16th May 2025

Youth Mental Health System Reform Consultation undertaken by Orygen for The Department of Health and Aged Care

Submitted online here

Contact Persons for this Consultation:

Lucy Barker
Dandolo Partners International Pty Ltd
Office: Level 6, 171 La Trobe Street, Melbourne VIC 3000
Phone: +61 3 9211 0015
Email: engagement@dandolo.com.au
Website: http://www.dandolo.com.au

Lived Experience Australia Ltd
Contact: Sharon Lawn
Executive Director
slawn@livedexperienceaustralia.com.au
PO Box 98, Brighton SA 5048
Phone 1300 620 042
ABN: 44 613 210 889

Contents

Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 11,500 people with lived experience of mental health concerns across Australia. This includes lived experiences with all parts of the mental health care system, NDIS, psychosocial disability support outside the NDIS, PHN commissioned services, public and private service options, and service provision across urban, regional, rural and remote Australia. All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care and psychosocial disability support services and support across the lifespan, across the whole Australian health and social care system, including within State and Territory jurisdictions.

We welcome the opportunity to provide our feedback to this consultation.

Background & Purpose of this Consultation

The Department of Health and Aged Care has commissioned Orygen / Dandolo Partners Pty Ltd 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.

The aim of this project is to understand the current landscape of youth mental health services in Australia, what is being delivered, how it is being delivered, to who and where. This includes mapping services and identifying where gaps, challenges and issues exist. We will seek the experience, expertise and advice from stakeholders across the country to determine what could be changed, added, or removed to build a youth mental health system that can meet demand and deliver outcomes.

To achieve this, they are seeking stakeholder feedback on the existing system, service map and the full spectrum of services across the stepped care continuum, the needs and preferences of young people including the unique experiences of young people from First Nations communities, the LGBTIQ+ community, rural and remote areas, multicultural communities, young people with disability, and families, carers and supporters.

Please Note:

For this submission, we drew heavily on the lived experience expertise of our LEA Representative Panel members, seeking their feedback on the consultation questions. In particular, I wish to acknowledge the outstanding contributions of young consumer/carer advocates John Attard and Kiara Roche. Kiara's detailed contributions have been kept together as a dedicated Appendix within this submission**. (See Appendix 1).**

Our Responses to the Consultation

1. Please tell us about your perceptions of/experience with the youth mental health system

We have heard many and varied experiences from our LEA 'friends' network about the youth mental health system, predominantly that it can be complex to access and navigate, lacks a truly youth focused delivery structure, and mirrors many of the challenges that are pervasive in adult mental health service systems. Young people and their families and supporters struggle to receive holistic recovery-oriented support; instead, the current system is not flexible enough, is too reactive and too clinically focused, too bureaucratic, with fundamental gaps in communication and collaboration between the various services and systems (e.g. schools, welfare, health, faith-based supports). Fundamentally, it is disconnected from the real lives of young people. What many young people need is informal, community-based outreach, delivered by workers who reflect the communities they serve and can build trust through lived experience, empathy, and cultural relevance.

Many current youth services reflect illness models that can 'capture' young people within care systems of individualised treatment that disconnect them from their natural supports, peers, culture and communities. This can increase marginalisation and stigma, confusion, hopelessness, isolation and loneliness. These impacts can set in motion a process of service engagement and provision that is unhelpful, can be unsafe and harmful, and doesn't create the conditions for the young person to recover, thrive and move beyond being within mental health systems. These impacts apply to young people and to their families.

> *I am a parent of a 24 YO male who first entered the MH system at 19 years of age due to drug induced psychosis. As a parent, I have witnessed my son's experience of the full gamut of services and systems since 2020. This ranged from emergency MH services, community mental health services and non-government services such as Headspace early intervention psychosis program. Additionally, drug and alcohol services and criminal justice system. Based on all of the above, the inconsistencies, fragmentation and limits of each services provision has been frustrating and draining for us as carers, and our son's recovery potential.*
>
> *My son has been more disengaged with Clinical services. He has had so many different diagnoses in 5 years that he has lost respect for psychiatric teams. Also, at times he says there are too many services involved. He just wants to be left alone. A lack of a holistic approach, with fragmented services and programs has been a negative impact. There needs to be stronger collaboration, partnerships and new intervention models for working with young people who have substance use and mental health issues. Instead, in SA, they only 'refer' but don't work together. Results in a lack of continuity of care.*
>
> *Services are out of touch, fragmented and too many barriers with criteria. High cost for professional services and it's difficult to get referrals especially when you have a young person that is already not engaging with the basics of life (like going to school, won't get out of bed)… so getting them to a publicly funded service for help with their mental health is almost impossible and is so disempowering for parents and care givers trying to get them help! The process of getting*

diagnosis, Disability Support through Centrelink and NDIS was the worst experience to go through! Often help and support is not available or is too expensive or difficult to access - especially without these supports - yet to apply for these required help that was not available!

Despite these challenges, when young people are given support for their mental health issues, are respected and supported to build self-agency within systems, they can thrive, as described by the following young person who is also a young carer:

I have been involved with the youth mental health system for a number of years, both through accessing services personally and participating in advocacy groups. I am currently a member of my local Headspace Youth Reference Group for the second time, my first involvement was way back when I was 14 years old. My experience has generally been positive, particularly when staff demonstrated an understanding of the Young Carer's role and facilitated educational sessions on this topic through partner organisations. I've appreciated when my feedback has been genuinely listened to and acted upon.

Mental health supports and services for young people in rural areas are also inadequate. The following comment from a family carer demonstrates particular challenges with engagement and help-seeking that can be exacerbated by the known challenges of distance and lack of services in rural areas:

Very limited involvement because it has been very difficult to access in regional/rural Australia. At a time when my daughter finally agreed to talk to someone, we drove 45 minutes to the nearest town which had an advertised "Walk In" service. When we "Walked in" they told us they did not have "walk-in" services available, and that we would need a referral or an appointment. My daughter was feeling so down, that I could not convince her to come back and do it all again, even with an appointment. Young people are nervous about making first approaches for health in general, let alone mental health. They often do not have relationships with GPs, therefore doing the standard 'Get a Mental Health Plan' or even a preliminary discussion is a discussion with a stranger about something immensely personal about which they often feel a sense of shame. These hurdles become worse as the young person's emotional state deteriorates. Even having a supportive adult/family member/friend alongside them is awkward.

Please consider the geographical requirements for those in remote, rural and regional areas. An hour and a half to drive to a service which isn't available (and wasn't contactable by phone) is not uncommon in rural areas. The time it takes for young people and their family/carers becomes a challenge. Young people don't want to waste their parents time, and parents have to take time out from work or other priorities, and while clearly the young person's mental health is a priority, it just makes this decision harder with these added complexities.

2. What services, models or approaches are working well in youth mental health (e.g. services that are accessible, effective and responsive to the needs of young people)?

While there are significant challenges within the youth mental health system, some young people and their families have also encountered services and approaches that offer hope, accessibility, and genuine support for young people, and staff with commitment to supporting them and delivering quality services.

Multidisciplinary teams that embed mental health support within education, housing, or community services are also having a positive impact. When mental health support is available through youth centres, schools, or wraparound services that understand the broader context of a young person's life - including housing, caregiving roles, and cultural identity - it becomes far more responsive and effective. These integrated approaches help reduce stigma, eliminate unnecessary barriers, and increase the likelihood of sustained engagement.

Young people and their families told us they value consistency in services and service providers, and effective communication and collaboration between services:

> *Headspace Early Psychosis program from 2020 - 2022 was a very good wrap around model with clinical and psychosocial interventions. However, when it finished my son was left in limbo whilst community services had long waiting lists, and at the time staffing issues. His mental health deteriorated significantly during this time. The psychosocial services seem to have a greater effect on maintaining my son's engagement than the Clinical services. Definitely needs to be more collaboration between the two sectors.*

Services need to meet young people where they are at, and this can be in online spaces with support accessible and delivered online (e.g., Website chats, SMS chats), given young people's high use of technology to help meeting their needs, how they source information and how they connect with others:

> *Hard to say, given the lack of availability of these walk-in services. Alternatives appear to be online services - Beyond Blue and Lifeline etc. More of the youth oriented online/text services need to be made known to young people, as often these 'normal' services appear too old for them. Promotion of these services is crucial so that it becomes as normal and as well-known as accessing other online services which is primarily how our young people do things.*

Several aspects of services delivered by current Headspace Centres were described as working effectively:

- Local Headspace centres providing taxi vouchers for young people, which reduces stigma and increases accessibility. This is particularly important as many young people prefer to access mental health services discreetly.
- Extended operating hours beyond 5pm at some Headspace centres, accommodating young people who have school, work commitments, or extracurricular activities during standard business hours.
- Headspace offering a diverse range of group programs that are not always held at the centre, demonstrating willingness to meet young people in the community and building strong relationships with local schools.

3. What is not working so well?

There continue to be serious and persistent gaps in the mental health system for young people, particularly those navigating complex trauma, neurodivergence, poverty, family violence, or caregiving roles. Young people can remain invisible to services for a long time and families can spend a long time looking for help

> *My son withdrew from the world when he was about 13 and basically 'lived' in his room for much of his teens, sleeping most of the time. We tried to everything; sought out many specialists, including sleep and physical health, but each one had no answers for us, other than that he would 'grow out of it'. The GP was the one consistent person, listening and believing us, providing empathy and support, and not giving up on searching for answers. But even getting him there was sometimes impossible. Luckily, they offered telehealth. Meanwhile, schooling and normal life vanished. As each year passed, we eventually landed in a private youth psychiatrist's appointment; they offered pills but little hope and little information. By then, anxiety and obsessional behaviours had become clear. That was 5 years later. My son quietly rejected that diagnosis and the pills path. The system had no answers for us and no tangible benefits for him. He is now slowly carving out a life for himself, quietly. We have learned not to look forward in time too much, not to be upset because that doesn't help any of us, especially him. Instead, we look back and reflect on the small positive steps he has made, being proud of each step in spite of the 'weirdness' of our lives. If we didn't do that, we'd have no hope.*

General practitioners (GPs) and psychologists are seen as effective sources of mental health support for young people, often their first and only accessible formal sources of treatment and care, and early intervention. However, young people's experiences of connecting with GPs is varied, as the following comments demonstrate:

> I once asked a service provider how young people were supposed to access mental health services - particularly those that are not severe, however would be critical to ensuring that their mental health didn't deteriorate any further. The person stated 'it's the same as an adult - you just take them to a GP and go through the assessment for a mental health plan'. And there's the problem. They are not 'the same as an adult', particularly when we are talking early to late teens… this format is hard enough for many adults to achieve, let alone children/young people who are not well versed in the health system, nor do many of them have regular GPs that they feel safe with. One of my daughters had not been to see a Dr for any physical health issue for 7 years, so for her first approach to a GP to be about her mental health was daunting. My other daughter had a regular GP, but hadn't seen her for 2 years, meaning she 'fell off the books' and was unable to continue her relationship with the previous GP, thus starting the story all over again, with a different GP for whom she didn't have the same rapport.

Long waitlists, closed books and costs are common issues experienced by young people and their families as part of their early efforts to seek information, assessment and answers to the young person's distress. The private system is an increasingly unpredictable and precarious space where consistent ongoing support is also not guaranteed, reflected by workforce shortages, including shortages of psychiatrists with specialisation in child and youth focused mental health.

Limited access to affordable psychiatrists. The high cost puts psychiatric care out of reach for many young people, resulting in longer intervals between medication reviews and potentially inappropriate continuation of prescriptions without proper monitoring.

Whilst University clinics can be lower cost, they can also be booked out and disconnected from other parts of the system.

We have received comments suggesting that more recent walk-in service models that are intended to be more accessible and responsive are not resourced sufficiently, which limits their ability to truly be responsive and adaptive. They are therefore not aligned to young people's needs, or ways of help-seeking and engaging with services, as the following example shows:

Clearly the funding behind the services is not adequate, given that what they are promoting that they offer, and what they ARE actually able to provide are not one and the same. If you promote a 'WALK IN' service, it needs to be available whenever anyone walks in. They may NEVER walk in again - it can't be to make an appointment, it can't be to come back later, it needs to be when they are ready and willing to make the approach.

Whilst there is an increasing focus on digital information and support services, family carers of your people also value locally accessible face-to-face drop-in support, with a particular focus on practical advice on how best to help their young family member, what to do and what not to do. That is, they value human contact that prioritises relational ways of working with young people and their families/supporters. Family peer workers are important trusted and credible sources of this support:

No drop-in centres or accessible places for youth to go to when experiencing mental health issues. No drop-in places for family to go to ask advice, meet people who can help support them in times of concern. A model that works well for Drug and Alcohol is Family Drug Support, although it too has its limitations. It would be good for drop-in centres to be available for family of young people to learn HOW to best support young people (their loved ones) from those who have ACTUALLY been through it. E.g. supporting a child/adolescent who self harms; who has borderline personality disorder… In my experience, what I thought was supporting my teenager was actually not helpful for them or myself. Online communities are great to build support, but in-person builds a sense of community more, I think.

We also wish to acknowledge the importance of schools, teachers, peers and school communities generally as sources of mental health and wellbeing support for young people. More could be done in this space, including supporting the mental health and wellbeing of teachers to then create supportive learning and wellbeing environments for their students. One of our LEA 'friends' offered the following ideas about potential opportunities within school environments:

After speaking with my 17-year-old daughter, she feels that services that come to young people are better than having to take time out to go somewhere (and risk not having those services). Her idea was school visits - similar to the Dental Van (in NSW Schools) which turns up a couple of times per year. Children access these services whose families are probably not able to afford or to get their children to other dental services. Her thoughts were that if something like this were available for mental health, it may make the services more approachable. The School Counsellor is not seen within their high school environment as being something which is useful and is often too full with other scenarios to be helpful. She also used the analogy of FIFO doctors in rural areas, where they have a set time they are there, and people just come to them for everything at that one scheduled

time. She also indicated that there are a large number of students at her high school who are already supported by the school for their physical health (such as provision of food and clothing, as well as care such as washing clothes) who don't have family/carers at home to do this kind of thing, and that taking care of these things was a priority, but that it would also need to extend to mental health.

A range of structural, resourcing and workforce challenges are apparent in mental health services for young people, including the following:

- Poor staff retention, particularly with short-term contracts (12-24 months). Young people build rapport with staff members and are then forced to retell their stories to new clinicians when staff leave. In practise such service delivery is not trauma-informed and can cause more harm than good.
- Staff members not thoroughly reading case notes or referral information before appointments. While clarifying questions are understandable, having to repeatedly retell one's entire story is exhausting, triggering and counterproductive.
- Face-to-face services are rarely available on weekends. This significantly reduces access opportunities for young people who work, study, or participate in extracurricular activities during weekdays. Weekend availability, even for limited hours, would reduce unnecessary emergency department presentations and provide better continuity of care.

4. What do you see as the gaps in service provision, models, services or approaches e.g. services that are not accessible, effective or response to the needs of young people, duplication, disconnection between services, barriers, etc)?

We have noted several concerns in our responses above.

Our LEA 'friends' have also stressed that hospital emergency departments, in particular, are very stressful environments for young people who are experiencing mental distress; they can be extremely traumatic and harmful environments for young people.

A complete reorientation of emergency mental responses is needed. Presenting to a general emergency department is NOT helpful for the individual, their carers, emergency staff and police, and public who have to witness the anguish and behaviour of someone who is suffering a serious mental health episode. There is plenty of evidence for this from international studies. A separate crisis response and location that takes a positive and sensitive approach will reduce escalation and further trauma is needed.

5. What should be changed?

Prevention, early intervention, and consistent belief in young people's voices must be at the core of any future improvements to our mental health service landscape. The system and those who work within it need to listen to lived experience, prioritise relationships over rigid eligibility, and empower young people through respect, flexibility, and genuine inclusion.

Too often, young people are denied access to services because they are "not unwell enough," or

conversely, “too complex.” This leaves those in need falling through the cracks. Services must move away from rigid diagnostic or severity-based thresholds and adopt needs-based frameworks that assess support requirements holistically, not just symptomatically.

We recommend the following changes to improve youth mental health services:

- Take a **holistic and developmental view beyond individualistic and clinical focus**. Young people’s needs evolve and change over time. This approach requires **Coordinated and Consistent Care** and access to **Longitudinal Support** and **Smooth Transitions** between services. Focus on building accessible services, rather than try to retrofit existing rigid models as an afterthought.
- Focus on building **Choice, Agency and Autonomy** for young people
- Models and programs need to take a **Personalised approach** (less rigid systems and service-driven criteria for eligibility and focus)
- **Skilled workforce** in youth engagement is essential
- **Incentivise collaboratively delivered models through commissioning:** Implement joint funding models for youth mental health services providing similar services to reduce duplication and improve coordination.
- **Increase Lived Experience Peer Workforce**: Increase funding for peer worker positions (consumer and family/carer peers) within government services, including Child and Adolescent Mental Health Services (CAMHS) in both inpatient and outpatient settings, and also non-government psychosocial programs. Young people often relate better to those of similar age who understand current youth challenges and share similar interests. More of this workforce for young people and parents/caregivers/kin.
- **Young Carer Peer Workers**: Establish at least one dedicated Young Carer Peer Worker position in each youth mental health service to improve identification and support for young carers.
- **Private/public health and education need to work together -** Cooperation not competition.
- **More services to meet young people where they are at:** reach into homes and other spaces where young people are rather than expect them to go to services which can be perceived as bureaucratic and unsafe spaces. Don’t rely on Medicare Mental Health Centres; focus more on safe spaces where young people are; offer more services that reach into homes
- **Follow-up support that is meaningful**, not just quick fix information then out the door
- **Stronger partnerships with and between regional services**: to strengthen regional, rural access.
- Services designed specifically for young people experiencing suicidality and imminent social risks rather than them being sent to ED.
- **Review PHN programs for young people:** Hold PHNs accountable, shift money from PHNs and programs that are not achieving benefits for young people; PHNs need to work better with state governments to build integrated pathways between services, a lot of money going to PHNs for bureaucracy rather than direct services.
- **Greater acknowledgement and support within Schools**: build more appropriate links with Schools, consider peer work within and into schools. More psychoeducation in upper primary and high school. Need medical certificate to return to school following mental health issue/mental distress, but not for physical health condition – This could be perceived as a form of stigma/discrimination, creates unnecessary hurdles for young people and their families.

- **Evaluate efficacy of programs, accountability and reform KPIs** to link more to performance. Hold services accountable for poor outcomes.
- **Workforce development regarding mental health/AOD intersections** to enable useful responses to young people. Invest in MH/AOD comorbidity services
- **Focus on prevention and early intervention, social determinants of mental distress.** Address the drivers of mental distress in young people (FDV, abuse, unemployment, education access, poverty, marginalisation, etc)
- **Ensure Culturally led models**: acknowledge young carers, identity, refugee experiences, family and community trauma; services need to be tailored to young people, not just secondary to mainstream models for adults.
- **Enhance Primary Care models for young people**: Consider role for primary care nurse focused on young people.
- **Afterhours / flexible service delivery models** to see young people outside of school and work times
- **Build Workforce Placement opportunities** to grow passion for working with young people
- **Invest in Workforce Development**: Funding that has adequate provision for administrative support, professional development, supervision, not just direct service delivery (LE workforce and others)
- **Don't assume digital services as the only or main format for young people**. Substandard services, APPs, not enough on their own; young people need face-to-face, relational services too.

6. Additional feedback on the Consortium Early Advice

We are pleased to see that the Headspace model will be expanded. Regarding Point 3 in the advice, we strongly support extended operating hours, particularly weekend services. All centres could provide and actively promote taxi vouchers to improve accessibility.

Point 5, establishing a central point of contact, would significantly reduce anxiety for young people navigating the system. This approach can be extended into the public mental health system for consistent support.

Before implementing any changes, we strongly recommend thorough consultation with young people in local communities through multiple channels including online platforms, in-person sessions, and community outreach to ensure diverse voices are heard.

7. Is there any other information you would like us to know to support our submission?

When young people experience mental health issues, their lives can be disrupted significantly in the short and longer-term. There can also be significant impacts for families of young people. They also need support to understand how to support in ways that are helpful to the young person and enable them to maintain hope for the future.

> *Carers and family members need more acknowledgement and support. We are the ones left to deal with our son's issues when he falls between the gaps. Greater holistic approaches between the needs of young people - homeless/housing, drug and alcohol, employment/ skills development etc. Additionally, review of Centrelink DSP requirements. Our son has just been approved for DSP, however there is no requirement for him to undertake anything in return. Whilst appears a relief initially, the lack of structure and activity in his day just leaves him bored and demotivated. He is*

capable of more, but without some level of mandatory skill improvement he will just become another young unemployed person with mental health issues.

Ultimately, changes that should be avoided include any reforms that increase bureaucracy, reduce face-to-face contact, or apply a one-size-fits-all model to service delivery. These approaches risk making young people feel more alienated and less inclined to seek help. Ultimately, the youth mental health system must be built on care, belief, and connection - values that empower young people, meet them where they are, and provide hope for a better future.

Contact

We thank you for the opportunity to put our views forward. We wish you well with the next steps and would be pleased to contribute our Lived Experience perspectives to any future discussions about this important topic.

Your sincerely

Sharon Lawn, John Attard, Kiara Roche

Professor Sharon Lawn, Executive Director
Lived Experience Australia Ltd
Email: slawn@livedexperienceaustralia.com.au
Mobile: 0459 098 772

John Attard
Lived Experience Australia Representative Panel
Advocate, Lived Experience Advisor
Young Carer Member – Western NSW LHD
Consumer & Carer Consultancy Committee
Carer Representative – Carers NSW
Email: attard.anthony@live.com.au

Kiara Roche
Lived Experience Australia Representative Panel
Advocate, Lived Experience Advisor
Carer Representative – Carers NSW
Email: kiara.roche@outlook.com

Acknowledgement to other members of the LEA Representative Panel who provided comments for this submission.

Appendix 1: Kiara's Story and Contributions

Please tell us about your perceptions of / experience with the youth mental health system.

My experience with the youth mental health system has been extensive, deeply personal, and began at a very young age. I first made contact with mental health services at age 12 following a period of significant trauma and distress, including the death of a close family member and ongoing exposure to abuse and neglect. Despite reaching out for help, my initial experience with a hospital-based mental health professional was invalidating and harmful - self-harm was dismissed as not severe enough, and I was told to return only if it got worse. This early experience with mental health services reinforced a message that I had to deteriorate further before I would be deemed worthy of care.

Throughout my adolescence, I had multiple inpatient psychiatric admissions, court-mandated psychological assessments, and consistent interactions with both community and emergency mental health services. I frequently encountered a system that was reactive rather than preventative, and often inaccessible to those who did not meet very specific and severe thresholds. At times, I was told I was too articulate or well-presented to be struggling, while at others, I was deemed "too far gone" for available support. This inconsistency left me, and many of my peers, feeling unsupported, invalidated, and without direction.

One of the most significant challenges I have observed is the lack of holistic and inclusive services that meet young people where they are - both physically and emotionally. Too often, services rely on formal, clinical environments that feel intimidating or judgmental. What many young people need is informal, community-based outreach, delivered by workers who reflect the communities they serve and can build trust through lived experience, empathy, and cultural relevance.

I now approach the youth mental health system from another perspective - as a full-time carer to my son, who has Level 3 Autism, Global Developmental Delay and Pathological Demand Avoidance (PDA). Despite our different circumstances, I see the same patterns repeating - long waitlists, inconsistent access based on arbitrary eligibility criteria, and a system that still struggles to listen to and validate lived experience.

While I am deeply grateful for the professionals who have believed in me and supported my recovery and advocacy work, I believe that Australia's youth mental health system is in urgent need of reform. Services must become more proactive, trauma-informed, culturally safe, and accessible - especially for young people from disadvantaged, marginalised, or high-risk backgrounds. My story is not unique. It is representative of many others who fall through the cracks due to systemic limitations. Prevention, early intervention, and consistent belief in young people's voices must be at the core of any future improvements to our mental health service landscape.

What is going well?

While there are significant challenges within the youth mental health system, I have also encountered services and approaches that offer hope, accessibility, and genuine support for young people.

Peer work and lived experience roles have emerged as one of the most effective enablers of trust and engagement. Services that include peer workers - especially those with similar cultural, socioeconomic, or lived backgrounds - create an environment where young people feel seen, understood, and less alone. These workers can build rapport more naturally and help bridge the gap between clinical systems and young people who may be hesitant to engage with formal mental health services. This model has proven especially beneficial in community

outreach settings and in supporting those navigating complex trauma, neurodivergence, and social disadvantage.

Multidisciplinary teams that embed mental health support within education, housing, or community services are also having a positive impact. When mental health support is available through youth centres, schools, or wraparound services that understand the broader context of a young person's life - including housing, caregiving roles, and cultural identity - it becomes far more responsive and effective. These integrated approaches help reduce stigma, eliminate unnecessary barriers, and increase the likelihood of sustained engagement.

Some telehealth services have also been invaluable, particularly during periods of crisis or when geographic or personal barriers prevent in-person support. The flexibility to access support from home, especially for young carers or those with mobility or sensory needs, has significantly improved accessibility for some cohorts.

Lastly, I have experienced individual professionals within the system - therapists, social workers, educators - who have gone above and beyond to advocate for young people and adapt their practice to individual needs. Their compassion, consistency, and trauma-informed approaches often make all the difference, even within a system that remains under-resourced.

These successes highlight what is possible when the system listens to lived experience, prioritises relationships over rigid eligibility, and empowers young people through respect, flexibility, and genuine inclusion.

What isn't going well?

Despite some positive examples, there remain serious and persistent gaps in the mental health system for young people - particularly those navigating complex trauma, neurodivergence, poverty, family violence, or caregiving roles.

Access remains one of the most significant barriers. Long waitlists, rigid eligibility criteria, and location-based service restrictions leave many young people without timely or appropriate support. Services often require a diagnosis, a GP referral, or for a young person to be in crisis before help is provided - by which point the situation may have already escalated to a point of disconnection, disengagement, or acute harm. Preventative care is talked about more than it is funded or implemented.

There is also a deep lack of trauma-informed, neurodiversity-affirming services that truly understand the intersection of mental health with developmental disability, autism, ADHD, and PDA. Many mental health practitioners still lack training in these areas, leading to harmful experiences such as pathologisation, misdiagnosis, or inappropriate treatment plans that don't reflect the lived reality of the young person. This can be particularly damaging for young people who mask, who have sensory needs, or who experience high levels of demand avoidance, and may disengage from services that feel unsafe or coercive.

Fragmentation across services is another major issue. Young people often have to navigate multiple systems - mental health, disability, housing, education, justice - without a clear point of coordination or support. There is little communication between these systems, and even less accountability. This results in young people being bounced around, retraumatised through retelling their stories, or falling through the cracks entirely. For young carers or those without a stable adult advocate, the burden of navigation can be overwhelming.

Cultural safety and inclusivity also remain inconsistent. First Nations young people, LGBTQIA+ youth, young people from refugee backgrounds, young carers, and those with experiences of homelessness or substance use are often met with services that are either unsafe or uninformed. Young people need spaces that reflect their identities and are free from judgment,

power imbalances, and systemic bias.

Finally, while the inclusion of lived experience is improving, it is still tokenistic in many areas. Lived experience roles are often underpaid, under-supported, and treated as secondary to clinical voices. Young people with lived experience must be genuinely included in co-design, policy development, and service delivery - not as a checkbox, but as critical partners with invaluable insight into what works and what doesn't. Overall, the system is still too reactive, too clinical, and too disconnected from the real lives of young people.

What should be changed?

To improve the effectiveness, accessibility, and coordination of youth mental health services in Australia, several systemic changes are urgently needed. These should be grounded in prevention, trauma-informed care, cultural safety, and genuine youth engagement.

1. Invest in Early Intervention and Prevention Services
The current system is highly reactive, often only engaging when a young person is in crisis. We must reframe this approach to prioritise prevention. Early intervention services, including school-based wellbeing programs, youth health hubs, and outreach programs, should be readily available, culturally competent, and embedded within communities. Services should be resourced to engage with young people before they reach a breaking point - not after.

2. Expand Holistic, Wraparound Support Models
Young people's challenges are rarely isolated to one domain. We need multidisciplinary, integrated models of care that recognise the social determinants of health - including housing, education, family violence, substance use, and disability. Case coordination should not fall on the shoulders of young people or their carers. Instead, services should communicate effectively and work collaboratively, providing wraparound support tailored to the unique circumstances of each young person.

3. Ensure Services Are Youth-Friendly and Culturally Safe
Services must reflect the diverse identities and lived experiences of the youth they are intended to support. This includes training staff in trauma-informed practice, cultural safety, LGBTQIA+ inclusion, neurodiversity, and disability awareness. Professionals who engage with young people should speak their language (literally and figuratively), show up in community spaces, and build trust before expecting disclosures.

4. Remove Eligibility Barriers and "Threshold" Models
Too often, young people are denied access to services because they are "not unwell enough," or conversely, "too complex." This leaves those in need falling through the cracks. Services must move away from rigid diagnostic or severity-based thresholds and adopt needs-based frameworks that assess support requirements holistically, not just symptomatically.

5. Resource Families and Carers
Many young people rely heavily on informal support networks. Carers - especially young carers - - should be recognised, included in care planning (with consent), and provided with their own support. This includes education on navigating services, respite, mental health supports, and financial assistance.

6. Reduce Wait Times and Increase Service Capacity
Long waiting lists, workforce shortages, and lack of after-hours services remain significant barriers. Increasing funding and staffing for youth mental health services, especially in regional and outer suburban areas, is essential. Services should be flexible in their hours and delivery methods, including telehealth, outreach, and home-based support.

7. Embed Lived Experience in Service Design and Policy
Lived experience voices must not only be heard but be central in policy design, implementation, and evaluation. Funding should be directed towards peer workforces, co-design processes, and youth advisory roles, ensuring reforms are not just top-down, but driven by those directly impacted.

Changes that should be avoided include any reforms that increase bureaucracy, reduce face-to- face contact, or apply a one-size-fits-all model to service delivery. These approaches risk making young people feel more alienated and less inclined to seek help. Ultimately, the youth mental health system must be built on care, belief, and connection - values that empower young people, meet them where they are, and provide hope for a better future.

Is there any other feedback you would like to give?

As a young carer with lived experience of complex trauma, homelessness, family violence, and navigating youth mental health services, I want to emphasise that connection saves lives - but too many young people feel disconnected from the systems that are supposed to support them.

Many of us are not just dealing with mental illness; we're also facing poverty, stigma, isolation, and systems that aren't built to accommodate our realities. We are more than our diagnoses - and we need services that see us as whole people, not just problems to be managed or risks to be contained.

Trust and safety are the foundation of effective support. Services must take the time to build relationships, to listen without judgement, and to believe in young people's capacity to heal - even when we are messy, angry, avoidant, or overwhelmed.

Young people also need flexibility and choice. Not everyone wants to talk. Some of us engage better through art, movement, culture, peer support, or hands-on work. Give us diverse entry points into the system, and don't penalise us if we don't fit into standard models of help- seeking.

Finally, don't just consult us - work alongside us. Lived experience is not a token add-on. It is a critical form of expertise. Young people and those with lived experience should be at the heart of designing, delivering, and evaluating the very systems we rely on. **Nothing about us without us.**

Views on the Summary of Consortium Early Advice (available here) which sets out some preliminary ideas about how to refine the youth mental health system.

The direction of the proposed reforms shows promise and reflects many of the core issues I have encountered personally and professionally as a young carer, mental health system user, and advocate. Several elements of the summary are especially encouraging:

- The inclusion of care navigators is a particularly valuable idea. As someone who has had to navigate multiple systems - mental health, disability, education, and housing - without any formal support or guidance, the concept of a consistent, trusted person to walk alongside a young person through these transitions could be transformative. Importantly, recognising that care navigation is already informally occurring (particularly within First Nations, LGBTQIA+, and carer communities) highlights the need to appropriately resource and formalise these roles, while valuing existing community- based knowledge and support structures.
- The focus on psychosocial integration is another crucial strength. In my experience, young people's needs are rarely purely clinical. Addressing mental health in isolation, without attending to housing, social connection, financial security, trauma, or cultural identity,

limits the effectiveness of any intervention. Embedding psychosocial supports into clinical settings, and vice versa, is essential for real, sustainable recovery.

- The recognition of the 'missing middle' and the limitations of headspace's current model is timely and appropriate. Many young people with complex or fluctuating needs fall into service gaps and are either bounced between providers or denied care due to arbitrary thresholds. Expanding both the capacity and scope of headspace - and introducing additional, specialised transdiagnostic services - would help close these gaps.

However, I would also like to offer the following reflections and cautions:

- Implementation must be community-informed, not just system-designed. While models such as care navigation or extended service delivery are promising, they will only be effective if co-designed and trialled with young people who have lived experience - particularly those from priority populations. Community-controlled organisations, First Nations voices, and youth-led advisory structures must be at the heart of this process.
- Digital tools and national data systems offer potential, but digital exclusion is still very real. Some young people do not have safe access to devices, internet, or private spaces to engage online. Solutions must include digital literacy support, device provision, and safe access points (e.g. in schools, libraries, and community hubs) to ensure equity.
- There is a risk that focusing too heavily on streamlining or integration could unintentionally create rigidity. Services need to be flexible, localised, and adaptable to the complex, non-linear journeys of young people. Systems should not become more centralised at the expense of diversity and accessibility.

Finally, I strongly encourage the Consortium to ensure that lived experience voices remain central in the ongoing phases of this work - not just in consultation, but in leadership, co-design, implementation, and evaluation. My story is just one of many, but it reflects the urgent need for a system that truly sees and responds to the whole person - not just their diagnosis or crisis moment.

Thank you for the opportunity to contribute.

Kiara Roche
Advocate | Lived Experience Advisor