CONSULTATION OUTCOMES REPORT

SECTOR-LED ADVICE ON YOUTH MENTAL HEALTH MODELS OF CARE

batyr

ips
MANAGEMENT CONSULTANTS

dandolopartners

orygen

Acknowledgements

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.

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Avant le Rock y'avait rien

About the project

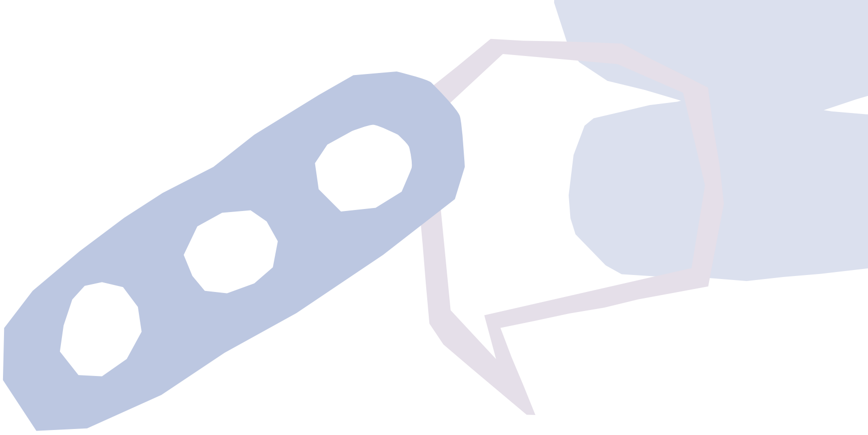
Orygen was engaged by the Department of Health, Disability and Ageing (the Department) to lead a diverse consortium of organisations from the youth mental health sector to deliver sector-led advice to the Australian Government on the existing system of mental health services for young people aged 12 to 25 years, and potential new and / or refined models of care for mental health services for young people.

Youth mental health research has flourished globally, generating significant evidence for effective treatments and service models. The primary aim of this project has been to understand the current landscape of youth mental health services in Australia and provide advice to the government on what can be done better to ensure service models are contemporary and fit for purpose.

Many of Australia's leading youth mental health organisations joined to form a consortium to deliver this advice, including Orygen, headspace, batyr, the Brain and Mind Centre (University of Sydney), yourtown, Youth Focus, Mission Australia, SANE and ReachOut, supported by subject matter and project management expertise from Department of General Practice and Primary Care (University of Melbourne), Indigenous Professional Services Management Consultants (IPS), Monash University Health Economics Group and dandolopartners (the Consortium).

Together the Consortium delivers a complementary blend of mental health expertise, project management skills, lived experience expertise, First Nations engagement, system and service design and delivery, along with technical, policy, research and evaluation expertise.

Recognising that extensive engagement with various youth mental health services and young people Australia-wide was essential, the Consortium engaged in nationwide consultations from late-March into early June 2025, seeking to prioritise the voices and experiences of young people across Australia, as well as their families, carers and supporters, in recommendations on models of care for youth mental health services.



Executive summary

About this document

This Consultation Outcomes Report has been produced by dandolo, Orygen, batyr and IPS to provide a summary of consultations under the Models of Care project. It has been developed to provide a summary of insights gained through the consultations conducted under this project. As such, it:

- Brings together insights from across all consultation streams (including with young people; families, carers and parents; First Nations organisations; and sector stakeholders)
- Focuses on reporting stakeholder views, including where possible in their own words
- Is intended as a supplement to the Consortium's Final Advice (which provides the consortium's recommendations on new and refined models of care).

Please note:

- A working version of the draft Consultation Outcomes Report was provided to the Consortium for their consideration as part of its development
- Where issues do not appear in the Consultation Outcomes Report, it does not mean that the Consortium does not consider them to be important, but rather that they may not have featured prominently in consultations
- This Consultation Outcomes Report focuses on reporting the perspectives of stakeholders external to the Consortium and is not intended to capture input from / discussions between consortium members (which are reflected in the Final Advice).

Perspectives on the existing system

Across all consultation streams, we consulted stakeholders on their perspectives of the existing system to understand what aspects of the current system are working well, areas of need, barriers and gaps, as well as areas of duplication and fragmentation.

System mapping

Between January and March 2025, The Brain and Mind Centre (BMC) and Orygen developed a service and system map to support consultation with stakeholders on the existing system.
The map sought to articulate the number of services focused specifically on young people (12-25 years); the number of services that are supporting young people at different levels of severity; funding sources for different services at different levels of severity; and geographical differences (by state and or metro / regional / rural) in the number of services that are available. The map was limited to number of services only, publicly available information on mental health services as described by PHNs and LHNs and government funding sources for services. It did not capture the number of young people supported by a service, service size, number of sessions provided, prevention services and non-government funding sources. Stakeholders identified additional limitations relating to the profile and interaction of services, contextualisation of services and localised challenges that impact service delivery, severity and type of need, and representativeness of data used to inform mapping.

What's working well

Young people highlighted mechanisms that support timely access and continuity of care, services that engage with families, schools or communities, the profile of headspace and warm, informal spaces that help young people feel at ease. Sector stakeholders emphasised the dedication of people working in the mental health system, uptake in co-design with young people, youth specific services and changing societal attitudes towards mental health.
Sector stakeholders and families underscored the importance of initiatives that such as

structured peer group support, support from lived experience workers, mental health first aid training and information and education initiatives and resources. They cited the value of programs that build the capacity of the young person to support their own mental health, such as peer mentorship, school-based mentoring and student wellbeing programs. First Nations stakeholders reiterated the benefit of culturally appropriate capacity-building programs, such as on-Country programs. Sector stakeholders drew attention to models that have demonstrated positive benefits and impact on service accessibility and appropriateness for young people and the communities in which they live. These include consortium approaches, digital and hybrid delivery models, digital tools, locally led responses, home-based care services, co-investment, and proactive and trauma-informed early intervention approaches.

Barriers

Stakeholders identified significant barriers for young people to access care. These include a lack of information on what services exist, stigmatising attitudes towards mental health care, inequitable distribution of services, exclusionary eligibility criteria, problematic referral pathways, wait times, affordability, inadequate Medicare subsidy and workforce attrition. Stakeholders also referenced barriers relating to the appropriateness and acceptability of care. These include an over emphasis on clinical approaches, a lack of culturally appropriate, trauma-informed care, limited rapport with clinicians, exclusion of young people's support networks, limited choice and control over treatment of personal information, and limited availability of crisis and recovery care.

Areas of duplication and fragmentation

There was strong stakeholder consensus regarding the high degree of fragmentation and duplication within models of care, which is characterised by a lack of coordination at a system level, between service and at transition points, inconsistency in eligibility criteria, and funding and contractual models that prevent collaboration.

Areas of need

Stakeholders identified areas of need in the current system. These include stronger engagement with the social determinants of mental health, improved access to appropriate care for marginalised young people, increased investment in prevention, promotion and early intervention, and dedicated support for the missing middle. They also called for better coordination, consistency and support, greater diversity of supports, including youth specific services, and improved workforce attraction and retention.

Opportunities to strengthen the existing system

We consulted all stakeholders on opportunities to strengthen the system, including through development of new and refined models of care. Insights from a consortium workshop conducted prior to national consultation shaped the early advice which was delivered to the Department in January 2025. The early advice was tested during national sector roundtables and through the public submission processes open to young people, families, carers, supporters and sector stakeholders. Consultation with stakeholders also included areas that were acknowledged as insufficiently addressed through the early advice, as well as ideas that emerged organically from consultations, beyond what was proposed in the early advice.

Young person-centred

Stakeholders strongly agreed on the importance of a youth-centred model of care that coordinates services and support offerings around young peoples' needs and preferences. Stakeholders called for a shift to a youth-centred model of care that views young people holistically, engages with the social determinants of mental health, honours their care preferences, supports co-design of services and takes a trauma-informed approach. They highlighted the importance of recognising the young person's cultural needs and empowering their community and chosen nexus of support.

Accessible and integrated care

The early advice contained two ideas relating to strengthened integration that were tested with stakeholders. These were harmonising the age range of the youth mental health system and building a national, person-centred data system. Stakeholders were generally supportive of harmonising the age range to reduce transition disruptions and increase the continuity of care, although not all organisations agreed on the proposed age range. Stakeholders expressed mixed support for a national data system and expressed concern regarding the cost of establishment and maintenance, privacy sensitivities and risk of stigmatisation.

Care coordination and service navigation

The early advice proposals to pilot approaches using care navigators, and establish a directory of evidence-based services, were tested with stakeholders through the consultations. Whilst stakeholders strongly supported piloting care navigators, they expressed concern that a directory would require significant resourcing to maintain, and that it could unfairly exclude organisations that do not have the resources to fund evaluations and gather the required evidence for inclusion in the directory.

Building the workforce while recognising current constraints

Stakeholders emphasised the importance of workforce as a critical enabler of a sustainable, effective mental health system. There was a clear consensus regarding the need for diversification and expansion of the workforce, including peer workers, long term funding, improved training and clearer career progression pathways. First Nations stakeholders also called for investment in training more First Nations people to work in youth mental health services.

Supporting and integrating psychosocial and clinical supports

The early advice proposal to better integrate clinical and psychosocial supports received strong support. Stakeholders called for a blending of psychosocial and clinical support that could be available under one roof or through well-coordinated referrals. Whilst most stakeholders supported integrated hubs, some warned that integration between psychosocial and clinical will not be appropriate in all cases, or acceptable for all young people.

Drawing on digital tools and platforms

Most stakeholders were supportive of the early advice recommendation to leverage digital technologies in practice and service but noted that there wasn’t enough specificity in the early advice around the design and application of these tools. They indicated that digital should be an alternative to, rather than a substitute for, in-person support and that trust is an essential precondition for digital delivery.

Strengthening prevention, promotion and early intervention

There was strong consensus across all stakeholder cohorts on the need for a strengthened approach to prevention, promotion and early intervention in the youth mental health system. Stakeholders asserted the need for whole-of-government collaboration and investment, as well as increased support for capacity building of schools and communities. They expressed mixed reactions to adjusting headspace’s existing footprint and noted that an adjusted headspace footprint would not work for everyone and could add to duplication where effective services are already operating in communities.

Addressing the missing middle

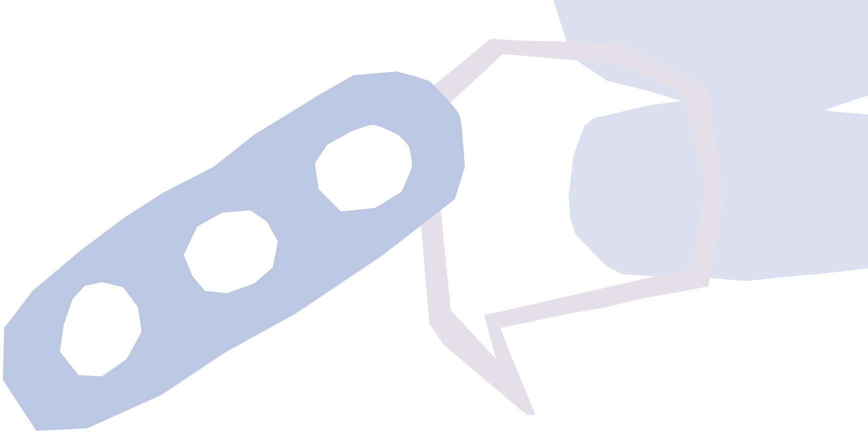
Stakeholders were consulted on two initiatives to address the missing middle that were proposed as ideas in the early advice: the establishment of an expanded headspace; and investment in specialist services. There were varying levels of support for the establishment of an expanded headspace, due to concerns that headspace is overly clinical, and that it may limit options for young people seeking care outside the headspace model. Stakeholders were relatively positive about the proposal to invest in specialist services, but raised concerns regarding accessibility, workforce demands, cultural safety, and the risk of creating further system fragmentation and complexity.

Priority populations

Stakeholders emphasised the need to recognise the strong intersectionality between priority populations and the need for a mental health system that views young people holistically, rather than through a narrow diagnostic lens. They highlighted the unique challenges for different cohorts of young people, and the tailored supports and interventions that these cohorts require. These cohorts include:

- Aboriginal and/or Torres Strait Islander young people
- Young people living in regional, rural and remote communities
- Young people experiencing socioeconomic disadvantage
- Young people who identify as LGBTIQA+
- Young people experiencing homelessness or housing instability
- Young people living with a disability
- Young people, including those living in out-of-home care
- Young people in contact (or previously) with the criminal justice system
- Young people from multicultural communities
- Young people experiencing or at risk of abuse and violence, including sexual abuse, neglect and family and domestic violence
- Young 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 or other drugs, or with substance use disorders
- People who have made a previous suicide attempt or been bereaved by suicide.

Throughout this document the terms Indigenous, First Nations and Aboriginal and/or Torres Strait Islander have been used interchangeably. In doing so, we wish to 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.



Consultation Methodology

Overview

The Models of Care project adopted a rigorous methodology delivered between January – June 2025. Central to this methodology was an extensive consultation process, which spanned young people; families, carers and supporters; First Nations organisations; and a broad cross-section of sector stakeholders. The methodology adopted for this consultation process is set out below.

Preparing for consultations

(December 2024 – March 2025)

The early stages of the process involved preparing to undertake consultations. This involved:

- **Ethics approval.** Ethics was sought through The University of Melbourne Human Ethics Committee and granted on 6 May 2025 prior to commencement of public (youth and family, carer and supporter) consultations.
- **Recruitment of youth Co-Researchers and Advisors.** batyr recruited a group of young people from around the country aged 16-25 to be involved throughout the project. This involved an initial consultation with nine young people in January to feed into the first consortium workshop and inform the early advice. Seven of these young people accepted a role as co-researcher and advisor (CoRA), received training and support from batyr, and provided input and lived experience expertise throughout the duration of the project, with six attending the second consortium workshop.
- **Delivery of early advice and associated materials.** During the first stage of the project, the Consortium developed materials and products that informed, and were used throughout, consultations. This included:
  - Rapid research and literature review
  - The consortium's early advice (which was prepared following a full-day consortium workshop in January)
  - Draft Service Mapping.
- **Preparation of consultation materials.** Once the early advice and associated materials had been produced, the Consortium partners prepared consultation materials (e.g. discussion guides, roundtable agendas, text for submissions processes). All materials were reviewed by batyr and IPS to ensure their appropriateness for audiences of young people and First Nations stakeholders. They were also provided to the Department for feedback and approval. Consultation materials broadly sought feedback on perspectives on the current system, including what is going well, what is not going well and what should be changed, as well as feedback on the summary of the Consortium's early advice on opportunities to refine the system.

Delivery of consultations

(April – June 2025)

The consortium undertook consultations between April – June. The process of obtaining ethics approval caused delays to the commencement of consultations with young people, carers, families and supporters. An agile and responsive approach was taken by Orygen and batyr to ensure enough young people, carers, families and supporters could be reached.

Recruitment strategies

A website was created in February 2025 to provide information about the project (www.orygen.org.au/Orygen-Institute/Models-of-Care-Consortium). It identified the members of the Consortium, the aims of the project and consultation, how potential participants could become involved and contact details for further information.

Targeted contact

Key consortium partners involved in the consultation activities emailed communication through their channels to target key stakeholders including networks with youth advisory groups and parent and carer groups; peak organisations; professional representative bodies; community-led services, health and mental health service providers at both state and local level; Primary Health Networks; parent and carer organisations; experts and academics; and various representatives from Commonwealth and state/territory departments.

A layered approach to recruitment was undertaken by dandolo, Orygen, IPS and batyr, as appropriate to the intended stakeholders and communities who were being contacted:

- dandolo and Orygen worked collaboratively to ensure a broad representation of stakeholders received invitations for sector roundtables held in each state and territory. Specific stakeholders with expertise were identified to be invited to participate in online discussion forums.
- IPS made telephone contact with an extensive list of First Nations-led organisations and then engaged with the organisations either online or over the phone.
- batyr, with the support of the CoRAs, developed a mailing list of key stakeholders, including some advocacy organisations identified through the sector roundtable process. An expression of interest form was widely distributed across this network through email and social media channels, which received a tremendous level of interest from young people aged 16-25, as well as young people older than 25 with lived experience during the ages of 16-25.
- dandolo and Orygen collaboratively targeted a broader cross-section of organisations for the online submission process including several priority population advocacy groups, universities, first responders and carer organisations. By sending the sector submission first, this enabled us to obtain interest from organisations who wanted to share the public submission opportunity with their network and provide them with a social media tile or paragraph to share. The online submission link for young people and parents, carers and supporters was then sent to this group for on-sharing as well as a significant number of additional stakeholder organisations across Australia and individuals who had expressed interest. The submission portal hyperlinks were also included on the project website.
- Across the duration of the project, dandolo also received interest via the Orygen website from individuals who wanted to be involved either through consultation or online submission, and these people were directed to the appropriate avenue for consultation. For example, young people who wanted to participate were connected via email with batyr, parents and carers were connected with Orygen for consultation opportunities, and sector stakeholders were also provided the appropriate avenues to be involved, which may have been a roundtable invitation, online discussion forum invitation or sector submission link.

Social media

A number of networking and social media channels were used to promote the project, these included:

- Orygen Institute newsletter (the website saw 678 site clicks after this newsletter was released).
- Orygen's X, Bluesky and LinkedIn channels to promote the project and online submission streams.
- Orygen's Instagram channel was used to promote the project and online submission streams with organic reach as well as targeted promotion of the online submission process.
- Orygen's general newsletter (which has around 10,000 subscribers)
- batyr's Facebook, Instagram, LinkedIn and TikTok platforms (with extensive reach for recruitment with over 12,700 on Instagram and 813 on LinkedIn)
- yourtown's ParentLine Facebook group (with around 9,000 parents).

Between 19-27 May 2025, Orygen used submission response data to undertake targeted Meta advertising (across Instagram and Facebook) to increase visibility and direct people to open submission platform. Submission response data was reviewed by dandolo on 23 and 26 May to inform a strategic approach with Orygen through paid advertising to address low target rates across some audiences:

Target Audience Engagement Metrics – Link Clicks and Reach (19-27 May 2025)

Audience	*Link clicks*	*Reach*
ACT, NT, TAS residents	263	20,197
WA, SA, rural and remote QLD, VIC, NSW residents	289	71,258
Young men	146	18,453
Multicultural communities	224	22,800
Young people with complex mental health / disability	144	14,312
Parents of adolescent and adult children, kin and carers	192	33,623

**Priority population groups not listed were due to positive response (eg. First Nations and LGBTIQ+) or absence of data availability or limits to advertising (eg. out-of-home-care, criminal justice system).*

Consultation Delivery

- Delivery of consultations involved: Delivery of in-person sector roundtables in every state and territory, as well as two online roundtables (one with an explicit regional and remote focus)
- Youth focus groups, conducted both online and face-to-face
- Consultations with parents, carers and families
- Individual yarns with First Nations organisations (and individuals associated with First Nations organisations), conducted both online and face-to-face
- Delivery of submission processes aimed at both the general public (young people; and families, parents and carers) and sector stakeholders
- Delivery of Online Discussion Forums aimed at select expert stakeholders to deeply explore particular areas of interest for the project
- Consultation with Primary Health Networks (PHNs).

In total, we heard from 544 individual stakeholders across 49 consultation activities. 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 the 146 young people and 70 parents, carers and/or supporters involved, at least 108 (50%) identified as being from a priority population group.

Analysis of consultations

(May – June 2025)

Because of short timeframe for this project, analysis of outcomes commenced while consultations were ongoing. This process involved:

- **Consultation partner analysis of consultation streams.** Consultation partners had primary responsibility for undertaking analysis of the streams of consultation that they had conducted. This involved:
  - Qualitative data analysis was undertaken by teams across Orygen, dandolo, batyr and IPS with lived experience representation from young people, First Nations communities, disability, neurodiversity, gender diversity, complex mental health including AOD, rural and regional backgrounds, low socioeconomic backgrounds, and staff with mental health and policy expertise.
  - Analysing consultation transcripts, workshop notes and other artefacts from consultations
  - Undertaking thematic synthesis in alignment with the key questions for the project
  - Quantitative analysis where relevant (for example, where tools such as Miro and Mentimeter had been used)
  - For the youth consultations, synthesis that was undertaken by the trained youth co-researchers, drawing on their lived experience and peer insight to ensure the findings remained grounded in young people's experiences. This participatory method strengthened the relevance and authenticity of the analysis, while also supporting skill-building among the youth researchers.

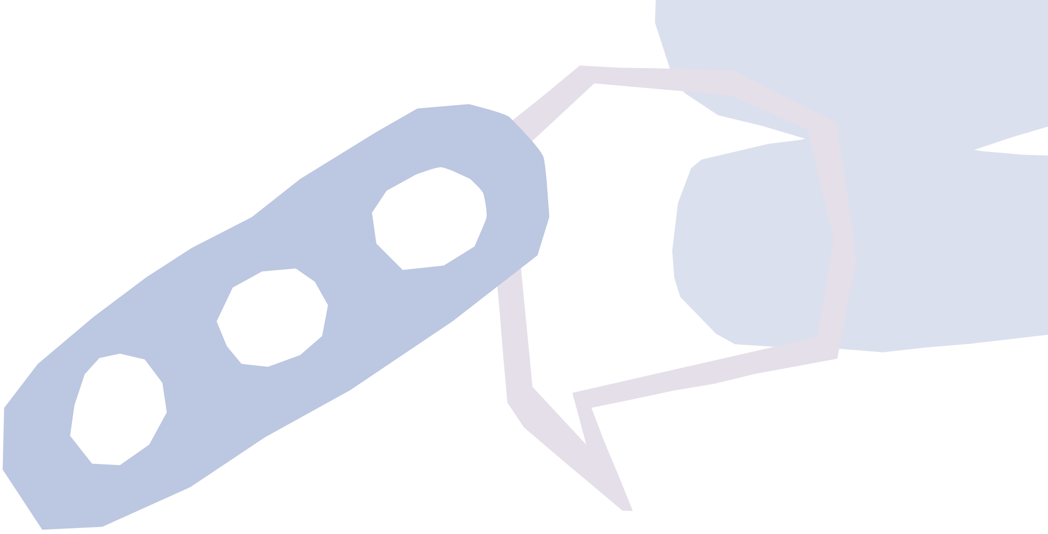
- **Development of a rough draft of the consultation outcomes report for the Consortium workshop.** To share the outcomes of the consultation process with the Consortium, we then developed a rough draft of the Consultation Outcomes Report. This provided an overview of insights from each of the consultation streams, organised thematically to inform discussions at the workshop.
- **Synthesis of findings across consultation streams.** We then undertook further thematic analysis to identify patterns, key commonalities and differences between the different consultation streams.
- **Development of Consultation Outcomes Report.** This report is intended to provide a summary of insights gained through all consultation streams conducted under this project.

Stakeholders consulted

This consultation report draws from the 49 consultation activities undertaken between 31 March – 30 May 2025:

- **Youth consultations**: batyr delivered a total of 13 consultations, comprising 11 online national focus groups and two in-person focus groups held in Brisbane, Queensland and Alice Springs, Northern Territory. The nature of delivery for this consultation stream was adapted to suit young people's preference for online rather than in-person workshops and included participant representation from each state and territory. In total, 83 individuals participated in this consultation stream. This group included members of the general public and representatives from national youth advisory groups affiliated with organisations (headspace, yourtown, Life Without Barriers, batyr and Orygen). Of the young people who chose to identify, 17 identified as Aboriginal or Torres Strait Islander and 23 identified as being part of the LGBTIQA+ community.
- **Families, carers and supporters' consultations**: Orygen conducted three online consultations and one face-to-face interview with family members, carers and supporters with a total of 23 participants engaged through this consultation stream. This number included at least eight participants from multicultural communities.
- **First Nations organisations**: In the First Nations sector consultation stream, IPS spoke with 12 organisations around Australia, including 2 individuals associated with First Nations organisations. (A further 10 representatives from organisations and sector workforce participated in the sector roundtables, discussed below.)
- **Sector roundtables**: dandolo and Orygen conducted in-person roundtables with sector stakeholders in every state and territory capital, plus an additional two online roundtables (one general in focus; one focused on regional and remote areas). Through these roundtables, we reached 229 sector stakeholders. These included:
  - Consumer and carer groups
  - Peak organisations
  - Professional bodies and experts
  - Service providers across Commonwealth, state/territory, local, private and community services
  - Primary Health Networks (PHNs)
  - Commonwealth and state/territory government representatives.

- **PHN focus group**: Orygen led a 90-minute online focus group during a PHN Community of Practice. 32 representatives across 21 PHNs in seven states and territories participated in consultation discussions. The PHNs that were not present were directly invited to provide input via the public submissions process.
- **Public submissions processes:** dandolo and Orygen also delivered the following submission processes:
  - A submission process for young people, their families, carers and supporters. We received 92 substantive submissions, including:
    - 52 from young people (this includes 6 participants who are over 25 but engaged with the system as a young person). Of the young people who chose to identify, 6 (12%) identified as Aboriginal and/or Torres Strait Islander, 26 (50%) lived with disability, 8 (15%) were from multicultural communities, and 26 (50%) were from the LGBTIQA+ community.
    - 47 from family members, carers and supporters. Of those who chose to identify, 2 (4%) identified as Aboriginal and/or Torres Strait Islander, 10 (21%) lived with disability, 5 (11%) were from multicultural communities, and 8 (17%) were from the LGBTIQA+ community.
  - A submission process for sector stakeholders. We received 155 substantive submissions from sector stakeholders representing mental health services, peak bodies, consumer and carer groups, professional bodies, state and territory governments and health services, social and vocational supports, advocacy organisations, the education sector, digital services, prevention bodies and priority populations.
- **Online discussion forums:** dandolo conducted three online discussion forums, which allowed testing of more detailed content on specific areas of interest with select specialist stakeholders who had expertise in the relevant topics (service model design, prevention and promotion, and systems integration) and CoRAs. The discussion forums covered the following topics:
  - Expanded and strengthened headspace and specialist service (15 participants)
  - Prevention and promotion (nine participants)
  - Integration (12 participants).



Perspectives on the existing system

Across all consultation streams, we consulted stakeholders on their perspectives of the existing system to understand what aspects of the current system are working well, areas of need, barriers and gaps, as well as areas of duplication and fragmentation. This chapter sets out what we heard from our consultations on the existing system.

System Mapping

Between January and March 2025, the Brain and Mind Centre (BMC) and Orygen developed a service and system map to support consultation with stakeholders on the existing system. BMC and Orygen drew on desktop research and input from other consortium members to produce two initial outputs. The first was a comprehensive database describing mental health services available to young people depending on age-range, location, delivery type (online-face to face), and clinical severity. The second output was a report documenting available data on funding, funding sources, Better Access contacts, prescriptions and psychosocial services including NDIS overview for young people.

BMC and Orygen translated these outputs into a two-page infographic summarising the mental health services available to young people in Australia. The aim of the infographic was to articulate the number of services focused specifically on young people (12-25 years); the number of services that are supporting young people at different levels of severity; funding sources for different services at different levels of severity; and geographical differences (by state and or metro/regional/rural) in the number of services that are available.

Limitations

BMC and Orygen identified several limitations to the system mapping:

- The mapping captured the number of services only, not the number of young people supported by a service, the service size, or number of sessions provided.
- The mapping was limited to publicly available information on mental health services as described by PHNs, LHNs (as well as youth services such as those delivered by Mission Australia services). This meant that it did not capture the complete spectrum of organisations supporting young people across a range of issues, including mental health.
- Identification of mental health services for young people required inclusion of child and adolescent services, and adult services (where they specified targeted programs for 16 and over). This meant that it was difficult to differentiate between youth only services and services that cater to both adolescent and adults.
- The mapping acknowledged government funding sources for services, but not philanthropic or private funding, nor the considerable differences in the level of funding they provide. Finally, the data informing the mapping didn't cover prevention services.

The graphic was used as the basis for consultation with sector stakeholders at state and territory roundtables. **Stakeholders identified additional limitations to the system mapping relating to the profile and interaction of services.** They noted the absence of information on the interventions and type of care delivered by the service, as well as service capacity and capability (including the size and the profile of the workforce) to deliver on the care that they claim to provide. Stakeholders suggested that the extent to which services are at or below capacity can provide a useful proxy for understanding need. They observed a lack of detail regarding service accessibility, including opening hours, distribution and physical accessibility, as well as service quality, effectiveness and outcomes. Stakeholders also highlighted the absence of information on the integration and relationality of services, including the extent to which they are working well with other services, as well as the contributions of the NDIS to particular cohorts, such as neurodivergent young people.

Stakeholders also drew attention to the lack of context presented in the system map, which failed to sufficiently account for the different experiences of young people and service providers in the system. As noted by one stakeholder, '*the system mapping does not contextualise…based on the context in which [people] live and work*.' This includes contextualising the experience of young people and priority populations in navigating services, as well as the presence of localised challenges that impact service delivery and the severity and type of need. Stakeholders also noted the underrepresentation of cultural considerations in the mapping, including '*what it means to be multicultural with mental health challenges*' in the system, the impact of racism and discrimination on service access, and the extent to which services are equipped to provide culturally safe care. The availability of services for First Nations young people, as well as their experience accessing them, was not captured in the mapping. Stakeholders cautioned that whilst services may claim to be culturally safe for First Nations people, this may not be the case in practice, and that data collected through desktop research on the cultural safety of services is unlikely to be accurate.

Finally, **stakeholders expressed concern with the data used to inform the mapping**. In one state, stakeholders warned against drawing inaccurate conclusions from the data and generalising these to contexts where they may not be representative of local experiences and services. More broadly, stakeholders emphasised the risk of the data creating a false sense of security in contexts where there are higher numbers of services. For example, even if a jurisdiction '*has so many services, it means nothing if a young person can't access them.*' A higher quantity of services is not synonymous with increased accessibility, acceptability or integration, but could actually be an indicator of fragmentation or duplication. Stakeholders noted that whilst individual PHNs conduct mapping at a regional level, the data is not widely available and has not undergone quality assurance. This limits the extent to which meaningful insights can be drawn beyond the regional level. Furthermore, stakeholders suggested that basing the mapping off point-in-time data provided an incomplete picture of the sector, and that more regular data collection would support insight into trends across the system. Stakeholders flagged the opportunities that exist to build on work that has been led by both the University of Canberra and an established group of data and system modellers, Acumen, to have a comprehensive, coordinated and ongoing approach to system and service mapping for youth mental health.

Case study – University of Canberra: Atlases of health and social care

Integrated Health Care Atlases and Directories assess and collate standardised information about specialised mental health services in a geographical area. Directories list service information while the Atlases present the information visually. Both tools account for local context, highlight disparities in access and identify service gaps with the intent of enabling a comparison of services across geo-demographic areas and supporting evidence informed policy and planning.

What is working well in the existing system

Young people highlighted **several features of the existing service system that are working well**, including:

- **Warm, informal environments** that help young people feel at ease, as opposed to spaces that are too clinical or childlike.
- **Mechanisms that support timely access to care and continuity of care**. For example, online, message-based mental health check-ins, interim therapy, triage services or short phone sessions offer brief but meaningful engagement during waiting periods or transitions, provided they are delivered by trained, caring staff. Some young people emphasised the value of effective and timely intake processes for acute distress. Participants also appreciated services that maintain contact and continuity between appointments, such as support workers or volunteers who reach out with a message or call.
- **Services that engage with families, schools, or communities** in the support process and make young people feel more understood. This broader involvement reflects the real-world complexity of their lives. Young people, families, carers, supporters and PHNs referenced the success of youth mentoring programs and outreach services.
- **The profile of headspace**, which remains a trusted entry point for youth mental health, particularly for milder presentations (rather than complex presentations or needs).

- It is possible that the young people engaged during the consultation process were more comfortable with the headspace brand and disclosing their experience of the mental health system. This contrasted with feedback received by several stakeholders, who noted that the headspace brand can represent an institutional barrier that prevents young people at risk of engaging due to stigma and distrust of mainstream mental health services.

Sector stakeholders echoed the value of headspace as an important element of the mental health system architecture. Despite some challenges, they noted that the brand is well established and recognised, and that young people largely view headspace as a service that they can go to for support. In addition, **sector stakeholders emphasised the value of**:

- **The dedication of people working in the mental health system** to their role, and to promoting the best outcomes for young people. This commitment supports a relational aspect of care that is critical for young people to remain engaged in services and respond well to mental health care.
- **Co-design with young people**, including those with lived experience. Stakeholders noted that in recent years, there has been an increase in co-design of models of care with youth and lived experience representatives that has improved the responsiveness of services to the needs of the young people that they are serving.
- **Youth specific services** that are often more suited to young people than generic services.

> “Youth mental health services often provide a far more youth friendly environment, with greater flexibility in what you can do, i.e. art, drawing and offer more avenues for consumer involvement (such as youth reference groups or community projects) than adult mental health services.”
>
> **YOUNG PERSON FROM CONSUMERS OF MENTAL HEALTH WA AND YOUTH DISABILITY ADVOCACY NETWORK SUBMISSION**

- **Changing societal attitudes towards mental health**. While stigma around mental ill health is still unacceptably high, there are indications that it has been reducing over time. However, participants from multicultural communities noted that internalised stigma and cultural preferences to refrain from talking about mental health continues to be a barrier, which could be reduced through education and advertising to reframe mental health as equally as important as physical health.

Consultation with sector stakeholders and families underscored the importance of initiatives that positively impact their own wellbeing, whilst equipping them to better support their young person:

- **Structured peer group support** led by a clinician that facilitates information-sharing and capacity-building amongst families with shared experiences of youth mental ill-health. This can reduce their feelings of loneliness and isolation, support them to prioritise their own self-care, address stigmatising attitudes or feelings, and improve their understanding of how to support their young person’s mental health.
- **A lived experience worker** attached to services who parents can relate to and feel valued and heard while they are waiting for care or are in between services.

> “My son connects with people with lived experience better than a fresh graduate with no experience of what he’s going through.”
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

- **Information and education** about mental health conditions, self-care, confidential peer support, and strategies to support conversations with their young person and build trust. Stakeholders also cited the benefits of a ‘starter kit of information for new migrants’ containing relevant information on what to look for, and who to approach for support if they suspect that their young person is experiencing mental ill-health.
- **Free mental health first aid training**, which equips families to identify signs early, conduct check-ins with their young person, and implement strategies to prevent escalation.

> “My concern is that my teens now trust ‘TikTok’ more than any professional counsellor or teacher or other authorities - how can we build back that trust with young people?”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

Families and sector stakeholders also cited the value of programs that build the capacity of the young person to support their own mental health, such as:

- **Peer mentorship programs**, including through sporting and recreational activities that help young people build resilience and learn more effective ways to regulate emotions through positive role modelling.
- **School-based mentoring programs** that pairs a young person with a mentor who provides personalised, targeted support to promote resilience, hope for the future, school engagement, and help-seeking skills.
- **Student wellbeing programs** that leverage the critical role of schools in supporting youth mental health and wellbeing (without task shifting mental health support onto teachers). These programs work best where there are strong linkages with community-based youth mental health services who can accept referrals or provide in-reach support into schools.

First Nations stakeholders reiterated the benefit of culturally appropriate capacity-building programs, such as on Country programs. Going on Country is a key feature of many First Nations mental health programs which recognises the inherent connection of First Nations people to Country. For example, in the NPY lands multi-day walks on Country are offered to men and women, and in the Great Southern of WA providers are working with Elders to create on Country programs. Despite the benefits of these programs, there have been mixed funding responses. They also spoke of the benefits of outreach programs that meet young people where they are.

Case study – Palmerston

Palmerston is a drug and alcohol service provider in the south of Western Australia. They developed and delivered a pilot program in partnership with Impact (an Aboriginal employment organisation) for First Nations young people in Albany and Katanning aged 12 to 25 who were disengaged from school. The program featured on-Country bush classrooms with Elders and Aboriginal mentors. Activities included hunting, fishing and cooking as well as psycho-social education around the campfire on harm reduction and mental health support. It also included family mapping for connecting with community as well as developing CVs and connecting with employment, training and education opportunities.

Sector stakeholders drew attention to **models that have demonstrated positive benefits and impact on service accessibility and appropriateness for young people and the communities in which they live**. These include:

- **Consortium approaches** to delivery of mental health services that tailor service development and responses to the needs of particular communities and maximise the capacity and strengths of local services, with opportunities for people with lived experience to play a meaningful role in the process.

> “These organisations are finally beginning to recognise young people’s invaluable perspectives and their role in supporting their peers through their recovery journeys.”
>
> **CONSUMERS OF MENTAL HEALTH WA AND YOUTH DISABILITY ADVOCACY NETWORK JOINT SUBMISSION**

- **Digital and hybrid delivery models** (e.g. telehealth), which have increased since COVID-19, that support increased delivery, including in locations that have previously had limited or no services.
- **Digital tools** that support service-navigation, such as crowd sourced platform ask izzy, the Alcohol and Drug Foundation’s Path2Help which tailors its search features to the ASSIST-Life screening process, and AI tools that reduce admin burden and free up staff time (e.g. yourtown kids helpline uses AI to support case note recording).
    - Where AI tools are used successfully, they recognise the need for informed consent, user protections and staff capacity building. This acknowledges the risk that case notes may be subpoenaed for criminal law and family law matters and unlimited disclosure of what is said (or errors in AI transcripts) could result in adverse outcomes for the young person and result in significant trauma for the sake of administrative convenience.
- **Locally led responses** that support connection, relationship building, and wrap-around supports that meet a range of both community and individual needs. These services are often delivered by a peer, community-led or youth service workforce and focus on service coordination, community education and care navigation. These were referenced by multiple stakeholders and were described as being particularly impactful in rural communities where there is limited clinical workforce; in Aboriginal and or Torres Strait Islander communities; multicultural communities; for young people at risk; and for people with disability. A notable example is the bicultural team approach adopted by CAAC headspace

Alice Springs, where Aboriginal Family Support Workers with strong connections to community are paired with caseworkers (social workers, counsellors or psychologists). This combines the skills and knowledge of both workers to build an understanding of family functioning through both the formal (Western) and informal (Aboriginal) world.

- **Home-based care services**, such as those used in the NDIS, that provide support for the person in their residence until the crisis has passed. This reduces the need to escalate to acute crisis response and in-patient care. Hospital in the home can also be deployed as an alternative to hospital admission.
- **Co-investment** by funders into platforms, rather than funding separate smaller, fragmented services. Examples include where state tertiary services have employed staff specifically to work in enhanced primary care settings to both boost capacity in those services but also create stronger links and integration to support seamless service transitions.
- **Proactive and trauma-informed early intervention approaches** can act as a protective factor for young people in crisis accommodation and out-of-home care by connecting them with mental health supports early, helping the young person to stabilise, make plans and start moving forward. This can be achieved through organisational partnerships that integrate mental health support into crisis accommodation and other settings.

Case study – Cornerstone program

Cornerstone Youth Services in Tasmania delivers a range of holistic services to young people aged 12–25, their families and friends. The organisation focuses on health promotion, education, early intervention and prevention, advocacy, case management, help-seeking behaviours and feeds into Aboriginal support programs. It caters to young people who have difficulties accessing mainstream services due to barriers including transport, cost and geographical isolation.

Barriers

Stakeholders identified **significant barriers for young people to access care**. These include:

- **A lack of information on what services exist**. Young people and families, carers and supporters all noted that a lack of accessible information on existing services makes it difficult to know what services exist, their relevance, and how to access them. Where resources do exist, such as the APS Psychologists directory, they are often outdated and don't help young people to assess what clinician would be the right fit for then. Many young people are unaware of what a Mental Health Care Plan is or how to use it, with some assuming psychology is only available

via out-of-pocket payments. Similarly, new migrant families are often unaware that mental health treatment is an option available through Medicare. As a result, the process can feel overwhelming and unclear, especially for those new to the system or facing other stressors. A lack of basic information delays access to care and creates confusion at the outset of help-seeking.

- **Stigmatising attitudes towards mental health care.** Young people indicated that stigma, particularly from parents or caregivers, can undermine access. Some were forced to stop seeing their psychologist due to parental views that therapy was unnecessary or a waste of money. This barrier is exacerbated by consent processes, particularly for younger people who rely on parental approval or who feel unsafe disclosing their needs within their family.
- **Inequitable distribution of services.** First Nations stakeholders reported on a significant lack of mental health services in remote communities. Despite the growing complexity and prevalence of mental health issues within the community, support services remain alarmingly limited. This means that many young people in remote areas do not receive the mental health care they need, leading to long-term negative impacts on their well-being. Where services are available, they are often infrequent and culturally misaligned. Families, carers, supporters and sector stakeholders emphasised the paucity of services accessible to young people in regional and remote areas, compounded by:
  - a lack of adequate **public transport** services to make in person services physically accessible to young people.
  - A lack of reliable **network connectivity** challenges can then present gaps in access to telehealth and digital services.
  - A lack of **workforce** available or willing to work in regional and remote areas.

> “We have a stepped model of care [in regional and remote areas], we just have the bottom step and the top step.”
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

> “You can multiply all of these [challenges] by 100 in a rural area and probably by 1000 in a remote area.”
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

- **Exclusionary eligibility criteria**. PHNs observed that some services use diagnostic or age criteria to limit service provision as a way of managing waitlists. This was echoed by sector stakeholders, who noted that a focus on diagnoses is exclusionary, and limits who services can and cannot provide services to. Similarly, young people called out the rigid and one-dimensional nature of the service system, which excludes young people unless they meet narrow criteria. They cautioned against the emphasis on seeking a diagnosis as a necessary step in accessing support, as this can lead to over-identification with clinical labels and worsening mental health outcomes. Families, carers and supporters referenced cases where their young person had been excluded from care due to trauma-related issues or the complexity of their diagnosis which was deemed to be in the ‘too hard basket.’

They noted that inexperienced staff who don’t identify eligibility barriers early can cause young people and their families to go through extended assessment processes only to be told that they’re ineligible. Sector stakeholders also noted that the focus on fixed locations, both of services and of young people, can lead to physically inaccessible services or the exclusion from care of young people who are experiencing homelessness or housing transition. Families, carers and supporters observed that geographical divides, such as local government areas or neighbourhood boundaries can act as a barrier to treatment, as well as grounds for exclusion from services.

- **Referral pathways.** Multiple stakeholders, including First Nations stakeholders and parents, carers and supporters, referenced significant difficulties in accessing Child and Adolescent Mental Health Services (CAMHS), with referrals often rejected, seemingly due to capacity constraints. The referral pathway to CAMHS is especially problematic for young people presenting with significant trauma, especially those in foster care or involved in care and protection contexts. While GPs technically have access to a hotline to seek psychiatric advice, the urgent nature of many issues makes waiting on the line impractical and unsafe. Parents, carers and supporters of young people with complex mental health needs, including alcohol and drug abuse and suicidal ideation, report being bounced between CAMHS and headspace.
- **Protracted wait times.** Across sector stakeholders, First Nations stakeholders, young people and families, there was consensus that extended wait times for access to the public health system present a major barrier to care. Young people noted that long delays discourage help-seeking, with many young people avoiding care because of long waits, both for online and in-person services. Families reported feeling exhausted and ‘broken’ from trying all options and being left without support unable to help their young person.

- **Affordability.** All stakeholder groups noted that increasing out of pocket costs are a barrier for young people to access treatment, and for families, carers and supporters to support young people to access treatment. This is particularly acute in the current economic environment. This was further acknowledged by young people, with three quarters of young people citing that cost had prevented them from accessing the support they needed, or that they had reduced spending on essentials to prioritise care. Affordability is exacerbated for international students, those without Medicare, and others facing financial hardship. First Nations stakeholders highlighted the disparity between the private and public mental health systems, and suggested that in some places, such as Canberra, there is greater availability of private services that are accessible only to those who can afford it. This leaves many First Nations families - who may not have such means - reliant on a stretched and underperforming public system.
- **Inadequate Medicare subsidy.** Young people described the cap of 10 subsidised sessions under the current Mental Health Care Plan as inadequate, particularly when early sessions are used to build rapport. The system's reliance on repeat GP visits to renew access to support creates frustration and fatigue. Once sessions run out, young people often pause care for extended periods, disrupting therapeutic progress and increasing the likelihood of disengagement. Even when government-funded supports exist, participants said they are poorly advertised or explained. As a result, young people who could benefit from them often do not know they exist.
- **Workforce attrition.** Sector stakeholders reported that there is an acute shortage of qualified staff, and that staff are increasingly burnt out. This delays assessment and diagnosis for a range of conditions such as ADHD and ASD, and exacerbates barriers to care young people.

> "Geographic location, socioeconomic status, ethnicity and race, have a strong association with a young person's ability to access care, rather than their actual need."
>
> **AUSTRALIAN PSYCHOLOGICAL SOCIETY SUBMISSION**

Stakeholders also referenced **barriers relating to the appropriateness and acceptability of care**. For example:

- **Over emphasis on clinical approaches**. Sector stakeholders observed that assessment and screening tools emphasise diagnosis and medicalisation, and lack consideration of social determinants, as well as the flexibility and nuance to work with diverse young people. First Nations stakeholders also noted the limitations of clinical approaches, which fail to recognise the importance of addressing basic needs (housing, food) before mental health issues can be effectively tackled. Furthermore, disconnection from Country and culture, as well as ongoing grief and loss complicate young people's ability to engage in mental health support. These barriers are exacerbated by intersecting factors of racism, discrimination on the basis of gender and sexuality, and lack of health literacy that's required to navigate services. Failure to engage with these social determinants precludes the impact of clinical approaches to care.
- **Lack of culturally appropriate, trauma-informed care**. First Nations stakeholders noted the paucity of culturally appropriate services that recognise the interconnectedness of family and community, and Aboriginal conceptions of health, as well as clinicians that speak First Nations languages. For First Nations organisations, genuine relationships between service providers and the community is important in the context of promoting cultural safety and tailoring effective, and acceptable supports to address the unique challenges and needs of communities. The lack of culturally responsive services is driven by current funding models which often overlook the necessity of integrating cultural practices into service delivery, as well as limited understanding of the costs associated with establishing culturally appropriate services, such as employing Elders.

Many services do not adequately fund trauma counselling, leaving First Nations young people unprepared to address their issues. First Nations stakeholders emphasised the higher levels of trauma for First Nations young people due to the likelihood of domestic violence and contact with child protection. They called for trauma-informed practices to be implemented in schools in order to create a more supportive, safe space for students to learn and grow. This is essential to effective engagement of students to counter low attendance rates and a lack of interest in education among young people. Parents, carers and supporters from multicultural and refugee backgrounds referenced limited awareness of the impact of conflict-related trauma, and advocated for relational story-telling approaches that promote healing, rather than western clinical models.

> There is a gulf between the models of Aboriginal and Western conceptions of health. It's important for us to understand those communities and what is important to them, rather than for those communities to understand the Western model of care.

SECTOR STAKEHOLDER; ROUNDTABLE

> Culture is part of a model of care – so the question is how we approach it. Families are often excluded – the reality is that they're not part of the process.

SECTOR STAKEHOLDER; ROUNDTABLE

> As soon as something is linked with a government model, kids and families don't trust you.

SECTOR STAKEHOLDER; ROUNDTABLE

> If we're having more local Aboriginal people on staffing, and then obviously if some of those Aboriginal workers have language skills, can talk and speak and understand language, interpret, that can help our young people a lot, hey?

SECTOR STAKEHOLDER; FIRST NATIONS CONSULTATION

- **Limited rapport with clinicians**. Sector stakeholders observed that short term contracts mean practitioners are not around long enough to build trust with young people. This means that young people can be left without support when a short-term program ends, or their trusted contacts move on. First Nations stakeholders reinforced barriers to trust that arise from the disjointed nature of the system and culturally unsafe practices. Young people noted that they can feel emotionally unsafe in therapeutic settings due to a mismatch in values or identity with their clinician, whilst others fear being judged or misunderstood by professionals from a different cultural background to their own.
- **Exclusion of young people's support networks.** Families, carers and supporters reported feeling excluded from their young person's treatment planning. They noted that some clinicians avoid including the family of a multicultural young person in treatment planning, rather than trying to work through the cultural and language barriers together. This can make young people feel more isolated and it also disempowers their support network from advocating on their behalf to ensure that treatment is appropriate and acceptable.

> As parents at the hardest time in our lives, a child who wanted to end his life, we needed support. Instead we were dismissed, excluded from his treatment.

PARENT/CARER/SUPPORTER SUBMISSION

- **Limited choice and control over treatment of personal information**. First Nations stakeholders expressed concern that young people are not given choice or visibility over how their information is recorded, treated, shared and used to inform decision-making.

> I’ve noticed kind of a lack of informed consent in a way of young people, especially not really knowing around notes as well, kind of who has access to notes and when that might be, like, when confidentiality has breached.
>
> **SECTOR STAKEHOLDER; FIRST NATIONS CONSULTATION**

- **Limited availability of crisis and recovery care.** First Nations stakeholders also reported that areas lack crisis care services, relying only on the emergency department at the hospital for urgent cases. Furthermore, while acute services may be available in moments of crisis, there is little support for ongoing care beyond the acute phase. This undermines rehabilitation and healing. Families, carers and supporters observed that limited to no supply of youth mental health beds in rural communities can cause young people to be discharged prior to stabilisation and recovery.

Areas of duplication and fragmentation

There was strong stakeholder consensus regarding the **high degree of fragmentation and duplication within models of care, which is characterised by:**

- **A lack of coordination at a system level.** According to sector stakeholders, this manifests:
  - Within jurisdictional governments where youth mental health services sit across departments and where young people may have multiple touch points with government services, for example education, community services and/or youth justice.
  - Between federal and jurisdictional-run services.
  - Between jurisdictions where youth mental health systems interact across jurisdictional borders.

> Sometimes it can feel that various services and organisations can work against each other -family court, in-stay mental health wards (not therapeutic), youth justice system, etc all need to have sensitivities around youth and family mental health and wellbeing.
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

A lack of coordination between services. Young people described the support system as fragmented and difficult to navigate, involving GPs, headspace, school counsellors, helplines, and informal networks with little coordination. This can manifest between different service types that young people need to access (for example, between mental health services and alcohol and other drug services). While young people often engage with several services at once, these providers rarely talk to each other. As a result, care is siloed, disconnected, and difficult to manage without a dedicated support person. For young people, this means having to repeatedly advocate for themselves across disconnected services.

This was reiterated by families, carers and supporters, who noted that the lack of coordination makes it difficult for them to access integrated care for their young person. The system places the onus on them and their young person to coordinate care, and to reach out to different providers and clinicians to access the information that they need. This is particularly difficult where parents, carers or supporters have a disability (intellectual, physical, neurodivergent, deaf or hard of hearing) and are required to navigate the NDIS, in addition to mental health systems that may not support their needs.

First Nations stakeholders indicated that navigation of a fragmented system that is strongly influenced by a white, middle-class perspective is one of the hardest things for families deeply in need of support. They said that it should not be the responsibility of families to visit or call services to access information and coordination support.

- **Inconsistency in eligibility criteria across services**. Young people noted that inconsistencies in eligibility, funding, and referral pathways across services lead to duplication. Some young people described feeling pressured to underplay recovery just to maintain access to sessions. For families, carers and supporters, different eligibility criteria across services can leave them without adequate support for their young person. Sector stakeholders further emphasised the impact of inconsistency in eligibility criteria based on age, which can force young people and their families, carers and supporters to move between services, programs and support teams at 14, or 16 or 18 years of age to maintain care.
- **Transition points that lack support and coordination, and that impede continuity of care and oversight.** Young people noted that fragmentation is particularly pronounced when transitioning between services stepping up or down in intensity, or during life transitions, such as finishing school or ageing out of youth-specific services.

Sector stakeholders noted that the lack of transition point support and coordination can result in incorrect prescriptions, gaps in prescriptions, and/or retraumatising care where assessments need to be completed again, or young people need to retell their story to gain access to the medication they need. It also precludes continuity of care, as there is no way to keep track of what happens to a young person as they interact with, or transition into other services or systems. Furthermore, primary care teams do not have access to clinical information on a young person's interactions with other parts of the system, for example an emergency room visit.

For young people, the shift from youth to adult services means that they have to start over and lose access to familiar providers at a time when support is still needed. This is exacerbated by workforce transience, such as the graduation or rotation of a student clinician, which forces young people to start over with new providers and delay sustained support. Sector stakeholders and young people asserted the impost that this places on young people to retell their stories multiple times to access care, which can be retraumatising. As young people observed, without a consistent clinician or shared care summary, they are left to repeat their stories and carry the admin burden of navigating a complex system.

> There have been moments where we thought things were improving however with no continuity in care or a whole-of-person approach this was not sustained. I remain very concerned about her future.
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

Sector stakeholders reflected that **funding and contractual models perpetuate fragmentation and duplication**, as they prevent services from collaborating due to the absence of incentives or funding available to support this. Short-term funding cycles make it difficult for processes or services to be formalised and embedded, and the use of inappropriate KPIs in funding structures don't promote meaningful outcomes (e.g. number of individuals serviced). This causes:

- Fragmentation between clinical and psychosocial services due to lack of funding and contractual arrangements to support and promote this. Stakeholders gave examples of youth homelessness and youth substance recovery services that are not integrated with youth mental health.
- Competition between services. As First Nations stakeholders observed, this prevents services that have 'skin in the game' from working together to provide continuity and the best outcomes for young people.
- Short term contracts for services and staff maintain a fragmented system with no continuity
- An increase in the number of services and duplication of services rather than a focus on strengthening the services that already exist. This is largely due to poor visibility, data and understanding of what is available when system actors are making funding and contractual decisions.
- Local imbalances of prevention and promotion, psychosocial and clinical services due to a lack of consideration of balance.

Areas of need

As well as barriers and areas of duplication and fragmentation, **stakeholders identified areas of need** in the current system. These include:

- **Holistic approaches to care and engagement with the social determinants of mental health.** Whilst these factors sit outside the system's control, they need to be considered in solutions due to their impact on mental health. According to sector stakeholders, this requires consideration of the young person's housing, education and employment needs, their relationship with family, carers or supporters, as well as interactions with community services and the justice system which increase the likelihood of mental ill-health. This was reiterated by First Nations stakeholders, who underscored the need for holistic support that includes housing and community resources alongside mental health services. Both First Nations and sector stakeholders also emphasised the importance of recognising cultural identity and background as a key social determinant, as well as the negative ramifications of disconnection from culture on a young person's mental health.

> I worry that we are putting the responsibility on the child and young person to navigate this, missing the environmental context that caused ill-health for them.
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

> [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; ROUNDTABLE

> It would be great to consider the complex political environment of [our jurisdiction] – we have the most incarcerated youth, which is rapidly increasing, we have 10-year-old kids at risk of incarceration… they will be transferred to [a major city] away from community. The political environment being racist, telling them they need to go to prison… housing, poverty, the social determinants are really real here.

SECTOR STAKEHOLDER; ROUNDTABLE

- **Improved access to appropriate care for marginalised young people**, including those who are disengaged from mainstream services, are in the child protection or youth justice systems, or are navigating life with a disability. Whilst there are programs around sport, further education and VET training that are giving young people connection and purpose, First Nations stakeholders noted that services and programs often miss young people who are disengaged or are on the fringes of society. Furthermore, they described mental health support for youth involved in the justice system as critical and highlighted the need to address gaps in timely diagnosis and support for young people upon exiting the justice system. They also asserted that the current child protection system does not adequately address the needs of children and families affected by domestic violence, and that a punitive approach can lead to further trauma. For First Nations organisations, this underscores the need for a more compassionate and effective approach to child protection that prioritises the well-being of children and families.
- **Increased investment in prevention, promotion and early intervention.** Sector stakeholders asserted that current government spending on prevention and promotion activities is insufficient and needs to be greatly increased. Sector submissions called for increased investment in early intervention supports, particularly those targeting young people engaging in harmful drug behaviours, living in out-of-home care, experiencing homelessness, or under the youth justice system. First Nations stakeholders acknowledged that the system primarily addresses acute needs, and that in jurisdictions such as Western Australia, less than one percent of the budget is directed towards prevention and intervention. They noted that recent legislative changes in Victoria have led to increased punitive measures, and that this reflects a tendency to engage with First Nations young people through legislated justice or child protection mechanisms. For example, stakeholders noted that mandatory reports by clinicians are often dismissed by child protection unless police are also involved. First Nations stakeholders affirmed the need for:
    - Preventative approaches to mental health that are culturally responsive and engage with the complexity of issues facing First Nations young people.
    - Easy and affordable access to mental health first aid, which could be embedded in school curriculums.
    - Early intervention programs to prevent long-term mental ill-health for children exposed to trauma, as well as for young people below the age of 12 (albeit out of scope for this project), due to an observable increase in this cohort requiring severe and complex support, without access to funding.

> I know when I was in school I was afraid to speak up about my struggles. With support and discussions from the people around me, I might've been more confident in speaking up. I'm sure there are many people out there who feel like I felt and would benefit from more discussions about mental health and what to do about it.

YOUNG PERSON SUBMISSION

- **Dedicated support for the missing middle** in the youth mental health system. The 'missing middle' describes the vacuum of services and supports for those whose needs exceed the expertise and resources of primary care but are deemed not severe enough by tertiary clinicians to qualify for that level of care[1]. Drivers of this unmet need identified by sector stakeholders include a lack of appropriate and available secondary services compounded by sector-wide workforce shortages. According to young people, it is also driven by narrow eligibility thresholds that only support crisis-level care. The missing middle impacts:
  - Young people who have been deemed either 'not unwell enough' to access tertiary care or 'too complex' to qualify for basic supports. Feedback identified that young people with complex needs (intellectual disability, neurological disability, eating disorders, trauma, complex PTSD) are often turned away because they are too difficult to treat or diagnose. For example, specialists may refuse to conduct a diagnostic assessment of young people with the overlapping symptoms of borderline personality disorder, complex trauma, autism and ADHD. Deaf and hard of hearing young people often reach crisis before access to support is granted, and they are frequently misdiagnosed, overlooked or referred to professionals with no Auslan skills.
  - Families, carers and supporters who are not taken seriously when they seek support for their young person. They reported being told that they couldn't access services until the young person's needs escalated and were left in emergency waiting rooms or discharged without follow up. For families in rural areas reliant on the private sector, they recalled being forced to seek help through the public system or move to a city after their private psychiatrists had refused 'complex cases.'

> I have accessed headspace with one of my children and found it to be a good service. I didn't like my experience when I tried to access the same services for my other daughter who has significant intellectual disability. I felt we were dismissed as not eligible as soon as they heard that.
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

> This middle gap is where people need support. My son got out of hospital not exactly recovered from psychosis and there was nothing really. This would have been a great opportunity to engage in an outpatient type group learning about what his brain had been through.
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

Case Study: YPARC

Youth Prevention and Recovery Care (YPARC) services are a model provided by different organisations in various jurisdictions. They provide accommodation and mental health care and psychosocial services to young people aged 16-25 experiencing moderate to severe mental health needs. They act as an intervention between home and hospital admission with support staff available 24 hours a day to help young people stabilise their mental health and build skills and routines needed to live safely and securely in the community. Stakeholders mentioned this model as prominent and effective, however not every jurisdiction has YPARCs.

> I have been trying to access YPARC for close to 3 weeks now which has been a horribly long effort, compared to the Frankston YPARC which takes self-referrals. It took weeks just to get in for an appointment to get the referral done. Please make the service more accessible [with the ability] to self-refer.
>
> **YOUNG PERSON SUBMISSION**

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[1] O'Dea B, Subotic-Kerry M, Borchard T, Parker B, Vilus B, Iorfino F, et al. A cross-sectional survey of General Practitioners' knowledge of the wait times for mental health treatment and services for adolescent patients with depression and anxiety in Australia [Internet]. medRxiv; 2024 [cited 2025 Jan 16]. p. 2024.09.12.24312088. Available from: https://www.medrxiv.org/content/10.1101/2024.09.12.24312088v2

- **Coordination, consistency and support.** All stakeholders emphasised the need to remove the burden that the system currently places on young people and their support networks to navigate services and coordinate care. Families, carers and supporters reiterated the necessity of improved transitions between services, including ageing in and ageing out, and better supports for escalation of care when in distress. They also called for transparent pathways and eligibility criteria across service providers. For First Nations stakeholders, there is a need to better understand and coordinate support for young people with diverse, complex needs or dual disabilities such as FAS and ASD, as well as with systems such as the NDIS and education. Young people emphasised the importance of coordination to support continuity of care when transitioning across services, as well as information sharing and handover processes when clinicians move on from their roles to minimise disruptions.

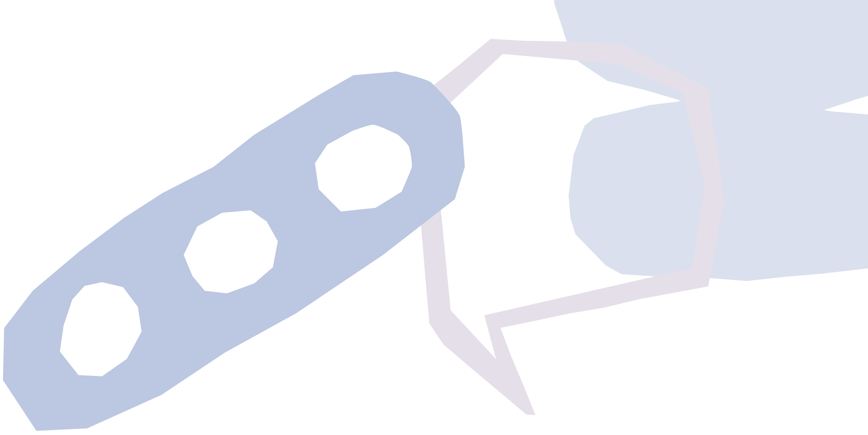
> “I took my daughter to an emergency department after she harmed herself. We waited for two hours they spoke to us for five minutes and then told me she would be discharged and that I could take her to a community health centre tomorrow. It’s very difficult to find an adolescent mental health team when you don’t know where to go looking.”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

> “When my daughter was diagnosed, I was given a piece of paper and told to come back in a week to see how the meds are working.”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

- **Greater diversity of supports, including youth specific services.** Sector stakeholders insisted on the need for more services that are tailored to young people. Currently, many young people are forced to seek help through adult services. Young people expressed a desire for flexible, low barrier supports and spaces that feel casual and safe, where they can talk to someone without committing to long-term clinical care. Whilst talk therapy is the predominant form of treatment, sector stakeholders also cited the need for other forms of treatment.
This acknowledges that for young people for whom talk therapy is not possible or preferred, they are excluded from accessing treatment, or accessing treatment becomes very difficult. For example, 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.

> “Accessibility does not equal acceptability.”
>
> **SECTOR STAKEHOLDER, ROUNDTABLE**

- **Improved attraction and retention of workforce**. The shortage of mental health professionals with appropriate training and availability, especially in rural and outer metro areas, was raised by all stakeholders. Sector stakeholders emphasised the need to improve incentives for people to enter and remain in the workforce, including in underserved areas. All stakeholders reinforced the importance of formalising the role of alternative workforces in the mental health system, as well as the need to create sustainable training pathways to support the development of local workforces. This was echoed by young people, who highlighted the need for structural changes to the training and placement system which is deterring people from entering or remaining in the psychology profession.



Opportunities to strengthen the system

As well as seeking stakeholder views on the existing system, we also consulted all stakeholders on opportunities to strengthen the system, including through development of new and refined models of care.

Prior to commencing national consultation, the Consortium engaged in a full-day workshop to reflect on the key challenges and opportunities for new and / or refined models of care. Insights from this workshop shaped the early advice delivered to the Department in January 2025.

The early advice was tested during national sector roundtables and through the public submission processes open to young people, families, carers, supporters and sector stakeholders, where participants were invited to provide feedback. While most young people, families, carers and supporters chose not to respond directly to the ideas in the early advice, among those who did, young people were generally positive about the early advice. Families, carers and supporters were also broadly supportive, though some offered more nuanced feedback, including some caveats and concerns.

Consultation with stakeholders also went well beyond the ideas put forward in the early advice. This included:

- Areas that were acknowledged as insufficiently addressed through the early advice – including prevention, how to support priority populations (such as those in regional and remote areas, and First Nations young people)
- Ideas that emerged organically from consultations, beyond ideas from the early advice.

The key themes we heard from consultation on opportunities to strengthen the system were:

- Young person-centred
- Accessible and integrated care
- Care coordination and service navigation
- Building the workforce while recognising current constraints
- Integrating psychosocial and clinical supports
- Drawing on digital tools and platforms
- Strengthening prevention and promotion
- Addressing the missing middle
- Supporting priority populations

The report incorporates case studies identified through consultation feedback that highlight how stakeholders have responded to opportunities to strengthen the system through implementation of specific processes, practices or mechanisms.

Young person-centred

Stakeholders strongly agreed on the importance of a youth-centred model of care that coordinates services and support offerings around young peoples' needs and preferences. Stakeholders called for a shift to a youth-centred model of care that:

- **Views young people holistically**, rather than through a narrow diagnostic lens. According to sector stakeholders, this involves recognising other contextual factors in the young person's life that impact their mental health, including family dynamics, trauma, care responsibilities and co-morbidities. For young people, feeling seen and understood is valued more than receiving a diagnosis. They expressed a desire for clinicians to engage with their whole story, not just symptoms or risk profiles, and to recognise their identities, including whether they identify as being LGBTIQA+, neurodivergent, culturally and linguistically diverse, or having a disability.
- **Engages with the social determinants of mental health.** Young people and First Nations organisations raised several social and structural issues that affect their mental health and wellbeing, and that need to be addressed

or acknowledged as part of a holistic approach to care. These factors shape their mental health challenges and their ability to seek and sustain support. They include:

  - A lack of adequate support for securing and navigating housing options, whether in planned transitions (e.g. moving out when ready) or during periods of crisis. Concerns were also raised about affordability and availability, with rising rental costs and limited housing stock in preferred locations forcing individuals to relocate away from their support networks, including family and employment. This is exacerbated for young people with disability, in out-of-home care, who are without family support networks, and/or involved with the criminal justice system.
  - Limited access to food. As one young person put it, *'It's impossible to get healthy feed, unless you're going to buy all the ingredients, take them home and cook it, and sell a kidney to buy them all.'*
  - Language barriers. For some First Nations populations for whom English is not their first language there are limited ways to describe their mental health. Migrant and refugee families also reported the challenge of learning English added increased complexity and misunderstanding when seeking help for their young people, often leading them to feel misunderstood or the young person disengaged. The Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council have developed visuals aids which can be used by police and nurses to help understand what people are feeling.

- **Honours young people's preferences regarding how they want to access care**.
  - Young people described wanting services that adapt to their lives, as well as flexibility in how and when support is accessed, choice of clinician, and meaningful consent processes. They emphasised the need for clinician matching platforms and clear alternatives where a relationship has not worked, to prevent young people from having to re-engage with clinicians that have previously failed them or delaying help seeking until crisis point. Young people called for subsidised or free trial sessions, as well as informal, non-clinical options, including community-led spaces, drop-in hubs, and casual check-ins with someone trusted and relatable. They recommended a broader range of treatment options from the outset, not just medication or individual therapy, but alternatives such as group support, digital platforms, or peer-led spaces. This would support informed decision-making and increase the likelihood of engagement.
  - Sector stakeholders recommended providing support through a non-clinical space that allows them to connect with other young people, and access basic amenities (e.g. a phone charger). For example, young people may be more receptive to seeking support from people they trust in community organisations/clubs or through their personal networks. They also highlighted the need to accommodate young people's preferred means of communication, and to deliver services in line with youth-friendly hours (e.g. after school and evenings).
  - Families, carers and supporters suggested friendly, public spaces like council libraries as a forum for engagement and connection with others through peer mentoring or small group therapy.

> “My kid didn't want to sit in a room with a psychologist, but they were happy to hang out in the school library doing art with a youth worker, who then transferred that engagement to the local headspace and showed my young person around, casually introduced them to psychologist and eventually my young person agreed to see them. My younger child hasn't had this option. They've just meet with an intake worker and then onto waitlist for counselling with a different person. That's scary for a 14yo!”
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

> “It'd be nice if these sorts of sessions could be after hours or on the weekends too as I liked being able to connect with other young people.”
>
> **YOUNG PERSON SUBMISSION**

> “Every service has a phone number, but kids want to text. We are missing a whole group of young people who don't want to talk on the phone.”
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

- **Supports co-design of services.** Sector stakeholders asserted the importance of services for young people that are co-designed with young people but insisted on the need to diversify the range of people consulted to ensure that the same individuals do not carry the burden of consultation. This was reiterated by families, carers and supporters who asserted the need for co-design that not only elevates lived experience to inform and improve services but also elevates the important role of lived experience workers.

- **Takes a trauma-informed approach to care.** Services and the care that they provide need to be trauma informed. This involves recognising the impact of trauma on a young person's mental health, and the impact of their mental ill-health on those around them. It also requires consideration of ways to minimise the burden of retelling for a young person, which can relive / revive that trauma. All stakeholder groups called for trauma-informed care that recognises the unique challenges experienced by young people, including the impact of war, displacement, exclusion from language and community as suffered by deaf or hard of hearing young people, as well as domestic violence and interaction with child protection. They affirmed the need for flexibility, patience, open-mindedness, empathy, and care when working with young people affected by trauma, as well as the importance of relationship and trust-building. They also highlighted the value of dedicated supports for family members experiencing trauma as a result of caring for a young person with complex needs, including difficult behaviours.
- **Empowers the young person's chosen nexus of support.** Sector stakeholders noted that the mental health system can alienate young people's families (or chosen families), carers and supporters. This was echoed by families, carers and supporters, who described a lack of consistency in terms of how parents or carers are treated by service providers. Whilst some services recognise and include families, carers and supporters, others dismiss and exclude them. For multicultural families, language barriers can be disempowering, and even where translators are available, misinterpretation of the cultural meaning behind words can create frustration and cause the person to feel ignored. Young people reflected that inclusion of chosen family, friends or peer mentors should not only be a fundamental part of care but can also increase accessibility and comfort. This also acknowledges that help seeking is often prompted by a young person's friends, family, carer or supporters, rather than professionals. Stakeholders suggested options to empower the young person's support network:
    - Sector stakeholders suggested that empowerment of the young person's support network can occur through scaffolding and supports that build resilience and equip them to minimise impacts on their own mental health. For example, siblings of young people experiencing mental ill-health have been identified as a group that is often particularly in need of support.
    - Sector stakeholders and families, carers and supporters called for information in a form and register that is accessible and meets them where they are (e.g. not being limited to complex written information in contexts where there is low literacy at a population level). This includes advertising across a variety of mediums – print, local community and digital – regarding available services, after-hours supports, associated funding and eligibility requirements, and other basic information on mental health.
    - First Nations stakeholders recommended models such as Foundry, which provide access to information and support for families regardless of whether their young person is engaged.
    - Families, carers and supporters recommended dedicated long-term funding to recruit local peer workers in the community to support language and accessibility barriers and help multicultural families navigate services.

> "There definitely needs to be more support and guidance for parents and carers when their child is facing these challenges. Until the child gets into a service the child really only has that adult so they need to be equipped with everything they can be to support their child during the waiting stage."
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

> "Another difficulty was the gap between generations. Young people were adapting quickly to Australian ways of life, while parents like me were still holding onto our traditions. This sometimes led to 'cultural shock' within our own families, with misunderstandings about what was acceptable or how to deal with problems. The mental health system didn't really help us bridge that gap, and in some cases, it made the divide feel bigger."
>
> **PARENT/CARER/SUPPORTER (REFUGEE BACKGROUND) SUBMISSION**

- **Recognises the young person's cultural needs and empowers their community**.
    - First Nations organisations stressed the importance of models of care that incorporate First Nations cultures and community involvement. This can take the form of increasing funding for culturally-led

programs, which promote factors such as healthy relationships and conflict resolution within a cultural lens. Service providers highlighted that on Country programs were also seen as very important to improving the mental health of First Nations young people. First Nations organisations also highlighted the value of cultural sensitivity training for all service providers, subject to ongoing evaluations to ensure effectiveness. For example, stakeholders reported that whilst organisations like Victoria police have participated in cultural sensitivity training, it has not translated into cultural competency. They also emphasised the need for services to be accessible and tailored to the unique needs of First Nations youth, including those aged 12-25. Whilst flexible outreach approaches can work well, organisations also called for access to ongoing care. First Nations organisations supported the establishment of First Nations controlled residential facilities that provide 24/7 support and a safe space for young people to receive care and address their mental health needs while also focusing on family reunification and community healing. Finally, they called for ongoing engagement with policymakers to ensure that models centre on the needs of First Nations young people, and their voices are adequately represented in policy recommendations.

- Families, carers and supporters highlighted the need for services to recognise and support diverse languages, including Auslan and languages other than English. They noted that language around mental health differs among cultural groups, and that collective approaches such as group-based counselling and storytelling may be more effective and welcoming than one on one counselling.

> There were moments where it felt like the services were not set up to understand our culture or how we do things—for example, we tend to talk about our problems in groups, not one-on-one, and we value sharing stories as a way of healing.
>
> **PARENT/CARER/SUPPORTER (REFUGEE BACKGROUND) SUBMISSION**

> Assessment tools that monitor illness and symptoms are often grounded in a biomedical model, which can inadvertently marginalise other explanatory frameworks of care—such as those shaped by cultural beliefs and values—that influence how individuals understand and present their health concerns.
>
> **SECTOR STAKEHOLDER; ONLINE DISCUSSION FORUM**

Case Study: Culturally appropriate clinical tools

Dr Tracy Westerman is a Nyamal woman and psychologist from the Pilbara region of Western Australia who has developed clinical tools that are tailored to the cultural factors of First Nations communities, and that are responsive to the unique circumstances and contexts of their young people. These tools support engagement with the cultural factors that are often missed in the mainstream system and actively involve the young person's kin in their mental health journey.

Accessible and integrated care

The early advice contained two ideas relating to strengthened integration that were tested with stakeholders. These were harmonising the age range of the youth mental health system and building a national, person-centred data system.

Harmonise the age range of the youth mental health system

The first idea involves harmonising the age range of the youth mental health system across Australia to encompass 12 to 25-year-olds. It arose in response to inconsistencies between different jurisdictions' approaches to defining the 'youth mental health' age range that exacerbates the challenges of transition, access, and integration between services.

Sector stakeholders at in-person roundtables indicated strong support for harmonising the age range as a mechanism to simplify the system and remove barriers to care. They described the use of the age range as a largely arbitrary measure that does not reflect the individual developmental needs of young people. Submissions provided by sector stakeholders reinforced support to align the age range to reduce transition disruptions and increase the continuity of care, although not all organisations agreed on the proposed age range.

Families, carers and supporters were also in favour of this idea and noted the need to make cut offs less restrictive. They observed that because it takes time for a young person to build rapport with a clinician, having to chop and change because of an age cut off is extremely disruptive.

> “Someone needing help is needing help on each side of their 18th birthday!”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

Sector stakeholders consulted at the roundtables drew attention to the complexities associated with implementation of this idea. In particular, they noted that changes in the age range would expand the scope of eligibility for existing services. This would exacerbate workforce issues and would also require changes to training and education of practitioners. Submissions made by sector stakeholders also foregrounded these challenges and highlighted that broadening the age range requires knowledge of services across a broader spectrum.

Stakeholders made different suggestions in relation to this idea. Some were supportive of harmonisation but took different views on what the age range should be. For example, some stakeholders suggested changing expanding the age range to 10 rather than 12 to years old, to minimise the upheaval in young people’s lives as they undertake parallel transitions from primary to secondary school, and from one mental health system to another. Families, carers and supporters also reported concerns about age restrictions for young people with moderate to severe intellectual disability, as a 14-year-old may have a cognitive age that is much younger. Others argued that, instead of harmonising the age range, we should focus on softening boundaries around the age range so that services can make referrals and care decisions for young people where it is developmentally appropriate.

Build a national, person-centred data system

The second idea involves the development of a standardised approach and enabling infrastructure to support collection of data on the youth mental health system.

Sector stakeholders consulted through the submissions process and the in-person roundtables expressed mixed support for this idea. This was partly driven by a lack of detail contained in the early advice as to what this idea would look like in practice.

Common reservations were expressed across all stakeholder groups regarding:

- The cost and difficulty for government of building a new data system, as well as the capacity of the workforce to implement a new system during a workforce crisis.
- The sensitivity of mental health data and risks relating to privacy and a loss of young people’s agency over the collection and treatment of their data.
- Potential for stigmatisation of young people by allowing past diagnoses to follow a young person and determine their eligibility, or exclusion from services.
- Imposition of a new system that would be costly to implement, rather than fixing gaps in existing approaches to data collection.

First Nations stakeholders were also reticent about the establishment of a national data system. They emphasised that data sovereignty is a critical concern, and noted the inflexibility of Western data systems in recognising or incorporating First Nations languages. There is a need to share any data collected with local communities.

> “Indigenous data sovereignty is critical, there is a need for First Nations communities to have access to data collected about them to inform local solutions.”
>
> **SECTOR STAKEHOLDER; FIRST NATIONS CONSULTATION**

Sector stakeholders in support of this idea emphasised the need to consider resourcing requirements to facilitate effective implementation. They recommended that the data system be designed to enable tracking of live capability and capacity across the system to enable referrals to services that are immediately available. This would mitigate wait times across the system, and could be used to track need and inform future planning. In addition to tracking system capacity, they also noted the need for the platform to follow individuals within not only the youth mental health system, but also across related systems. They reiterated the importance of young people’s agency in determining how their data is stored and used, and highlighted the potential for the system to safely share their stories without the burden of re-traumatisation. The platform could also be used to share care plans between services, and better articulate outcomes for priority populations through collection of demographic data.

Some young people were supportive of a platform that centralises information relating to their condition and care. They identified that the platform, which would need to be codesigned with young people, could capture information on areas of focus for improvement or development, as well as agreed actions. This could potentially support continuity of care across service touchpoints, whilst also reducing the burden on the young person to continually repeat themselves across services.

Further suggestions for integration

Sector stakeholders shared further suggestions for strengthening integration. They suggested building flexibility into funding and contractual models to encourage collaboration and integration between services. They noted that this would depend on covering the full cost of integration and attaining leadership buy-in. First Nation stakeholders echoed this sentiment and advised that long term funding is needed to build rapport with the community. According to sector stakeholders, the benefits of co-location, which is a useful, but not essential feature of integration, are dependent on fulfilment of these preconditions. Finally, they highlighted the value in supporting communities of practice to strengthen relationships between services, with current examples including the forums convened by PHNs.

Case study – Sector alliance

A PHN from one region discussed a Mental Health Drug and Alcohol Alliance formed by all service providers in that region in the areas of mental health and treatment support for users of alcohol and other drugs (AOD). This has been one of the strategies implemented within the region to help address the ebbs and flows of staff. The Alliance meets monthly to discuss support coordination, emerging issues, trends and best practice. It has reduced siloing of services in that region and enabled more effective cross-collaboration to navigate wait times and lead group projects, such as the co-development of a Lived Experience and Peer Workforce in that region.

First Nations stakeholders recommended a holistic approach to enhancing youth mental health services for First Nations young people, including through provision of services on Country that support young people to engage in culturally relevant healing practices. They emphasised that the ongoing impacts of intergenerational trauma underscore the critical need for responsive, wraparound support systems. Winnunga Nimmityjah Aboriginal Health and Community Services in the ACT advocated for a more coordinated and integrated model of care. As part of this model, a child sees a GP for initial medical assessment, is referred to paediatric specialists for diagnosis, and then receives tailored support from psychologists and other specialist practitioners. Ideally, these services would be co-located to reduce barriers and create a more seamless patient experience. Derby Aboriginal Health Service described collaboration among services in Derby, including community mental health and Anglicare, and noted its efforts to coordinate services to reduce overwhelm for families, and simplify service navigation for young people. It was recognised that schools are an important community asset in many areas and have the potential to play an important role in assisting First Nations young people with their mental health. However, schools are often not seen as safe and welcoming, and many First Nations young people are disengaging. It was recommended that school engagement strategies be considered.

Case study – 13YARN service directory

13YARN has built a directory of services that can provide culturally safe care to First Nations young people. 13YARN acts as a referral service and this is incredibly valuable to their operation but requires significant resourcing to ensure it remains up to date and can provide services (e.g. text based) that young people want to engage with.

Young people called for better collaboration across education, health, housing, and social services to create seamless care and reduce the need for retelling the lived experience of mental ill health. They advised that mental health systems be connected to other youth-facing services like child protection, justice, and digital platforms to ensure no young person falls through the gaps. To support collaboration and connection, they encouraged establishment of integrated hubs with wraparound supports located in the community.

Participants also supported the presence of mental health services in schools, universities, and other familiar settings. Whilst they welcomed school-based supports, they cautioned that these must be implemented carefully to avoid retraumatising or stigmatising students. They also warned that the transition from these settings to broader systems is a major gap that creates difficulties for young people to maintain continuity of care once they have aged out or left education settings.

> “Governments have included the need for better systems integration of services and departments for years without ever achieving it, so when will they achieve it, and what is stopping them?”
>
> **YOUNG PERSON SUBMISSION**

Care coordination and service navigation

The early advice proposal to pilot approaches using care navigators was tested with stakeholders through the consultations. Care navigation has already been applied across many settings and systems and can look very different depending on the context in which it is implemented. A range of people, from peer workers to other types of professionals, can perform a care navigator role. Sector stakeholders expressed strong support for the use of care navigators through both the in-person roundtables and the submissions process and referenced several examples where the model had been effectively implemented.

Sector stakeholders identified conditions for success:

- They emphasised the need to formalise and build the capacity of the existing workforce and infrastructure. This includes people, either within services or the community, that may already be playing a similar role in the system or are well positioned to play this role (because of trusted relationships within the service / community). Often these people perform this role without formal role clarity, recognition or renumeration. Empowering this workforce through partnerships, role formalisation and capacity building and integration within the system is critical to minimising duplication and fragmentation and leveraging what is already there.
- They advised that co-design be undertaken with young people, families, carers and supporters to ensure that the care navigator role is responsive to their needs and contexts.
- They suggested that care navigators be collocated across services / stepped care continuum to support whole of system understanding / knowledge.
- Finally, they encouraged adoption of digital tools to complement the care navigator role.

> “Governments have included the need for better systems integration of services and departments for years without ever achieving it, so when will they achieve it, and what is stopping them?’Love the sound of care navigators so they have one person that the young person and family can turn to. My young person started in headspace and had a clinician he loved and then she moved to private. He was left floundering and wasn’t interested in talking to anyone else.”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

Young people welcomed the establishment of a navigator role, or single consistent worker responsible for guiding them across multiple services, organising follow ups and managing referrals. They were particularly encouraging of a navigation or case coordination support for young people with complex needs, those transitioning between services, and priority populations. Families, carers and supporters were also supportive of a care navigator role. They affirmed the value of appointing case workers to help them navigate the system, including in hospital or in emergency. Given the lack of interim assistance between admission and meeting with a psychiatrist, which can take several days, they suggested that care navigators could provide interim support by acting as a point of contact while young people are waiting to access services. In submissions, young people, families, carers and supporters did stress the importance of ensuring that navigators were properly trained, supported and not given too high a caseload if they were to be effective.

> "It's not going to fix anything but to have someone who has some nice words to keep you company in between while you wait."
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

> "Families get blamed for their kids not accessing services – when actually we aren't supporting the families to navigate and coordinate."
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

Case Study: Blackbird Initiative

The Blackbird Initiative was recently established as the first care navigation model within eating disorder services in regional Queensland. The 18-month program included 143 participants between 14 and 67 years old, referred to the program by their local health service provider after meeting the criteria for an eating disorder. The program was delivered by service providers trained in eating disorder treatment, with the support of one nurse-led care coordinator. The care coordinator played a central role, engaging patients with treatment, guiding them through the care system and assisting clinicians to implement team care (i.e., triaging referrals, supporting formation of treatment teams and matching services to patient needs). At completion, 100% of service providers agreed that employing care coordinators was the top priority for establishing an effective eating disorder care system.

Case Study: Indigenous Social and Emotional Wellbeing at University

An Indigenous Social and Emotional Wellbeing worker at an Australian University described the role that she plays as a point of contact for Indigenous students. She chats with them about their mental health, helps them to engage with clinical psychologists and supports them culturally throughout the process. She reported that many Indigenous students don't present to a service until they are in crisis and often have mental health concerns or learning difficulties that have gone undiagnosed due to cost or accessibility. Her role helps to facilitate internal and external referrals to services that are culturally sound. (Supporter, online submission)

Develop a directory of evidence-based services

The early advice introduced the idea of developing a national resource for practitioners to provide improved advice on mental health supports and services. Consultation with sector stakeholders at the in-person roundtables revealed some reluctance towards this idea. Stakeholders expressed concern that a directory would require resourcing to support oversight and regular updates, and that it could unfairly exclude organisations that may be providing valuable services, but do not have the resources to fund evaluations and gather the required evidence for inclusion in the directory. They highlighted the risk that this presents to organisations whose cultural impact may be undervalued within western evidence criteria and emphasised that this may result in a power imbalance where certain views and judgments dominate determinations regarding what constitutes sufficient evidence. They also noted the risk of duplication with existing PHN directories, the lack of a coherent data dictionary to support the directory, and its irrelevance to remote areas where there are no services.

Stakeholders in support of the idea highlighted the value of a user-facing or practitioner-facing directory of services, both psychosocial and clinical. They suggested that the directory could support identification of services according to need, and that this process could be enabled through application of AI technology. They also spoke to the benefits of a service directory that captures the capability and capacity of services, to target referrals to services with immediate availability. Support for this idea was particularly strong among young people, and families, carers and supporters.

Building the workforce while recognising current constraints

Sector stakeholders emphasised the importance of workforce as a critical enabler of a sustainable, effective mental health system. Through the in-person roundtables and the submissions process, there was a clear consensus that attraction, retention and development of the mental health workforce requires:

- **Understanding of the existing workforce capacity** and areas for uplift prior to introduction of new services.
- **Diversification and expansion of workforce** through strengthening and incorporation of informal, non-clinical workforce, local upskilling and authentic partnerships with communities. This was echoed by young people, who referenced a clear need to grow and diversify the mental health workforce through more funded university places, support for placements, and incentives to work in youth-specific settings. They also noted that there are many sporting clubs that want to partner with initiatives or support youth mental health, subject to funding.
- **Long-term, sustainable levels of funding** to support the retention of staff, and by extension, the knowledge and expertise that they bring to a service or relationship with a young person. This was reiterated by young people, who noted that it takes time to build a relationship, but as staff move on, the trust that had been built over time goes with them. They expressed a desire for long-term relationships with clinicians or services that understand their story.
- **Improved training to facilitate capacity building** and scaffolding to support wellbeing and resilience. This involves also ensuring that early career staff can shadow experienced staff. Investment in training is particularly important because services that are stretched for resources or have particularly rigid funding are unlikely to be able to prioritise staff development.
- **Clearer career progression pathways** would benefit staff retention, development and services overall.

Young people also drew attention to the need for teachers, school staff, and residential care workers to undertake ongoing training in mental health to respond effectively and with care. Families, carers and supporters corroborated the importance of training to better equip them to support their young person's needs. Whilst there is some training for peer workers and lived experience workers, they noted the potential for improvements to optimise the effectiveness of the workforce. They stressed the need for staff working in the youth mental health system to be trained in family inclusive practices, including understanding how to respectfully engage people of different languages and cultures.

Stakeholders were strongly supportive of efforts to strengthen the peer workforce. Sector stakeholders referenced the likelihood of increased rapport between young people and peers who share similar experiences of mental ill-health or are at a similar stage of life. They acknowledged that young people with mental ill-health already feel marginalised from other young people, and that this model counters that isolation through creation of peer connections. An enhanced peer workforce also has the potential to reduce the burden on young people to articulate their stories to adults who may not easily understand them. In contrast, peers are better placed to understand the young person and advocate on their behalf. Young people noted that lived experience roles, peer mentors, and youth workers who already have trusting relationships in the community should be recognised and better supported. Sector stakeholders were in favour of expanding and strengthening the peer workforce through better funding, pay and training, including placements and a supervision system to support people doing Cert IV. Families, carers and supporters recommended family peer support as a mechanism for promoting information sharing, community and belonging, and noted its benefits for families newly arrived in Australia, or for parents, carers or supporters whose own family and friends are reticent to speak about mental health. They also suggested appointment of peer workers at every headspace centre.

> “Lived experience roles are often underpaid, under-supported, and treated as secondary to clinical voices.”
>
> **LIVED EXPERIENCE AUSTRALIA SUBMISSION**

> “We all see the value of social support and peer support groups, I see a lot of groups like that in the neighbourhood but many have funding problems so they could only stay for 6-10 months – we need sustainable funding for social groups.”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

> “We talk a lot about peer workers. I would like to see a family peer worker at every headspace centre. I’ve been at a centre as a parent and talking to clinicians, it’s like okay now what. We couldn’t relate. There should be more opportunities for lived experience workers who ‘get it’, then people are going to feel safer to open up and ask questions.”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

Young people called for services to have more staff embedded in schools and expressed interest in the appointment of an in-between person to help improve service experience.

First Nations organisations highlighted the unique workforce challenges that they face when delivering services and support to First Nations communities. Winnunga Nimmityjah Aboriginal Health and Community Services in ACT reported that its workforce was exhausted and burnt out, and that in the absence of an adequately resourced and responsive system, it was shouldering the burden in Canberra as the primary provider of culturally safe care. It was also forced to fill gaps in psychological services, despite lacking access to paediatric psychology or psychiatry. The organisation called for immediate support to expand its psychology services, with a view to eventually integrating broader psychiatric support.

Issues raised by other organisations include that no one is funding culture, and that currently the cost of becoming a culturally safe organisation is borne by the not-for-profits through surpluses. They also described the paucity of First Nations representation in senior roles required to create culturally safe and racism-free services. This is compounded by a lack of First Nations people with lived experience and the necessary skills in services. Services don’t have the means nor the understanding to effectively build and roll out a culturally responsive workforce at the scale required.

To address some of these challenges, they called for appropriate funding to support quality, culturally safe programs on Country that involve Elders, as well as cultural competency training for all workers. They encouraged investment in training more First Nations people to work in youth mental health services and noted the need for wrap-around support to enable participation in programs. This is important, as First Nations young people reported feeling a greater sense of comfort engaging with other First Nations people who are more likely to understand them.

Case Study: Groote Eylandt

An employment pathway trainee pilot program in Groote Eylandt is supporting Aboriginal people to pursue a career in healthcare without having to leave their community and families. The program, which is a collaboration between NT Health, the Department of Corporate and Digital Development’s Early Careers Team and the Northern Territory Primary Health Network, aims to grow the local workforce and ensure that Aboriginal people can access culturally appropriate healthcare delivered by people they know and trust. Trainees build foundational knowledge and skills over time in a flexible and supportive training environment

Supporting and integrating psychosocial and clinical supports

While there is increasing evidence of the benefits of psychosocial supports, clinical and psychosocial services are not currently well-integrated. The early advice proposed to better integrate clinical and psychosocial supports. This idea received the strongest support from sector stakeholders consulted through the roundtables and was echoed through sector submissions (including from organisations that are already delivering integrated services).

> A shift away from a purely biomedical model is essential. Emphasising psychosocial and culturally relevant explanatory models allows for a more comprehensive understanding of a young person's experience and needs.
>
> **SECTOR STAKEHOLDER; ONLINE DISCUSSION FORUM**

First Nations organisations welcomed this idea and noted the need to dedicate funding to activities that promote well-being rather than merely addressing mental health crises. Young people were overwhelmingly in favour of a blending of psychosocial and clinical support that could be available under one roof or through well-coordinated referrals. This would combat services operating in siloes and be responsive to a wider range of needs. Similarly, families, carers and supporters called for stronger investment in community-based and place-based youth mental health programs and central hubs that provide integrated care beyond clinical interventions.

> [First Nations young people] fear clinicians, because they fear getting labelled.
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

PHNs referenced the benefits of expanding the Commonwealth Psychosocial Support Program (CPSP) to direct funding into a youth CPSP, which includes clinical and psychosocial support. The model blends CPSP with mental health clinical care coordination in a step-up-step-down approach that wraps around the young person to meet them where they are at and has reported very positive outcomes for young people and families.

Nevertheless, sector stakeholders also raised concerns regarding this proposal:

- They warned that integration of psychosocial and clinical would require considerable resourcing, and that there is not currently evidence or data collection approaches that straddle clinical and psychosocial care.
- They stressed the need to consider workforce challenges, ensuring that psychosocial care doesn't sit solely with an already strained clinical workforce, and to resource practitioners to undertake case management as part of their regular workload.
- They highlighted the risks to young people's confidentiality, autonomy and choice in determining who has access to their information. For example, integrating housing services with clinical services could be problematic in the context of a young person's mental ill-health affecting their ability to pay rent.
- They recommended that lessons be taken from the psychosocial supports that have had the greatest impact on neurodiverse young people accessing the NDIS.
- Whilst most stakeholders supported integrated hubs, some warned that integration between psychosocial and clinical will not be appropriate in all cases, or acceptable for all young people.

> Mental health education for psychosocial partners and simple processes for preventative education of young people engaging with other supports, and for early detection and identification of mental health needs for even earlier intervention and integrated support.
>
> **SECTOR STAKEHOLDER; ONLINE DISCUSSION FORUM**

Drawing on digital tools and platforms

Stakeholders were consulted on the early advice recommendation to leverage digital technologies in practice and service. Most stakeholders, including First Nations organisations, young people, families, carers, supporters and sector representatives expressed support for this idea. However, they noted that there wasn't enough specificity in the early advice around the design and application of these tools. This may have compromised support for the idea, due to varying interpretations and levels of understanding amongst stakeholders.

Discussion at the roundtables elicited the following reflections from sector stakeholders on the positive potential of digital technologies to:

- **Improve access to care** for young people living in regional, rural and remote areas, and facilitate flexible service delivery including out-of-hours
- **Support prevention and promotion** and improve mental health literacy
- **Provide a destigmatised alternative to physical services** (which young people may be reluctant to visit for fear of identification / stigma)
- **Alleviate administrative burden** on the workforce, through tools that streamline processes and substitute or minimise manual tasks. For example, stakeholders referenced technologies that can record case notes to enable staff to free up their time for other work.

Young people echoed sector stakeholders' acknowledgement that digital tools can increase accessibility, especially for those in remote areas or outside usual hours and noted the potential for digital innovations like VR or app-based communities to reach isolated young people. They suggested that digital delivery take the form of video calls, email check-ins, and moderated peer forums, and that digital engagement strategies should be clear, safe, and easy to navigate.

Families, carers and supporters reiterated the role of digital technologies in providing a more approachable, less judgemental form of support for young people. For example, they referenced the potential benefits of a national texting service for young people who prefer the anonymity of text to open dialogue, and for members of multicultural communications where mental health is not discussed, as well as a ChatGPT platform designed specifically for youth mental health. They emphasised the benefits of digital delivery for accessibility and suggested that it can provide an important bridge to rural and remote areas where people may have limited services (subject to availability of internet and data coverage). They also highlighted the value of digital information resources that build their capacity to support their young person and navigate the mental health system, such as a mobile app through which they can filter services according to their needs, as well as ChatGPT (for generic information). In contrast, some parents felt that technology had caused their young person to become disconnected, isolated and lacking in purpose and agency, and that this in turn diminished their ability to support them. Similarly, First Nations stakeholders indicated that digital offerings had been well received by many young people and also pointed to the benefits of digital offerings that provide information resources in indigenous languages, and assist with identifying and booking services.

> "As much as it is quite scary, I've been relying on ChatGPT. I have an Autistic son with a PDA profile, one night my husband and I weren't doing well, so I put it into ChatGPT and it helped me. It started off being empathetic, saying 'that must be really hard' and then went into information. It's there, it's accessible. It helped me feel better."
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

> "When I first came to Australia, I wanted to access mental health services, but my daughter wasn't keen (there is a general distrust with authority – teacher counsellors). Technology seems to be the common denominator for young people. They don't like talking verbally, they like texting – if there is a way to talk to them via text. I felt my daughter was more comfortable with that. For them, computers don't judge."
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

One example of leveraging digital tools that was provided by a family member / supporter stakeholder was the possibility of developing an app similar to the existing 'Be My Eyes' app to improve service accessibility. 'By My Eyes' connects blind or low vision users anonymously with volunteers who can provide real-time descriptions or assistance through video. The person who is blind or has low vision can use the app to put out a call if they need help 'seeing' something or navigating a task. A notification is then sent out to volunteers and an available volunteer can respond immediately to provide visual support through verbal instruction. The stakeholder proposed that headspace, in collaboration with digital providers of mental health services, could pilot this kind of app where the 'volunteers' are clinicians and trained youth mental health workers. If a young person wanted to use the app to speak to a free clinician or mental health worker via video connection or telephone, a notification would go out to all registered providers and clinicians who had the app and anyone who did not have a current work demand would be able to respond immediately.

However, sector stakeholders expressed concerns with the use of digital technologies, and suggested the following caveats:

- **Digital should be an alternative to, rather than a substitute for in-person delivery**. In some cases, young people may prefer in-person delivery during their first few sessions and may be comfortable transitioning to online delivery following the relationship / trust establishment phase. It is important that young people retain the choice to determine what mode of interaction is best suited to their needs.
- **Digital tools should be inclusive of all young people.** There are some young people who are excluded from digital platforms, may not have access to private devices or may have specific accessibility requirements. As described through sector submissions, digital

tools and platforms need to be inclusive of all young people, such as members of the deaf community who require Auslan and captioning in plain English, as well as young people for whom English is a second language.

- **Upskilling is required to support use of digital tools.** It cannot be assumed that all young people know how to engage with digital platforms and systems. Digital delivery should be complemented by training or instruction / guidance on how to engage with the platform.
- **Trust is an essential precondition for digital delivery**. Digital delivery needs to cultivate trust with users, including by ensuring that young people have access to a private device and have faith in the privacy of data collected through digital settings.

> "It's about choice – what works for someone isn't going to be something that works for another."
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

These concerns were also articulated by First Nations stakeholders, young people and families, carers and supporters who emphasised the need for digital offerings to complement in-person offerings. During consultations with families, carers and supporters, a rural parent gave an example of a young person who had lost their life to suicide after only engaging with online support services. Despite the value of online offerings, they agreed that these should ideally be used in conjunction with in-person, face to face offerings to minimise potential risks and optimise results. Similarly, First Nations stakeholders warned that digital offerings can't be a substitute for human connection and relationships. They observed that for adults who are not technology savvy, it is important that there are still spaces where families, supporters and carers can come to access information and develop the tools they need to support their young person.

First Nations stakeholders warned that digital services are unlikely to be as individualised and culturally responsive as an in-person services. Young people expressed concern that AI-led services lack nuance, personal connection, accuracy and security protections, and also highlighted the risks that digital technologies present for privacy and safety. This was echoed by families, carers and supporters, who noted the potential for information collected via digital platforms to negatively impact the young person's future, including their economic and employment outcomes. They noted the need for digital offerings to be codesigned with young people, including from priority populations, and underpinned by strong privacy and cybersecurity controls, as well as transparent processes around information sharing and informed consent.

> "I do not support the use of apps etc. for mental health problems. Period. They do not do what needs to be done for every individual. Human interaction is always desirable. I would like to see organisations and governments stop viewing apps and similar technology as, ultimately, a cost-effective alternative."
>
> **YOUNG PERSON SUBMISSION**

> "Having someone who understands who they are what their culture is, a digital service isn't going to be as individualised."
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

Strengthening prevention, promotion and early intervention

There was strong consensus across all stakeholder cohorts on the need for a strengthened approach to prevention, promotion and early intervention in the youth mental health system.

Through the submissions process, sector stakeholders acknowledged the negative impact of intervening at the point of crisis, when a young person's symptoms are severe and the opportunity for timely de-escalation has passed. They asserted the importance of prevention, promotion and early intervention in improving outcomes for the young person and minimising the impacts of long-term dependency on the system. Sector stakeholders, through the submissions process, roundtables and online discussion forum, called for prevention and promotion to be embedded at all levels of the system, and for improvements to be made to the scale and impact of current approaches across the system through:

- **Greater investment and federal government leadership** to expand the depth and breadth of prevention and promotion activities across the country. This is critical to ensuring that prevention and promotion are a core focus of the mental health system, and that they have the sustainable funding base and government endorsement to have the required impact.

> 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.

YOUNG PERSON SUBMISSION

> Digital supports, while promising, still face issues of digital literacy, safety, and equitable access, especially for young people in lower socioeconomic groups.

SUICIDE PREVENTION AUSTRALIA SUBMISSION

> 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.

LIVE4LIFE SUBMISSION

> There is an important role for digital strategies here - the evidence base exists but most young people don't have access until they hit crisis - how can we leverage digital to provide a national mental health promotion initiative to support all Australian young people, and children!

SECTOR STAKEHOLDER, ONLINE DISCUSSION FORUM

- **A national mental health promotion strategy** and/or public education campaign to educate, inspire and motivate young people to learn how to support positive mental health practices into their everyday, building resilience and understanding developmentally appropriate responses to conflict.
- **Whole-of-government collaboration**. This requires government portfolios (such as Education, Justice, Housing, Health and Social Services) to come together to promote the needs of young people in their work/policies and share information to support intelligence-led prevention. For example, families, carers and supporters called for states to work with relevant government services to provide immediate support for a young person who has recently lost a parent to suicide. They underscored the importance of better collaboration between mental health services, child safety and youth justice to address the mental health needs of young people in complex arrangements, including out of home care and juvenile detention. Similarly, sector submissions called for increased early intervention targeting young people engaging in harmful drug behaviours, living in out-of-home care, experiencing homelessness, or under the youth justice system. They also noted the need to ensure that workers in other sectors (such as education and social services) receive adequate training to know how to recognise young people presenting with mental ill health and connect them to support.
- **Capacity-building of whole-of-community prevention models** that are led by a community for that community. These models are better equipped than one size fits all / externally developed approaches to respond to the unique circumstances and dynamics of the context in which they operate. Communities require funding and support to develop and implement these models.

> Schools should be one pillar in a multi-disciplinary, community-wide approach – not the default providers of complex mental health care for young children.

AUSTRALIAN PRIMARY PRINCIPALS ASSOCIATION SUBMISSION

- **Promotion of the social conditions that support prevention.** Positive relationships, community connection, purpose, meaningful opportunities for growth (including employment), and hobbies are important protective factors against mental ill-health. This was also highlighted by families, carers and supporters, who suggested that a peer connection program for young people aged 12 – 16 would likely have a significant, protective impact on young people.

> Young people need safety, love, respect and an environment to be curious, to learn and to thrive.

PARENT/CARER/SUPPORTER SUBMISSION

- **Meaningful engagement of schools and communities** to improve mental health literacy and support prevention and promotion amongst young people and their support networks. Schools and communities, including community members, organisations and clubs, are well positioned to influence, connect with and build trust amongst young people. It is important to recognise that they alone cannot bear responsibility for prevention and promotion, and that they are one facet of a system-wide approach. To play a more active role in prevention and promotion:
    - Schools require adequate resourcing and support to exercise this function within a clearly defined scope (e.g. prevention and promotion, not complex intervention). This acknowledges that teachers are already stretched, with considerable workloads and limited time, and that they are not necessarily well-equipped to assume this role.
    - Schools and communities, including the friends of young people (who are often the first point of call for a peer in distress), require appropriate information materials to equip them with a common language for understanding mental health and identifying signs of distress etc.
    - Health services need to focus on primary prevention and capacity building in the community, working more closely with stakeholders, schools and GPs. This was strongly emphasised by First Nations stakeholders.

Young people reinforced the role of education settings in prevention and promotion. In regional and remote areas, particularly in communities with significant First Nations populations, young people emphasised the need for positive role models, such as inspirational sportspeople, to foster hope and positive influences. They stressed the importance of mentally healthy communities and workplaces, where all staff receive mental health training, dedicated personnel are available on-site for mental health first aid and wellbeing, and there is a safe space to de-stress. They reiterated the need for capacity-building of parents, carers, supporters, teachers and communities to ensure that they are equipped to respond to early signs of distress, and not just crisis. Young people called for more expansive support and training for educators to navigate mental health and neurodivergent needs. They also suggested that available supports, particularly those that are online as well as in schools, should be better promoted to increase awareness of prevention and promotion resources and reduce stigma.

Similarly, families, carers and supporters highlighted the importance of mental health literacy programs in preparing the young person's support network to identify distress and intervene to prevent an escalation. They reflected that services aren't openly made available unless people either know about it already, or are informed through a friend, family, colleague or doctor. As a result, they recommended embedding young people and their families in service design to enhance mental health literacy, reduce stigma and increase visibility of services. They suggested that partnerships with sporting clubs and local communities can help reach people who may distrust authority or not be aware of what is available. Families, carers and supporters also echoed the important role that schools can play in keeping young people in education, rather than using suspension or exclusion as a means of dealing with mental health related behaviour.

> “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, CONSULTATION**

> “It was such a big eye opener when I did the youth mental health first aid course – for someone who is just going into parenting blind or starting out teaching, the whole youth mental health first aid is catching things early to pick up on the telltale signs that something's not right.”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

> “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; ONLINE DISCUSSION FORUM**

Adjusted headspace footprint

As part of discussions on prevention and promotion, the proposal was put to stakeholders to adjust headspace's existing footprint, including service locations and resource allocations, based on a data and needs-based approach. This would require consideration of the availability of other youth mental health services in an area, equity concerns such as geographic and cost barriers, feasibility of outreach services and digital infrastructure.

Sector stakeholders, through both the in-person roundtables and the submissions process, expressed mixed reactions to this proposal. They noted that whilst the model is working well in some places, it does not work in all locations and that an adjusted headspace footprint could add to duplication where effective services are already operating in communities. They also cautioned that establishing headspace centres is a complex and resource intensive task. First Nations stakeholders also expressed some hesitancy about this proposal. They indicated that the centre-based nature of headspace does not always work for First Nations young people as it inevitably requires travel, and that culturally safety hasn't been embedded across all centres.

Sector stakeholders suggested the proposal be further refined to recognise the need for consideration of workforce and community appetite, as well as accessibility and alignment with young people's needs irrespective of political influence. They asserted the importance of flexibility in responding to complex community needs and noted the need for the model to facilitate periodic travel for outreach and treatment in rural and remote areas where brick and mortar models may be inappropriate. Some headspace centres, such as those in Katherine and Alice Springs, already perform this function. Young people also described the need to increase the availability of outreach services for those who are disengaged or reluctant to engage and proposed the use of a headspace bus to visit communities without a centre.

> “Young people's mental health needs are diverse and complex, requiring a comprehensive approach to support their well-being.”
>
> **TORRES STRAIT ISLANDER YOUNG PERSON SUBMISSION**

Addressing the missing middle

Stakeholders were consulted on two initiatives to address the missing middle that were proposed as ideas in the early advice: the establishment of an expanded headspace; and investment in specialist services.

Expanded headspace services

While headspace was originally conceived to provide enhanced primary care, a lack of secondary services has meant headspace now provides services to young people with moderate, and moderate to severe needs. This proposal positions headspace to respond to the 'missing middle' by formally extending the capacity of headspace services to support to a proportion of young people with more complex presentations.

There were varying levels of support and hesitation amongst sector stakeholders:

- Some stakeholders expressed concern that expanded headspace services may limit options for young people seeking to access care outside the headspace model.
- Others felt that the headspace model was overly clinical, and that expanded headspace services risk perpetuating an overly clinical approach to youth mental health care.
- They warned against creating further duplication and fragmentation in the system, including by limiting funding for local services that are already delivering in communities. Given the inflexibility of the model of care, they indicated that the model could also limit the flexibility of service provision.
- Stakeholders highlighted the potential for expanding headspace services to exacerbate workforce shortages by increasing pressure and competition where supply is not increasing.
- They noted that the expansion of headspace services as a dominant model risks dampening the evolution of innovative approaches and models and could also exacerbate the lack of consistency and quality across headspace centres.

Submissions from young people, families, carers and supporters were generally supportive of the idea of an expanded headspace. Numerous submissions noted that headspace isn't currently able to support all young people who present to it - however, for some, this was an argument in favour of formally expanding the role of headspace; others saw this as an argument against expanding headspace's role (as it indicated that it wasn't the best vehicle to support all young people).

Sector stakeholders at the in-person roundtables suggested additions or adjustments to the original proposal. They recommended that expanded headspace services be collocated with CAMHS and primary health services, that it encompasses other services including justice, community, settlement and education services and that it includes a broad range of social supports. Stakeholders emphasised the need to ensure that GPs are adequately funded to operate within headspace centres. They also called for additional funding for services other than headspace to support young people with mild to moderate needs and noted the importance of empowering local communities to determine what model of headspace works for them.

An online discussion forum was conducted with sector experts to further refine the proposal and address areas of concern. Sector experts recommended that young people, families, carers, supporters and communities be engaged in co-design to ensure that the model is responsive to their needs. To minimise the risk of inconsistency across centres, and the potential for duplication with other services, they advised that robust operational processes and clinical governance be established. They also noted the need for roles to be clearly defined to avoid scope creep, and for sustainable funding to support recruitment and retention of a skilled, multidisciplinary workforce, including experienced clinicians and non-clinical staff such as peer support workers and Aboriginal support staff. In terms of accessibility, they suggested that the model have multiple access points, including proactive outreach and community engagement conducted both online and in real life, as well as in schools, community centres, digital platforms and social media. They encouraged incorporation of non-clinical supports and models of care that support a more holistic approach to youth mental health, as well as the elevation of mental health literacy and peer-led support models that facilitate prevention and promotion. Finally, they emphasised the need for care navigators to support interaction between services, as well as practices that are inclusive of young people's families, carers and supporters. This could look like actively including families, carers and supporters in the care plan of the young person or extending service access to them to support their own mental health and wellbeing.

> "headspace is not for everyone, nor can it be everything to everyone but it can be a key platform in the primary care space to greatly benefit transition to more specialist enhanced services where this may be indicated."
>
> **SECTOR STAKEHOLDER, ONLINE DISCUSSION FORUM**

Specialist services

This proposal involves the establishment of transdiagnostic, specialist services to support young people with specific and complex needs that go beyond what headspace can provide. Stakeholders were consulted on the proposal as it was articulated in the early advice, at the roundtables and through the submissions processes. Sector stakeholders acknowledged that there is a missing middle in the system for young people with more complex and serious mental health concerns. They saw young people who are particularly disadvantaged by the missing middle as including those with higher risk profiles, either due to suicidality or risky behaviours that cause them to come into contact with the justice system or family violence situations. Parents, carers, supporters and young people who provided feedback on the early advice ideas in submissions were generally supportive of this idea (with several noting that it would be important to ensure that the service could support young people with multiple diagnoses).

> I think section 2 [youth specialist services] needs to be a little bit more specific about who those services would provide care for and ensure that people with multiple diagnoses are included.
>
> **YOUNG PERSON SUBMISSION**

Stakeholders consulted at the in-person roundtables were relatively positive about this proposal. However, they expressed concern regarding:

- **The risk of creating further system fragmentation and complexity** if services are not well integrated, and if competition for funding precludes collaboration. To mitigate this risk, they emphasised the importance of ensuring that services build on and leverage local infrastructure.
- **The limitations of an overly clinical approach**. Stakeholders observed that diagnostic assessment and screening processes are often used to exclude young people from care. Whilst they acknowledged the need for specialist services to address the clinical gap in the system for young people with complex needs, they called for services to have a broader, more holistic orientation that is responsive to young people's social, physical, family and vocational needs.
- **The cultural appropriateness and safety** of specialist services. Stakeholders emphasised the need for any specialist service to be culturally safe and responsive to the needs of First Nations young people.
- **Workforce demands**. Stakeholders highlighted issues associated with sourcing the workforce required to support the specialist service. For example, in some jurisdictions such as the ACT where there is already significant competition for a limited workforce, recruitment of workers for the specialist service would be equivalent to 'robbing Peter to pay Paul.' The implication is that poaching workers from other services doesn't resolve the issue of limited workforce supply and creates problems elsewhere in the system.
- **Accessibility** for rural and remote communities, who risk being excluded from transdiagnostic care due to low population size and the high cost of providing care in these settings. This was echoed by First Nations stakeholders, who highlighted the difficulty of accessing services for highly mobile populations and for young people with complex living arrangements, including involvement with Child Protection services.

Sector specialists with expertise in service model design, as well as CoRAs, were invited to participate in an online discussion forum to further refine the proposal and address areas of concern. Stakeholders provided feedback relating to:

- **The risks associated with implementation of this proposal**.
  - Stakeholders reiterated issues with workforce supply, which risk delaying the establishment of services and impeding efforts to recruit and retain sufficiently skilled staff.
  - They cautioned against an overly clinical orientation which further pathologises young people, as well as narrow eligibility criteria that exclude young people rather than supporting them to access care.
  - Whilst they highlighted the potential for further duplication and fragmentation of services, they indicated this is outweighed by the imperative to address the missing middle for young people with complex needs and could be mitigated through effective collaboration and integration.
  - They suggested that a lack of clarity as to the distinction between the specialist services and an expanded headspace could create confusion for young people and their GPs regarding the most appropriate service to access care.
  - They echoed concerns relating to equity of access, particularly for marginalised cohorts, or young people living in underserved areas, and emphasised the need to ensure support for those most in need.
  - Finally, they noted that failing to implement appropriate commissioning and governance models could compromise objectives, and that insufficient stakeholder engagement and community consultation during development and implementation could limit buy-in and responsiveness to community need.
- **The factors required to successfully operationalise and implement this proposal**.
  - Stakeholders called for clear frameworks to ensure quality, safety and accountability across service settings, as well as strong clinical oversight and governance.
  - They emphasised the need for lived experience and community input into model design and implementation through targeted commissioning practices and co-design, including consortium arrangements.

- They highlighted the value of embedding lived experience leaders in service planning, staffing and delivery, and underscored the need for sustainable funding to attract and retain skilled, multidisciplinary teams, and support ongoing training, including in trauma informed care and cultural safety.
- They affirmed the importance of accessible, flexible and holistic approaches to addressing both clinical and functional needs across the mental health spectrum.
- While stakeholders recommended defining access and care pathways, including inclusion and exclusion criteria, they noted that this should be counterbalanced with the need to prioritise support for young people where and when they seek help.
- They also recommended piloting or building on services that are already doing good work in this space and establishing collaboration and communication mechanisms to support service integration and clarity of care pathways.
- They encouraged investment in flexible service delivery, including mobile teams, digital access and safe in-person spaces to meet young people where they are, and improve availability in underserviced areas.

> The youth mental health system is not prepared nor skilled to be able to work with youth with dual diagnoses, i.e. Intellectual Disability and Mental Health issues, Autism and Mental Health issues, Intersectionality, AOD & ID or Autism & Mental Health Issues. This frequently manifests as what appears to the young person to be discrimination.
>
> **GIPPSLAND DISABILITY ADVOCACY INC. SUBMISSION**

Supporting priority populations

The Consortium is grateful for the contributions of multiple stakeholders across all priority population groups that were engaged in this project. Input received across all consultation streams highlighted a lack of services and/or service continuity that effectively met their needs. Many of these needs, challenges and opportunities have been included within the body of this report, however this section has been included to better reflect the nuances and ensure their valuable contribution was not lost in the detail.

We also recognise that there is strong intersectionality between the priority populations listed below, and that many young people will fall into more than one of these categories. This further highlights the need for a mental health system that views young people holistically, rather than through a narrow diagnostic lens.

> Twenty percent of young people miss out every time. How can we design something for that twenty percent… and have a system that works for all, rather than only for some?
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

Young people living in regional, rural and remote communities

Stakeholders called for bespoke, tailored models for regional and remote communities such as flexible outreach, community-led solutions that engage and develop local workforces, targeted support to address transport and digital disadvantage, and education initiatives to destigmatise mental health. These models recognise the unique circumstances and associated challenges encountered by young people living in regional, rural and remote communities including:

- **Workforce constraints**. There are limited incentives to attract and retain external workers, inadequate housing infrastructure to accommodate workers, and high turnover of workers (such as GPs). This places a high burden on the community to constantly re-educate new workers and attempt to rebuild trust and relationships with the workforce. There need to be more opportunities and initiatives to grow the local workforce and services, as they are more likely to be trusted by community members and to remain in the community.
- **Transport disadvantage.** Young people in these communities may not have the means to travel to services where they are not available in their communities. They may also be reluctant to ask parents to drive them where distances are significant. Transport and distance need to be considered where services are working with vast geographies. Approaches such as headspace centres providing taxi vouchers to overcome transport disadvantage were called out as good practice in submissions.
- **Lack of choice in care and services.** There are significant gaps in service availability and delivery in regional and remote communities, which limits young people's choices and reduces both the accessibility and acceptability

of services. Where there is one service in a community, young people may be deterred due to the risk of being identified by someone they know, or confiding in the same practitioner as other people in their community. There needs to be adequate choice for young people in these communities in terms of services and the care that they provide.

> “Throughout my adolescence and early adulthood, I experienced ongoing suicidal ideation, compounded by years of relentless bullying – both of which deeply eroded my sense of safety and self-worth. Despite my family’s efforts, I endured two traumatic hospitalisations, one of which involved being chemically restrained for over three months. It wasn’t until I moved to a larger city that I was finally able to access more appropriate treatment and begin to reclaim my life.”
>
> **YOUNG PERSON SUBMISSION**

- **Digital disadvantage**. Young people in regional and remote areas may have limited access to the internet and private devices or landlines. It is important that models provide in-person options for young people in this cohort, as well as support to enable engagement with digital services.
- **Outreach**. There was a consistent theme for the desire for outreach services to be integrated into services. The sector also noted these can be expensive to deliver which creates a barrier to service delivery. Funding often doesn’t support overnight stays for workers and is dependent on targets such as five sessions a day which may be unrealistic during the relationship establishment phase. Service providers highlighted the risks associated with sending staff by themselves to visit young people in their homes and indicated that this was a source of reluctance to provide outreach support. Where outreach to communities is infrequent, it is even more difficult for workers to build rapport and encourage young people to trust and engage with them. Options to address this include supporting local people and services to provide immediate support or reducing barriers to outreach through increased resourcing, flexibility around session targets, and safeguards to mitigate risks to staff providing outreach support.
- **Family context** can affect whether a young person can access support. For example, there are regional and remote contexts with very low mental health literacy and where mental health is not a discussion that a young person feels they can have with their families. Other family members and parents may be experiencing mental ill health, and young people may be acting as their carers or not wanting to burden someone to help them seek care. This highlights the need for capacity-building among young people’s support networks.

First Nations young people

First Nations organisations called for culturally responsive, community-led care that engages with the spectrum of factors impacting youth mental health, and that acknowledges the lingering impacts of colonialism and racism in preventing engagement with youth mental health services. They reflected that approaches to youth mental health care are very westernised and fail to recognise the unique circumstances, cultural practices and belief systems that are critical to, and that impact, the mental health of First Nations young people.

> “There are challenges in producing resources and information appropriate to the local cultural context, recognising that for many First Nations people English can be a second or third language and concepts around mental health can be misunderstood by non-Indigenous workers.”
>
> **CENTRAL AUSTRALIAN ABORIGINAL CONGRESS SUBMISSION**

Young people face additional barriers to access due to institutional mistrust, historical trauma, and concerns about how their information is used. Some young people avoid both mainstream and Aboriginal services due to past harm or safety concerns, with few alternative options available.

> “The political rhetoric that the referendum opened up and what people think is ok to say has had a huge impact on the mental health of First Nations young people.”
>
> **SECTOR STAKEHOLDER, ROUNDTABLE.**

Stakeholders emphasised the need for alternative models for First Nations people in remote and very remote locations to be designed in collaboration with communities, and with existing First Nations medical services. Stakeholders referenced alternative models such as the Staying Deadly Model, which could be adapted to remote and very remote communities, as well as local

workforce development programs (e.g. Groote Eylandt program), and mechanisms including outreach and digital delivery to diversify service provision. They noted that whilst co-located services and more coordinated and integrated models of care do exist in the private sector, they often require sustained advocacy from families or support organisations to function properly. For many First Nations families, this level of advocacy is not always accessible, particularly without the right support structures in place. As a result, First Nations families and communities require support to optimise implementation of these models and ensure that the right structures are in place to inform success.

Finally, they recommended that governments invest in preventive measures to close the gap in mental health outcomes for First Nations youth and that policies be evaluated based on their long-term impact on future generations. First Nations stakeholders emphasised the need for preventative measures that are relational, culturally responsive, delivered on Country and targeted to young people or communities at risk of developing a mental illness.

Case Study: The Staying Deadly Model

The Institute for Urban Indigenous Health (IUIH) has developed the Staying Deadly model of mental health care, which is a community-owned and evidence-based model of care delivered in urban areas in Queensland. The model is co-designed with Community, embedded in trusted spaces, and delivered with a focus on healing, cultural identity, relational care, early engagement and holistic support across systems, not just symptoms. The Hubs offer early intervention, sub-acute mental health support, and post-discharge care, and focus on timely, holistic and flexible care that includes therapeutic supports, case management and warm referrals to additional services where required.

Young people experiencing socioeconomic disadvantage

Throughout the consultations, we frequently heard about the difficulty of accessing mental health services for young people experiencing socioeconomic disadvantage. The Smart Justice for Young People submission, for example, noted a “documented connection between access to health services and social discrimination and inequality, including racism.”

Stakeholders also called out the need to recognise the impacts that socioeconomic disadvantage can have on young peoples’ mental health, as part of efforts to recognise and address the social determinants of mental ill health.

> “There is a growing child and youth population with significant socioeconomic disadvantage with increasing expectations that the YMH system address issues stemming from social determinants and a fragmented welfare system.”
>
> **INDIVIDUAL RESPONDENT, MENTAL HEALTH SECTOR SUBMISSION**

Costs are a major barrier to accessing services, meaning that young people experiencing socioeconomic disadvantage are more reliant on free / bulk-billed services, and may face more significant delays and barriers to accessing services. Given the current economic environment with the increased cost of living, this level of disadvantage is increasing. Some families are needing to decide between accessing treatment or buying food for their family or working two jobs which means they cannot be present for their young person.

> “Emergency care is often the only pipeline to accessing any care at all, especially for those who are socioeconomically disadvantaged.”
>
> **INDIVIDUAL RESPONDENT, MENTAL HEALTH SECTOR SUBMISSION**

> “I found services which were able to help at no cost, which was very helpful, especially since I was struggling financially.”
>
> **YOUNG PERSON SUBMISSION**

In addition to the delivery of services, the ongoing cost of medication places further strain on these families and young people.

> Living with a complex mood disorder, including features of treatment-resistant depression, continues to come with immense challenges. While treatments like TMS and ketamine have shown real promise in my recovery, their prohibitive out-of-pocket costs have made continued access impossible – leaving effective care just out of reach once again.
>
> **YOUNG PERSON SUBMISSION**

Young people who identify as LGBTIQA+

LGBTIQA+ representatives in attendance at the roundtables emphasised the need for greater visibility of LGBTIQA+ people in the youth mental health system to improve accessibility and ensure that their needs are met. They noted that LGBTIQA+ communities are often isolated and marginalised within the mental health system and rarely encounter or interface with other young people who share their experience, or look like them.

There are also issues with mental health services not being consistently safe or affirming places for LGBTIQA+ young people to seek help, with a lack of training in inclusive practices. For example, when responding to the question '**What didn't go well?**', one young person reported:

> The people who misgendered me or asked me inappropriate questions about the wider trans community or expected me to educate them on queer topics. The people who told me that I could never expect people to use my pronouns.
>
> **YOUNG PERSON SUBMISSION**

> Services are not consistently safe or affirming for LGBTIQ+ young people. Staff often lack appropriate training in inclusive practice.
>
> **LGBTIQ+ HEALTH AUSTRALIA SUBMISSION**

We heard frequently throughout the consultations that LGBTIQA+ young people entering the mental health system are more likely to relate to peer workers with similar experiences. Peer relationships can reduce their isolation in the system, improve accessibility, and minimise the impost on them to singularly tell their story and advocate for their needs.

> 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 SUBMISSION**

Young people experiencing homelessness or housing instability

Many stakeholders expressed concern that a disproportionate percentage of young people experiencing homelessness or housing instability have very high levels of existing and emerging mental health conditions, including mood, anxiety, substance use and post-traumatic stress disorders. Sector stakeholders reported that a lack of adequate funding for specialist services further marginalises young people and increases the risk of homelessness and acute mental health issues.

Stakeholders identified that additional service delivery and systemic barriers can prevent young people experiencing homelessness or housing instability from accessing mental health supports.

> There is a lack of homelessness specific understanding for mental health practitioners.
>
> **HOPE STREET YOUTH AND FAMILY SERVICES SUBMISSION.**

They also noted that young people experiencing homelessness are often excluded from receiving support. This is often a result of service requirements that do not take the needs of young people experiencing homelessness into account (e.g. requiring young people to provide a fixed address or emergency contact person in order to access services, or excluding a young person from a service for missed appointments). Cost of services can also be a significant barrier for young people experiencing homelessness.

> The lack of scope to include those with comorbid AOD, FDV-behaviours, or homelessness is also a huge barrier, leaving the young people to feel like the world has given up on them.

INDIVIDUAL RESPONDENT, MENTAL HEALTH SECTOR SUBMISSION

Submissions called out the need to ensure young people experiencing homelessness are not excluded from accessing services, and to improve crisis responses and admissions pathways for homeless young people. There is also a need for mental health services to integrate with organisations providing homelessness services.

> [The Homeless Youth Dual Diagnosis Initiative (HYDDI)] bridges the divide between the homelessness, the mental health and the AOD systems. Because it's all in house, it makes the process a lot smoother for our young people. They're not needing to go anywhere to get that support. This approach definitely has more success in engaging the young people with support.

HOPE STREET YOUTH AND FAMILY SERVICES SUBMISSION

Young people with a disability

Stakeholders stressed the need for mental health services to be adequately funded to ensure they are accessible and can meet the diverse needs of the young people they are seeking to support (for example, ensuring access to specialist interpreters for deaf young people, or accessible premises for young people requiring mobility aids).

> I wish there would be care teams that can provide wrap around support in coordinating both physical and mental health, through the public specialists etc.

ABORIGINAL YOUNG PERSON SUBMISSION

Stakeholders also highlighted the strong need to ensure that mental health staff are educated and trained to meet the needs of young people with disability or dual diagnoses.

> 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 SUBMISSION

> Often as a young person living with a disability, there's difficulties for youth accessing MH services that may cater to the intersection of mental health and physical health.

YOUNG PERSON SUBMISSION

Stakeholders called out the difficulty for young people in navigating both the NDIS and mental health system, and the need for the two systems to coordinate better to ensure that young people with both mental ill health and disability can put in place the supports they need for their functional capacity and quality of life.

> As a young person I had an experience of living in a NDIS [Supported Independent Living] house for a short time where I was housed with extremely unwell much older people and it was absolutely traumatising.

ABORIGINAL YOUNG PERSON SUBMISSION

Additional pressure was reported from young people by needing to respond in specific ways to accommodate to service administrative requirements across different service delivery platforms. Services placed the expectation on individuals with disability to have a formal or informal support person available if they were unable to do it themselves and provided little relationship-building support to help them navigate the services in a way that supported them.

> The divide between mental health support and NDIS supports for neurodivergent kids creates an incoherent (not holistic) approach to care and management.

PARENT/CARER/SUPPORTER SUBMISSION

Submissions also noted the important role that allied health professionals play in supporting young people with both mental health and disability, calling for inclusion of allied health professionals on multi-disciplinary mental health teams. A multi-disciplinary team within services and schools can also help facilitate a strength-based approach to lead a change of culture in way disability is viewed to help young people thrive in the areas they are passionate about in favour of the clinical deficit-based approach that pathologises the young person and can lead to a perception of what is 'wrong' with them.

> “After getting support in school, I was discriminated where I became ineligible to hold a leadership position, was forced to be removed classes due to my grades “dragging down the rest of the cohort”, constantly attending performance reviews where it was made clear that I would be “unlikely to score a raw study score of above 30”, and being barred from subjects that teachers thought would be too much work for me such as arts (an area I was passionate about).”
>
> **YOUNG PERSON SUBMISSION**

Children and young people in out-of-home care

Consultations strongly highlighted the fact that children and young people in out-of-home care (OOHC) are particularly vulnerable to mental ill health and require dedicated support. Children and young people in this situation may have significant experiences of trauma, which can include experiences of family violence, abuse and neglect, exposure to drug and alcohol abuse, and interactions with the justice system.

> “All children and young people with care experience have significant trauma, or post-traumatic stress, and need the benefit of expert and evidence-based interventions and treatments to address and resolve the continuing impacts of trauma and harm.”
>
> **CREATE FOUNDATION SUBMISSION.**

This was reiterated by First Nations organisations, who noted that children presenting with significant trauma, especially children in care or protection arrangements, face immense barriers to receiving appropriate support.

Stakeholders stressed the importance of a mental health workforce that is trauma-informed, understand the specific experience of young people in OOHC, includes peer approaches, and involves young people in the design of the care they are to receive.

> “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; ANONYMOUS SUBMISSION**

Stakeholders also stressed the importance of ensuring coordination and integration between mental health providers and government departments with responsibility for young people in OOHC. This could include establishment of mental health response teams to respond when there are issues or young people abscond from care. First Nations stakeholders called for child and adolescent psychologists to be embedded in the child protection system two to three days a week, acknowledging that First Nations children represent the highest need cohort within the child protection system.

To ensure children and young people in out of home care can access the care they need, sector stakeholders are advocating for 'Gold Card' priority access to mental health services for children and young people in care.

Sector stakeholders also argued that harmonising the age range of the youth mental health system from 12-25 would have particular benefits for young people in OOHC, as this assures access to mental health support over the period of transition from care to independent living.

Young people in contact (or previously) with the Criminal Justice System

Sector stakeholders highlighted the increased likelihood of mental ill health for young people in the youth justice system. Despite their increased risk of mental ill health, they experience higher barriers to accessing services and care.

> “Mental health service for incarcerated populations is pitiful.”
>
> **SECTOR STAKEHOLDER, ROUNDTABLE**

Additionally, family, carer and supporter feedback indicated that in their experience, custodial officers are not equipped to respond effectively or appropriately to young people who are impacted by mental ill health. This is further compounded by the amount of young people in custody with intellectual disability, mental illness and undiagnosed health problems.

> “I’ve had many conversations with case managers stating that they are dealing with kids who urgently need help that are being sent to juvenile detention. I’ve also had conversations with the juvenile corrections officers that are stating that they have a large amount of children in detention that should be in a mental health facility such as brain injuries and severe intellectual disabilities and the staff are not educated to manage these kids in this setting.”
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

First Nations organisations reported that mental health services for First Nations young people in custody can be very unsafe. Many young people who experience psychosis in custody fly under the radar and are often reluctant to seek help and support in those environments due to shame and safety concerns. The referral pathway to CAHMS is especially problematic in these cases, and whilst GPs technically have access to a hotline to seek psychiatric advice, the urgency and complexity of young people’s needs make it unsafe and impractical to wait on the line for extended periods of time.

Some stakeholders called for a more fundamental shift. Sisters Inside’s sector submission noted the ‘ongoing fragmentation and punitive nature of systems that criminalise young people rather than supporting them’ and argued that ‘the youth mental health system – like the criminal legal system – is often crisis-driven, risk-oriented, and built around institutional priorities rather than the self-determined needs of children and young people, especially Aboriginal girls and gender-diverse children and young people.’ It called on the sector to embrace community-based approaches that are ‘relational, culturally grounded, and structurally transformative – not merely trauma-informed but trauma-responsive, not only aware of inequality but committed to dismantling it.’

> “We are using the criminal justice system to deal with mental health issues. It costs $1 million a year to incarcerate a young person, what else could government spend that money on?”
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

Sector stakeholders also emphasised the need for strong transitional supports for young people coming out of the justice system and into education.

Young people from multicultural communities

The need for culturally responsive, trauma-informed services was reinforced through consultation with young people and sector stakeholders. They noted that most therapeutic interventions are highly westernised and do not have space for alternative knowledge systems, nor do they engage with broader social determinants such as war and unrest in other countries which may affect young people’s families and friends. Cultural differences and approaches to mental health care can make seeking help more complex for multicultural young people, whilst past trauma can also result in mistrust of services for families from refugee and asylum seeker backgrounds. Diagnostic frameworks that do not reflect culturally diverse ways of experiencing distress can result in harm for multicultural young people. For example, some ESL speakers reported being pressured to sign voluntary admission forms without sufficient translation or understanding, often during moments of crisis.

Young people also reflected on the exclusion of some multicultural communities from data collection practices (for example, refugee and asylum seeker young people, as well as international students). This obscures the extent to which their needs are understood by policy makers, and actively addressed in service design and delivery. It is critical that data collection processes capture the voices of multicultural communities to ensure that their needs are identified and met.

> “How can someone feel ok when [their family and friends] are unsafe due to war, racism?”
>
> **SECTOR STAKEHOLDER; ROUNDTABLE**

> “Overall, there is limited understanding of the experience of young people from refugee background in Australia.”
>
> **QUEENSLAND PROGRAM OF ASSISTANCE TO SURVIVORS OF TORTURE AND TRAUMA SUBMISSION**

Young people highlighted the value of community-led approaches that are grounded in cultural practice, as well as factors such as yarning, connection to Country, and peer-led support that promote healing and accessibility in a more meaningful way than clinical models. They noted that culturally responsive practitioners who understand diverse lived experiences are in short supply but are urgently needed, and called for flexible models that allow young people to choose practitioners who reflect their cultural background and values. They advocated for culturally inclusive branding (e.g. rainbow or First Nations flags) that is matched by culturally safe practices, as well as a deeper focus on relational, values-aligned service environments, particularly for transgender, non-binary, and trauma-impacted communities. They reinforced the need for cultural competency training in services, and support for young people to engage in talk therapy or alternative interventions where there are language barriers. Finally, young people noted that tailored outreach, funding, and service design are needed for international students, young people in out-of-home care, culturally diverse communities, and those without Medicare.

Similar challenges and requests for change were revealed through consultation with families, carers and supporters. They reflected that addressing stigma, discrimination and negative attitudes towards mental illness in some culturally diverse communities is critical for improving engagement with services and building trust amongst young people’s families, carers and supporters. They called for online counselling and self-help tools to be co-designed with multicultural youth and families so that they have the resources to help their young people with mental health services, and also emphasised the need for mental health services and clinicians to develop relationships with cultural organisations and community members to build trust.

> “In multicultural communities, to engage with families who don’t trust mental health organisations it’s about having organisations that they do trust to do events with headspace to build that connection. Then they can start to associate an organisation they trust with headspace.”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

> “I see a lot of advertising targeting white Australians that isn’t going to reach migrants who don’t know where to get help.”
>
> **PARENT/CARER/SUPPORTER CONSULTATION**

Young people experiencing or at risk of abuse and violence, including sexual abuse, neglect and family and domestic violence

Stakeholders told us that young people experiencing abuse or violence, including family violence, are particularly vulnerable; however, this experience of violence can make it even more difficult for young people in these circumstances to access the support they need.

In some cases, experiences of violence can exclude young people from accessing mental health services, on the basis that these young people are too complex for particular services.

> “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.”
>
> **SMART JUSTICE FOR YOUNG PEOPLE AND YOUTHLAW JOINT SUBMISSION**

> A CAMHS service told me that they could not see my son because there was conflict between me and my ex-husband. My perspective was that this was exactly the reason why my child needed support for his PTSD relating to family violence.
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

For young people experiencing family violence, fear that information will not be treated confidentially, or that services will require contact with parents or carers, may also prevent young people from being able to seek out and access mental health support.

> 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.
>
> **MELBOURNE CITY MISSION SUBMISSION**

Stakeholders also stressed the importance of the youth mental health system being strengthened to respond better to family violence.

> [They] asked me to forgive my parents while I was actively living in a hostile environment under their roof.
>
> **YOUNG PERSON SUBMISSION**

Stakeholders identified that this could involve embedding youth-oriented family violence supports and services into the system, ensuring mental health professionals have training and education in trauma-informed care, and building staff understanding of the impacts of being subjected to violence, including sexual violence. They noted that there is also a role for lived experience workers to play in providing support to young people that responds to their experience of violence and trauma.

> Regulation and funding requirements must also shift to make space for leadership by people with lived, direct experience of criminalisation, trauma, and systemic violence.
>
> **SISTERS INSIDE SUBMISSION**

> If not in house, then there needs to be regional specialist services that can go beyond trauma-informed care to actually treating the disorders caused by trauma. This is rarely available due to a lack of clinicians trained in the skills, but training is now available.
>
> **SECTOR STAKEHOLDER, ONLINE DISCUSSION FORUM**

Those at risk of experiencing violence can include siblings of young people with severe mental health conditions who are themselves displaying violent behaviours. Stakeholders noted that siblings of young people with mental ill health are a particularly vulnerable group requiring targeted support in their own right.

> The trauma to our whole family will have a lifelong impact on my other 3 children who were never offered any help during this period. [They] now adults as well have mental injuries and c-PTSD from what they have had to endure and witness their brother go through.
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

Young people with complex mental health needs, including people with co-occurring mental health and cognitive disability and/or autism

Throughout consultations, we heard from stakeholders about the specific difficulties faced by stakeholders experiencing both complex mental health needs, including those experiencing these together with a cognitive disability, neurological condition and/or behavioural conditions.

> My daughter and I tried to access a local public mental health support network but because she has a significant intellectual disability, we couldn't find a service that was able to support her. We were shuffled around between Headspace and CAMHS with no one wanting to take ownership or show any willingness to support her. In the end we were unable to find a service that would accept her.
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

Service administration requirements are noted as being particularly overwhelming for neurodivergent individuals. Young people reported struggles with the difficulties of finding help and then trying to engage with services.

> But honestly the worst is just the sheer difficulty of understanding the system. Who to go to for help when, what they can and can't help with, where to go if you can't afford the services you need, and most importantly where to turn when you don't think you can keep yourself alive but can't talk on the phone or handle the hospital.
>
> **YOUNG PERSON SUBMISSION**

Stakeholders noted that few mental health professionals have a strong understanding of complex co-occurring conditions and called for greater training for professionals.

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

Stakeholders noted that often it is difficult and expensive to access diagnoses for complex conditions, even where diagnosis would be beneficial.

> There is a desperate need for better access to ADHD and Autism assessment. This is what I have needed since I was 16 and I wouldn't have been in crisis if I had gotten diagnosis and support sooner.
>
> **YOUNG PERSON SUBMISSION**

> FASD training is not available in the NT, and there is a limited amount of people who can conduct these assessments.
>
> **AUSTRALIAN CHILDHOOD FOUNDATION SUBMISSION**

We also heard from stakeholders about the difficulty of accessing specialist supports and treatment, particular in regional and remote areas. Submissions noted that there is rising demand for mental health neurodiversity services, and that mainstream and specialist services frequently do not meet the needs of these cohorts.

Service supports that have helped neurodivergent young people included:

- warm referrals onto services more fit for what the young person was going through,
- communicating with services via email/online to make direct bookings
- flexibility of sessions to deliver additional support during times of crisis
- answering 1-5 scales or other tick box questionnaires rather than re-telling symptoms and experiences
- having low noise and subtitles on waiting room televisions
- accessibility guides that introduce the space and provide social scripts that can help a young person understand and ask questions.

Similarly, better support and understanding is required for other complex mental health conditions, such as eating disorders and personality disorders. The sector highlighted a need for an increased focus on early intervention and acknowledged that, while there is an increasing understanding of the complex and intersecting presentations of eating disorders, service coverage and diagnostic approaches can vary, particularly across geographical areas.

> After 1 year and still no access to a psychologist we made the decision to move our daughter to Melbourne so she could get the mental health services she needed… We found an eating disorder specialist psychologist and her support for the 3.5 years has been fantastic.

PARENT/CARER/SUPPORTER SUBMISSION

> My daughter has been discharged from private services due to being too complex but then placed on waiting lists for public services. Eventually she becomes so unwell she gets placed in a local public hospital for medical reasons and traumatised by well-meaning staff who have no idea about severe eating disorders.

PARENT/CARER/SUPPORTER SUBMISSION

> ARFID [avoidant/restrictive food intake disorder] is not included in the current eating disorder plan and without a dual diagnosis of another qualifying eating disorder people with ARFID miss out on treatment that can improve their health.

PARENT/CARER/SUPPORTER SUBMISSIONW

People with harmful use of alcohol or other drugs, or with substance use disorders

The sector reported that investing in alcohol and other drug (AOD) prevention is a cost-effective approach to minimising AOD harms, citing evaluations showing high returns on investment, with every $1 spent on prevention returning $14, reducing the burden on treatment and other support services and other direct/indirect costs. However, these early intervention opportunities that reduce the likelihood of transition from occasional to problematic or dependent use of AOD, are not well developed and need further attention to prevent escalation of harm and care needs.

> The outcome of such approaches are stronger and more resilient communities that experience reduced harm from a range of modifiable outcomes including AOD use and mental health issues, along with increased early access to supports for the individuals within those communities when they need it.

ALCOHOL AND DRUG FOUNDATION SUBMISSION

Stakeholders also highlighted the specific needs of young people with substance use disorders, and who engage in harmful use of alcohol or other drugs. Stakeholders noted that the mental health system and AOD system are not well integrated with each other. They called for increased integration and coordination between these services.

> The mental health system and AOD system acts in silos from each other. “Chicken and egg” scenarios occur between the two all the time but they can’t even sit in the same room with each other and talk about wrap around responses.

PARENT/CARER/SUPPORTER SUBMISSION

As with some other co-morbidities, stakeholders told us that substance use disorders can also be cited as a basis for excluding young people from specific services. This can result in young people being denied care or lying to providers about issues with substance use due to fear of exclusion. Young people also talked about feeling judged by mental health professionals for disclosing alcohol or drug use.

> We have been discharged from adolescent mental health services twice because he has child substance abuse issues related to his mental health and they won’t deal with them as dual presentation.

PARENT/CARER/SUPPORTER SUBMISSION

> 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 SUBMISSION**

People who have made a previous suicide attempt or been bereaved by suicide

We also heard from many young people, families and carers about experiences accessing the mental health system while experiencing suicidal ideation or following a suicide attempt.

> I did a million safety plans that never worked, I often felt pressured to say I would be safe at the end of appointments because they "had to ensure my safety". This was the same with helplines. I often left feeling worse and with therapy having to wait at least a fortnight to try to get help again.
>
> **YOUNG PERSON SUBMISSION**

Some stakeholders told us that often efforts to access supports did not succeed until the young person had reached the point of experiencing suicidal ideation or attempting suicide. Others reported young people being discharged without adequate supports soon after a suicide attempt and noted the lack of recovery and follow up supports available following such experiences.

> My child was released from a suicide attempt out onto the street as there were no adolescent psychiatric beds at hospital, he was volatile so paediatrics would not take him.
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

> It took 2 suicide attempts before my teenage son was referred to CHYMS.
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

Consultations highlighted the need for greater specialist support for young people, and in communities, bereaved by suicide.

> The prohibitive expense and lack of qualified child psychologists that are equipped to treat the mental health ramifications of a child losing their parent to suicide and how to integrate into school and community life are what appear to be non-existent.
>
> **PARENT/CARER/SUPPORTER SUBMISSION**

Sector stakeholders called for increased focus on expressly embedding suicide prevention across youth-focused service planning. There were also calls for greater investment in suicide prevention initiatives in communities that had been impacted by suicide.

> Models of care must integrate suicide-specific interventions – including safety planning, assertive aftercare and postvention – as core components.
>
> **SUICIDE PREVENTION AUSTRALIA SUBMISSION**

All written submissions that were received during the consultation activities, together with the findings from the Youth, Parent/Carer/Supporter, and Primary Health Network consultation activities have been provided to the Department of Health, Ageing and Disability to supplement this Consultation Outcomes Report.

REVOLUTION IN MIND

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