on potential new and/or refined models of youth mental health care.

The consortium brought together a diverse and experienced group of partners with expertise spanning translational research, system modelling, service delivery, lived experience and various service platforms. This breadth of knowledge provided a strong foundation to identify the key challenges and solutions outlined in this advice.

The consortium includes: Orygen, headspace National Youth Mental Health Foundation, Brain and Mind Centre (University of Sydney), batyr, dandolopartners (dandolo), Department of General Practice and Primary Care (University of Melbourne), Indigenous Professional Services (IPS) Management Consultants, Mission Australia, the Health Economics Group at Monash University, ReachOut Australia, SANE, yourtown and Youth Focus.

Through this consortium, the project has sought to engage widely with stakeholders, including young people, families, carers and supporters, and priority population groups including First Nations communities and organisations, to present the following advice reflecting sector-led experiences and feedback on where the system is working, where it is failing and what new models or refined models need to include to improve mental health outcomes for young people into the future.

The project was delivered between January and June 2025.

1.2 Project scope

The aim of this project was to understand the current landscape of youth mental health services in Australia, what is being delivered, how it is being delivered, to who and where.

From there the project sought experience, expertise and advice from stakeholders across the country to determine what could be changed, added or removed to what currently exists to improve young people's access to support and services, their experience of care, and outcomes.

Key areas to be explored through all phases of the project included:

- areas of duplication and/or fragmentation in the existing system of mental health services for young people
- areas of need and barriers and gaps in the existing system of mental health services for young people
- the needs and preferences of young people and the specific needs and preferences of priority population groups
- overarching principles and key design features for new models of care for mental health services for young people
- opportunities to leverage and refine existing mental health services for young people.

In addition, the early and final advice was to explore models of youth mental health care across the full spectrum of services and stepped care continuum that:

- are contemporary, fit-for-purpose, feasible, effective, evidence-based and consistent with best practice
- consider the patient journey across the system of mental health services for young people and support step-up and step-down care
- are integrated with existing mental health services for young people and other relevant services and systems
- consider transitional pathways for young people who will be moving beyond the 12-to-25-year age cohort
- consider broader mental health and other relevant system reforms.

Note: An Australian Government election was held in May 2025 during the project period. During the election campaign, support was provided by the returned government to key youth mental health commitments which included: 58 new, upgraded or expanded headspace services, 20 new youth specialist services and a National Institute for Youth Mental Health. The total commitment to deliver these initiatives was $700 million over four years. While the project continued to explore all potential new or refined models, additional focus was placed on developing specifications and implementation considerations for these election commitments given they were to become Australian Government policy.

2. Methodology

The full scope of the project was to be delivered across four streams:

- provision of early advice
- service mapping
- sector and stakeholder consultations
- provision of final advice.

The approach to the development of each of these streams is described briefly below.

2.1 Early advice

The early advice was produced by the Consortium during a full-day workshop. Inputs into the discussions and solution brainstorming included:

- early mapping of the existing youth mental health system
- consultation report from a pre-workshop facilitated by batyr with young people with lived experience of the youth mental health system
- a rapid literature review on models of care in youth mental health which included the evidence-base for key principles, components, and enablers.

Following the workshop, a draft was circulated to members for feedback and finalised by Orygen and dandolo.

While the workshop enabled well-informed discussions and agreement on several high-level priorities, the complexity and breadth of the youth mental health system meant there was limited time to explore the finer details. Significant aspects – including operational considerations, key enablers, system-level implications, priority populations, school approaches and prevention – could not be explored within a single day and were further examined as consultations continued.

The early advice document was presented to the Department of Health and Aged Care in late January 2025 as a foundational piece from which to further consult and build on, rather than a definitive or exhaustive position.

2.2 Service mapping

Initial service and system mapping was conducted between 3 January and 25 March 2025 via a desktop review of available published information from health directories, AIHW data, MBS data, research publications, Primary Health Networks and Local Health Networks, along with service information provided by members of the Consortium. Data was extracted based on a pre-developed web scribing and summary AI engine and was cross checked and audited with additional information that is available online, e.g., PHN websites.

The mapping sought to understand:

- the number of services that focus on young people (12-25 years) specifically
- the number of services supporting young people at different levels of severity
- the funding sources for different services at different levels of severity
- geographical differences in the number of services available.

The outputs of the mapping included:

- a detailed file with state and territory specific service information, along with identified digital services
- a summary and full report developed by the Brain and Mind Centre, University of Sydney which explored service availability and use from available through health data
- a two A3 page national snapshot which sought to synthesise some of the key findings from the mapping as infographics for testing in the stakeholder roundtables in each state and territory.

There were a considerable number of caveats to the analysis or interpretation of the data captured through this rapid process. These are listed below.

- The service mapping captured the **number** of services only, not: the size of the service, the size of the workforce, the number of young people supported by each service or the number of sessions provided.
- It also captured agencies that had service delivery centres/points in multiple locations. Each location was counted as a service. Some of these would be small in size.
- A significant number of Non-Government Organisations (NGOs) supporting young people experiencing mental ill-health across a range of other needs (such as housing, vocational supports, family violence) were not included.
- The task to identify mental health services for young people required inclusion of child and adolescent mental health services (inclusive of 12–17-year-olds) and adult services (inclusive of 18–25-year-olds). In that regard, almost all tertiary mental health services were included rather than youth specific services only. This presents further issues for utilising this mapping exercise to understand specifically what care young people can and are accessing.
- The mapping didn't capture the private system or the number of private clinicians delivering care to young people subsidised through Better Access (noting the use of Better Access sessions in this age group was captured through analysis of AIHW data).
- The mapping did not include services focused specifically on upstream prevention activities (such as youth groups run by local councils, recreation/sport programs for at-risk young people, school re-engagement programs).

Note: One of the most significant factors inhibiting accurate mapping is the lack of clear and consistent definitions – of services, of care types and of who the target population is. As recommended in the SANE Digital Navigation project, there is an urgent need to refresh and implement the National Minimum Data Set for Mental Health Community Managed Organisations (NGOE) minimum data set to standardise approaches for measuring and mapping community and NGO mental health services and facilitate context analysis of local mental health care. There is a need to then also to apply this approach and integrate it with state/territory data sets.

2.3 Consultations

The third stream of the project involved national consultations with a broad range of key stakeholders in the youth mental health sector. A particular focus was to ensure representation from young people, families, carers and supporters and other priority population groups including (but not limited to) First Nations, multicultural communities, LGBTQIA+, rural and remote and young people with a disability.

In total, we heard from 544 individual stakeholders. This included 146 young people, 70 parents, carers and/or supporters, and 328 people across 294 organisations (including health and mental health service providers, community organisations, Primary Health Networks, carer and advocacy groups, peak and professional bodies, principal associations and government departments). Of these organisations, 142 (48%) support priority populations. Of these young people, parents, carers, and supporters, at least 108 (50%) identified as being from a priority population group.

In all consultation streams sector stakeholders were provided access to a summary of the project, the early advice and an areas of enquiry document presenting opportunities and challenges identified in the research review. Stakeholders were invited to provide:

- reflections and experiences on what is working and what isn't with the current youth mental health system
- feedback on the early advice
- any suggestions for new and/or refined models of youth mental health care that was outside that advice.

A Consultation Outcomes Report was provided separately and is intended to be read in conjunction with this final advice.

544
Individual stakeholders

7
Young Co-Researchers & Advisors

146
Young people with lived experience

70
Parents, carers and supporters

22
First Nations Organisations

294
Total organisations

155
Service providers across Commonwealth, state/ territory, local, private and community

18
Consumer and carer groups

26
Peak organisations and advocacy bodies

30
Primary Health Networks

31
Professional bodies, experts, academics and educational representatives

44
Commonwealth and state/ territory government representatives

CHART: BREAKDOWN OF STAKEHOLDER ENGAGEMENT BY TYPE

Young people

Youth engagement in the project was led by batyr. In January 2025, batyr brought together a group of nine young people to provide feedback on the early advice. Of this initial group, seven young people aged 18 to 25 years, based across Victoria, Tasmania, New South Wales, Western Australia and Queensland, accepted a role as co-researcher and co-advisor (CoRA) with batyr and continued to provide input into all deliverables for the duration of the project. The CoRA team received training and ongoing support to inform and build the approach methodology and analyse the findings from the youth consultations. This participatory method strengthened the relevance and authenticity of the analysis while also supporting skill-building among the youth researchers.

In May 2025 batyr facilitated 13 group consultation activities, comprising 11 online national focus groups and two in-person focus groups. The in-person events were held in Brisbane and Alice Springs. First Nations young people from across Central Australia attended the Alice Springs focus group. One-on-one interviews were also conducted with participants who were unable to attend the scheduled times.

Consultations were mostly delivered online in response to young people's preferences (they were provided the option for either online or in-person workshops when registering interest) and included participant representation from each state and territory.

In total, 83 young people participated in batyr's consultation stream. This cross-section of young people included members of the public and representatives from national youth advisory groups. Of the respondents who chose to identify 17 young people identified as Aboriginal or Torres Strait Islander, and 23 young people identified as being part of the LGBTQIA+ community.

The CoRA team led the coding and thematic synthesis process, drawing on lived experience and peer insight to ensure findings remained grounded in young people's experiences.

In addition, 52 young people (including six participants who were older than 25 years but engaged with the system when they were a young person) provided input into the consultations through the online submission process. Submissions could be provided as either answers to general prompts, or as uploaded documents.

Families, carers and supporters

Orygen conducted three online focus group consultations and individual interviews reaching 23 family members, carers and supporters through this consultation stream. These consultations were scribed with key themes and non-attributable quotes extracted.

In addition, 47 contributions to the open submission process were from family members, carers, or other identified supporters of young people. These submissions were provided either as answers to general prompts, or as uploaded documents.

Multiple channels were used to share the family consultation opportunities, drawing on the Consortium's stakeholder networks as well as using social media (via organic reach and targeted paid advertising) to maximise reach and engage with the public.

Sector

Sector engagement was facilitated through several mechanisms:

- **Sector roundtables:** dandolo and Orygen conducted in-person roundtables with sector stakeholders in every state and territory capital, plus an additional two online roundtables to support participation across broader geographical reach (one focused on regional and remote areas; one general in focus for participants who could not make the in-person events). 229 sector stakeholders participated nationally. Topics for discussion included the presentation of the service mapping for feedback; the existing system for youth mental health; and new and refined models of care and opportunities identified in the early advice. In preparation for these roundtables, a desktop review was undertaken to identify which jurisdictions already had existing models of care or supporting resources to ensure that discussions built on existing work. A list of documents identified or provided during this consultation activity is included in **Appendix A**.
- **Sector submission process:** A submission process for sector stakeholders was open between Wednesday 16 April and Friday 16 May. Submissions could be provided as either answers to general prompts, or as uploaded documents. In total, 155 submissions from sector stakeholders were received. A list of organisations that made substantive written submissions is included in **Appendix B**.
- **Primary Health Network (PHN) consultation:** Orygen facilitated an online 90-minute consultation with representatives from each of the PHNs on 18 March 2025. 32 representatives across 21 PHNs in 7 states and territories participate in the consultation which focused on two key discussion areas: a) service fragmentation, gaps, and integration; and b) feedback on early advice and recommendations on the model of care. An invitation to participate in the sector submission process was emailed to all PHNs, including those unable to attend this consultation.
- **Online discussion forums**: dandolo facilitated three online discussion forums, which allowed for testing of more detailed content on specific models or areas of interest with 36 stakeholders who had expertise across the following topics:
  - Expanded and strengthened headspace and specialist service
  - Prevention and promotion (with supporting documentation provided by Prevention United)
  - Integration.

First Nations and Priority Population engagement

An Aboriginal owned and led company Indigenous Professional Services (IPS) Management Consultants were engaged to undertake culturally appropriate, safe and accessible engagement with First Nations organisations and services.

In total, IPS engaged with 12 organisations across all states and territories either through small group consultations or one-on-one discussions. The key themes and non-attributable quotes were also extracted and utilised to inform the consultation report and the final advice. As noted above, the youth consultations also engaged a high proportion of young people who identified as Aboriginal and/or Torres Strait Islander. A further 10 First Nations sector organisations and representatives participated in the sector roundtables.

Along with First Nations engagement, the project also made assertive efforts to ensure engagement from other priority population groups including:

- LGBTQIA+ people
- Culturally and linguistically diverse communities and refugees
- People experiencing homelessness or housing instability
- Children and young people, including those in out-of-home care
- People living in regional, rural and remote areas of Australia
- People experiencing or at risk of abuse and violence, including sexual abuse, neglect and family and domestic violence
- People with a disability
- People experiencing socioeconomic disadvantage
- People in contact with the criminal justice system
- People with complex mental health needs, including people with co-occurring mental health and cognitive disability and/or autism
- People with harmful use of alcohol, drugs, or substance use disorders
- People who have made a previous suicide attempt or who have been bereaved by suicide.

This was achieved through targeted outreach to organisations serving priority populations, supported by broader engagement via network emails and data-informed targeted advertising through social media. The approach leveraged existing consortium relationships while also identifying key organisations, experts, and stakeholders for extensive engagement throughout the submission period.

Particular care was taken to ensure broad sector representation across consultation activities with a balance across all states and territories. Of the 294 organisations, services and/or departments that engaged with the project, the diagrams below reflect the percentage that directly support priority population groups and the numbers engaged per state and territory.

Across the consultation activities with young people and families, carers and supporters, the following priority population groups were represented: Aboriginal and/or Torres Strait Islanders, multicultural backgrounds, disability, LGBTIQA+, families bereaved by suicide, complex mental health needs and co-occurring conditions (including autism, eating disorders and substance abuse), involvement with the criminal justice system, and people from rural and remote areas.

Note: Qualtrics was used for online submissions and Recollective for online discussion forums for accessibility standards. Due to the time constraints, engagement approaches for these online options were not able to be specifically adapted for people who face barriers to engaging with written and/or digital material.

2.4 Final advice

The development of this final advice was informed by the feedback and considerable input from the consultation process, feedback on the service mapping, the evidence developed from the rapid review of the literature, a full day workshop that brought together the consortium members along with the youth co-researchers from batyr, and Consortium input on the draft advice and recommendations.

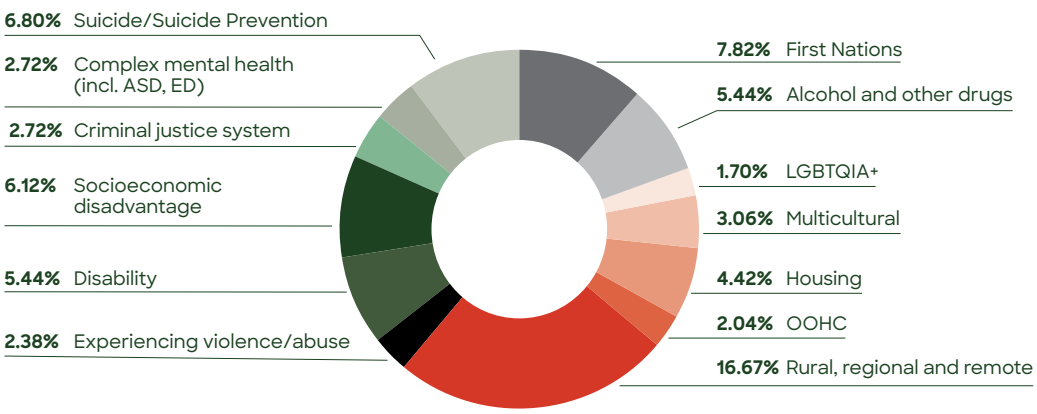


CHART 1: BREAKDOWN OF SECTOR ORGANISATIONS, SERVICES AND/OR DEPARTMENTS THAT DIRECTLY SUPPORT PRIORITY POPULATION GROUPS

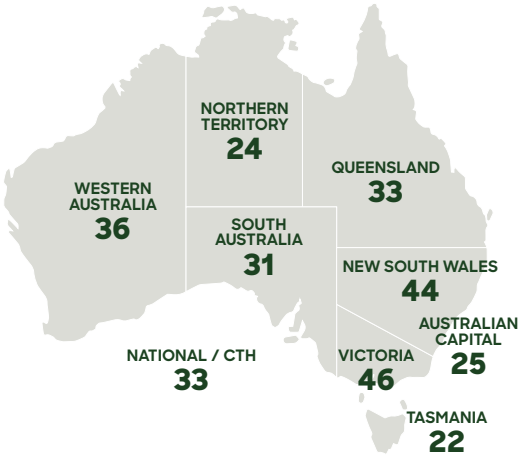


CHART 2: BREAKDOWN OF SECTOR ENGAGEMENT BY STATE/TERRITORY

Note: These numbers do not reflect where some organisations, services and/or departments had 2+ staff sharing expertise or engagement with young people, parents, carers or supporters.

3. Context: Young Australians' Mental Health

3.1 Snapshot data

Over the past two decades there has been a substantial increase in the proportion of young people experiencing mental ill-health, both in Australia and globally.[1] In Australia, this growing prevalence is reflected across multiple national datasets and diverse population groups.

Increasing prevalence of high psychological distress and mental ill-health among young people

Young people have reported an increased prevalence of psychological distress (measured through the K10 survey) in several national datasets:

- the Household Income and Labour Dynamics Analysis (HILDA)[2]
- the National Drug Strategy Household Survey (NDSHS)[3]
- the National Study Mental Health and Wellbeing (NSMHW)[4]

High (score of 22-29), and very high (score of 30-50) psychological distress is commonly used as an indicator suggesting the possible presence of mental ill-health. The proportion of young people who reported high K10 levels ranged from around one-in-four up to more than one-third. Figure 1 below highlights that across all datasets, psychological distress has increased overall since 2007.

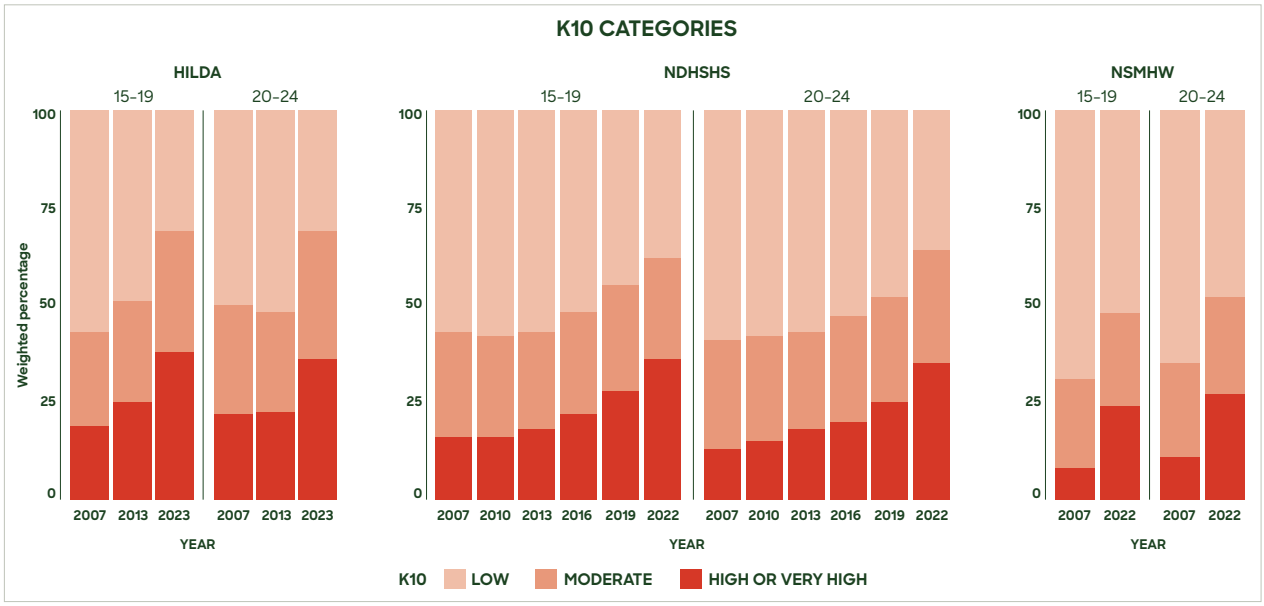


FIGURE 1: K10 TREND, WEIGHTED PERCENTAGE OF K10 CATEGORIES AMONG YOUNG PEOPLE.

Across the datasets females showed higher rates of high K10 than males with younger females (15-19 years) experiencing higher proportions of high/very high distress compared to those aged 20-24 years. In contrast, for males, the pattern reverses, with the 20-24 age group showing higher rates of psychological distress than their younger counterparts.

The increasing prevalence of high psychological distress was also evident across a range of population groups including First Nations young people; multicultural young people; and young people living in regional areas.

All three datasets also show an increased prevalence of diagnosable mental health conditions among young people between 2007 to 2022/2023 (Figure 2). Analysis of data from the most recent HILDA and NDSHS surveys found that just under one-quarter of young people report currently having a mental health condition, while the prevalence of mental health condition evident in the NSMHW data was 33.2 per cent for 16-19 years and 43.9 per cent for 20-24 years.

Again, the percentage of young people with a mental health condition was higher in females, in all three datasets. For both males and females, the older group (20-24 years) had higher proportions of being diagnosed with mental health conditions compared to their younger counterparts (15-19 years).

Outside of these national data sets there is strong research and evidence to demonstrate higher rates of mental ill-health among young people in contact with the justice system[5], child protection/out of home care[6], young people who are homeless[7], have experiences of family violence[8], young people with disabilities[9], and/or who identify as LGBTQIA+.[10]

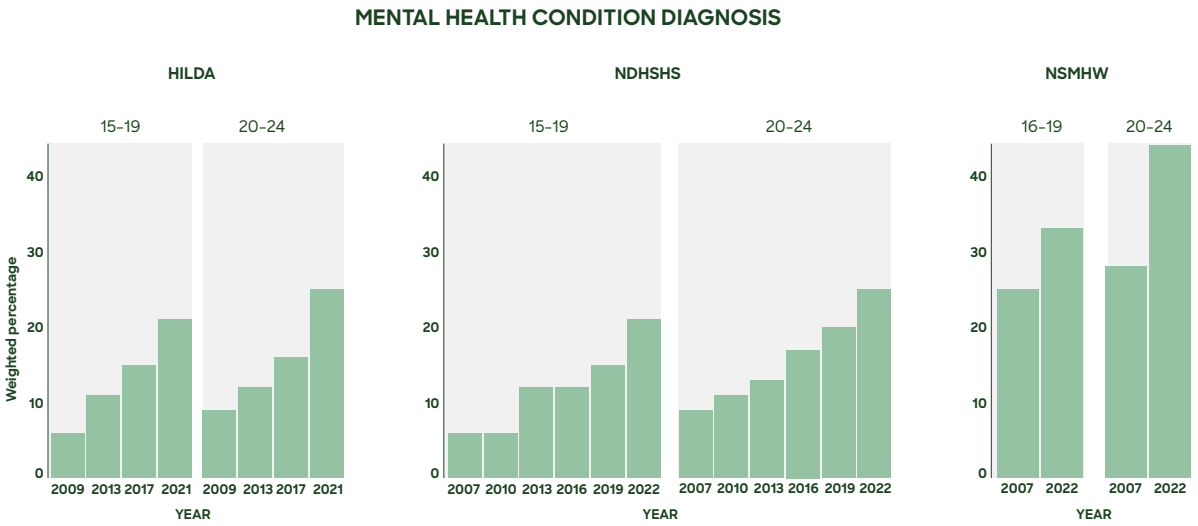


FIGURE 2: MENTAL HEALTH CONDITION DIAGNOSIS TREND, THE WEIGHTED PERCENTAGES OF YOUNG PEOPLE THAT HAVE ANY MENTAL HEALTH CONDITION DIAGNOSIS OVER THE YEARS.

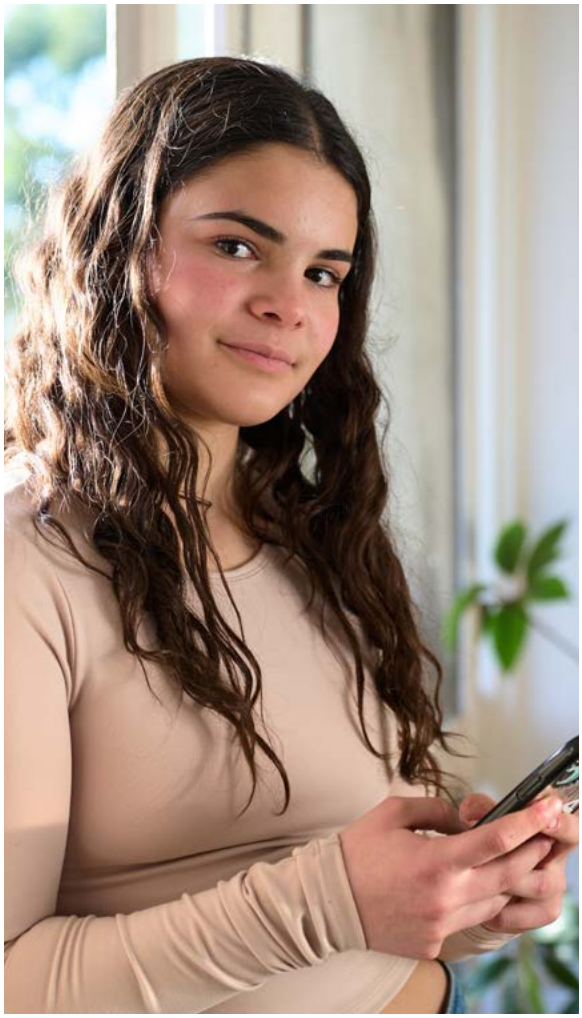
4. Youth mental health services in Australia – landscape analysis

4.1 Available services/ programs

Service mapping undertaken for this project identified 1912 services/programs across Australia that provide mental health supports to young people across the primary care, community-based, residential and hospital services. A further 97 digital services were identified.

These services included:

- headspace network (over 170 services nationally)
- Youth Enhanced Services (over 60 services)
- Early Psychosis Youth Services/headspace Early Psychosis (EPYS/hEP)
- Youth prevention and recovery centres/youth short term residential care
- Youth inpatient units
- Psychosocial services and day programs for young people including recreation based, counselling, group programs
- Some youth services operated by community NGOs that include mental health components of care, along with other supports such as housing, employment etc.
- Digital/teleservices either as a delivery component which connects to face-to-face care (such as eheadspace or Orygen's Moderated Orygen Social Therapy platform) or as stand-alone digital platforms (such as ReachOut, Kids Helpline).



As described in the methodology, the mapping also included Child and Adolescent Mental Health Services and Adult Mental Health Services given young people 12-18 years and 18-25 years can access this care. In addition, the new federally funded Head to Health services, now known as Medicare Mental Health Centres, were included as recent data indicated that approximately a quarter of service contacts have been people aged under 25 years, with the majority (78 per cent) of these contacts attributable to 18- to 24-year-olds.[11]

When all services were included:

- The youth-specific support (i.e. those designed and delivered for 12–25-year-olds) made up 28.6 per cent of the total services mapped.
- Across all services, 49.4 per cent were defined as supporting those with mild to moderate mental health concerns, 41.6 per cent for those with moderate to severe issues and 9 per cent for higher levels of severity.
- For youth specific services the proportion of services for high severity was even less at 4.4 per cent, with 45.6 per cent defined as supporting moderate to severe.*
- When adjusting for services that had multiple delivery locations, the proportion of youth specific services for high severity was 4.4 per cent and 33 per cent for moderate to severe.*
- 6 in 10 services mapped were located in metropolitan areas.

*Note: As described in the methodology section, the mapping task encountered several challenges. As such the data in the dot points above should be interpreted with considerable caution. For example, the high proportion of services for moderate to severe conditions may represent many smaller programs supporting a limited number of young people rather than meeting levels of need.

Service mapping

The exercise in mapping mental health services and care for young people nationally highlighted the need to develop standardised tools (including definitions, data extraction methods) and building capabilities to map youth mental health services and systems at a regional, state and national level.

For mapping to have utility for local, regional and national planning, along with informing policy, it would need to capture service capacity, capabilities, and outcomes (rather than outputs) and be available for public access.

Advice on how to progress this could be sought from a current group of leading mental health biostatisticians and modelers through the Acumen Alliance for Mental Health Systems Models (Acumen - Alliance for Mental Health Systems Models). Further information is provided at Appendix C.

4.1.1 Young people's mental health service use

Mirroring the increase in prevalence, the system mapping undertaken by Brain and Mind Centre found an increasing number of young Australians have accessed mental health services and care over the past decade. Key findings included the following.

- The proportion of adolescents and young adults aged 12-24 years receiving Medicare-subsidised mental health services increased from 9.32 per cent in 2013-2014 to 14.4 per cent in 2022-2023 (Figure 3) with half of all mental health-related general practitioner services (50.9%) involving preparation and review of a Mental Health Treatment Plan.[12]
- The proportion of 12-24-year-olds receiving community mental health care services (provided by states and territories) increased from 2.52 per cent in 2013-2014 to 3.27 per cent in 2022-23.[13]
- The proportion of adolescents and young adults aged 12-24 years prescribed one or more mental health-related medications increased from 8.22 per cent in 2013-2014 to 13.0 per cent in 2022-23.[14]

Over the past 10 years

A **50%** increase in the proportion of young people receiving Medicare-subsidized mental health services

Prescriptions have risen **50%**

A **30%** increase in young people receiving specialist community-based care

≈6x no. of young people in highest **SES areas accessed pyschiatry or clinical pyschology** in 2022-2023 compared to young people in the lowest SES areas.

Variations

The mapping also highlighted wide geographic variation in the proportions of young Australians receiving mental health care. For example:

- The proportion of 12-24-year-olds receiving community mental health care services in Victoria (2.14%) was less than half that of the Northern Territory (5.03%).[15]
- Patterns of growth in access to Medicare-subsidised specialist and allied mental health services between 2013 and 2023 has been significantly greater in Primary Health Networks (PHNs) located in more advantaged areas - those with higher socioeconomic status. This highlights an exacerbated socioeconomic disparity in service provision with access to care increasing disproportionately in areas with the lowest need.[16]
- The mental health-related emergency department presentation rate for remote and very remote areas was 2.9 times that for major cities, while the presentation rate for the Northern Territory was more than 3 times that for Victoria.[17]

Youth mental health service locations

Given the current inequity in service use and availability for young people across Australia, the location of new future youth mental health services (particularly those that provide free access to care) needs to be carefully considered by the funding government agency, Primary Health Networks and Local Health/Hospital Networks to ensure more equitable distribution of mental health resources across all communities - and particularly where need is greatest.

A data-led and needs-based approach to decisions about where future new services are located or current services are enhanced is required. This would need to:

- consider the availability of data
- consider the availability of other youth mental health services
- review equity issues facing young Australians in varying locations
- examine the feasibility of outreach services and digital infrastructure.

4.1.2 Upcoming mental health system changes to consider

From 1 January 2026, a new National Early Intervention Service will be available for those over 16 years of age to access free, evidence-based digital mental health support if they are experiencing or at risk of experiencing, mild mental ill-health or transient distress. The service will provide low intensity talking therapies delivered by skilled and trained professionals, via phone or video and a curated set of free, evidence-based online tools and resources for people able and willing to try self-guided support. As at the time of delivering this advice, the approach to market for tender of this service was underway. This consultation has demonstrated that it will be important for the NEIS service delivery to accommodate the needs and preferences of young people, as well as, different cultural and linguistic needs, including Auslan-trained professionals.

While the service will be targeted to people 16 years and over, help-seekers aged 12-15 years are eligible to access NEIS if all the below conditions are met:

- no other mental health services are available or appropriate for the help-seeker's age and needs
- the help-seeker could benefit from the NEIS
- there is appropriate consent from a parent or guardian.

As such, there will be a requirement for the NEIS provider to develop separate procedures to support eligible users aged 12-15 years.

In addition, the Australian Government is in the process of developing a Foundational Supports program to support people with disabilities through community-based services who do not meet the eligibility criteria for a National Disability Insurance Scheme (NDIS) package.

Only 4 per cent of NDIS psychosocial disability recipients are aged between 15 and 24 years – approximately 2500 people out of 64,000 in the scheme in total.[18] The recent report on the analysis of unmet need for psychosocial services in Australia found almost 9 in 10 young people with moderate or severe mental health conditions not accessing psychosocial support.[19] With such low numbers of young people in receipt of a NDIS care package for psychosocial supports (most likely due to the eligibility criteria requiring demonstration of enduring and/or permanent disabilities) it is important that the Foundational Support program play an important role in addressing the gap in psychosocial care for young people.

Other reforms/reviews that may have an impact on the delivery of new and/or refined models of youth mental health care that are still pending include:

- Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement
- headspace governance and funding reviews
- review of the Primary Health Network Business Model & Mental Health Flexible Funding Model.

4.2 What's working well?

The expansion of youth mental health services and service options available have delivered many benefits and positive experiences for services, young people, families, carers and supporters.

> "These bits–youth-focused services, flexible access, practical approaches, and some coordination–show what's working. They're responsive to our needs, but the challenge is making them more widespread especially for rural kids or those who can't afford the extra cost."
>
> **FIRST NATIONS YOUNG PERSON**

Examples highlighted through the consultations include:

Youth / lived experience co-design has meant that services are able to be more responsive to the needs of the people that they are serving and provide warm, more informal spaces (in person and online) for support that help young people feel at ease and provide positive environments for staff to work in.

Digital options and online mental health check-ins, interim self-directed therapy, and triage services were seen as helpful, particularly when psychologist appointments are delayed or in between appointments, provided they were delivered by trained, caring staff. These supports often provided brief but meaningful engagement.

Youth-specific services were seen as more suitable for young people than general all ages or child/adult services. A notable example of this is headspace which, despite some known challenges, is a well-established, trusted and recognised brand that young people know they can go to for youth specific support. It has been emulated in 15 different other countries around the world.

Services that maintain contact between appointments, via a message or call were seen as positive. These interactions provide a sense of care and continuity.

> "Headspace Centres: These are a ripper for young people. They're designed for us—chill vibes, not like a sterile doctor's office—and they focus on the 12-25 age group, so you don't feel out of place."
>
> **FIRST NATIONS YOUNG PERSON**

Inclusion of families, schools, or communities in the support process such as school-based programs, family group and peer support and the role of local community groups and infrastructure such as libraries were often spoken of positively.

Locally-led or co-designed responses that support connection, relationship building, and wrap-around supports that meet a range of both community and individual needs. These were particularly valued in rural communities where there is limited clinical workforce, in Aboriginal and/or Torres Strait Islander communities, multicultural communities, and for supporting young people at risk, but this also applies to other more described models such as headspace where they were effectively adapted to respond to local needs.

Consortium/partnership approaches to the governance and delivery of mental health services were seen as an effective way to tailor service development and responses to the needs of communities and maximise the capacity and strengths of local services. These were viewed as most successful where there is shared leadership and could help to build trust in multicultural communities and areas of low engagement with headspace services.

Home-based care and step up/step down support, as alternatives to hospital admission with examples including psychosocial support workers who can stay with a person in their residence until the crisis has passed, Hospital in the Home, which can be provided as an alternative to hospital admission and Youth Prevention and Recovery Centres.

Let's talk about 'codesign'

Best practice youth engagement requires involving young people meaningfully in all aspects of a project, from ideation to evaluation. This could involve providing a variety of avenues and levels of engagement, to suit their individual needs and capacities, meeting the young person where they are. It is critical that young people are valued as experts, given the resources and support to bring their whole self to the table and gain value from their time and contributions.

Co-design is a specific type of youth engagement where young people share power and decision making equally with adults. This differs from consultation, which is often shorter, irregular touchpoints where young people provide feedback or advice on something that has already been created. It is critical that young people are therefore involved from the earliest stage of the project, have the resources and support they need to engage fully, and have the genuine ability to shape the project and its outcomes. This may look like recruiting young people into roles where they have clear decision-making responsibility.

Co-design requires investment and commitment to ensure it is done in an authentic and non-tokenistic manner. It might not always be possible to engage in true co-design, but it should always an option to consider before moving onto other types of youth engagement.

4.3 **Barriers**

While acknowledging the significant development and expansion of youth mental health prevention and early intervention programs and services over the past two decades, several well-known barriers persist in both the access to, and experience of, these services.

> "There are such massive hurdles for young people to access mental health. If you can find a GP who can actually talk to an adolescent to do a mental health care plan, if the parent can afford the non-bulk billing doctor, if you can find a practitioner with a waitlist less than six months who specialises in working with adolescence, if you need more than your 10 session sessions, if you can tolerate sitting in a room, then you might be able to get the mental health support you need."
>
> **PARENT/CARER/SUPPORTER**

4.3.1 **Stigma and low mental health literacy**

Stigma and low mental health literacy were raised through consultations as barriers to young people seeking mental health support. While stakeholders noted that stigma around mental ill-health has been reducing over time, it remains unacceptably high – particularly for some conditions like personality disorders. Stakeholders reported that stigma also remains particularly prevalent in certain communities (including multicultural communities).

Stigma can act as a barrier to seeking mental health support in several ways. Self-stigma, or internalised stigma, may mean young people are unwilling to reach out for support due to shame, or fear of how they will be perceived if others know they are suffering from mental ill health.

> "As a young man, I felt a great deal of stigma when I first interacted with the youth mental health system. I felt like I was giving up or resigning. Rationally, I know this is not true – but it held me back for years."
>
> **YOUNG PERSON**

Stigma from other important people in a young person's life can play a particularly strong role in undermining access to mental health supports, with some young people reporting that they had been forced to stop accessing mental health supports due to family views that therapy was unnecessary, or a waste of money.

In addition to stigma, low mental health literacy among young people and the broader community can also be a significant barrier to seeking mental health support. Low mental health literacy may mean young people and their support networks don't recognise the signs of mental ill health, or don't realise that help is available.

> "If the world was just more educated on mental health I feel like we'd be able to support each other so much more."
>
> **YOUNG PERSON**

4.3.2 **Cost**

Affordability is a major issue. Three-quarters of young people consulted for this project said cost had prevented them from getting the support they needed, and many had reduced spending on essentials to prioritise care. International students, those without access to Medicare (such as asylum seekers without bridging visas), and others facing severe financial hardship experienced even greater challenges.

In 2021, Deakin University estimated Medicare spending on youth mental health services to be around $200m annually, however an additional $37m was spent by young people and their families in out-of-pocket costs.[20]

Another recent report found that on average young people aged 15-24 years were paying $104.79 for a Medicare subsidised non-inpatient appointment with a psychiatrist, $64.84 for a clinical psychologist, and $72.34 for a non-clinical psychologist. In the financial year 2022-23, young people aged 15-24 paid over 35 per cent more for a Medicare subsidised non-inpatient mental health service than those aged 45-64, nearly double that of 65-79-year-olds, and triple that of 80+ year olds.[21]

The Out-of-pocket costs for young people **has risen** by **50%** in two years.

And are paying **a third more** than people aged 45-64 and double that of a 65-79 year old

Ref (7)

The impact of high costs of mental health care on young people and their families includes young people 'rationing' mental health care sessions (leading to ineffective care), not accessing support at all, and increasing numbers of young people relying on overwhelmed free public services, with long waitlists and/or increasingly stringent eligibility criteria (discussed further below). Young people aged 15-24 with a mental health condition were almost twice as likely to not see a GP because of cost barriers compared with those without a mental health condition, and two and a half times more likely to delay or not get prescribed medication due to cost compared with those without a mental health condition.[22]

Salary-based funding models are needed to support models of youth mental health care that are free for young people

Young people and their families, carers and supporters need service options that don't require additional co-payments to access, as they would need to do with a private provider.

More youth mental health services require salary-based funding models to directly employ GPs, psychologists, psychiatrists, peer workers, youth workers and other allied health staff in multidisciplinary teams.

A review and benchmarking of the salary levels for professionals is also needed to ensure that the salaries offered are competitive; otherwise, it will remain difficult to attract and retain staff.

There would still be opportunities to further bolster these services by integrating and leveraging other funding streams including government grants, private sector contributions, MBS and bundled payments for specific services.

4.3.3 **Waitlists**

Reports of long wait times to access services were raised during the consultations. While recorded data of wait times for young people vary from averages of two weeks to just over three months,[23] [24] [25] [26] anecdotal evidence from the consultations suggests wait times far exceeding this in many parts of Australia. Some services (including state/territory services) do not hold a waitlist, with concerns that a young person on a waitlist will fall under their clinical governance even though they are not actively providing care to them. This is a risk management-driven response rather than one that focuses on the needs of the young person.

> "The waitlists to access support have had devastating impacts .... I once needed help with medication. For months, I begged GPs, helplines, CAT teams, psychiatrist offices for help, explaining that I was seriously suicidal, and was unable to see anyone. Ultimately, I had no choice but to be admitted to hospital to receive this help."
>
> **YOUNG PERSON**

With a long wait to access a service, young people can experience increasing levels of distress and poorer mental health. Long wait times also can have a negative impact on the family of the young person awaiting care. Many families report feeling overwhelmed, stressed and anxious during this period.

Long delays can also discourage help-seeking. Many young people reported not accessing care because the wait was too long, both for online and in-person services (noting that the tolerance threshold for waiting to access support online or on the phone may be a matter of minutes or hours, whereas for an in-person appointment an unacceptable wait time might be weeks, not days or hours).

> "By the time I tried to seek help, it took me a couple of weeks to procure a mental health care plan, followed by almost 1-2 months to get professional help, which led to me, from mild anxiety and depression, to self-harm and suicidality."
>
> **YOUNG PERSON**

Monitor waitlists and provide demand management responses

There is a need to ensure all youth mental services are required to monitor wait times and prioritise actions to reduce these. Models of youth mental health care should therefore consider:

- Demand management strategies – these include (but are not limited to):
  - Care pathways/service offerings, including single session therapies, brief interventions, integrated digital services
  - Service access approaches e.g. patient led scheduling
  - Methods to determine whether young people are on the right waitlist
- Supports that can be made available for young people while they are on a wait list, including (but not limited to):
  - digital supports that can provide young people with evidence-based online tools and clinician assisted self-support resources
  - peer-based/outreach support
  - access to other supports from community-based organisations.

4.3.4 Lack of information on available supports

The service mapping task for this project highlighted how difficult it is to find clear, accurate and useful information on what mental health services are available, who is eligible, what is delivered, how to access and what evidence/model sits behind the service. This problem is exacerbated for people who face barriers to accessing or engaging with digital platforms.

This experience was echoed throughout the consultations, across service providers who were also frustrated at difficulties finding information on services to refer to, and particularly by young people and their families. The process felt overwhelming and unclear, especially for those new to the system or facing other stressors.

> "In our regional areas, there is no support for young people to navigate services, it's very difficult. We see returning young people with anxiety about just accessing the system."
>
> **SECTOR STAKEHOLDER**

Many young people also reported being unaware of what a Mental Health Care Plan is or how to use it, with some assuming psychology sessions were only available via out-of-pocket payments. New services and supports coming into the system also meant that the information available could be incomplete or out of date.

> "For young people between the ages of 18 and 25, there is confusion between the role of community health clinics such as head to health and headspace services."
>
> **SECTOR STAKEHOLDER**

A lack of basic information about mental health care in Australia was seen as creating confusion from the very outset of help-seeking, resulting in delayed or no access to support.

Further, for young people, families and service providers the lack of information on service models – what they offer and for who – meant that young people were often directed to, or self-directed to, services that aren't designed to meet their needs. However, this often only became clear after multiple phone calls, emails and appointments are made.

Young people and their families who were consulted for this project strongly supported aspects of the early advice for this project that called for the service navigation support and development of an evidence-based directory of services. Sector stakeholders, familiar with the difficulties of developing and maintaining service directories, were more hesitant, noting many directories exist already but were difficult to maintain. The recommendations of the SANE digital navigation project to establish a directory that drew data from existing repositories rather than reinventing the wheel provides an opportunity to address these concerns.

Evidence-based service directories

The Australian Government recently contracted SANE and a consortium of partners to provide advice on digital navigation. The project recommended a high-quality national directory and information solution which would standardise information on services, including community mental health services, linking in with the multiple directories that exist across the mental health system, accessible in one place.

The findings from the consultation for this project provided further endorsement of the need for this directory, along with the importance of engaging young people and families, carers and supporters in its development to ensure acceptability and accessibility, with features that enable clear and easy access to the supports and services they need.

This directory of services should then be supported by national and sustained public education and promotion campaign.

Service navigation support in youth mental health services

New and/or refined models of youth mental health care should include roles and positions within services that are the central contact for a young person and/or their family as they access supports within the service or connect to services across and outside the health system.

These could be specific 'service navigator' roles or a specific responsibility built into existing roles (with adequate time and resourcing provided). Peer workers, generalist youth workers, community outreach workers for example could be well placed to deliver this support. Navigation should always focus on doing 'with' the young person, not doing to and ensuring that young people are supported to lead their own pathways through the system, avoiding the 'tick and flick' nature of referring on.

Deployment of evidence-based digital navigation tools should also be included. These can be used to scale and facilitate access to a range of support relevant to a person's needs.[27]

4.4 Duplication/Fragmentation

Fragmentation and a lack of integration across services can lead to delays in access to appropriate care or young people missing out on necessary support, falling 'through the cracks' in the system. This is particularly a challenge for those with more complex or co-occurring needs.[28]

Rather than being interpreted as an indication of good service coverage, stakeholders engaged in roundtable consultations told us that the volume of services identified through the service mapping painted a picture of an overrepresentation of small, underfunded, disconnected programs and fragmentation of the service system. This was particularly noted for regions/states where the number of services appeared particularly high when considering population size.

Transition points, particularly between child/youth to adult services were experienced as abrupt and destabilising. This was pronounced during life transitions, such as finishing school or ageing out of youth-specific services. Many young people and their families said turning 18 years of age meant starting over and losing access to familiar providers at a time when support was still needed. This was also highlighted by young people and their families when describing how they were moved between headspace and state health services such as CAMHS or tertiary care.

> "Duplication, competition, and short-term funding cycles continue to undermine system coordination. New pilot programs are frequently introduced without a clear plan to embed or sustain what works. There is often a rush to innovate without building on existing community knowledge or learning from past evaluations. The result is fragmentation, inefficiency, and a constant reinvention of the wheel."
>
> **SECTOR STAKEHOLDER**

Fragmented funding and contractual/commissioning models were seen as hindering collaboration between clinical services, as well as education, vocational, social and community supports, as there is little incentive or financial support to promote it. Short-term funding cycles and inappropriate Key Performance Indicators (KPIs) e.g. focusing on quantity over meaningful outcomes, were also seen to contribute to this issue. Solutions to this, including options to move to collaborative and/or co-commissioning models which are currently being considered by the Productivity Commission through the *Australia's Productivity Pitch* initiative.

Even among digital services, where technology to support greater connectedness between providers is advancing rapidly, an insufficient focus on and investment in capability and technology has restricted services' ability to improve systems and pathways between both online and in-person services.

Despite these challenges, there are examples across the youth mental health system, where services have been established with a degree of integration, and where services have worked collaboratively to develop a more integrated approach. Examples include headspace services (where service integration is a key component of the model of care), the headspace Early Psychosis program and activities under the bilateral agreements under the National Mental Health and Suicide Prevention Agreement (particularly in Queensland). Further, the use of service mapping and systems modelling approaches to service commissioning can be used to increase transparency about funding decisions, and their potential impact on community outcomes.[29]

Youth mental health commissioning approaches

Considering the level of fragmentation within the system, it is important that future youth mental health commissioning includes strategic, integrated, and collaborative planning and provide sustained funding to evidence-based and defined models that can be locally adapted, rather than a proliferation of smaller, underfunded and disconnected programs.

Youth mental health commissioning should:

- Be based on a collaborative commissioning model rather than a competitive market-based approach.
- Consider vertical integration of primary and secondary services within a single agency for a region where this is feasible or appropriate.
- Include a requirement for any new youth mental health services to connect with existing headspace services, tertiary services and other local youth mental health and/or youth focused services.
- Build in learning with a focus on outcomes and 'what works best?'
- Provide safeguards around the outcome requirements to ensure that there are not incentives for services to steer care toward young people who might be more likely to have better outcomes.

Recommissioning should be avoided for the purpose of testing the market, while being used where issues of service underperformance need to be addressed.

4.5 Gaps

4.5.1 Missing middle

Despite increased funding and more services available in person, via telehealth and online, the surge in prevalence and need for support has meant it has become more difficult for young people to access timely, quality care, with many services like general practice, emergency departments, and government funded community-based agencies (including headspace centres) under strain.

In particular, there has been a widening gap between primary care and tertiary services, leaving many young people with more complex and serious mental health issues, that aren't 'unwell enough' for acute state services without access to support and critical opportunities for early intervention when symptoms first emerge.[30]

As the prevalence of mental ill-health increases, meeting the needs of young people in the system's 'missing middle' has become increasingly challenging. These young people are confined to whatever care is available, even if those services are not equipped with the right personnel and resourcing level to provide the sustained and specialised care needed to respond effectively. As a result, young people experience minimal or no outcomes or improvement.[31] [32]

> "There is nothing for young people if they are too 'severe' for headspace. Most of the time they get discharged without a referral. And the only help they get afterwards is if they get hospitalised."
>
> **YOUNG PERSON**

This gap also hinders access for individuals who could benefit from preventive or early-stage interventions at the primary care level. This population remains increasingly underserved, increasing the risk of their mental health issues worsening and progressing to more severe conditions.[33]

The service mapping undertaken in this project indicated a high proportion of services categorised as providing support for young people with moderate to severe mental health conditions. However, feedback from the consultations suggested this was indicative of the flaws in 'counting services' without understanding the size of the service, the type of support provided and even a clear understanding of the definition of a 'service' compared to a 'program' or 'initiative'.

Overall, stakeholders consulted for this project widely agreed that there is a clear service gap for young people experiencing more complex and serious mental health challenges and that particular population groups, as described in more detail in Section 5, are excluded or missing out on care due to additional barriers to access.

> "There is lots of young people that fall through the gaps. Not enough services or support so young people in the middle that are not meeting thresholds for tertiary services like CAMHS."
>
> **SERVICE PROVIDER**

Case study: A young person's experience of the missing middle

Georgia* is a young person who has lived experience of the missing middle. When Georgia experienced her first episode of psychosis and was diagnosed with bipolar disorder, she was admitted to a private hospital. At the hospital, she attended psychotherapy, group therapy, art therapy, exercise physiology, mindfulness classes and music therapy. She had a particularly positive experience with the hospital nursing staff.

However, after discharge, Georgia was left with no scheduled follow up care for three months, despite still being acutely unwell. She had to organise her own follow up care through her GP, and it took several months to see an outpatient psychologist. Georgia has found that the ten subsidised psychology sessions per year are not enough to manage her condition, and she would not have been able to afford even subsidised psychology support if her parents didn't pay for it.

She told us: "I am stuck in this missing middle of support needs where the short intervention programs are not enough, but I am not able to get any further support since I have higher functional abilities and thus do not qualify for NDIS."

Case study provided via submission from young person. Name changed to protect identity.

Addressing the 'missing middle service gap' requires a new tier of care as well as greater integration between federal and state and territory funded services.

The Australian Government has funded and established youth mental health services to address more complex and serious mental health challenges, including the Early Psychosis Youth Service (EPYS)/headspace Early Psychosis (hEP) and the Youth Enhanced Service (YES). While the EPYS has a prescribed model for which fidelity is monitored it is limited in scope to psychosis. The YES is funded within the PHN flexible funding pool, without requirements to deliver a specified model of care. This has meant that the YES services have been varied in their focus, target population groups, funding levels and outcomes. While there are many YES services that have delivered good outcomes for young people, others have been established as 'innovation approaches' based on limited evidence and there remains a lack of visibility of the demonstrated outcomes in some instances.

Some of the youth mental health inclusions in the bilateral agreements, under the National Mental Health and Suicide Prevention Agreement, were designed to increase integration in the youth mental health systems. While there have been ongoing challenges to achieving this goal, this work shows some promise and should be progressed more widely and actively. Implementation has progressed most rapidly in Queensland, where headspace centres and tertiary services are exploring models of working across service boundaries. Using established infrastructure, governance and clinicians, more young people are getting their needs met through the headspace service they know and trust. This replicates experiences from similar, rapidly established arrangements to stand up surge capacity in Victoria during the Covid pandemic. However, they will not be the solution on their own.

Putting youth mental health service integration at the centre of the next Mental Health and Suicide Prevention Agreement

Through the review of the Mental Health and Suicide Prevention Agreement, the Productivity Commission has an opportunity to recommend clear directions, actions and activities to enable integration. This will require clearly defined funding and service delivery responsibilities that integrate existing service systems. Rather than a list of desired outcomes without goals, targets and appropriate levels of funding attached the next national agreement and the bilateral agreements need to be driven by a genuine commitment between government to achieve service integration outcomes.

4.5.2 Eligibility criteria

> "I also have difficulty with the usual classification of "youth" ranging from 16-24, when many problems begin earlier, and may even begin in infancy, problems can be fully entrenched by age 12, and there should not be any gaps for people to fall through because of age or any other eligibility criteria."
>
> **YOUNG PERSON**

Sector representatives and families, carers and supporters raised concerns about the rigid eligibility criteria for services being used to exclude young people from accessing care.

While not in scope for this project, the issues for children under the age of 12 were a common example provided, with many stakeholders describing:

- an increased prevalence of serious mental health issues and self-harming behaviours presenting in children and young people aged 10-11
- genuine missed opportunities to intervene early in risk and symptoms
- a lack of focus and investment on children's mental health services and support outside of the handful of Kids Hubs.

> "These are 11- and 12-year-olds who are still incredibly vulnerable and need continuity of care. Instead, they are forced to re-navigate systems that do not speak to their needs, their stories, or their developmental stage. This gap reflects a much broader issue: a lack of coordinated, integrated pathways that can support children as they grow into adolescents and young adults."
>
> **SECTOR STAKEHOLDER**

Eligibility criteria that focused on clinical symptoms and diagnoses, rather than the needs of the young person, was also raised as a significant challenge – and exacerbated gaps in care for young people with multiple, complex needs and experiences of trauma.

Through the consultations, some stakeholders reported instances where services and providers in both the public and private systems would not accept and support young people with higher risk profiles. This included young people with:

- evidence and history of suicidal behaviours, with some young people being discharged/exited from a service while risk of suicide was still high
- challenging behaviours from young people (including young people who had contact with the justice system or engagement with extremist/radicalised groups) resulted in them being excluded from care due to elevated risk.

> "The exclusion of young people from mental health services on the basis of 'risk' or 'complexity' is one such example. In the mental health space, we often see young people with experiences of family violence, homelessness, criminalisation and/or alcohol and other drug use being precluded from accessing support on the basis of these complex, intersecting needs, compounding existing vulnerabilities and entrenching cycles of over-representation."
>
> **SECTOR STAKEHOLDER**

> "(There is an) ongoing perception of viewing symptoms/signs of trauma such as aggression, self-harm, and therapeutic resistance as 'behaviours' that preclude support from acute mental health youth services remains ingrained despite efforts to embed a more trauma-informed approach."
>
> **SECTOR STAKEHOLDER**

Services with the capacity and capability to provide high care and high connection in response to complexity and risk

New models of youth mental health care are needed that have the scope and capabilities to identify and respond to risk and complexity among young people. This will require:

- training of staff in competencies related to supporting young people with higher risk and complexity, to improve confidence in accepting referrals and presentations
- clinical governance frameworks and other service policies and processes to provide scaffolding for staff
- competency and capability to work with the family as a whole (where appropriate), including opportunities to influence the school environment and supports available within education settings
- access to integrated support and secondary consultation opportunities
- referral pathways to services most appropriate.

Support flexibility at either end of the age range for service provision.

Flexibility is needed at both ends of the age range for youth mental health services to provide support for young people who are close to, but not yet 12 years of age who are unable to get supports from child focused services (particularly in primary and enhanced primary care) and to accommodate longer service transitions out of youth mental health services at 25 years should this be required.

4.5.3 Outreach and out of hours

> "The current design of services also reflects a medicalised, crisis oriented and problem focused approach, with limited out-of-hours available, minimal outreach, and requirements that young people engage or quickly be replaced with another from a waitlist."

SECTOR STAKEHOLDER

Many young people – and their families, carers, and supporters – face a lack of accessible support that meets them where they are, especially when additional barriers such as geography, transport, or reluctance to engage with clinical settings exist. Support is also often unavailable outside standard hours, despite young people frequently needing help during evenings, weekends, or at times of crisis.

Stakeholders also identified the need for much greater flexibility in the delivery of mental health services, including support for in-reach/outreach activities, longer opening hours, hybrid service delivery, services provided directly in the environments where young people are (such as schools) and providing support to young people and their families with transport and other costs associated with attending sessions.

> "Transportation in rural communities needs to exist. There should be some sort of funding for workers to go to youth, meet youth in a middle location, or for a youth minibus to pick up and drop off youth. At the very least, fuel cards for youth that do travel."

YOUNG PERSON

Youth mental health care where and when young people need it

Key components and features of new and/or refined models of youth mental health care to better meet young people where they are and provide support when they need it must include:

- longer service hours and weekend access
- access to out-of-hours support
- adequate resourcing and requirements for delivery of outreach
- support within the school environment (services delivered within schools), and support to adjust the school environment itself, particularly for children and young people who are neurodivergent, or experiencing school-related challenges such as bullying, loneliness, academic difficulties and social isolation
- strengths-based programs that build social and psychosocial skills delivered through community, creative and sport frameworks that connect to and complement with clinical treatment and allied health care models.

4.5.4 Culturally safe and appropriate care

> "For young people from diverse backgrounds—Indigenous, migrant, or refugee—the system often feels like it's not built for them."

FIRST NATIONS YOUNG PERSON

Aboriginal and/or Torres Strait Islander young people

A strong theme to emerge from consultations was the gap in culturally safe and appropriate care in mainstream youth mental health service models. While there are pockets of approaches that have worked well, by and large feedback from Aboriginal and/or Torres Strait Islander young people, communities and organisations was that many youth mental health services did not provide a culturally safe experience of care that responded to the experiences of racism, intergenerational trauma and the ongoing harms and impact of colonialism.

Consultations highlighted the need for increased and sustained investments in culturally-led and owned programs, and programs delivered on Country. Centring and prioritising Aboriginal controlled solutions and self-determination in line with the Transforming Indigenous Mental Health and Wellbeing and Gayaa Dhuwi frameworks remains a strongly supported approach. The Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBATSISP) maintains an extensive list of best practice programs.[34]

> "For many Aboriginal and Torres Strait Islander young people, mainstream clinical services are experienced as unsafe, judgmental, or irrelevant. The key elements that support engagement, such as trust, cultural safety, continuity, and relational care, are often absent or underdeveloped in mainstream models."
>
> **SECTOR STAKEHOLDER**

> "I would love easier access to know who the respected elders of my community are and easier ways to access them and be able to talk with them and learn from them, this would be exceptional ."
>
> **FIRST NATIONS YOUNG PERSON**

> "[First Nations] young people that come into [mental health] care and can't remain on Country safely, they lose their culture and identity, that is one of the hardest things for young kids. The [workforce] in those communities are at capacity."
>
> **SECTOR STAKEHOLDER**

Stakeholders also identified the need for mainstream services to become culturally safe and enable co-designed, community-driven approaches to service provision, particularly for First Nations youth and rural communities. Suggestions include mobile outreach teams, culturally competent staff, programs that connect young people to country and programs grounded in the Aboriginal Social and Emotional Wellbeing framework.

headspace's work has shown that addressing cultural governance can help services provide a culturally safe experience for First Nations young people coming to a mainstream service. This can include, for example, having clinicians present their cases to an Aboriginal clinical supervisor to build knowledge and skills in Aboriginal social and emotional wellbeing. Further examples are provided below.

Examples of First Nations initiatives:

- Sisters Inside is culturally governed and led by an all-Aboriginal board to centre Indigenous knowledge systems, community leadership and Country as key to healing. The organisation provides holistic and individualised support, which includes intensive support and crisis support, therapeutic and culturally appropriate responses to trauma, grief, and mental distress, assistance navigating systems such as housing, education, legal, and mental health services, and advocacy. Reconnection with culture, language, and land is treated as vital to wellbeing and self-determination.
- 13YARN have built a service directory that can provide culturally safe care to First Nations young people. 13YARN acts as a referral service which is valuable to communities but requires ongoing resourcing to ensure it remains up to date and funding to support it to tailor to the specific needs of young people e.g. through chat/text-based service options.

Examples of First Nations initiatives:

- The Institute for Urban Indigenous Health's Staying Deadly Hubs (QLD) provide culturally responsive place-based approaches co-designed with Community, embedded in trusted spaces, and delivered by multidisciplinary teams that centre healing, cultural identity, and relational care. They provide culturally safe, community-based mental health and AOD support for Aboriginal and Torres Strait Islander people aged 15+ years and engage young people early, walk alongside them during times of vulnerability, and offer holistic support across systems, not just symptoms. The Institute worked with funding partners to contextualise the Staying Deadly model within the parameters of 'mainstream' models of care supported under the Qld-Commonwealth Bilateral Agreement.
- CAAC (NT) headspace and wraparound supports have salaried multidisciplinary teams to promote staff retention and collaborative community partnerships including (but not limited to):
  - Bi-cultural pair model where Aboriginal Family Support Workers with strong connections to community are paired with Caseworkers (social workers, counsellors or psychologists), combining the skills and knowledge of both workers to build an understanding of family functioning through both the formal (Western) and informal (Aboriginal) world.
  - Youth workers incorporated into headspace services allow for a soft referral service, provide outreach and support a more flexible engagement process. Youth workers also help to facilitate community activities which can act as an introduction to the headspace clinical team with a more dynamic and organic relationship-building approach. This has increased capacity for the service to build relationships with schools and foster positive engagement with young people who are disengaged with schools.
  - headspace service in Alice Springs has recently expanded to provide outreach services to meet the needs of young people and families in Mutitjulu and Yulara.

Prioritise community-based approaches for First Nations young people

Sustained and adequate resourcing is needed for Aboriginal community-controlled youth social and emotional wellbeing models that are place-based, culturally grounded, and flexible to local context. Funding levels need to recognise the full cost of delivering culturally responsive and relationally based models of care. Programs that connect young people to country are particularly important.

There is also a need to ensure mainstream organisations are provided funding (with accountability measures) to improve their cultural safety and build links with local communities.

Multicultural young people

In addition, consultations and submissions highlighted a gap in the current youth mental health service system for responding to the needs of multicultural communities, families and young people.

Multicultural families are often unaware of what services are available and the process of cultural adaptation can lead to feelings of isolation, disconnection and uncertainty. Within the current service structure, multicultural families engaged in consultations reported feeling excluded from treatment planning due to communication barriers and privacy requirements. Internalised stigma and discrimination further compound the ability of families to engage with service providers.

> "Overall, the models that work best are those that prioritise relationships, cultural understanding, and community involvement. These approaches are helping to break down stigma and make mental health support more accessible and effective for young people in our community."
>
> **PARENT/CARER/SUPPORTER, REFUGEE COMMUNITY**

Sector stakeholders identified that a contributing factor was the lack of cultural diversity in the mainstream mental health workforce and the need to build stronger connections with cultural, faith-based organisations to develop trust and relationships.

> An African male youth from refugee background seeing an Anglo female mental health worker who has no understanding of his journey and challenges to settling in Australia, no understanding of his culture and faith values. These are immediate obstacles.

SECTOR STAKEHOLDER

The importance of connecting into cultural and community leaders and elders was also highlighted as a critical pathway to engagement and improving mental health outcomes for multicultural young people. Examples of this have been developed in other countries[35] and referenced in a case study in Section 7 from Zimbabwe.

4.5.5 Rural and remote areas

Young people living in rural and remote regions encounter distinct mental health challenges, such as social isolation and environmental stressors like droughts, floods and bushfires.

Access to mental health care, let alone youth specific or specialist services, is also very limited in rural areas compared to cities and suicide rates among young people and their local community are higher in rural and remote areas.[36]

A major obstacle to providing services in these regions is the widespread shortage of trained and supported staff. For many young people in these communities, primary health practitioners, such as GPs, some digital and/or telehealth services (where there is connectivity) or fly-in fly-out services like the Royal Flying Doctor Service, are often the only point of care.[37]

The need for tailored solutions for rural and remote communities was raised frequently in consultations. This included enabling sustainable place-based and community driven responses (for example Youth Live4Life) that worked with local government, schools and community groups and built capabilities within the available workforce (local mentors, local elders, community health staff/nurses, teachers and youth workers) rather than relying on importing skilled professionals who often would only stay for short periods of time.

> Mental health training, peer-led initiatives, and awareness campaigns within the community can make all the difference.

SECTOR STAKEHOLDER

Case study: Rural experiences (provided by Youth Live4Live)

Emma, a 16-year-old from a small rural town in Victoria, is like many young people in her community. The town, which has a population of just over 2,000 people, offers very little in the way of mental health services or community support. The closest mental health clinic is a 45-minute drive away, and public transport isn't an option for Emma, who relies on her parents to drive her. But there's another challenge: Emma's parents don't allow her to have a phone.

This situation, while specific to Emma, is not uncommon in her rural town or in many similar communities across Victoria. In rural areas, some families hold different views about technology, often restricting phone use due to concerns about safety, overuse, or the influence of social media. Emma's parents are no different. They worry about the negative impact of too much screen time and have chosen to limit her access to digital communication. Unfortunately, this means Emma cannot use her phone to reach out to services like Kids Helpline or eheadspace when she's struggling. She can't text a friend, ask for help, or even look up mental health resources in her own time. If Emma wanted to reach out, she would need to ask her parents for permission to use the family phone, something she often feels uncomfortable doing when her struggles are private and deeply personal.

It's not just about missing out on digital support—it's about the larger issue of limited local options for in-person care. In rural communities like hers, mental health services are often not just distant but scarce. Emma has heard of headspace, but the closest centre is in a neighbouring town, requiring a long drive and often a parent's permission. When she experiences anxiety or depression, Emma is left feeling isolated, unsure of where to turn.

> Growing up in a small rural town, mental health support was – and still is – alarmingly limited. Services were only equipped to manage low-threshold conditions like mild anxiety or depression. ... For any meaningful intervention, my parents had to drive me between 1.5 to 2 hours to the nearest metropolitan city – a journey that came with both emotional and financial strain.

YOUNG PERSON

Building capabilities in rural and remote communities

Given the well-known challenges recruiting and retaining specialist workforces in rural and remote communities, there is a need to build and nurture the youth mental health skills and capabilities of local community members and existing organisations through fully funded training opportunities and recognition.

Funding for regional, rural and remote areas youth mental health services should include dedicated resourcing for professional development and networking (e.g. travel budgets for conferences, training etc) to better support and retain the existing local workforce.

National and state/territory youth mental health services should also be required and funded to:

- integrate their service offerings into remote outreach models such as Royal Flying Doctors Service, Central Australian Aboriginal Congress (CAAC) to create a more streamlined pathways of care
- provide access to specialist secondary consultation and expertise where required.

4.5.6 Focus on prevention

Many participants in the consultations identified gaps in a focus on prevention and mental health promotion for young people, both in action to address the broader social determinants which increase the risk of mental ill-health, but also as a core objective and component of youth mental health services, whether they be early intervention or tertiary acute care.

> "we strongly advocate that prevention must be elevated as an urgent priority within any future youth mental health model. Without a parallel and equitable investment in prevention—particularly for young people in rural and remote Australia—the system will remain reactive and under strain."
>
> **SECTOR STAKEHOLDER**

The importance of a stronger focus on prevention is especially evident in rural and remote communities, where limited capacity to employ or support clinical workforces reinforces the need to prioritise keeping young people well.

> "There's also not enough focus on prevention—like teaching young people coping skills before things get bad."
>
> **FIRST NATIONS YOUNG PERSON**

Prevention should not be viewed as separate from mental health care and treatment but rather as an integral part of the system. Interventions across all levels - universal prevention (promoting overall mental well-being and preventing mental health issues before they arise), indicated prevention (addressing early signs or symptoms that do not yet meet diagnostic criteria), and targeted prevention (supporting young people at higher risk due to known factors such as poverty, adverse childhood experiences) - should be embedded within primary, enhanced primary, and tertiary youth mental health services.[38]

Further, the dramatic and steady rise in prevalence cannot be ascribed only to the known risk factors for mental ill-health and illness. Several other societal and economic trends and changes may also be having an impact, including a perceived broken social contract to protect future generations as evidenced by a lack of action on climate change, job security and housing affordability. If prevention efforts are to have an impact, then a whole government approach including the impact of economic, housing and environmental policies on youth mental health needs to be undertaken.

Responding to social determinants as a key pillar of youth mental health care models is discussed further in Section 6.2.

Increase the focus on and resourcing for prevention in youth mental health

Models of youth mental health care need to specifically describe and resource components and activities that support wellbeing and recognise the social determinants of poor mental health.

Future government policies across several portfolios including, but not limited to health, should also include implementable and funded actions that deliver outcomes related to mental health promotion and prevention across all portfolios.

> "My son was having trouble regulating his emotions and building resilience. We were fortunate to meet someone through his basketball club who'd had his leg amputated and was now working with youth. He was like a mentor for my son and it changed the way he saw things."
>
> **PARENT/CARER/SUPPORTER**

5. Needs of priority population groups

Consultation for this project reflected the need to ensure that new and/or refined models of care specifically addressed service barriers and gaps for young people across several priority population groups. It is also important to consider the intersectional nature of these experiences and attributes and respond to the holistic needs of young people.

Note: The needs of Aboriginal and Torres Strait Islander young people and multicultural young people were discussed in Section 4.5.4. The following presents the considerations for other priority population groups.

Neurodivergent young people

> "[We need] comprehensive mandatory education for clinicians on autism in young adults and adolescents, particularly the differences in how autistic women present."
>
> **YOUNG PERSON**

Many youth mental health stakeholders identified an increase in the number of autistic young people and/or young people with Attention Deficit Hyperactivity Disorder (ADHD) characteristics presenting for support. However, young people and their families said that often the services provided did not meet their needs. Along with needing better access to public funded assessment, diagnosis and specialised care – particularly in regional areas – participants in the consultations identified the importance of training clinicians in co-occurring conditions (e.g. Autism, ADHD) and ensuring early identification, service delivery modifications and wraparound supports were included.

Young people with co-occurring substance use

A young person's use of alcohol and other drugs (AOD) can mask and/or exacerbate symptoms of mental health conditions. The extent to which mental ill-health presents in co-occurrence with AOD use is one reason why the Queensland Government has a fully integrated mental health and AOD in policy and through governance and regional systems and service models.

In other areas of the country, stakeholders raised the need for much stronger integration of AOD services with youth mental health services to cease policies and practices that exclude young people from accessing care due to substance use and co-occurring conditions. There is also a need for greater training for clinicians around stigma and judgement of AOD use and adoption of evidence-informed AOD harm reduction strategies within mental health care and treatment.

> "The war on drugs, just say no approach forces young people to censor, lie or avoid situations that brings it up. Distressed people self-medicate that's just the reality. By encouraging harm reduction strategies instead of lectures there would be better outcomes."
>
> **YOUNG PERSON**

Young people experiencing socio-economic disadvantage

As described previously, the cost of care is a significant barrier for many young people and their families, carers and supporters. However, for those experiencing financial hardship it can be completely exclusionary unless they can access a service fully funded by government, philanthropy or corporate donors. Models of youth mental health care are needed that are free, located in areas where there are higher levels of socio-economic disadvantage and placed in trusted, community-based settings.

> "Emergency care is often the only pipeline to accessing any care at all, especially for those who are socioeconomically disadvantaged."
>
> **SECTOR STAKEHOLDER**

LGBTQIA+ young people

LGBTQIA+ young people are at greater risk of mental ill-health due to their experiences of discrimination, social exclusion, harassment, prejudice and family relationship breakdown. This means it is particularly important that when these young people seek support from a mental health service that it includes attributes that make them feel safe, included and understood.

> "LGBT inclusivity is something that I have observed to be occurring across youth mental health services, and it has done a good job at creating an open and safe environment for people like me who are queer or otherwise LGBTQ."
>
> **YOUNG PERSON**

While a lot of good practice is already occurring, young people identified this could be further strengthened through employing LGBTQIA+ peer workers, increasing visibility of LGBTQIA+ staff and inclusive practices, providing specialised training for clinicians, and creating culturally safe, affirming environments.

Young people experiencing homelessness

Several youth housing and homelessness support services engaged in the consultation process highlighted the need to understand and respond to the significant barriers for young people presenting for care unaccompanied and without a fixed address.

> "Consent laws, confidentiality protocols, and service entry points often assume a caregiver is present or available. Appointments, referrals and follow-ups are difficult to manage alone, especially for those without transport, digital access or a stable address."
>
> **SECTOR STAKEHOLDER**

Young people's experiences of homelessness and mental ill-health are often compounded by trauma and other adverse circumstances which can require additional relational support. Factors such as family violence, childhood trauma and inadequate social supports increase a young person's vulnerability. The instability, isolation and stigma that often occur with homelessness and housing instability exacerbate mental ill-health and create further barriers to accessing care. These young people require integrated and trauma-informed mental health services as well as supported accommodation options to establish the situational stability necessary for recovery.

Stakeholders identified the following opportunities within new and/or refined models of youth mental health care to improve support this group:

- the removal of service barriers – such as fixed address, next of kin consent requirements
- the removal of catchment boundaries to enable young people to remain engaged with the same service provider during periods of transient living arrangements
- improve service coordination to provide stronger outreach, establish mobile models, and implement flexible service delivery.

Young people living with disability

The barriers to accessing mental health care that exist for young people living with disability, or young people with parents or carers who are living with disability, are well documented and were highlighted again by several stakeholders involved in the consultations.

Suggested responses included capability building for staff to increase understanding and confidence in supporting individuals with disability (including invisible disabilities), stronger coordination between youth mental health services and the NDIS and NDIS providers, consistent implementation of accessibility standards, funding services to uplift staff capability in ability-affirming support, promoting Auslan as a clinical professional development opportunity, and providing interpreters and assisted services, implementing family-inclusive approaches, and ensuring there is an overarching requirement for – and monitoring of – youth mental health providers adhering to accessibility standards.

> "Standard talk-based therapies are inaccessible for Auslan users unless specialist interpreters are provided – and even then, the trust, nuance, and relational safety required for therapeutic engagement is often missing."
>
> **PARENT/CARER/SUPPORTER**

Young people in out-of-home care

Young people in out-of-home care (OOHC) are often excluded from mainstream primary and secondary care services, or these services are not flexible or sufficiently skilled to respond. The traumatic experiences that necessitate pathways into child protection and out of home care systems are a considerable driver of mental ill-health.

Services supporting these young people who participated in the consultations recommended the need for youth mental health models to extend beyond delivering trauma-informed care and provide trauma specific and specialised interventions. They also emphasised the importance of peer-led approaches and the need to integrate care with child protection systems. The work of the Centre for Relational Care was noted, calling for a Child Connection System ahead of a Child Protection System. Stakeholders also noted that extending age ranges in state and territory mental health services to 25 years would support continued therapeutic alliances and minimise unnecessary transition points which are particularly important for this group.

> "Young people in OOHC experience a greater range of risk factors for self-harm and suicide, and very few of the protective factors compared to the general population. This group experiences much higher rates of trauma, abuse and family breakdown, sexual abuse and exploitation, mental health issues, harmful alcohol and drug use."
>
> **SECTOR STAKEHOLDER**

Young people involved in the criminal justice system

The intersection between a range of social determinants, justice involvement and mental ill-health was raised repeatedly through engagement with stakeholders, with gaps were reported in custodial settings and in community-based mental health responses both in early justice involvement and once young people were exiting a period of detention.

> "The criminalisation of children and young people experiencing mental ill-health, neurodevelopmental disabilities, and complex trauma is reflective of broader health inequalities in the community."

SECTOR STAKEHOLDER

Stakeholders raised the need for more in-custody and post-release supports, more training for justice and corrections staff in trauma and mental health, a shift from punitive to community-based, early intervention and relational models, and the need to address systemic and cultural safety concerns (particularly noting the overrepresentation of Aboriginal and/or Torres Strait Islander young people in justice settings).

Young people who have experienced abuse and violence, including family and intimate partner violence

Ensuring a sense of safety within models of youth mental health care was noted as being particularly important for young people in situations of family and/or intimate partner violence. Again, the need for trauma responsive (specific) care, not just trauma informed care was highlighted, along with confidential, safe access pathways.

> "I became suicidal by age 10, I attempted suicide several years later, I developed severe depression, multiple other difficulties, multiple biomedical conditions caused by abuse & trauma. … I have not had interaction with one psychiatrist, GP, clinical psychologist or other professional working in mental health, including in research, who understands all of the complexity of these problems"

YOUNG PERSON

Case study: Transforming Trauma

Transforming Trauma Victoria's model, developed through a two-year project funded under the Royal Commission into Victoria's Mental Health Service, led by the Phoenix Centre for Post Traumatic Mental Health produced a scalable, statewide trauma service that offers integration, community of practice and iterative development of evidence-based approaches to trauma. It offers an opportunity to be explored as a national model that could improve the consistency of trauma support and integration between providers that provide services to young people impacted by violence, trauma and child sexual abuse.

> "Staff have reported that while local CASAs provide valuable support to young people when they are able to access them, there may be up to nine months delay in accessing services due to high demand. After such a delay, the young person is unlikely to engage. The impacts of the trauma therefore often remain unaddressed and add to the burden of cumulative harm."

SECTOR STAKEHOLDER

Co-design models with greater consideration of intersectionality

New and/or refined models of youth mental health care need to reflect youth perspectives, ensuring programs meet lived experience needs and embed young people and their families, carers and supporters' expertise in service design and policy development.

While youth engagement in services has been noted as a strong feature of what's working well, there remains a need to focus on increasing opportunities for co-design in the development of models and service approaches and take an intersectional approach which ensures that engagement and co-design activities include those most at risk of exclusion (including, but not limited to, LGBTQIA+, young people living in remote areas, young people experiencing homelessness, multicultural young people, Aboriginal and/or Torres Strait Islander young people). These activities also require appropriate resourcing to ensure psychosocial safety for participants and appropriate aftercare is provided.

6. Fundamentals of evidence-based youth mental health care

6.1 Core principles for models

With the advancement of youth mental health models and services globally over the past two decades, several core principles have been consistently presented and underpin evidence-based models that are accessible, appropriate and acceptable to young people. Key globally developed documents also set these out and include: the Lancet Psychiatry Commission on Youth Mental Health[39], The Global Youth Mental Health Framework[40] and the World Mental Health Report: Transforming mental health for all.[41]

Noting that while there is variation in the terminology and/or the manifestation of each principle in practice based on local context, the following should be considered a baseline expectation across all models presented within this advice. These have been adopted from other models including Youth Enhanced Services and Early Psychosis Youth Services.

Young person centred: Young person-centred care is a key element of safe, high-quality healthcare and is essential in youth mental health services. It means respecting and responding to each young person's individual needs, values, and preferences. This approach includes actively listening to and understanding what matters most to the young person and their family, taking into account their stage of development and background. The focus is on building a trusting relationship, being respectful of the young person's experiences and perspectives and partnering with them to plan and deliver care.

Prevention, early intervention and recovery-focused: Models of youth mental health care should acknowledge and respond to the complex causes of mental ill-health - including biological, psychological, social, and environmental factors. Functional recovery is a key goal, especially for young people, recognising its close link with mental health and is best supported by a mix of clinical, allied and functional supports as well as opportunities to build strengths and capacity through psychosocial support including arts, sport, and social and emotional wellbeing programs. Further, the involvement of families, communities and support networks beyond clinical care, encouraging self-management, is critical for recovery.

Socially and culturally inclusive and safe: Socially and culturally safe and inclusive care recognises the diversity of young Australians, including their cultural backgrounds, religious beliefs, gender identities, sexual orientations, and their Aboriginal and Torres Strait Islander identity. It acknowledges that experiences of distress and wellbeing are shaped by cultural, social, and historical factors. Young people need services that are inclusive and culturally responsive services that uphold human rights, consider language and ability, offer accessible information, involve family and community, and understand how different aspects of identity intersect.

Trauma informed: Trauma-informed care recognises that both past and present trauma contributes to the onset, complexity, and severity of mental ill-health for a young person. All youth mental health services need to be able to identify the signs and impacts of trauma, assess for the level of trauma-related needs and provide a response. Through the policies, procedures, and everyday practices, services also should be actively work to avoid causing further trauma.

Family inclusive: Families provide important scaffolding in a young person's recovery, including after they reach eighteen years of age. As such the model promotes family inclusive practice and responding to families' own need for support. Family inclusive practice should recognise that family does not simply mean parents but can include siblings, partners, friends and other support people, and supporting a young person may be best achieved by providing support to the whole family.

> "Being judged as parents, families and carers when we have and continue to deal with some of the most extraordinary and challenging circumstances anyone is likely to experience with their young person... "Nothing about us without us" ... This includes parents, families and carers."
>
> **PARENT/CARER/SUPPORTER**

Shared decision-making: Shared decision-making is a collaborative approach to treatment planning that involves the young person, service providers, their family or support network, and other professionals. It supports choices in care that reflect both the best available evidence and the young person's preferences. Taking this approach has been shown to increase engagement and satisfaction with treatment, leading to better overall outcomes.

Relational and engagement focused: Forming strong relationships and building engagement between young people, their families, carers and supporters and service providers helps improve attendance and involvement in services. A solid therapeutic alliance also supports more accurate understanding of the young person's needs and encourages them to access other supports now and in the future. Trust and relationship-building are essential for promoting a sense of choice and control, which in turn improves outcomes for young people.

Equitable, accessible and timely: Care must be available when and where young people and their families, carers and supporters need it most. It should be appropriate for the complexity and severity of needs and circumstances. Equitable care also means ensuring that additional barriers to access such as cost, location and service hours are considered to ensure that no young person is excluded from accessing care due to financial hardship or socioeconomic status, diagnosis, ability or background.

Effective and efficient: Models of youth mental health care should be grounded in the principles of effectiveness and efficiency to create a responsive, scalable and cost-effective system that adapts to the evolving needs of young people while maintaining high standards of care. Effectiveness ensures that interventions are based on the latest scientific research and tailored to the unique developmental needs of young people. This means using approaches that have been proven to reduce symptoms, build resilience, and promote long-term mental health. Equally important is efficiency, which ensures that resources - whether time, funding, or personnel - are used wisely to maximise impact. An efficient model will hopefully reduce wait times, streamlining access to care across model components, making it easier for youth to get help when they need it most. It also supports sustainability by ensuring resources are used in the best possible way, with resource wastage minimised.

6.2 Pillars to enable best practice across models

Responsive and effective models of youth mental health care rely on several foundational pillars that ensure young people access services designed to meet their needs.

6.2.1 Equal value to psychosocial and clinical support

Experiences of mental ill-health can have a significant impact on a young person's ability to engage with activities of daily living, develop social skills, attend school and work, access secure housing and participate in social activities, thereby limiting a young person's life trajectory, persona l confidence and hope.

Equally, experiences of unemployment, school disengagement, homelessness and social isolation can impact on a young person's mental health. Without addressing these needs, there can be limited value in only achieving clinical outcomes. A lack of progress towards functional recovery is more likely to result in a relapse in mental health symptoms and severity.

Psychosocial supports in youth mental health care

Psychosocial supports in Australia have largely been described in the context of someone experiencing severe mental ill-health, assisting individuals to manage daily tasks, undertake work or study, find housing, get involved in activities, and make connections with family and friends.

However, psychosocial care within youth mental health models requires valuing and providing support across these activities across all levels of severity, and utilising psychosocial approaches in prevention, primary care and enhanced primary care.

One example is the integration of Individual Placement and Support (IPS), a vocational recovery program into clinical mental health services. IPS was originally developed for adults with severe and longer-term mental illness and had since been adapted for young people and now implemented in 50 headspace centres across the country. Housing and legal support are two other areas where services need to be focused within a broad health and social model of care.

Psychosocial supports to improve recovery can also include programs that provide free access to a broader and more inclusive range of activities across sport and the arts that can enable young people to develop social connection, social skills, increase personal confidence and hope and reduce the degree to which a young person's life is dominated by symptoms.

As described in Section 4.1.2, the unmet need for psychosocial support is significant.[42] This may have been exacerbated through the inclusion of psychosocial disabilities within the NDIS framework which shifted resourcing from community-based supports into care provided through individual packages with eligibility criteria that largely prevent young people who will not have an enduring and lifelong psychosocial disability from accessing them.

Given the level of unmet need, psychosocial support is critical to all youth mental health care models and should be held with equal value. Ideally, youth mental health models will move beyond differentiating strands of psychosocial and clinical supports and view them in combination as features of effective holistic youth mental health care.

> "Rebalance the youth mental health system to equally prioritise psychosocial and clinical supports, delivered at the appropriate time in each person's recovery journey."
>
> **SECTOR STAKEHOLDER**

Breaking down silos between clinical, psychosocial, and peer-based services

New and/or refined models of youth mental health will need to:

- be resourced to provide psychosocial and peer-based services
- enable leadership, organisational strategies, workforce development and processes to support and promote working across disciplines; care coordination; information sharing and joint planning.

Preference should be provided, where possible, to delivering psychosocial supports and clinical care under the governance of one organisation employing a skilled multidisciplinary workforce.

HOW CAN THIS BE STRENGTHENED

The following presents several opportunities to provide equal value to psychosocial and clinical support in youth mental health models of care.

Governance and funding

- Set an expectation of equal value for psychosocial and clinical supports in the establishment of all youth mental health services through sufficient funding, funding models and contract requirements and incentivise a diverse range of providers with experience and skills across these domains to develop integrated service offerings and warm referral pathways.
- Provide funding to support alternative avenues to build connection and purpose e.g. social and emotional wellbeing programs such as those that take young people on Country, creative, sport, outdoor recreation and other types of physical activity. Evaluate these to build the evidence base for the outcomes in relationship building, clinical symptom improvement, service engagement and functional recovery.

> We found a small organisation called Human Nature and his psychologist met him outdoors. They walked they rode bikes they fished, and he developed strategies to handle his anxiety enough to be able to see a psychiatrist to be diagnosed with ADHD and generalised anxiety disorder.

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Codesign

- Develop clarified standards on what it looks like to incorporate lived experience perspectives in service design, for example ensuring services are codesigned with diverse groups. Genuine lived experience engagement will enhance the value and commitment to psychosocial support within youth mental health models.

> Relationships. Young people need relationships with people who 'get' them and aren't trying to 'fix' them or 'teach' them. People other than their parents who accept them for who they are and can help them figure things out. Not everything has to be clinical, especially when it's early intervention and recovery.

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Workforce

- Ensure the workforce has the right mix of capabilities and skills to value and provide psychosocial support which: a) promotes strength-based capacity-building of young people and aims to reduce barriers for functional recovery (school/work/community participation) and b) delivers peer support to allow for mutuality, relational work, trust building, and working alongside the young person.

Digital integration

- Recognise the role of digital platforms in supporting social connection, wellbeing, identity and self-agency. This would also enable broader, functional and strengths-based definition of digital psychosocial support to be integrated (arts, social connection, music).

6.2.2 Enhanced through digital technology

High quality digital tools and platforms are a way to meet young people in their world, improve their experience of care, and support quality and efficiency in the delivery of services. This pillar therefore involves three key aspects:

- Integration and delivery of digital and online tools and services, resources and platforms within in person services.
- Use of digital technologies to enhance the efficiency, reach, effectiveness and experience of delivering youth mental health care.
- Supporting system integration and service navigation through digital tools and platforms.

Integration and delivery of digital tools, resources and platforms within youth mental health care models

> Digital is not as effective as an isolated 'add-on'; it is much more effective when embedded within the broader mental health system.

SECTOR STAKEHOLDER

Noting that young people still overwhelmingly indicate a preference for in-person engagement, there are significant opportunities to integrate digital tools into youth mental health care. It can improve the experience of care and provide support while on a wait list, in periods between assessment and treatment and between appointment. These tools include (but are not limited to): chat and text options for service engagement, telehealth, online assessment tools, moderated peer support platforms and navigation, self-guided care, Virtual Reality and AI.

However, digital tools should meet young people where they are at and reflect young people's digital expectations, aligning with the norms of their online engagement generally (e.g. social media, immediacy, accessibility 24/7).

> Online services sound great, but a lot of them are clunky. I tried an app for support, and it was slow and hard to navigate—nothing like the slick apps we're used to. Digital mental health tools need to be as easy as Instagram to be effective, but most aren't there yet. Plus, they often feel impersonal, like you're just another user, not someone who needs real connection.

FIRST NATIONS YOUNG PERSON

Effectively integrating digital tool into youth mental health care requires:

- embedding young people's voices at every stage (inclusive of priority populations) - from co-design to delivery and evaluation
- allowing for personalised, culturally appropriate interactions and content, including the option to choose support provided by peer workers, clinicians, or cultural workers; as well as content that is relevant to the young person's age, presenting issues and communication modality preference
- co-designing with and training clinicians in the use of the tools will also support greater uptake and improve their confidence in using and valuing the tools
- respecting that many young people still maintain a preference for relative anonymity when accessing digital services and for transparency in how their data will be collected, stored and used.

In addition, there is a strong role for technology and digital tools to support families, both in responding to mental health needs of a young person but also in providing them with connection and support.

Case study: Moderated Online Social Therapy (Orygen)

The MOST platform is one innovation that governments are utilising to fill the gaps in mental health care and increase accessibility. It connects young people (aged 12-25 years) with support that has been proven to be effective in addition to face-to-face therapy. The platform:

- provides instant access to low intensity clinician-supported online care, including self-help resources and networks of peers, clinicians and career consultants
- integrates digital care with face-to-face clinical services for young people with more moderate to complex mental health needs
- provides ongoing access to support once face-to-face care has ceased, to avoid relapse or increase the duration of time between relapses.

Use of digital technologies to enhance the efficiency, effectiveness and experience of delivering and accessing youth mental health care

Digital technologies can meet young people where they are to provide responsive support to young people when they need them. Examples of this include:

- Asynchronous (SMS, direct messages) and real-time (webchat, phone, audio-video) communication modalities to match preferences (e.g. self-paced content, chat-based support, peer forums, telehealth). Many evidenced-based and effective examples of these digital offerings exist, including but not limited to eheadspace, Reachout, kidshelpline, yarnsafe, 13YARN.

> "I believe there needs to be more variety in terms of services available to youth. There needs to be more of a focus put on digital means to help.... Majority of teens would much prefer to text then talk verbally to someone. We should be making more mental health apps with live chat options."
>
> **PARENT/CARER/SUPPORTER**

- Designing for low-barrier to entry - free to use, low data consumption, quick exit capabilities (triggering follow-up support), with consideration given to what sign-up requirements are necessary and what requirements will add additional barriers.
- Considering availability of evidence-based digital services at various phases of treatment: while waiting for treatment, between therapy sessions, and after discharge.

There are also significant opportunities to utilise digital technologies to enhance the efficiency and experience of planning for and providing youth mental health care. Reduced administrative burden using existing technologies (e.g. ID scanning) or new and emerging tools such as AI to generate case notes has been identified as one opportunity to then free up time for a service to provide more direct care.

A recent study on clinicians' use of AI technology in mental health care found the most popular uses were for administrative task support, synthesising the latest clinical evidence and training and simulation, with least popular including assisting assessment and diagnosis, and enhancing consumer engagement with treatment.[43]

Digital tools and technology can further support service providers and planners to coordinate support and deliver personalised and measurement-based care for young people. These include co-designed platforms that enable "assessment, feedback, management, and monitoring of their mental ill health and maintenance of wellbeing by collecting personal and health information from a young person, their clinician(s), and supportive others. This information is stored, scored, and reported back to the young person, their clinicians, and the service provider to promote genuine collaborative care".[44]

Case study: Right Care, First Time, Where You Live (Brain and Mind Centre)

The Right Care, First Time, Where You Live approach builds local capacity to use systems modelling and simulation to inform better, more timely decisions in youth mental health.

Using systems modelling, regional health authorities, social service providers, and community stakeholders are provided with the tools, processes, and insights needed to more effectively allocate limited available resources.

The program supports health and social systems to navigate complexity, coordinate care through digital tools, and remain responsive to changing needs. Features of the approach include participatory decision support ecosystem, cross-sectoral care coordination through digital technology, workforce capacity building, and integrated, long-term monitoring and evaluation.

Supporting system integration and service navigation through digital tools and platforms

A key recommendation from the recent work undertaken by SANE on digital navigation was for investment in "digital tools that allow services to *talk to each other*, so help seekers don't have to repeat their story every time and have an easier experience booking and managing services."[45]

To achieve this there is a need to develop partnerships between digital service providers and between digital service providers and in person services and supports. AI and technologies can then be utilised to enhance triage, navigation, and continuous care, particularly in underserviced areas.

Other current tools that can be further maximised to support care integration for young people in mental health care includes the My Health Record. Changes are needed to make it easier to use, to build the trust and engagement of both consumers and practitioners in the system and to communicate its value.

> "The system should be linked to a shared medical record, where you opt to share it with whoever you like. Integration of systems and silos are clearly evident processes."
>
> **PARENT/CARER/SUPPORTER**

Support digital infrastructure, innovation, service delivery, and ongoing evaluation.

Digital technologies are changing the way health care is delivered and young people's use and understanding of new technologies is rapidly advancing. As such, new and/or refined models of youth mental health care need to include clear digital strategies that include:

- investment in technologies,
- building digital capabilities across the workforce,
- embedding their use in clinical practice and protocols, and
- building the evidence base for what is effective and efficient.

The consortium also supports the four key recommendations made through the SANE digital navigation project and recommends the Australian Government move to fund and implement these.

Note: In several discussions on digital tools and technologies, young people (along with their families and some in the sector) flagged concerns regarding control of data that was being captured and utilised through their use of digital tools and resources or in the use of technologies in the back-end/reporting aspects of their care. They continually emphasised the need to have control over their data. Data collected from First Nations communities and the need to protect data sovereignty should also be a key principle for any digital integration or enablement. Protection and enhancement of data sovereignty requires real investment in First Nations governed expertise, organisations and infrastructure.

HOW CAN THIS BE STRENGTHENED:

The following presents several opportunities to enhance the use of digital technologies in youth mental health models of care.

Governance and funding

- Government investment is needed in major digital infrastructure and connectivity that allows many digital tools and providers to exist, rather than picking specific tools. This allows for digital providers to focus on innovation while the digital standards framework provides the mechanism to ensure this happens and new providers comply.
- Include expectations for digital infrastructure, interoperability, clinical governance and regulation for digital offerings, data privacy and sovereignty into future youth mental health service commissioning and/or contracting at a regional, state and federal level. Digital offerings should be shown to be evidence-based and acceptable to young people.
- Design for consistency across services - e.g. shared assessment frameworks, consent processes, and platforms.
- Invest in expert organisations and infrastructure to support a national approach to data sovereignty for First Nations people.

Workforce capacity

- Provide training, incentives, and clinical integration support to encourage use of digital tools and technologies by practitioners. Employ staff with specific expertise and roles in supporting the delivery and integration of digital technologies and tools in models of youth mental health care.
- Build a digitally literate and digital-ready workforce that includes peer workers, clinical staff, cultural workers, and technical experts (e.g. UX/UI designers) to ensure service delivery is well prepared for current and future advances in technology (e.g. AI) and can communicate these advances in common language to young people and families seeking support.
- Embed digital tools into routine workflows and ensure they reduce, not increase, workload, and do not create additional barriers to access for young people and families.

Interoperability

- Introduce data exchange standards to drive interoperability – currently, secure messaging or electronic medical software are developed by vendors in different ways, preventing interoperability and resulting in double entry across separate systems. Data exchange standards are required to facilitate interoperability and information sharing across services.
- Government investment in data security is needed to ensure services can meet all health data and privacy standards, to maintain trust in systems.

What young people said:

(batyr youth co-advisors and consultations)

Young people identified digital tools as a valuable way to improve accessibility, particularly for those in rural or remote areas, those without transport, or those needing support outside typical service hours. They described digital care as helpful when it offers flexibility and continuity, such as video calls, check-ins between sessions, and moderated peer-led forums. These formats were seen as most effective when they enhance in-person care, not replace it.

There was consistent concern about the limits of artificial intelligence in mental health settings. Participants highlighted that AI cannot understand context, build trust, or show empathy in the way a human can. While they recognised the role technology can play in triage, data sharing, or low-risk administrative support, they stressed that AI should never take the place of lived experience or clinical judgement. Privacy, data safety, and the risk of impersonal or dismissive responses were raised as significant barriers to trust.

Some young people saw potential in emerging tools like VR or digital support communities, particularly when designed to meet users where they are and create space for connection. However, they called for stronger regulation and clearer information about which platforms are safe, inclusive, and grounded in best practice. Young people also advocated for more transparency and user control over how their data is used, and for systems that allow continuity of care across services without requiring them to repeatedly retell their story.

6.2.3 Learning and Data/ evidence driven

All models of youth mental health care would be strengthened and more effective and efficient through access to data and evidence from a range of sources, including services, government agencies in real time. This would enable: an understanding of what is happening in real world services (i.e. what services are being provided by whom and to whom); to understand what is working and what isn't; and then utilising this information in a continuous process to inform the adaptation and improvement of models of care and services.

Currently youth mental health services collect a range of data, including service usage, financial information, client details, and outcomes (e.g. K10 scores). headspace National Office, for example, collects a large and impactful national minimum data set through a purpose-built data collection application (hAPI). hAPI captures information on young people's presentations, their experiences and outcomes, alongside the services being provided across the national centre network. These data are utilised by staff to inform and improve the care they provide to young people and at the service and national levels to effectively support service monitoring, planning and reporting.

However, in many other areas of youth mental health, the collection and use of data by services and service planners is inconsistent, disjointed and fragmented, limiting its effectiveness in informing individual service and regional needs, planning, and improvement. There are many reasons for this, including the large cost for providers in developing fit-for-purpose data systems and not having a standardised and agreed set of collection requirement and outcome measures across funders of youth mental health services.

This could be addressed through:

- harmonised evaluation measures both between youth mental health services and with other youth service providers, this could include integration of Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) into clinical quality improvement across youth mental health care providers
- national infrastructure to support learning systems and data platforms
- investment in infrastructure for rapid reviews/ living reviews of research and evaluations to support policy and other decision-making
- feedback mechanisms that can support real-time learning and improvement at the frontline of both delivering and receiving care and support (i.e. direct input from young people and their families).

Case Study - IYS Learning System and Data Platform (Canada)

Integrated Youth Services (IYS) across Canada will soon be connected by a IYS Learning System and Data Platform to allow researchers, decision makers and other key knowledge users and service providers to share information and have more timely, accurate, comprehensive, and diverse data sets on youth mental health and substance use.

The goal of the IYS National Data Framework and Infrastructure project is to collect consistent data across provincial IYS networks. This investment will establish common measures, evaluation frameworks, governance, and digital platform infrastructure. This work will contribute to improved understanding of youth service needs and outcomes, help build and test new services, and help services pivot more effectively when crises arise.

HOW CAN THIS BE STRENGTHENED:

The following presents several opportunities to embed learning through data and evidence in the development and delivery of youth mental health models of care.

Infrastructure

- Develop regional and national infrastructure and a strategic plan to support centralised data collection, integration, analysis, reporting and connection with research, learning and evaluation. The new National Institute for Youth Mental Health committed to by the Australian Government could provide a platform for this, partnering with other national data institutes such as the AIHW and large service data collectors and managers such as headspace National Office.

New and/or refined models of youth mental health care need to be supported through a learning mental health system approach

Developing a National Learning Youth Mental Health System (described in more detail in Section 9 and Appendix C) would enable continual improvement in the delivery of models of youth mental health care. This could involve the development of a national data framework and centralised infrastructure, along with research, evaluation and implementation science capabilities.

Workforce

- Develop technical capability across the workforce including roles for, or establishing partnerships with, data analysts, biostatisticians and research organisations. Across mental health care in Australia, technical support and assistance is available to support analysis and guide improvements in national and regional data collection. Aspects of data governance, stewardship, and oversight (to support ethical use, balance of privacy, and sharing) are currently supported by a range of government committees and advisory groups, including the Mental Health and Suicide Prevention Data Governance Forum and the Mental Health Data Standards Technical Advisory Group.

Designed with and for the people who will use it

- Develop and harmonise measures and data collection in a way that makes sense to collect across all levels of care and is useful to people whether they are delivering care, managing services, regionally planning for systems or national policy.
- Consumers, carers, and especially young people need to be at the centre of a learning youth mental health system design through co-design and co-researcher roles.
- To address concerns around use of data there is a need to establish:
  - clear frameworks for data governance that address privacy, ethics, legal and regulatory considerations
  - data sharing agreements that balance access with protection of individual rights, particularly for young people
  - include lived experience governance mechanisms and roles.

6.2.4 Integrated and coordinated

Evidence shows that integrated care provides the best outcomes for young people. Integrated models place the burden of responsibility for managing the inherent complexity in care options on the system rather than the individual e.g., easily accessible, and recognisable front door supports with service navigators, producing better engagement and clinical and functional outcomes.

Services can **vertically integrate** with other levels of clinical care, such as multiple enhanced primary care supports and/or tertiary services. **Horizontal integration** with other social and psychosocial supports (such as vocational, housing, educational, financial, and justice) is also needed.

> "The system is complex. It requires the young person and parent to retell the story many times. It involves too many complex systems working in silos. As a parent of a young person, I feel very isolated and burnt out."
>
> **PARENT/CARER/SUPPORTER**

Examples of integrated services include those described as 'one-stop shops' of multidisciplinary teams of clinical and non-clinical staff, all accessed in a single location (e.g., Foundry,[46] headspace,[47] Jigsaw[48]).

These models include a standardised assessment of the young person to assign them to relevant mental health care (e.g., enhanced primary care, secondary or tertiary care) and other supports (e.g., physical health and substance abuse services, sexual health services, educational and vocational supports, etc.). These services can be complemented or delivered online through standalone (e.g., telehealth) and blended care models, allowing for greater access and continuity of care when in-person support is unavailable.[49]

Effective integration relies on models that support collaboration and have available capacity within the system. This may be hindered by structural challenges including (but not limited to) fragmentation and commissioning issues such as the misalignment in federal and jurisdictional funding streams and age-based service boundaries and limited location availability.

> "Effective implementation and scaling of service integration depends on a range of factors, including robust governance structures and strong inter-agency partnerships (pooled funding, joint accountability); information sharing and streamlined/integrated systems and processes; genuine partnership with service users (children, young people, family, carers, kin); and commitment to continuous improvement."
>
> **SECTOR STAKEHOLDER**

Case study: Mindgardens Youth Integration Project

In NSW the Mindgardens Youth Integration Project is currently researching and piloting opportunities to 'fine-tune' the youth mental health system to enable integration of different services and provide young people and their families with support and information to navigate their care.[50]

A report produced by the project explores several real-world examples of integrated youth services around the world and provides a framework for understanding what different integration approaches consist of in practice, from coordination to co-location and then full integration. This framework has been applied to the headspace model and could be utilised by other services to understand what level of integration they are currently operating at and what they would need to change to increase integration.

HOW CAN THIS BE STRENGTHENED

Strengthening integration across new and/or refined models of youth mental health care will require the following.

Shared frameworks across regions and nationally

- Establish regional shared-leadership governance mechanisms to enable flexible, context-appropriate integration. Accountability and clearly defined roles and responsibilities are essential.
- Harmonise age ranges to deliver a consistent youth mental health system for 12-25-year-olds between state and federal services which will support integration of youth mental health care between primary, enhanced primary and tertiary systems of mental health care and reduce transition gaps.
- Encourage federal, state and local government joint funding or co-investment of resources and workforces into shared service platforms (rather than siloed programs) to enhance collaboration and sustainability.
- Foster networks for shared learning and relationship building across services (e.g., PHNs hosting cross-service collaborations and sector alliance meetings).
- Build systems and agreements to enable cross-service communication.

Harmonising the age range

Harmonising the age range of youth mental health system across Australia to encompass 12 to 25-year-olds would increase ease for both services and young people. Central to this is the shift for state and territory governments from Child and Adolescent/Adult service paradigms to a Child (0-11 years), Youth (12-25 years) and Adult system (26+). This would enable better integration of services but also increase the ease of implementing a nationally cohesive youth mental health system.

Resourcing

- Provide secure, long-term funding to support integrated service delivery, future planning, meaningful relationship building across the sector.
- Embed integration principles into commissioning and funding models, prioritise opportunities to build on the strengths of existing local community agencies and incentivise local partnerships and networks.
- Resource system navigation supports as a core component of youth mental health models of care to help young people and families move through the system.

Commission to support integration and collaboration of mental health services and providers

Funding the full costs of integration and coordinating care is needed to ensure that mental health services are accessible, comprehensive, and tailored to the needs of young people in communities with the greatest need. This is particularly important in the context of introducing new and/or refined youth mental health models into a local community or region.

6.2.5 Recruitment and retention of a skilled workforce

A skilled and available youth mental health workforce is a central pillar for the successful delivery of new and/or refined models of youth mental health care.

There are specific attributes and knowledge required to deliver youth appropriate and effective care, and several higher education and vocational courses, training packages and micro credentials are available for people to develop competencies and skills specific to delivering youth mental health care.

Stakeholder consulted for this project also placed high value on the recent growth of the lived experience and peer workforces, along with other roles, such as community mentors, development workers and youth workers to provide early engagement and support to young people and help with key tasks such as service navigation.

> "I wish there were youth workers in the youth mental health system who could do the engagement work, build relationships with young people and be a 'connection' between school and mental health services..."
>
> **PARENT/CARER/SUPPORTER**

Workforce issues in mental health are well known and were repeatedly raised through the consultations. In public funded mental health services, there are challenges in attracting the medical workforce, including psychiatrists and psychologist, due to the lower salaries that are on offer compared to working privately[51] and considerable variations in awards and remuneration across different states and territories.

> "We need to make it easier for psychologists and psychiatrists to become qualified. The process to become qualified is far too difficult. More support needs to be provided so that we can increase the workforce and reduce wait times... Training that challenges stigmas would be great too."
>
> **YOUNG PERSON**

HOW THIS CAN BE STRENGTHENED

Acknowledging there is no short-term solution to the shortage in trained and experienced staff in some disciplines the following presents several opportunities to recruit and retain the skilled workforce required to deliver youth mental health models of care.

Build community capacity

- Support community-driven workforce development which is particularly important in regional areas that struggle to recruit health professionals. Provide resourcing specifically to community service providers to support their workforces to build skills and credentials in youth mental health and create local pathways into youth mental health careers.
- Tailor strategies based on local needs, such as funding relocation and living costs for individuals from regional or remote areas to undertake tertiary education or providing on-Country training options.
- Recognise and formalise the value of non-clinical roles such as Social and Emotional Wellbeing (SEWB) workers, youth workers, peer workers, and community engagement/development workers. Expanding and promoting credentialing, professional development, and career progression for these roles will help build parity of esteem with clinical professions.

Pipelines and pathways for new workers

- Develop and expand workplace-integrated learning models, such as "earn while you learn" programs, apprenticeships in mental health, and paid cadetships. These pathways lower financial barriers and attract a wider range of candidates, including mature-age and culturally diverse applicants.
- Provide more course and training places at universities, particularly for clinical psychologists and allied health workers.
- Increase investment in supervision capacity, structured placement programs, early career entry programs and partnerships with universities and training organisations to provide real-world learning opportunities.

Retention of skilled workers

- Foster supportive, positive and recovery focused work experiences that allow people to do the work they most enjoy and are skilled to do, and provide opportunities for further learning, research and teaching, and utilisation of digital technologies.
- Review and benchmark salaries regularly to ensure that wages are competitive with other public, but more importantly private sectors.
- Provide staff with access to ongoing education, networking and mentoring.
- Expand access to continuous professional development to workers in non-clinical/allied health roles, and to regional and rural settings, with a focus on current evidence-based practices, culturally responsive care, trauma-informed approaches, and new models of youth engagement. This should be resourced, and consideration given to capacity for backfilling roles and modes of delivery, which is particularly important for workers in rural and remote areas who are often excluded from training as it requires travel and accommodation costs.

Prioritise workforce approaches

Significant and urgent action is required to build and retain a specialised youth-focused clinical and allied health workforce to support the delivery of new and/or refined models of youth mental health care. Non-clinical workforces do play an important role, however the biggest gaps in the current public youth mental health system, which will need to be addressed to support any new models of care/service platforms, remain clinical.

There is also an opportunity to respond to the findings of the broad consultation for this project which called for stronger recognition of and investment in non-clinical/allied health roles, including (but not limited to): the youth and family peer workforce, generalist youth workers, community mentors, social and emotional wellbeing workers, and those working in sport, recreation, culture and arts.

6.2.6 Responds to social determinants

Mental health is often caused or exacerbated by social determinants such as poverty, housing insecurity, and disconnection; addressing these is essential to improving wellbeing.

> "At no point did anyone try to get to the root cause of my anxiety and depression."
>
> **YOUNG PERSON**

Mental health cannot improve without basic needs like shelter, food, and safety being addressed and future risk of mental ill-health (resulting in even further need for support and services) being mitigated by ensuring that action is taken to address basic human needs. Examples include strengthening the social welfare system and real investment in social and supported housing.

While it is not expected that youth mental health services will be able to directly address these broader structural and systemic issues, the underpinning models of care do need to consider the holistic needs of young people presenting for support.

An intergovernmental and cross-sector approach is also needed to mitigate barriers to mental health care and recovery and increase to the youth mental health system's ability to respond to young people who are exposed to the mental health impacts of:

- unstable, insecure, transient or lack of housing
- financial distress both individually and within the family
- geographic and/or social isolation
- experiences of trauma, including intergenerational trauma.

> "Similarly, people with mental health challenges are often excluded from housing and to varying degrees, end up in the homelessness system. Many are unable to even access this due to inadequate resources and related exclusive approaches and eligibility. Housing as a human right would prevent deterioration of mental ill health and similarly, provision of housing would enable young people to access mental health support. Often young people who do not have a permanent address are excluded from mental health support programs."
>
> **SECTOR STAKEHOLDER**

To be effective, new and/or refined models of youth mental health care will need to address some of the processes and structural issues that are evident in the current youth mental health system including:

- Rethinking current mental health assessments and intake processes that can act as a gatekeeping tool, highlighting and excluding those who don't fit the service model, rather than adapting to the young person's needs.
- Shifting the burden of navigating a fragmented system from people already in crisis and supporting them to prioritise urgent basic needs while staying connected with mental health services or outreach to prevent further mental health deterioration.
- Balancing the focus on family participation with individual need. While family inclusive practice is an important component of evidence-based youth mental health models, this can fail to respond to the needs of young people for whom those stable and caring family environments do not exist.

> "Part of the challenge we see in regional areas with the intersection of mental health issues and criminalisation is significant difficulty in connecting children who have disengaged from education, are at risk of contact with the criminal justice system or have been charged with criminal matters with appropriate support."
>
> **SECTOR STAKEHOLDER**

Models of youth mental health care also need to consider, understand and respond to several more recent social and economic trends that appear to be impacting young people's wellbeing, including:

- climate change
- social media use
- cost of living
- future job market changes and precarity
- intergenerational inequality.

HOW CAN THIS BE STRENGTHENED

The following presents several opportunities to strengthen how social determinants are responded to within models of youth mental health care.

Local partnerships

- Utilise early intervention in mental health services to identify and act on unmet social needs contributing to mental ill-health. There are various multidisciplinary partnerships already taking this approach within government-funded community-based services around Australia.
- Respond to social determinants through a whole of system, whole of community approach which can be activated at a local level, supported by local, state and national resourcing.

> "I strongly support the idea of building partnerships with community-led organisations, as they are trusted and understand the complex needs of our youth, especially those from refugee and multicultural backgrounds."
>
> **PARENT/CARER/SUPPORTER**

Strengthen prevention in youth mental health services

- Improve access and priority pathways into mental health care for young people facing complex social challenges.
- Upskill the workforce to build the capability to understand and respond not only to clinical needs, but also to the broader social determinants of mental health.
- Embed community mentors, peer workers and/or navigation support workers within services to strengthen engagement, address immediate social needs, and ensure effective connection to appropriate services and supports.

Provide inclusive and safe services

- Embed cultural literacy, safety, and responsiveness must be embedded across youth mental health services. This includes a strong focus on improving outcomes for diverse population groups, particularly First Nations young people.
- Broadly define family to include chosen family, as part of family-inclusive practice.

Emphasise protective factors

- Build strong connections to education and employment support within youth mental health models. These are important protective factors and need to be resourced accordingly.
- Recognise the key role schools play in fostering inclusion and connection. Creating welcoming, supportive school environments is essential to preventing disengagement and promoting mental wellbeing.
- Review of all government policies to assess their impact on youth mental health.

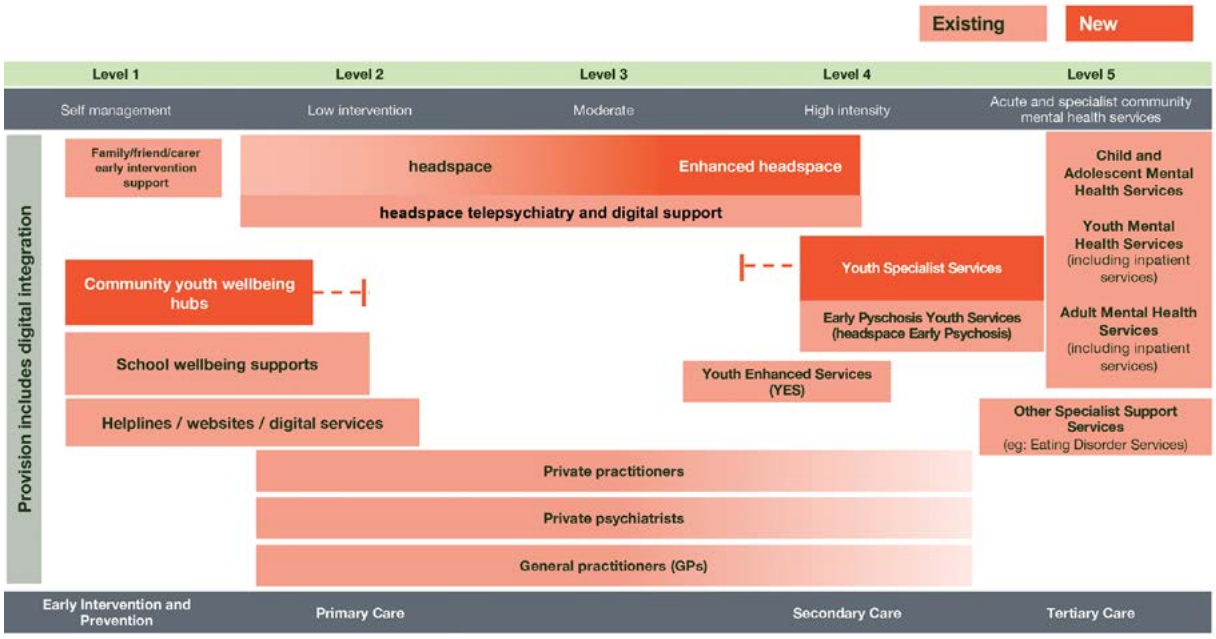
Case Study: The Geelong Project

A community of schools and youth services' model of early intervention (COSS), a place-based model to reduce disengagement from education and early school leaving and to help where family issues are heading towards a crisis and possible homelessness as well as other adverse outcomes. The model is represented as consisting of four foundations – community collaboration, early identification, the practice framework and early intervention support work with families and a robust, embedded longitudinal monitoring and measurement of outcomes. These foundations comprise a significant reform of the local service system of support available for vulnerable young people and their families.

7. New and/or refined models of youth mental health care

This section outlines three models of care to refine current approaches and reshape youth mental health care in Australia. These models, Enhanced headspace, Youth Specialist Services and Community Youth Wellbeing Hubs, present an avenue to help address the various barriers, gaps, and opportunities discussed above that were highlighted through the service mapping, literature review and extensive consultations.

The three models are only components of a full system of care which includes a much broader range of delivery and service approaches across prevention, school-based supports and the state/territory funded system (as presented below). Opportunities for prevention and school-based supports that were also surfaced through this project are also explored in Section 8.



Note: This service map is provided as a general representation of the national youth mental health system and doesn't capture the variation in service delivery between states/territories and regions. While many of these services (including headspace) provide holistic services for young people, this representation focuses on mental health supports. The Initial Assessment and Referral Decision Support Tool (IAR-DST) is included as a reference point, noting that in practice the IAR-DST forms a guide for recommending level of care for individuals, whilst being subject to clinical judgement.

YOUTH MENTAL HEALTH SERVICES MAP – INCLUDING NEW MODELS OF CARE

7.1 Enhanced headspace

7.1.1 Rationale

Since 2007, the Australian Government has built and invested in over 170 headspace centres nationwide, providing young people with support across four key areas: mental health, physical and sexual health, alcohol and drug use, and work and study pathways. This network of centres represents a vital component of Australia's youth mental health infrastructure and will continue to deliver services to young people nationally.

A strength of the headspace model is the need to for centres to adhere to a defined headspace Model Integrity Framework (hMIF) which is reviewed by headspace National Office. However, the ability of headspace centres to deliver consistently on this model has varied over time and in different locations due to funding limitations, local workforce availability and 31 different contracting arrangements via PHNs.

With a rising prevalence of mental health conditions among young people driving increased demand, many centres are managing long waitlists, and both young people and First Nations organisations have raised concerns about inconsistent service quality, sustainability, and culturally safe care.

While the headspace model is well positioned to respond – already incorporating many key components and practices for an enhanced headspace model – there are underlying structural, funding, and workforce challenges that must be addressed. These include:

- greater complexity in presentations, with many centres supporting moderate to severe needs
- limited access to specialist services for referrals or shared care, leaving headspace to manage complex cases without adequate funding
- difficulties in consistently delivering services across all four pillars with current funding levels
- short-term funding cycles, particularly for supplementary funding packages such as the Demand Management funding, that hinder the implementation of best practice and the retention of a skilled workforce
- a funding model that has not kept pace with sector changes, including increased competition for private practitioners and subsequent lower capacity for bulk billing, and fewer resources for outreach and early intervention.

Addressing these issues is essential to ensure an enhanced model for headspace can meet current and future demand while delivering high-quality, accessible care to young people across Australia.

What young people told us (batyr youth co-advisors and consultations)

Young people described headspace as a well-known and youth-friendly entry point; however, the model could feel too generalised, not always allowing time or space to explore individual experiences in depth. They recognised the need for balancing greater consistency and standardisation across sites alongside the flexibility to adapt to local needs, particularly in rural and regional areas.

Many young people stressed the importance of outreach roles and stronger community presence, and building relationships with local organisations, councils, and services to better reach those who might not engage through traditional pathways and to enable visibility and relational engagement that reflects the specific needs and strengths of different communities. Frustration was also expressed around difficulties navigating services, both online and in-person, with participants emphasising the need for clearer pathways, streamlined access, and proactive support for transitions between levels of care.

Critically, young people voiced that enhancing headspace needed to involve more than expansion of capacity – it must include deepening the service's ability to respond to diverse and intersecting needs, including those with more complex presentations, those from priority populations, and those seeking care outside traditional hours. The role of care navigation was seen as vital, helping to reduce the administrative and emotional load often placed on young people to self-manage their journey through the system. Young people stressed that any future enhanced model must position them not only as service users but also as co-designers, ensuring their lived experiences and local insights shape what quality care looks like in practice.

7.1.2 Who will it support and how will it be accessed

headspace centres already offer a stigma free soft entry point for all young people. The enhanced headspace model would continue the no-wrong door approach but with a greater capacity to respond to the increasing number of young people with mild to moderate mental health needs who are presenting for support.

For young people with moderate to severe mental health needs, enhanced headspace would have greater capacity to provide needs assessment for more specialised care, support for more complex mental health and alcohol and other drug needs, and shared care with the Youth Specialist Services where relevant and available.

The enhanced headspace model will also have a stronger focus on outreach, to meet young people where they are in the community. This can help engage with young people and help reduce stigma and other barriers to accessing support. Under the enhanced model, headspace services can also use outreach to build connections with young people and with communities to better meet the needs of priority populations, including First Nations and multicultural young people.

7.1.3 Areas of focus

As highlighted above, headspace centres already have a defined model of care. This includes 10 service components (youth participation, family and friends participation, community awareness, enhanced access, early intervention, appropriate care, evidence-informed practice, four core streams of physical health, mental health, drug and alcohol and vocational recovery, service integration, supported transitions) and six enabling components (national network, Lead Agency governance, local consortia, multidisciplinary workforce, blended funding, monitoring and evaluation).

A strengthened and expanded headspace model would see centres resourced to fully deliver to the headspace model with some enhanced areas of focus. The table below outlines these areas and provides examples of implementation. The specific details will need to be developed by headspace National Office in collaboration with headspace services and Lead Agencies. In addition, each of these changes (e.g.: an outreach program or extended service hours) needs to be designed in consultation with local communities, to be locally responsive.

Areas of focus	Description of current headspace model	Enhanced model implementation*
Community engagement and mental health promotion	Build mental health literacy, reduce stigma, and improve help-seeking through outreach and promotion in the broader community.	• Additional capacity for community awareness and engagement • Further develop and leverage relationships with local schools and communities
Engagement-focused intake and experience of care	Prioritise welcoming and meaningful engagement with young people and families to ensure a positive care experience and enable effective early needs assessment.	• Flexible entry points for care, for example drop in, Single Session Therapy (SST), peer engagement • More outreach capacity • Extended hours of access to centre-based services
Timely and appropriate assessment pathways	Undertake skilled, high-quality assessments promptly and efficiently, to facilitate timely referral and care escalation when required.	• Utilise models of care that prioritise engagement and focus on priority presenting needs of young people such as brief intervention and SST • Leverage digital assessment tools • Expanded, skilled clinical workforce, and clear and effective demand management strategies which reduce wait times to enable and effective assessment outcome
Multi-disciplinary, teams providing integrated support	Deliver coordinated clinical and non-clinical care (e.g. GPs, psychiatrists, psychologists, peer workers, youth workers) with mental health occasions of service delivered by salaried clinicians	• Employ GPs and psychiatrists in consultation/ liaison in each centre • Adopt flexible workforce models (e.g.: digital, shared workforce models) • Expand multidisciplinary teams including psychologists, mental health nurses, peer workers, IPS and alcohol and other drug workers

Areas of focus	Description of current headspace model	Enhanced model implementation*
Provide a mix of services tailored to local needs, including AOD, work and study, housing support, social and emotional wellbeing	Offer a flexible, needs-based menu of supports (e.g. AOD services, peer support, homelessness and housing support, social and emotional wellbeing, cultural support) tailored to each community's context.	• Employ more peer workers, youth workers, social and emotional wellbeing workers and other diverse roles
Culturally competent and safe service delivery	Ensure services are culturally responsive and safe, particularly for First Nations young people and other diverse populations.	• Employ staff from communities that reflect the community they serve, such as staff from diverse multicultural background and those from the LGBTQIA+ community • Increase culturally responsive care via service provider access to cultural supervision • Funding provided within centre budgets to provide culturally responsive services • Increase disability awareness and competence through training for all staff • Deliver regular training in neuroaffirming, gender-affirming, trauma-informed approaches to service delivery • Employ peer and/or professional workers with lived experience of disability.
Family-inclusive and family-specific services	Provide or link to services that include and support families, recognising their vital role in young people's mental health and wellbeing. Build mental health literacy and resilience among families and carers through education, support, and connection.	• Support family inclusion throughout the care pathway • Employ family peer workers • Facilitate recurring dedicated supports for families (e.g.: host group sessions) • Review/strengthen referrals to family services • Provide a walk-in support and information service or safe space for families after hours.
Measurement-based care	Routine monitoring of outcomes (e.g. functioning, symptoms) using consistent tools to guide care, evaluate progress, and inform improvement. Enable young people to access information about their care and outcomes.	• Increase use of, and understanding of measurement-based care tools • Strengthen use of assessment tools, particularly psychosis screeners • Continue to develop outcome measures focusing on outcomes that matter to young people and their families.
Service coordination, navigation and avoidance of duplication	Build strong links with local service providers, leveraging existing services and activities where available/ appropriate.	• Employ additional peer workers • Employ dedicated care navigators • Build capability in knowledge of local support services including NDIS supports • Further strengthen community relationships via outreach activities • Review/strengthen referral pathways.

*This is a non-exhaustive list which will require further development through consultation with the headspace network, led by headspace National Office.

Note on local adaptability

The existing headspace model allows for differentiated approaches across different locations, depending on local context, delivered through a consortium approach.

While delivery of a headspace centre requires adherence to a model integrity framework, the adaptation of the model to respond to local needs and priorities, available workforce, cultural safety and appropriateness and existing service infrastructure and networks is a key feature of success for existing centres and a future enhanced headspace model.

Case study of a headspace enhanced client

Alex (they/them), is a 14 year-old student in Year 9, who is having frequent panic attacks, feeling very anxious when leaving the house has stopped attending family events, basketball games and more recently attending school. They recently identified as non-binary and their friendship group at school were not supportive and had started bullying them both during the school day and online. Alex has become very withdrawn and is refusing to seek support.

Alex's mother reaches out online to eheadspace, and a clinician provides her with a connection to an enhanced headspace service that is near where they live. As Alex continues to refuse to engage with support, she makes an initial appointment which included a family peer worker to discuss options for engaging Alex. They provide her with resources about the service and conversation aids to talk to Alex about how they are feeling and encourage help-seeking. Alex subsequently indicates they are ready to see someone at the service but remains anxious about leaving the house, Alex is agreeable to attend a local community service where the enhanced headspace service has staff two days a week.

A mental health clinician and a peer worker from the enhanced headspace service meet Alex at the community service to have an initial conversation and provide them with an options including connection with a group run at the centre, to undertake a digital assessment in their own time that can help them work with Alex and their family to identify the best support options next time they met, and or continued sessions at the community service.

Alex was assessed as having moderate to severe anxiety, which had been exacerbated by the bullying. At the enhanced headspace Alex was able to access treatment for their anxiety, as well as peer support from the trans and gender diverse peer worker. The headspace enhanced team worked closely with the family through all stages. They also contacted the wellbeing office and leadership team at the school, who were unaware of the bullying that Alex had experienced. Together they developed a strategy and plan for how the school would ensure a safe and supported return and provide interim opportunities for Alex to remain engaged with learning through the transition back.

Two months later Alex has returned to school, continuing to manage anxiety with the support of the enhanced headspace including attending social connection and skills-based groups at the enhanced headspace service site and less frequent one to one sessions, some at the enhanced headspace site and some at the local community service. Alex and the family reported their increased confidence in navigating social and academic challenges.

7.1.4 Enablers

In addition to the key pillars to support the successful delivery of new/refined models of youth mental health care described in section 6, there are several specific enablers for an enhanced headspace service.

Funding and governance

Most of the key areas of focus for an enhanced headspace already exist in the current model but lack consistent, sufficient or sustainable funding which impacts delivery and centre operations. Further, the current funding and contracting arrangements can impact workforce sustainability, resulting in high turnover of staff therefore limiting the development of trusted relationship with young people, their continuity of care and overall service outcomes.

For a strengthened and expanded headspace model to have the capacity to deliver services, the core funding for a standard headspace centre needs to be increased substantially to enable services to:

- adopt a salaried model for staffing, with less reliance on private practitioners and MBS funding. This can be trialled with various incentive payments to encourage value-based health care (ensuring minimum service levels are met and outcomes achieved are what is expected)
- increase capacity to support more young people, greater complexity and improve integration and coordination with other services
- fund any costs associated with the transformation to an enhanced headspace service, including for digital enhancements and physical spaces.

This funding needs to be increased progressively over time to ensure funding responds to inflation, wage increases and career progression and professional development opportunities to support staff retention and satisfaction.

In addition, the governance and funding model for headspace is complex, involving multiple layers of accountability (headspace National, PHNs, lead agencies), which may affect centre-level decision-making and implementation of changes. Centres will need consistent leadership during the transition to an enhanced service and to enable integration, coordination and the strengthening of referral pathways.

Service stability in enhancing existing services

The consortium recommends no headspace services are recommissioned during the transition to the enhanced service model unless there are concerns regarding underperformance.

Workforce

Workforce development is critical, with a need to support recruitment, retention, and progression—particularly given the prevalence of early-career clinicians.

To deliver an enhanced model, headspace will need a workforce that is diverse, including from different cultures and identities, a mix of clinical and non-clinical staff (including a multidisciplinary team), and a range of levels of experience, from graduate roles through to experienced leaders and clinicians. The headspace network is widely viewed as an effective environment for the early career workforce to develop skills and gain experience in youth mental health service delivery. This is the case for many disciplines.

The headspace Early Career Program has capitalised on these perceptions and provides a formal, structured and supervised program to support student and graduate training and development. There is strong support for ongoing funding to provide a sustainable pipeline and continue support for the early career workforce.

Strategies to grow and retain experienced workers will also be important as services build their capacity to respond to young people with complex needs. Resourcing additional senior roles, including clinical educator roles, under the enhanced headspace model will help provide career pathways and incentives to remain in the youth mental health system.

Outreach/In-reach support

> "Important not to underestimate the value of proactive outreach for young people. Does not need to be clinical - can be focused on connecting with young people who won't or can't attend a centre but need to build trust and rapport. Centres can miss this cohort."
>
> **SECTOR STAKEHOLDER**

Consideration needs to be given to supporting young people who are not able to access a service in person due to geographic/transport challenges or on the phone or internet. Outreach via mobile units could be important to ensure these services are accessible in under-served areas and to young people who do not have the means/capabilities to present to a service.

> "One thing that really stood out to me was when therapists would send me follow-up resources after our sessions. It might seem like a small thing, but it made me feel like they genuinely cared and wanted to support me beyond just the time we spent talking."
>
> **YOUNG PERSON**

Partnerships and integration

Providing holistic and integrated care is particularly important when working with young people with complex needs and/or moderate to severe mental health needs. headspace services are designed to provide holistic care, and to work collaboratively with other service providers where appropriate.

This can be difficult under the current funding model; with minimal salaried positions, much of the work required for care coordination is unfunded. Additional resourcing to employ more staff is required to enable this.

Across the network, the coordination of care between headspace services and other local services (including GPs, state services and Aboriginal Community Controlled Health Services, private psychiatrists and psychologists) can vary. Some services have benefited from the investment under the National Mental Health and Suicide Prevention bilateral agreements and have strong partnerships with local tertiary services, while others have stronger relationships with other primary care services. Establishing strong links between headspace and other services – including the youth specialist service model (described below) – will be important for the enhanced headspace services.

Other tools that could support coordination and integration include:

- improved data exchange and interoperability, to facilitate information sharing across services
- investment in tools and products that support integration and coordination, such as assessment tools, telehealth rooms, online care plans across providers
- greater use of digital assessment tools (noting that at times face-to-face assessments with a clinician is more appropriate)
- greater coordination of care by tertiary services, through joint case review and care meetings, streamlined step up/down referral processes, or through colocation where feasible
- a directory of evidence-based services
- leveraging and further development of headspace's digital tools, such as the headspace account, particularly for care navigation.

Continuous improvement and knowledge sharing

Given the complex governance and operating environments for headspace services, the transition process to an enhanced headspace model needs to be informed by contemporary implementation science. This includes leveraging the experience and knowledge of headspace centres that are currently delivering on the areas of focus of an enhanced headspace model (via other funding streams and/or local partnerships). This could include creating resources and materials to share between headspace centres. It also includes capitalising on headspace National's experience and established mechanisms for establishing new services, introducing models and processes, and translating evidence into clinical practice.

Comprehensive monitoring, evaluation, research and continuous improvement will continue to be important as services transform to an enhanced model. Our consultations highlighted four areas for continuous improvement in the enhanced headspace model:

- Continue to ensure that the treatments provided are evidence based as far as possible and that this is measured.
- Providing culturally and identity safe services – while important for all services, this will be particularly relevant for enhanced headspace services as they work with young people with more complex needs. This can be affected by other symbols and practice, and the consultation process indicated that centres may face different challenges in improving cultural and identity safety across metropolitan, regional and remote areas. Urban services may require more intentional efforts, while more remote areas may need to consider young people's physical access needs.
- Providing disability-inclusive and ability-affirming services that understand the barriers people with disability already need to overcome to participate in society and proactively seeking to work with these young people and families in the community to better meet their needs and overcome barriers together.
- Strengthening ways to share information between young people and service providers – including ways young people provide feedback to service providers.

7.2 Youth specialist service

7.2.1 Rationale

Many young people experience a range of complex social and clinical needs that exceed the capacity of even an expanded headspace model. They require longer term case management and integrated care that addresses not only clinical aspects, but also functional and social recovery across education, employment, social participation, housing, physical health, and legal support. Currently, it is this group of young people who are most likely to fall through the gaps in the system as they are often seen as too complex for primary care services or not unwell enough to enter the state tertiary system.

Current federal programs like the Early Psychosis Youth Service (EPYS) and Youth Enhanced Service (YES) partially address this 'missing middle,' but their scope is limited – either by diagnosis, resources, or geographic coverage. In the case of the latter there is also no requirement to provide support against a developed model of care[52].

As a result, many young people across Australia remain without access to appropriate specialist care. Introducing specialist multidisciplinary clinical and social care expertise earlier – via timely and targeted assessments – can better guide care decisions.

> "Theres a big issue in the 'missing middle' in that there are a lot of services for 'low' needs (not exactly low, but low in this context) such as depression and anxiety, and services for severe needs, such as active psychosis, but for those with intermediate needs like myself, there aren't many appropriate services. For example, I really need a psychologist, psychiatrist, and GP to be linked, preferably in the same service, however I am unable to access this. headspace sees me as too "high needs", while I am too "low needs" to be accepted into other services."
>
> **YOUNG PERSON**

There is a clear and urgent need for new Youth Specialist Services that:

- provide multidisciplinary, holistic care for young people with severe and complex clinical, social and functional needs across a range of diagnoses
- include access to psychiatrists, clinical staff, and psychosocial supports such as housing, vocational, and legal assistance
- offer evidence-based care streams, including continued investment in early psychosis, while remaining flexible to support young people with uncertain or evolving presentations
- provide back up to other services such as headspace centres, other primary care options such as GPs and Better Access providers, and enhanced headspace services.

> "I would argue that the biggest distinction (between the specialist service and other options such as headspace or enhanced headspace) would be the ability to provide complex and assertive case management."
>
> **SECTOR STAKEHOLDER**

What young people told us (batyr youth co-advisors and consultations)

Young people identified a clear gap in the current system for those whose mental health needs are perceived as too complex for primary care but do not meet the threshold for tertiary services. Many described this "missing middle" as a place of inaction, where they felt dismissed, unseen or left waiting until their mental health worsened so they could qualify for specialist support. This lack of appropriate support leads to desperation and poorer mental health outcomes. Participants also highlighted the emotional toll of needing to pursue a diagnosis to access care, with some sharing they felt pressure to present as more unwell than they were to be taken seriously and be referred to services.

There was a strong support for specialist services that were accessible, trauma-informed and equipped to provide tailored support to young people with complex or intersecting needs, including neurodivergent youth and those in out-of-home care. Affordability was repeatedly raised as a barrier, with young people describing how even initial steps like seeing a GP for a mental health care plan were often financially out of reach. This was particularly pronounced for those seeking specialised or trauma-informed clinicians, where options were limited and too costly for young people or their families. Participants called for a model that reduces financial barriers, supports access to specialist diagnosis where needed and doesn't rely on strict diagnostic criteria.

Young people also expressed a desire for care that extends beyond clinical sessions. They spoke positively about services that provided social and peer-based supports, emphasising that holistic and integrated models helped them apply therapeutic tools in daily life and foster connection. Participants valued services that recognised the broader factors influencing mental health, such as the social determinants of health, and embedded peer activities, group sessions and everyday support alongside clinical care. Young people advocated for youth to have a voice in shaping the design and delivery of these services.

7.2.2 Who will it support and how will it be accessed

The specialist service would be designed to support youth whose needs go beyond what an expanded headspace model, Better Access or a multidisciplinary General Practice clinic can provide. Eligibility for the specialist service would be determined by the need for more expert and intensive, and typically longer term, care. Access would also be prioritised for young people who are evidently at significant risk of long-term mental health impacts and/or long term social and functional impacts of untreated mental ill-health.

This may be due to any of the following:

- Complexity and severity of specific or cooccurring specialist mental health disorders (e.g. complex mood disorders, personality disorders, eating disorders, psychosis, post-traumatic stress disorder, substance use disorder).
- Co-morbidities (e.g. neurodiversity, addiction, physical health issues).
- Challenges around social determinants (e.g. housing, employment status, family or domestic violence, involvement with policy and criminal justice system, poverty and disadvantage). For example, a specialist service would be well placed to support young people who have had contact with youth justice community settings or in out of home care, due to the increased likelihood of mental ill-health, barriers to accessing care, and additional contextual complexity.
- The content and structure would be determined by the best available evidence regarding interventions for specific mental health conditions, clinical practice guidelines, models of community mental health care for young people and flexibility influenced by local geography or cultural needs.

The specialist service would accept referrals from a range of different contexts, including headspace, enhanced headspace, GPs, schools, youth justice providers, family and community services (including out of home care), homelessness services, family violence services, CAMHS and emergency departments.

7.2.3 Areas of focus

Component	Description*
Early detection and assessment	• Prioritise young people from referral pathways including justice, child protection and homelessness services. • Deliver diagnostic and functional assessments across clinical, neurological, social, educational, vocational, and physical domains (supported by digital assessments where appropriate). • Remain in communication with primary care team either in headspace, enhanced headspace or GPs and other referrers. • Evaluate level and type of care to be provided (e.g. assessment and care planning only, secondary consultation and advice to existing care team, episodic or ongoing care).
Access to specialist psychiatry	• Ensure young people have timely, sustained and regular access to psychiatrists for diagnosis, formulation, risk assessment, overall management, including but not limited to, medication management. • Access to specialist care streams for specific mental health conditions e.g. eating disorders, mood disorders, personality disorders, early psychosis, PTSD, and substance use disorders.
Physical health care and other needs	• Coordinated medical screening and psychiatric assessment • Management for medications and any physical health issues • Metabolic monitoring • Partnerships with local GPs to facilitate smooth referrals and shared care • Referral pathways for hospital-based psychiatric and medical care should also be established when required.

Component	Description*
Integrated psychosocial and functional support	• Include psychosocial supports (e.g. education, employment, housing) alongside clinical care This should be delivered and supported by a multidisciplinary workforce of occupational therapists, social workers, vocational workers, speech therapists, dieticians, peer workers, etc..
Enhanced outreach	• Outreach to a non-clinical location where the young person feels comfortable such as other services they are already engaged with, e.g. community spaces, shopping centres, or home environments. This would be supported by a team (including peer workers and/or cultural workers) with the capacity to outreach and engage with a view to connecting young people to the service (including out of regular business hours). Clinical care would only be provided in appropriate settings such as services and home environments. • Proactive and continuous education of the local community and primary care providers regarding the early signs of potentially serious mental illness such as early psychosis or anorexia nervosa.
Family, carer, and supporter engagement*	• Provide structured support, education, and engagement opportunities for families and carers, recognising their central role in supporting recovery and the providers of key information regarding history and response to previous treatment approaches. • Provide structured family assessment and intervention; family peer support programs, family group counselling and/or family therapy. • Provide structured support, education, and engagement opportunities for siblings, recognising their role in the young person's life and their increased risk of vicarious trauma and poor mental health outcomes.
Centring of young people and their families in the design and delivery of services	Design and refine the service in partnership with young people to ensure it meets their needs and preferences, embedding lived experience in governance and delivery. This would include young people from priority populations. The youth and family peer workforce would be embedded in this model with their role including: • support with service engagement • service navigation • providing instruction, skill development and mentoring • emotional support, such as understanding, validating and providing hope • providing information/education • advocating for the needs of the young person they are engaging with.

*Note: The model will also recognise and provide for young people where family engagement (particularly biological family and/or statutory carers) is not appropriate.

These include young people experiencing homelessness who are presenting for support unaccompanied and young people in child protection or family violence situations.

> "I wished there was more emphasis on how to get help for young people who did not have supportive family and that being their main reason of holding back."
>
> **YOUNG PERSON**

Component	Description*
Multidisciplinary, needs-based and ongoing care and coordination	• Flexible, evidence-based care streams including clinical treatment, case management, and psychosocial support based on assessed need. • Trauma-informed and capable services so that experiences of trauma are responded to within the service. • Provide secure long-term tenure of care, with the ability to refer to and coordinate with other services as needed, and for the young people to be referred back to the service if they experience a relapse in recovery. • Develop a collaborative management plan in collaboration with the young person and, where appropriate, their parents, carers/guardians and develop team-based care arrangement (e.g. inclusive of existing or community-based teams, or within specialist centres). • Case management coordinating access to a range of treatments that can be provided across different mental health presentations or syndromes, and occasions where more specialised care may be required.
Embedded and partnered service delivery	• Deliver key support internally while forming strong partnerships with external services (e.g. housing, legal aid and community legal centres, education, family violence, justice, translation services) to ensure coordinated, wrap-around care.
Empowerment of young people	• Empower young people to put in place structures that they need to support them when they step back / move from the specialist end of the spectrum. • Ensure young people are provided with options for their care and have support persons (whether connected to the service or a related service) available to walk alongside them while they transition out of care and into the community if they would like a point of contact. • Occasionally check in with the young person to see how things are going and provide support to access options if they have not been able to self-initiate.

*This is a non-exhaustive list and further work on designing and implementing the Youth Specialist Services needs to include key stakeholders, including (but not limited to) the Department of Health, Disability and Ageing, Orygen National Programs team, the EPYS Medical Directors, headspace National Office.

Case study of a youth specialist service client

Emily (she/her) is a 22-year-old woman who was referred to the Youth Specialist Service by a social worker from a women's refuge in a state of agitation and risk of self-harm.

Emily has a complex psychosocial history marked by significant trauma from adolescence, she experienced family estrangement and a series of harmful relationships since. Her situation has been further complicated by substance use. She had on multiple occasions presented to the Emergency Department in a state of high distress but was not assessed as acute enough to be admitted into a mental health bed.

The Youth Specialist Service outreach team engaged Emily at the refuge where she was staying. At the time of engagement, she lacked identification documents, a bank account, and access to income support. She was effectively homeless, relying on unstable and high-risk living arrangements.

The team worked with Emily and her homelessness and housing support service to obtain necessary documentation and establish financial support through Centrelink. The team also undertook a diagnostic and functional assessments to develop a coordinated care plan.

With comprehensive and sustained specialised care appropriate for her mental health diagnosis, Emily has significantly reduced her substance use and adheres to her treatment plan.

She has made meaningful progress across several domains of her life. With vocational assistance, she is commencing full-time employment in retail and is preparing to transition into private rental accommodation. The Youth Specialist Service team remain connected but have begun a process of sharing the support with a GP clinic near where she is now living which also offers integrated care, including drug and alcohol support. However, at any point where Emily's mental health deteriorates, she can reengage fully with the Youth Specialist Service.

Although Emily continues to manage the complexities of her diagnosis and trauma history, her recovery journey demonstrates the effectiveness of coordinated, trauma-informed, and youth-focused care. Over 18 months the Youth Specialist Team has been instrumental in supporting her toward greater safety, stability, and independence.

7.2.4 Enablers

In addition to the key pillars to support the successful delivery of new/refined models of youth mental health care described in section 6, there are several specific enablers for a youth specialist service.

Flexible and adaptable service structure and delivery model

The specialist service must be underpinned by a set of core evidence-based components and a robust governance framework across the country. Flexibility should allow for:

- local adaptation to reflect regional needs, demographics, and existing service landscapes
- service responsiveness, innovation, and local design
- delivery by a range of providers—including NGOs, state-based services, and private providers—depending on what best meets the needs of each region.

Commissioning should ensure that the model of care is:

- standardised with adherence to fidelity
- incentivised to support collaboration, vertical integration and shared outcomes with consideration in the initial planning and implementation phases given to the viability of some Youth Specialist Services and enhanced headspace services operating effectively under an integrated governance and shared accountability model.

However, decisions about delivery models and providers should include a centralised process overseen by the Department of Health, Disability and Ageing (building on bilateral agreements between the Australian and state and territory governments), informed by local context and lessons learned from existing services.

> "Being on a youth specific ward made a massive difference to my care. The care was age appropriate and the staff were incredibly caring. The therapists where incredibly knowledgeable and we had to participate in groups from 9:30-3 every week day, which helped provide structure and education."
>
> **YOUNG PERSON**

> We would be very supportive of a model which operates similarly to the way that headspace National does currently with a central model development, support function and assessment of fidelity, but the feedback that we have been given has placed a strong emphasis on local operations and one organisation can't do this nationally.

SECTOR STAKEHOLDER

Equity of access

The youth specialist service needs to be designed to ensure equitable access. This will require a flexible, mixed-model approach to service delivery such as:

- **Pop-up or satellite spokes** that extend the reach of central hubs into smaller or less-resourced communities.
- **Telehealth services** to provide clinical and psychosocial support virtually, overcoming barriers related to distance, disability and workforce shortages.
- **Digital platforms** that offer information, peer connection, early intervention tools, and self-guided support.

In addition to these infrastructure elements, flexible outreach must be embedded as a core component. Services should have the resources and requirements to physically meet young people where they are – whether that's in their home, school, community setting, or elsewhere – and to safely transport them to and from care when needed. This is particularly critical for young people experiencing instability, isolation, or disengagement, who are often least able to seek out support on their own.

Integration with existing systems and supports

Strong integration is essential to ensure that the Youth Specialist Services do not have the unintended consequence of adding to service duplication and fragmentation and contributing to workforce issues with consideration given to:

- headspace centres
- expanded headspace services
- General Practitioners and private clinicians
- state and territory services (including hospital and community care), and
- social, educational, and family systems

Integration mechanisms may include shared workforce arrangements, joint appointments, case conferencing, and co-location. In the overall design and implementation of the model nationally it will be important for key government and national youth mental health organisations with clinical expertise such as Orygen and headspace National, to work together. Addressing issues of duplication can be progressed by aligning all the age ranges and levels of care from the Commonwealth and State funded services.

Adaptation of the service model at a regional level should be a shared responsibility between headspace enhanced services, the specialist service provider and tertiary services to ensure integration across the three services collectively.

> Have the facility to work in partnership with other agencies e.g. NDIS, other care organisations for young people with disability including intellectual disability.

SECTOR STAKEHOLDER

At a clinical level, integration should also enable flexible movement between specialist, tertiary and enhanced primary care levels through 'grey space' boundaries. This supports young people and families to make informed choices and ensures care transitions are smooth, person-led, and recovery-oriented.

To strengthen data integration and referral pathways between headspace, enhanced headspace and the youth specialist service, there might be an opportunity to leverage and strengthen the existing hAPI digital platforms for use by the two services and use common digital tools for assessment such as the IAR-DST.

Workforce

The Youth Specialist Services will require a substantial team with a breadth of professions, qualifications, skills and expertise to deliver the intensive multidisciplinary clinical, psychosocial and specialised support described in the model.

These would include psychiatrists, GPs, psychologists, occupational therapists, nurses, peer workers, social and youth workers, family counsellors, Social and Emotional Wellbeing Workers as well as a range of administration, operational and leadership roles.

Sustained investment is essential to attract, train, and retain a multidisciplinary specialist level mental health workforce. Key strategies include:

- training youth specific clinicians of all disciplines in the special skills required to work in youth mental health care
- incentivising the transition from private to public practice
- support for clinical placements and early career pathways
- enhancing supervision and training pathways (including those from priority populations)
- partnering with states and territories to grow and share across systems, both specialist and emerging workforces.

> "It is worth noting that the young people who many benefit from this service are likely to be experiencing a lot of confusion and distress – they have probably had many diagnoses, seen different professionals, may be disconnecting with peers. It is vital that there is a lived experience / peer workforce component to the service, that can help the young person navigate this confusion and distress and maintain hope and optimism."
>
> **SECTOR STAKEHOLDER**

In addition, the workforce must be supported to provide non-clinical care and develop a strong understanding of the social and structural factors that shape mental health needs. This includes:

- a strong youth and family lived experience workforce which includes leadership roles, supervision structures and training pathways
- capabilities and understanding required to provide neuro-affirming, gender-affirming and ability-affirming approaches to care
- recognising, diversifying, and further developing psychosocial skillsets across the sector

- a trauma-skilled workforce and service approach, noting work undertaken by Transforming Trauma Together[53] which includes a complete model for tackling trauma at scale, from trauma informed practice to therapeutic care.

> "As it is now clear that complex developmental trauma is the main driver of severity of comorbidity and severity of disorders, both physical and mental, the services must be designed to have the assessment of the effects of trauma and the actual specific treatments of the trauma at its core, as trauma informed care is not enough."
>
> **SECTOR STAKEHOLDER**

As the multidisciplinary workforce continues to grow, it is critical to regularly review roles and responsibilities to ensure that young people's clinical and social needs are being met by the right professionals, working within the scope of their roles. This will help maximise the effectiveness and value of a truly collaborative care team.

Learning and evidence / data driven

Building on the pillar for learning and data/ evidence driven models of care, the youth specialist service will need to embed innovation and scientific research and engage with clinical quality registers, clinical trial capacity and connecting into an enhanced national data system.

7.3 Community-based youth wellbeing hubs

7.3.1 Rationale

Sector stakeholders, young people, families and First Nations organisations highlighted the need for complementary models of support for young people that focused on wellbeing, holistic supports and community and cultural needs and appropriateness. This was particularly important for young people for whom mainstream, traditional clinical or primary care models are not appropriate and responds to the need for increased soft entry models specific to priority populations and communities.

These services were seen to be more appropriate and accessible for: rural and remote communities (where clinical workforces are limited or non-existent); Aboriginal and/ or Torres Strait Islander communities; some multicultural communities and other young people who needed a softer, non-clinical entry into wellbeing supports and later supported links into more intensive mental health care if needed. However, this should not mean we exclude metro and more populated areas.

Globally there is evidence for these 'community powered' models of care, including the Friendship Bench[54], headspace Denmark[55] and the mental health cafes in Gippsland.[56]

> "Engaging in activities that bring joy and relaxation, such as exercise, hobbies, or spending time in nature, can help improve mental well-being."
>
> FIRST NATIONS YOUNG PERSON

What young people told us (batyr youth co-advisors and consultations)

Young people consistently advocated for local, community-led spaces that support wellbeing through connection, culture, and early intervention. There was strong support for drop-in hubs grounded in community as familiar places that are open to everyone regardless of where they are in their mental health journey. They supported models that reduce formality and remove unnecessary thresholds for care, allowing for support to begin through everyday connection - whether that's a conversation with a peer worker, a chat with a youth worker, or an encounter with a community elder.

These kinds of entry points were especially important for First Nations youth and those from culturally and linguistically diverse backgrounds, who often experienced traditional services as impersonal or mistrustful. Several participants described a stronger sense of comfort and autonomy in settings shaped by community values, cultural practices, and personal relationships.

There was a clear expectation that youth wellbeing hubs should respond to the full context of a young person's life, including housing, food security, financial stress, and social connection. Young people valued practical support alongside mental health care, and highlighted the importance of services that are flexible, non-judgmental, and community driven. They spoke positively about drop-in spaces, activity-based programs, and support that doesn't require a diagnosis or formal referral. Community-led approaches, including those grounded in cultural practices such as yarning and healing on Country, were consistently identified as more effective and meaningful than standardised models.

Young people also noted that it was important for these services to be funded and evaluated to show their impact. They pointed out that lived experience and peer knowledge are often overlooked, even when young people clearly identify certain services as helpful. They called for more weight to be given to community feedback and frontline insight in shaping and sustaining what works. For many, the idea of a youth wellbeing hub was not only about receiving support, but also about having a place to connect, learn, and be part of something that strengthens mental wellbeing in everyday life.

7.3.2 Who will it support and how will it be accessed

While the focus is on wellbeing, this is not a purely prevention service and the young people who will most benefit from this model (including as an entry point into further mental health supports) will be those who have significant personal, social, economic and geographic barriers to accessing care through GPs, allied health professionals, headspace, enhance headspace services or specialist services.

This model supports all young people who are experiencing challenges with their wellbeing with a safe place to seek support. It is not designed to provide clinical mental health interventions or more intensive social support within the service, but to identify where mental health services (like headspace, enhanced headspace or specialist services) or other psychosocial or vocational supports should be engaged.

Case study: youth wellbeing hubs

Jamal (he/him) is a 17-year-old whose family migrated to Australia through a humanitarian refugee intake program 12 years ago. Jamal has been experiencing emotional difficulties, feeling sad a lot of the time. However, given his parents experiences of war and trauma he doesn't think they would understand, or should be burdened by his problems, and so he doesn't bring it up. Instead, he begins spending more time away from home and channelling some of his negative thoughts into risk-taking behaviours with a peer group.

He lives in a multicultural and diverse suburb and a local youth wellbeing hub has been set up to provide a safe place for young people from different cultural backgrounds to connect, engage in games and activities, access information about various other supports. Someone from the hub recently came to Jamal's school and provided some information so he dropped in one evening to find out more.

There he was greeted by a peer worker and they had a chat. The peer worker gave Jamal some more information on what was happening at the hub each week. On Thursday nights Jamal began attending a young men's session run by a respected member of the community with training in mental health. Jamal began to feel comfortable to open up about his feelings of sadness, and the peer worker suggested that they could reach out to the local headspace service to see if someone would be happy to come out to the wellbeing hub to connect with Jamal. Meanwhile, the community mentor also offered to connect with Jamal's parents too and support conversations with them so that they were aware of how Jamal was feeling and how they could also support him.

Jamal, through the engagement in the activities at the hub and the conversations he was now able to have at home with his family, began to feel less sad. He also knows of the supports available through headspace and other services now if he needs them.

7.3.3 Areas of focus

Component Area	Description
Holistic, non-clinical foundation	• Focus on wellbeing, broader health needs (including sexual health) and holistic, non-clinical support. • Family, carer, and mob involvement in a young person's journey. Options for individual and family group support. • Emphasises prevention and help-seeking in a safe, youth-friendly and family inclusive environment.
Peer and community powered	• Peer mentors and community connectors and mentors reflective of local diversity are the core workforce. They then connect to clinical supports and education providers.
Accessible and flexible entry	• No referral required, free of charge, open after business hours, not time limited. • Flexible, young person-led engagement.
Needs-based, not diagnosis-driven	• Focus on identifying needs and goals without requiring a clinical diagnosis.
Diverse support services	• Low-intensity/general counselling, group work, family support, sport, social and nature-based activities, creative programs (e.g. art therapy).
Digital and peer navigation tools	• Peer and/or digital support to help navigate services, provide connection and support after hours. • Integration with digital tools for self-help and wellbeing, and options for digital psychosocial support offerings to be nationally developed (for consistency and value for money in ensuring quality and cybersecurity) but able to be syndicated and white-labelled to local face to face providers and services.
Practical and everyday supports	• Access to food, internet/Wi-Fi, and a welcoming physical environment with sensory safe areas. Spaces are available for group work by visiting services.
Vocational and functional recovery	• Support with employment, training, and education. Links to mental health nurses, OTs, and recovery-focused professionals.
Referral pathways and embedded in community infrastructure	• Clear referral processes. Promotes awareness of other services. Technology systems are interoperable with national frameworks. • Strong links with GPs, schools, clinical mental health, AOD, housing services, and cultural/community orgs. Co-location in existing, accessible public spaces.
Value for money to enable greatest reach and service access	• Examination of commissioning and implementation models should consider and test investments against a framework for what investment mechanisms will achieve the greatest possible access for young people with the greatest needs and ensure efficiency around overhead and capital costs.

7.3.4 Enablers

In addition to the key pillars to support the successful delivery of new/refined models of youth mental health care described in section 5, there are several specific enablers for a youth wellbeing hub model.

Community co-design

Community youth wellbeing hubs will require genuine co-design processes delivered by skilled people, and that can build trust with communities. These hubs need to be built from community. Funding arrangements and contracting must be appropriate, include longevity, and have funds built in for genuine codesign, relationship building, and learning.

Community partnerships for delivery

Community led approaches that enable the community to deliver for each other, rather than delivery being imposed, and encourage innovation of solutions. Establishing a local community partnership allows a collective of organisations and community leaders to collaborate on the direction, design, and delivery of these wellbeing hubs.

The model could include a lead agency—such as a local council, community health centre, youth service organisation or Aboriginal Community Controlled Organisation (ACCO)—which holds formal Memorandums of Understanding (MOUs) with key partner organisations. Importantly, governance and partnership coordination roles need to be explicitly funded to avoid reliance on in-kind contributions or goodwill alone. These arrangements need to be well-structured, supported, and sustainable over time.

Workforce

Workforce design should be locally determined to reflect the specific needs, values, and cultural context of each community. Provision mapping of several types of these services identified a range of key roles that may be required, including a Youth Service Manager or coordinator to provide operational leadership; a peer workforce supported by dedicated peer work supervisors; cultural leaders and youth workers who can provide initial engagement, culturally safe care and low-intensity case support.

While the focus is non-clinical, clinical backup must be available for secondary consultation and advice. Direct clinical care is not delivered through the hub, but through linkages and coordination with local youth mental health services when a young person is willing and ready to engage.

Care coordination and Social and Emotional Wellbeing roles for Aboriginal and/or Torres Strait Islander young people should be embedded where appropriate, with the flexibility and resources to respond to individual needs in a timely manner. These roles must be grounded in local knowledge and support systems to be effective and trusted.

Training and professional development must be culturally relevant and community-based, with active involvement from community leaders. Upskilling should be funded and offered regularly, ensuring that a lay or community-based workforce is well-equipped and confident to support young people.

Data systems

This model would need a different approach to data collection, given that engagement in a community space might look very different to other settings (e.g. headspace centres).

A young person telling their story to a youth worker might look very different, and much less clinical, than a psychologist's intake form. As with all proposed models, it will be particularly important that young people be able to own their own data and choose who it is share with (particularly given concerns heard in consultations around the need for data sovereignty).

There is also a need for a coordinated evaluation framework for these models. While they will be highly adaptable to local context with variable service structures and staffing profiles, a common agreed set of key outcome measures, particularly those that are known to be protective factors of wellbeing (such as school engagement, social inclusion and connection, healthy behaviours and diets, good self-esteem), will be needed to build the evidence-base and confidence in the models overall efficacy and efficiency.

7.4 Scope, assessment and referral pathways across models

Each model must have a clear purpose and defined role so that young people and families understand what support is available, who it is for, and what to expect at each stage of care and connect to existing service offerings such as headspace centres and state/territory tertiary service. Clarity about who each service is designed to help - and how pathways link them into a joined-up system - is essential for a positive experience and better outcomes. This clarity provides the basis for consistent **commissioning, funding** and **regional planning**, described in the following sections, to ensure these models work together as an integrated youth mental health system in practice.

While acknowledging there is some overlap between scope of each model as shown in the system diagram on page 54, this can be beneficial in:

- enabling seamless transition points
- providing shared care between services,
- addressing current issues of regarding use of eligibility criteria
- providing choice for young people of preferred service where appropriate.

In addition, the overlap represents that no single service model will be able to fully meet the needs of all young people with more serious and complex mental health issues in a particular geographic area. Instead, in some areas a youth specialist service and enhanced headspace services will be needed to provide population coverage.

The table below aims to show the high-level scope and pathways between each and with existing headspace and tertiary care services.

Again, the IAR-DST is included as an example of a tool that could be used to identify eligibility for different services, noting that in practice the IAR-DST forms a guide for recommending level of care for individuals, whilst being subject to clinical judgement, it currently has versions developed for child and adolescent and adult, but no youth specific tool is available, and there may be more appropriate shared assessment and screening tools that could be developed.

Where possible consistent operational guidance should define how referrals and step-up and step-down occurs, ensuring young people are both assessed for the most appropriate type of service, move smoothly between services as their assessed needs change.

Integrated governance - including shared IT, workforce support, training and communication – could help deliver a seamless experience. Regardless of whether the services are provided through a shared governance arrangement or by separate organisations referrals should be supported through a shared assessment and triage approach.

	Youth Wellbeing Hub	**Headspace**	**Enhanced headspace**	**Youth Specialist services**	**Tertiary care**
Scope	Mental health promotion, prevention, early identification and connection to supports.	Prevention and early intervention for young people with mild-moderate mental health issues.	Early intervention support and psychosocial support for moderate-to complex mental health, physical health and AOD presentations.	Longer term care and enduring support, with clinical diagnosis specialisation for more severe conditions and intensive case management for psychosocial needs.	Residential step-up step down, acute inpatient and outpatient care for acute mental health presentations.
Assessment level (IAR-DST)	**Level 1**	**Levels 2 and 3**	**Levels 2, 3 and some Level 4**	**Level 4**	**Level 5**
Entry and referral	No referral needed Connection into other supports such as GPs, school wellbeing, online self-directed support and headspace/ enhanced headspaces.	No referral needed Provides a warm entry point for young people connected via the youth wellbeing hubs, schools, local GPs.	No referral needed A warm entry point for all young people, Can support greater complexity and severity of mental ill-health but would connect a young person to the Youth Specialist Services where specific clinical presentations would be better addressed and longer-term case management required.	Referral required Accept referrals e.g. from GPs, homelessness services, police, EDs, headspaces and enhanced headspaces, could share care with referring provider particularly at points of transition in and out of service. Would refer step-up to tertiary services for acuity requiring inpatient, residential, and some outpatient care.	Referral required Accepts referrals from youth specialist services (as well as current referral points) Can utilise Youth Specialist Services as a step-down option.

8. Other models for further consideration

Several other important models of youth mental health care were discussed through consultations and the evidence review for this project. Three are presented here for further consideration and development.

8.1 Education based

The importance of schools in models of youth mental health care was widely acknowledged. This included a recognition of:

- The role of schools and school staff in preventing mental ill-health through wellbeing initiatives, respectful relationships programs, anti-bullying programs, educational and vocational supports for young people at risk of leaving school early.
- A requirement that all schools at a minimum should offer evidence-based interventions that have been shown to improve mental health in education settings.
- The role of teachers, other school staff and students in early identification of students who may be struggling with mental health concerns and supporting them to access help, resources and education.
- The role of schools as a connection point with families, carers and supporters, to access information and local support for a young person experiencing mental health issues.
- The positioning of schools as an 'integrated service platform' for mental health workers, psychologists, occupational therapists and clinical providers to support early access to new youth mental health care through either outreach or in-reach models, particularly in rural areas.
- Employment of dedicated health and mental health trained staff working in schools to support students experiencing mental health challenges and connect to the community service system to provide referrals and pathways to care.
- Engaging in collaborative efforts between the school and health sectors, guided by evidence-based practices, will be critical in ensuring sustainable and impactful outcomes for young people and their communities.

What young people told us (batyr youth co-advisors and consultations)

Young people recognised the central role that schools play in shaping mental health outcomes, given how much time is spent in those environments.

They saw value in schools helping to connect students with community-based supports but were clear that teachers cannot be expected to take on this role alone. Participants advocated for dedicated roles within schools that act as bridges to the community, helping students find belonging, support, and role models.

There was a strong view that any expansion of mental health initiatives in education must avoid adding pressure to already stretched school systems.

Consultations with stakeholders also highlighted the increasing burden on schools and teachers to become experts and providers of broader health and social supports (in addition to their role as educators).

> "I work as a school counsellor in a secondary school. I have a full case load with a lot of demand for on-the-spot crisis management. With minimal free counselling services available in the area for families from low socio-economic background or the means of transport to get to these services, a lot of the work falls on to us."

SUPPORTER, EDUCATION SECTOR

> "The need for trained counsellors in schools has never been greater. In too many cases, school welfare officers are unqualified or out of their depth, leading to poor identification of mental health issues and a lack of proper referrals."

PARENT/CARER/SUPPORTER

However, several examples provided through consultation highlight the important and impactful role that schools have in the broader youth mental health model. Below are a couple of examples.

Doctors in Secondary Schools (DiSS)

Through the Doctors in Secondary Schools (DiSS) program students at 100 Victorian government secondary schools can access consultations with a General Practitioner (GP) or Practice Nurse (PN).[57] The aim of the program is to lower barriers to primary health and enable earlier identification of health problems. There are no out-of-pocket fees for the service.

The program is implemented through PHNs in partnership with local medical centres, GPs and PNs, and the program lead within the school. Participating schools have dedicated consultation facilities. If there is a vacancy in the program schools have access to a telehealth service.

An early study of the program in a rural school found that it provided a responsive needs-based service and that 'no-shows' for appointments were low. Appointment times were longer compared with average GP appointments.[58] Published highlights from a program evaluation commissioned from ACIL Allen found that the program improved student health literacy and system navigation.[59]

The Victorian Government is extending the range of health professionals available in schools through the Mental Health Practitioners (MHPs) in secondary and specialist schools program.[60] The aim of the program is to (i) enhance mental health promotion and prevention, (ii) provide early intervention support, (iii) coordinate support for students with complex needs.

Through the program schools can employ AHPRA registered occupational therapists, psychologists, mental health nurses, social workers (with AASW membership) and prescribed classes of counsellor. Schools are funded (based on student enrolment), and supported by an area coordinator, to employ a mental health practitioner.

Similar approaches are implemented in schools in other states and territories (including but not limited to New South Wales and Queensland).

Be You

Be You is a national mental health in education initiative funded by the Australian Government and led by Beyond Blue in partnership with headspace and Early Childhood Australia. The Be You program has integrated a range of existing school-based programs into a single program. Be You provides programs and resources, implementation tools and a range of fact sheets. These are designed for early learning services, primary and secondary schools. Resources have also been developed for use in relevant VET courses.

The Be You program covers a range of topics to support student wellbeing. These include child and adolescent development, grief and trauma, mental health, social and emotional learning and communication and relationships. Wellbeing toolkits are available for students, educators and leaders. These toolkits include links to online resources.

The Be You program was evaluated in in 2021-2023 by the Australian Council for Educational Research.[61] The evaluation focus was on implementation, workforce and user experiences. The evaluation found that the program is evolving in response to need and identified opportunities to further improve the program.

8.2 Prevention and promotion

Australia's mental health system is already stretched and many young people are not currently accessing the support they need. As discussed earlier in this advice, young people face a complex array of barriers to help-seeking including distance, availability, cost and stigma. Therefore, it is both for young peoples' mental health and the health of the system, that mental health promotion and prevention be elevated as a reform priority.

Prevention was seen by many stakeholders involved in this project as an area that had less attention and investment yet could play a significant role in keeping young people well, responding early to risk and/or symptoms and in recovery from mental illness or episodes of mental ill-health. This includes recognition of prevention as requiring a population-level approach led by education, youth affairs, and community sectors—not solely the health system, along with targeted and indicated approaches to young people at greater risk.

What young people told us {batyr youth co-advisors and consultations)

Prevention was seen as essential but often deprioritised when funding is tight. Young people stressed that investment in prevention should be ongoing, not reactive or one-off. They expressed frustration that system responses often focus on treatment without addressing the social and structural factors driving distress. Several participants emphasised the need for continued consultation and long-term commitment to initiatives that address root causes, not just symptoms. Without this, the system risks continuing to fall short of what young people need.

> "Adolescence / young adulthood (as well as earlier) is a prime opportunity to establish / consolidate lifelong wellbeing, including into the next generation."

SECTOR STAKEHOLDER

While there are many examples of programs and initiatives that focus on prevention, including those that build mental health literacy, resilience, help-seeking skills and community/social/vocational connections, stakeholders consulted for this project described key elements of a comprehensive, multi-layered approach to prevent mental ill-health and promote wellbeing among young people across policy, place-based initiatives and digital solutions.

8.2.1 Nationally

> "We need to educate, inspire and motivate young people to learn how to support positive mental health practices into their everyday - and from a young age. Just like we have with learning that brushing our teeth is essential everyday - through to being sunsmart - these health behaviours have been taught. We need to apply the same approach to mental health... Why wouldn't we have a national approach to this?"

SECTOR STAKEHOLDER

To really create systemic, sustainable change there is a need to embed prevention and mental health promotion in national strategies and intergovernmental action. This would require a plan for all governments to commit to actions and targets that:

- Reduce childhood maltreatment
- Promote education and self-management strategies
- Are inclusive of priority population responses
- Address risk factors and the social determinants of mental health across individual and societal levels, this includes recognition of the new drivers of youth mental ill-health such as climate change, social media, intergenerational inequity, future job market concerns and housing unaffordability
- Coordinate efforts across health, education, and community sectors
- Align policy and data efforts with existing frameworks such as the ARACY Nest Wellbeing Framework and the Child and Youth Wellbeing Atlas, supporting data-informed planning at a local level.

8.2.2 **Regionally**

There is a need for regionally coordinated efforts focused on improving and sustaining the mental health of young people.

To deliver this, PHNs could be resourced to lead community-based youth mental health promotion and prevention partnerships, enabling a region-wide approach to understanding need and addressing social determinants of health that contribute to well-being e.g. education, employment, safe secure housing.

This would be strengthened through:

- Youth-codesign and engagement
- Connecting with ARACY's the Nest to support regional efforts to plan, deliver and evaluate youth mental health promotion strategies in an evidence-based, developmentally appropriate way that accesses and amplifies existing resources.
- Sharing the learning and data from projects like the Right Place, Right Time (youth mental health systems modelling) led by the Brain and Mind Centre to help inform design and delivery of region-wide MHPP activities.

8.2.3 **Local communities**

There is a need to support local communities to activate mental health promotion and prevention where young people live, play and work. This would include:

- Supporting education settings as prevention hubs rather than responding to crises. Embed mental health literacy, early intervention and psychological skill building self-management skills in schools using programs such as:
  - Be You (whole-school mental health promotion)
  - Thriving Minds (primary schools)
  - Our Futures (secondary prevention)
  - Sleep Ninja (sleep intervention for adolescents)
  - I CAN Schools (empowering autistic students)
  - Gatekeeper training for teachers and parents
  - Friendly Schools Program
- Access to hubs and safe spaces (as per the community youth wellbeing hub model) and establish accessible community spaces for young people to connect, participate in activities, and seek support.
- Mentoring programs: Programs like menslink and Fearless Women provide one-on-one support and connection, particularly for youth disengaged from school or lacking strong family networks.
- Whole of community approaches which bring schools, local councils and mental health supports together to build community capacity and mental health literacy, such as Youth Live4Life.

8.2.4 **Online**

There are several well-established evidence-based digital services that support mental health promotion. There is growing evidence that digital services can be an effective entry point into the mental health system, supporting young people through both the promotion of mental wellbeing, and active help-seeking through prevention, early intervention and beyond.

However, a mechanism to bring together a coordinated digital strategy approach would assist in better connecting young people to supports they need and through the online channels most preferred and appropriate to them.

The strategy should also support the resourcing of scalable, evidence-based digital prevention programs that:

- offer early mental health support outside traditional service systems
- are integrated into youth education, community, and digital platforms
- extend beyond health care into broader youth wellbeing contexts.

9. Implementation, evaluation and oversight

Implementation of the new and/or refined models of youth mental health care will require significant engagement by key stakeholders, including the Department of Health, Disability and Ageing; other relevant state and territory government departments; Primary Health Networks (PHNs); Local Hospital Networks/Districts (LHN/LHDs); national implementation support organisations such as headspace National Office; existing local service providers; and, critically, young people, their families, carers and supporters.

While the enablers for the new models have been described in detail in the preceding sections, successful implementation will also require targeted actions to ensure that each model is fully integrated with one another, and with existing services, especially state and territory service systems. Clear governance, strong agreements and a culture of ongoing improvement must underpin every stage of delivery to ensure consistent, coordinated and sustainable youth mental health care nationwide.

A clear set of core functions must guide how the models are planned, commissioned and integrated at every level. These functions define the essential actions, structures and processes needed to turn policy commitments into high-quality, connected services for young people in every community.

9.1 Strategic alignment

Delivering these models must complement and strengthen Australia's broader reform efforts.

- Implementation must align with the upcoming National Health Reform Agreement (NHRA 2026) and renewed National Mental Health and Suicide Prevention Agreement, ensuring clear commitments to joint funding, shared governance and integration.
- Updated bilateral agreements must spell out responsibilities for youth mental health, describe funding allocations, and embed data integration and performance monitoring.
- Build on proven state co-investment examples (e.g. NSW, Victoria and Queensland augmenting headspace and psychiatry capacity) and extend shared investment principles nationally.
- Align with findings from the Productivity Commission evaluation of current national agreements to strengthen accountability.
- Ensure the new models connect and integrate with key national reforms currently underway, specifically:

Implementation of the Digital Navigation Project recommendations to improve system connectivity and navigation.

Funding and governance reviews of headspace

Procurement of a service provider and subsequent roll-out of the National Early Intervention Service to expand upstream support.

Development and funding direction for Foundational Supports programs outside of NDIS plans.

This alignment must connect all commissioning, funding and monitoring arrangements described in later sections to these national agreements.

9.2 Commissioning and funding

Effective commissioning and sustainable funding arrangements are critical to delivering the intended scope and pathways for each youth mental health model and ensuring integration with existing services. Updated commissioning approaches must reflect the commitments made under election funding, anticipated PHN review findings, and new functions agreed in bilateral agreements under the upcoming National Mental Health and Suicide Prevention Agreement.

Further, it is important to ensure that any new funding arrangements or changes in funding arrangements do not create any unintended perverse or unexpected incentives or consequences. This can be mitigated by comprehensive monitoring of expected client outcomes as well as service efficiencies.

Commissioning considerations for each model are described below.

Youth wellbeing hubs	Enhanced headspace	Youth Specialist Services
Community Youth Wellbeing Hubs operate largely outside the formal health system and are best supported through flexible state, regional and local funding arrangements. Funding could come from partnerships between local governments, PHNs, LHNs, state government grants, or the Foundational Supports Program, reflecting the non-clinical, community-based nature of these hubs. Commissioning and funding should remain a local decision, but the need for these hubs need to be formally recognised and supported within national and state service plans to ensure sustainability and consistency of purpose.	Funding for enhanced headspace sites has already been committed through the election; budgets must be used efficiently to expand and strengthen existing local headspace centres. These sites should not be recommissioned during the transition to the enhanced service model unless there are concerns regarding underperformance. Instead, local providers must be supported to develop their services to meet the enhanced model benchmarks. Currently headspace centres are commissioned by PHNs in partnership with headspace National Office. Commissioning arrangements must maintain continuity of care, support workforce retention, and ensure accountability for delivering the enhanced scope and quality standards.	Youth Specialist Services require national oversight of commissioning to create and maintain model fidelity and consistent quality across jurisdictions. These services should ideally be commissioned through the department or central agency through an open, collaborative process including advice from PHNs or, if delivered through PHNs, require engagement of a central process to ensure alignment with a national model of care and standards. The design and development of these should include several key partners including headspace National Office and Orygen. The existing Early Psychosis Youth Services (EPYS) providers, including current hubs and spokes, should be prioritised for scale-up to the full specialist model where appropriate. This would leverage established infrastructure and local relationships while avoiding unnecessary recommissioning.

Note: The upcoming PHN review may recommend changes to commissioning responsibilities and oversight functions. Future commissioning arrangements for all three models should align with these recommendations where they are accepted by the Australian Government and any new roles agreed under the National Mental Health and Suicide Prevention Agreement and bilateral agreements.

Commissioning for learning: It is essential that funding is also included to encourage the providers to learn as they operate, sharing that learning with funders, partners and the people they seek to support. This should be in the spirit of continuing development, what is working, where are the system gaps and the system blocks. How can we work collaboratively to constantly evolve. Commissioning may be linked to maturity stages described in the Learning Mental Health System roadmap (Section 9.6).

9.3 Regional planning and integration

Effective regional planning is critical to delivering integrated, seamless youth mental health care that reflects local needs, community strengths and existing service contexts. Strong regional arrangements ensure that each model operates in practice as intended - preventing gaps, duplication and fragmentation - and delivers care that makes sense to young people and their families.

Joint regional plans: The upcoming bilateral agreements should require that PHNs, LHN/LHDs, and local governments work together to co-design regional service maps and pathways that respond to local needs and make use of available infrastructure. Planning must describe how young people access services, move between Community Youth Wellbeing Hubs, headspace, enhanced headspace, Youth Specialist Services and tertiary care and receive ongoing follow-up and support when needed. All young people who present for care at any of these services should be supported until they are engaged in the appropriate level of care/with the appropriate service.

Clear assessment and referral processes: Regional plans need to include clear local protocols and consistent processes for assessing young people's needs and determining when long-term or more intensive support is required. This is essential to clarify when care should remain within an enhanced headspace centre and when referral to a Youth Specialist Service is appropriate. Strong referral pathways and shared assessment tools will help ensure young people do not fall through the gaps between models.

Integrated governance and shared accountability: Consideration in the initial planning and implementation phases may be given to the viability of some Youth Specialist Services and enhanced headspace services operating under an integrated governance and shared accountability model. This would ensure that everything - from IT and communication systems to workforce procurement, support and training, model of care design, and end-to-end communication and collaboration - is a shared responsibility and is well-integrated from the ground up.

Role clarity for Community Youth Wellbeing Hubs: The absence of a clinical workforce within the Community Youth Wellbeing Hub model should distinguish it from what can be accessed through headspace and an enhanced headspace model, although all aim to provide young people with a safe, soft and referral free entry point into the system.

Community Youth Wellbeing Hubs will focus on providing initial, easy access; they can be smaller in scale, located within existing local infrastructure, and connect people to basic support needs and then to headspace or other services if required.

In regional and rural areas, Youth Wellbeing Hubs may be co-located with other services - such as local government youth services, headspace centres or broader community health facilities - to make the best use of local workforce, infrastructure and outreach capacity. Where co-location occurs, regional plans must clearly describe each model's distinct purpose and scope, how young people are triaged between them, and how joint governance will maintain clear roles while supporting seamless care for local communities. Local governments, Aboriginal controlled organisations and agencies outside the health system should be actively involved in planning or delivering these hubs to ensure they reflect community priorities and local contexts.

Embedded community co-design: Regional planning should actively involve young people, families, carers and local community representatives in co-designing how services are configured, delivered and improved over time. This ensures the services and system are culturally safe, relevant and grounded in real-world experience.

Alignment with broader reforms and performance monitoring: Regional plans should link to other key national and state-level reforms, including relevant state mental health reforms, the Digital Navigation Project, the National Early Intervention Service and the Foundational Supports Program. They should guide local commissioning decisions and embed local performance monitoring to support continuous system improvement.

Workforce capacity and readiness: Regional planning should directly address the need for a sustainable, skilled workforce to deliver each model effectively. Priority must be given to recruiting, retaining and supporting mental health professionals across all disciplines - including psychiatry, allied health, peer workers and youth mentors - with a particular focus on regional

and rural areas where workforce shortages are most acute. Integrated regional workforce strategies should map local workforce supply and gaps, strengthen training and supervision pathways, support flexible roles such as outreach and telehealth, and invest in staff wellbeing and retention. Close collaboration with local education and training providers, community health services, and primary care networks will be essential to building and sustaining a workforce that can deliver joined-up, youth-friendly care where it is needed most.

9.4 The role of digital services

Further consideration is also needed regarding the role of digital services and how they are effectively and efficiently integrated into these youth models of care, reducing duplication and enhancing user experience.

This is critical given the rapidly evolving digital environment that young people inhabit, their expectations for seamless transition between their online and offline worlds, and the rapid advancement of digital technologies, including AI.

This work should be undertaken ahead of the next Digital Mental Health Program funding round to ensure that this process and its outcomes can be reflected in the procurement decisions of the government.

9.5 Workforce and capacity

Ensuring a sustainable, skilled and supported workforce is essential to deliver what has been planned regionally and to maintain quality and continuity of care across all models. National, state and regional planning must coordinate recruitment, training and retention strategies to build and secure this workforce across clinical, peer and community roles, and to prevent service gaps.

Just as importantly, a stable and capable workforce underpins effective evaluation and oversight. Consistent staffing allows services to maintain trusted relationships with young people and families, and supports the collection of high-quality data to engage meaningfully in continuous quality improvement cycles. Robust workforce planning at every level is therefore integral to the governance and accountability arrangements for the new models.

9.6 Independent oversight and a Learning Youth Mental Health System

Delivering on the promise of Australia's new youth mental health models requires trusted, independent oversight and a system that continuously learns and adapts. Together, these elements ensure that policy settings, funding, commissioning and workforce strategies translate into high-quality, integrated services for young people and their families – and that this quality is sustained and strengthened into the future.

Independent oversight: A national, independent structure, possibly as part of the new National Institute for Youth Mental Health, should be established to monitor progress, uphold system accountability and provide transparent advice to governments on performance, integration and sustainability of new and/or refined models of care funded by the Australian Government. This oversight function must be positioned above or alongside commissioning and funding bodies, to ensure that each model stays true to its agreed purpose and pathways, that consistency is maintained across jurisdictions, and that national policy directions and bilateral agreements are met in practice.

A National Learning Youth Mental Health System: To complement strong governance, a staged National Learning Youth Mental Health System can underpin how services are planned, delivered and improved. This means collecting and linking service data, outcomes, workforce information and lived experience insights to pinpoint what works, where gaps persist and how to respond in real time. A staged approach is essential to ensure that each model, service platform and service provider - in every region and local network - develops the capabilities, systems and culture needed to participate fully and benefit equally. This must be supported by building national-level infrastructure and expertise to coordinate and guide this development. Together, this avoids a patchwork of variable progress and ensures that monitoring evolves from a static compliance task into an active driver of quality, equity and innovation - with all parts of the system learning and improving together. See **Appendix D** for more information on Learning Mental Health Systems.

A well-governed Learning Mental Health System bridges national reforms - including the renewed National Mental Health and Suicide Prevention Agreement, and the Scope of Practice Review's workforce enablement recommendations - with consistent, responsive care on the ground. It enables local teams to practice to the full scope, fosters continuous improvement and keeps young people and families at the heart of system design and evolution.

A staged roadmap for maturity

Implementation should follow a clear roadmap that sets national maturity benchmarks, moving in simple, manageable steps:

Stage	Core Idea	What This Means in Practice
Stage 1: Build Strong Foundations	Get the basics right everywhere	Agree who is responsible for what, map what data and systems exist, and set shared rules for collecting and sharing information safely and consistently.
Stage 2: Build Data and Analytics Capacity	Turn data into useful information	Develop simple tools and dashboards so teams, funders and communities can see what's working and where to improve; build local skills to use this information well.
Stage 3: Realise a Mature Learning Mental Health System	Make learning and improving routine	Embed real-time feedback, research and co-design into how services and funding decisions are made – so the system keeps getting better and more resilient over time.

This proposed staged approach highlights the need for clear, staged investment to build and sustain the Learning Youth Mental Health System as a **robust, practical and adaptive backbone for implementation and evaluation.** Resourcing must enable consistent capability-building at local and national levels, support continuous monitoring and improvement, and provide the flexibility to respond to emerging needs, evidence and lived experience. This ensures that the vision outlined throughout this advice - integrated, high-quality youth mental health care, designed with and for young people and families - is delivered not just today, but sustained and strengthened into the future.

Appendix A – Table of resources

State resources

Throughout the consultation activities existing resources were identified that establish the benefit of leveraging an intergovernmental cross-sector approach to implementation across Australia.

State	Title	Source
NT	NT Infant, Child and Adolescent Mental Health System Roadmap to Reform (not yet published)	NT Health
NT	Northern Territory Suicide Prevention Implementation Plan	Desktop review
WA	Infant, Child and Adolescent (ICA) Taskforce Implementation Program Child Mental Health: A Model of Care (2022)	Desktop review
SA	Youth Mental Health Services for South Australia Models of Care (2023)	Desktop review
SA	Aboriginal Mental Health Clinical Practice Guideline and Pathways – A culturally appropriate guide for working with Aboriginal mental health consumers	Desktop review
TAS	Health in Tasmania: Primary Health Tasmania needs Assessment 2025-2028	Elizabeth Story, Primary Health Tasmania
ACT	Youth at Risk Project: To improve outcomes for young people with complex needs and affected by trauma	Cass Tinning, Director Youth at Risk Project ACT
NSW	Evaluation Report Executive Summary: OOHC Health Pathway Program enhancement funding (2022)	Desktop review
VIC	Home in Mind Report (2025)	Melbourne City Mission
VIC	Diverse Communities Mental Health and Wellbeing Project – Victorian Refugee Health Network Community Engagement Framework	Queensland Program of Assistance to Survivors of Torture and Trauma
NAT	National Strategy: Stepped System of Care for Eating Disorders	National Eating Disorders Collaboration
NAT	Being Equally Well: A National Policy Roadmap to better physical health care and longer lives for people living with serious mental illness	RACGP
NAT	National Guide to preventive healthcare for Aboriginal and/or Torres Strait Islander people (RACGP & NACCHO)	RACGP
NAT	Communication between medical and mental health professionals: Best practice guide	RACGP
NAT	headspace Evaluation Framework Summary Report	Desktop review
NAT	Developing Performance Indicators and Targets for Youth Enhanced Services	Desktop review

Commonwealth resources

We also wish to acknowledge the following valuable resources identified during preparation for the Consultation Activities which provide further valuable insight to enhance implementation preparation activities.

Year	Title	URL
2024	National Children's Mental Health and Wellbeing Strategy	
2025	National Roadmap to Improve the Health and Mental Health of Autistic People 2025–2035	
2024	National Action Plan for the Health and Wellbeing of LGBTQIA+ People 2025–2035	
2024	National Review of First Nations Health care in Prisons: Final report	
2024	Evaluation of the Remote Area Health Corps	
2023	Lived Experience Workforce Guidelines | National Mental Health Commission	
2021	Evaluation of National Psychosocial Support Programs: Final Report	
2020	National Agreement on Closing the Gap	
2020	Mental Health: Productivity Commission Inquiry Report Volume 2	

Appendix B - Sector submissions

This table lists the organisations that provided written submissions during consultation activities.

Organisations	
Alcohol and Drug Foundation	Melbourne City Mission
Anglicare Vic	Mental Health Coordinating Council
Australian Association of Social Workers	Mental Illness Education ACT
Australian Association of Psychologists	Mind Australia
Australian Childhood Foundation	Mission Australia NSW/ACT
Australian Primary School Principals Association	Multicultural Youth Advocacy Network with Centre for Multicultural Youth (Vic)
Australian Psychosocial Alliance	Multicultural Youth Advocacy Network NSW
Australian Psychological Society	National Eating Disorders Collaboration
BEING Mental Health Consumers	Northern Territory Mental Health Coalition
Carers ACT	Occupational Therapy Australia
Carers SA	Occupational Therapy Society for Invisible Disabilities
Central Australia Aboriginal Congress	PeakCare
Centre for Community Child Health	QLD Alliance for Mental Health
Centre for Multicultural Youth (CMY) and the Multicultural Youth Advocacy Network (MYAN)	Queensland Program for Survivors of Torture and Trauma
City of Rockingham WA Youth Service	Regional Disability Advocacy Service
Consumers of Mental Health WA with Youth Disability Advocacy Network	Royal Darwin Hospital | Head of Paediatrics
Deaf Youth Australia with Deaf Australia	Siblings Australila
EACH	Sisters Inside
e-Hub Health	Smart Justice for Young People with Youth Law
Families Australia	South Australian Primary Principals Association
Flinders University Institute for Mental Health and Wellbeing	South Western Sydney PHN
Gippsland Disability Advocacy Inc.	Southwest Advocacy Association
headspace Joondalup	Speech Pathology Australia

Organisations	
Hope Street Youth and Family Services	Suicide Prevention Australia
Independent Schools Australia	Royal Australian College of General Practitioners
Institute for Urban Indigenous Health	This Way Up | St Vincent's Health Australia
LGBTIQ+ Health Australia	Uniting NSW ACT
Lifeline Australia	Victorian College for Deaf
Live4Life	WA Mental Health Commission
Lived Experience Australia	Wakwakurna Kanyini for Aboriginal Children and Families
Lives Lived Well | Youth Mental Health Services	Youth Advisory Council SA
Macquarie University Centre for Lifespan Health and Wellbeing	Yourtown (Kids helpline)
Marathon Health	YouTurn
Marymead Catholic Care	

Note: We received an additional 12 submissions from organisations, service providers and government departments who requested not to have their submissions published.

Appendix C – Youth health system modelling

Towards better youth mental health system modelling and the ACUMEN Alliance

The mapping exercise undertaken as part of this project presents a snapshot of youth mental health services across Australia. Some 1900 services or programs were identified.

The snapshot used a combination of techniques to search and gather information. This process was hindered by a lack of consistent definitions – what is a service, a program etc.

Need for Consistency

Australia already has experience overcoming these definitional inconsistencies, through the conduct of Integrated Atlases of Mental Health. Using an internationally recognised classification system, these Atlases allow planners to build a clear picture of the mental health services available in a region and make valid comparisons between regions.

These Atlases have been developed over recent years so that they cover around half Australia's population, across numerous Primary Health Networks and Local Health Districts.

This kind of approach, which can be automated to simplify data collection, would make the establishment and maintenance of a consistent, valid picture of youth mental health services possible.

New Modelling Tools

These Atlases are one example of a suite of emerging mental health service planning tools that can be deployed to help decision-makers capitalise on precious, limited resources in mental health. A national group – the ACUMEN Alliance, started by Professor Harvey Whiteford, has been established to drive further development and implementation of new mental health service planning models. ACUMEN is an alliance of Australia's leading experts in mental health systems modelling, service planning and policy. ACUMEN's focus is the development of sophisticated modelling techniques to assess options for improving population mental health in Australia and this could clearly include youth mental health services.

ACUMEN's techniques can help decision-makers with difficult choices about the placement of services, modelling the impact of different decisions across locations and over time, using systems modelling and other techniques to permit comparison.

Beyond Historical Budgeting and Planning

These techniques also encourage a systemic approach to planning, linking new youth and other services together to better see and understand different options and impacts across the whole of the mental health system. This kind of modelling can help decision-makers understand likely future changes in mental health service demand and more intelligently choose appropriate responses. It can also support greater scrutiny, accountability and transparency of these processes. For example, this kind of planning could help determine where best to place a new youth service so that it has the most impact, both on young people and on other parts of the service system, such as the Emergency Department. Not only can these models help drive better choices, they can also help planners explain these choices to decision-makers and the community more broadly.

Youth mental health services in Australia have developed and evolved with only limited general oversight nationally. The process has been more 'organic', meaning that the availability, type and location of some 1900 youth services is often more an artefact of history and chance than strategic planning. ACUMEN's models can bring greater rigour and transparency to future youth mental health service planning processes.

What is a learning mental health system?

Definition

A **Learning Health System (LHS)** is an integrated approach where scientific research, routinely collected administrative and clinical data, consumer experiences, and policy settings are aligned to continuously improve the quality and outcomes of care. Originally defined by the US Institute of Medicine (now the National Academy of Medicine), an LHS transforms every care encounter into an opportunity for shared learning and rapid improvement (1).

A learning Health System is not a separate research project- it's an efficient, data-driven way of working. An LHS embeds evaluation, co-design and adaptive learning directly into professional development, daily care delivery, service improvement, governance and commissioning. By combining routine clinical and administrative data, with meaningful fit-for-purpose measures, LHS provides the infrastructure and capabilities for system improvement at every level, national, regional, local and service-based, **turning every interaction into an opportunity to learn, inform decisions and improve care.**

Relevance to youth mental health

Youth mental health systems face unique complexities such as uneven access, workforce challenges, evolving needs, and the constant emergence of new issues. This demands a system that can learn and adapt rapidly.

An LHS makes this possible by:

- Capturing lived experience and clinical data continuously for local and national decisions.
- Equipping teams with clear, actionable insights- not just raw data.
- Embedding feedback into everyday care and professional development.
- Streamlining reporting so leaders spend more time on active leadership and change management.
- Keeping services adaptive, responsive and truly centred on young people and families, even as circumstances change.

For mental health, this means that measurement, co-design and real-time feedback are embedded in routine practice, enabling frontline workers to deliver evidence-based care more consistently and equitably, without adding unnecessary burden.

Key features

A robust LHS typically includes:

- **A learning community:** Patients, families, researchers and decision-makers co-create priorities and guide action.
- **Shared data infrastructure:** Secure systems link and analyse data from health records, outcomes, experience surveys, and social determinants, supported by clear governance, privacy safeguards and ethics processes.
- **Technical backbone:** Investment in interoperable systems, digital transformation, analytics capacity and protected time for staff to use insights effectively.
- **Repeatable learning cycles:** Evidence is translated into daily practice through pragmatic research, adaptive guidance development, quality improvement and rapid feedback.

International examples

Some examples of Learning Health Systems applied in mental health care include:

- **US Veterans Health Administration (VHA) –** Embeds research in routine care to test and spread evidence-based suicide and opioid interventions nationwide (2).
- **Canada, SARPEP –** Canada's first rapid-learning health system for early psychosis, using core indicators and local co-learning to strengthen care (3).
- **USA, OnTrackNY –** A statewide learning network for early psychosis, combining stakeholder partnerships and data science to drive equitable care improvements (4).
- **South Africa, S-MhINT –** Scaled collaborative depression care using embedded learning cycles, workshops and real-time quality improvement to adapt services (5).

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Section 3: Context: Young Australians' Mental Health

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CSV0000358- ORYGEN25