System2

Centre for Behavioural and System Change

Launchpad:

A fresh approach to improving access to quality mental health services for young Australians

3 April 2025

About System 2

We are an applied research not-for-profit, created in 2022 by BIT (Behavioural Insights Team) Australia and UK innovation charity Nesta.

Our mission is to enable young Australians experiencing disadvantage to thrive.

We bring together behavioural science, systems thinking, and insights from deep collaboration with those with lived experience, to co-design, test, and scale practical solutions.

Acknowledgment of Country

We acknowledge the Traditional Custodians of the land on which we operate, the Gadigal people of the Eora Nation, and pay our respects to Elders past and present. We recognise their ongoing connection to this land, waters, and community, and honour their rich cultural heritage.

Centre for Behavioural and System Change

We established the Centre for Behavioural and System Change to undertake research that supports our mission. The Centre is an Approved Research Institute with Deductible Gift Recipient (DGR) status. It is overseen by our **Research Committee** (below), chaired by Dr Robyn Mildon.

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Acknowledgements

We would like to thank all those who generously contributed to this research project, without whom this report would not have been possible. A full list of organisations and participants is provided in the Appendix.

Suggested citation for this report

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System 2 Launchpad

'Launchpad' is the name we give to our exploratory research projects. Projects were initially undertaken in three priority research areas, each led by a dedicated System 2 Research Lead specialist. This report is one of three summarising the project findings.

To select our three research priority areas, we began with a review of 60 Australian youth surveys published from 2020–2024. Our Youth Advisory Board, in collaboration with our Research Committee, used this review to identify the three most important issues affecting young Australians experiencing disadvantage:

- **Youth mental health**, and in particular the challenges associated with accessing high quality mental health services. ***This topic was identified as the top priority issue and is the focus of this report.***
- **Fair access to post-school career opportunities**, with linked concerns about employment, cost of living, and debt. The preferred focus was on the role of career education and support prior to leaving school in driving access to career opportunities. *This topic was identified as the second priority issue, and is the topic of a separate report available on our website.*
- **Early years**, and in particular early childhood education and care. *This topic was not a priority identified in youth surveys, but was identified by the Youth Advisory Board as the third priority issue. It is also the topic of a separate report.*

Each project shared several goals including:

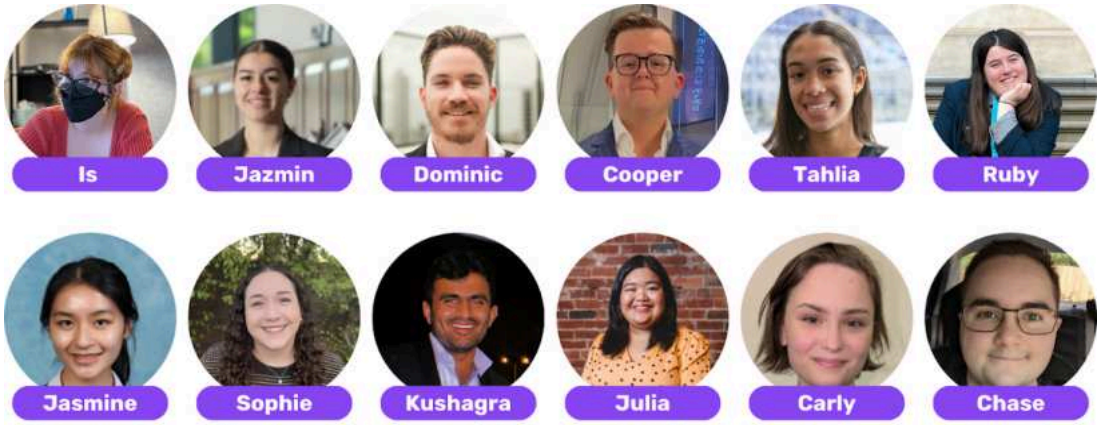
- Understanding the extent to which systems are working as intended
- Identifying areas ripe for policy reform
- Posing important research questions
- Understanding where System 2's unique approach can have the most impact.

While activities to achieve these goals varied between projects, they typically involved building a system map informed by a rapid evidence review and consultations with experts and other stakeholders in the system — including those with lived experience.

Youth Advisory Board

Our research is guided by our Youth Advisory Board, comprising 12 young people, with three main objectives:

- Amplify the perspectives of young people on the big issues they identify.
- Support the decision making of our Research Committee.
- Participate directly in our research projects, where their lived experience is valued.



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! **This report discusses mental health.** If you or someone you know needs help, you can access free resources at:

- **BeyondBlue**: https://www.beyondblue.org.au/

  Provides mental health information and free mental health counselling and coaching.
- **Lifeline Australia**: 13 11 14

  A free, confidential, 24/7 crisis support and suicide prevention hotline.
- **Kids Helpline**: 1800 55 1800

  A free, confidential, 24/7 phone counselling service for young people aged 5 to 25.
- **Medicare Mental Health**: https://www.medicarementalhealth.gov.au/

  Helps you find and connect with mental health supports that are right for you.

Introduction

Mental health is a psychological and behavioural state describing how well someone is feeling and functioning.[1] When a person falls outside a 'healthy' state of feeling and functioning and moves into a state of 'unsettledness', 'struggle', or 'healing',[2] it is their basic human right to have ready access to quality mental health care.[3]

Australia has increased its investment into mental health services since 2006-2007 via initiatives such as headspace and the Medicare Better Access scheme. Since then, uptake of mental health services among young people aged 15-24 has increased substantially.[4] At face value, this increased utilisation of services among young people could be taken as evidence that access to mental health care has improved over time. However, such a conclusion would be misleading for two reasons. First, the mental health of young people in Australia (and other 'WEIRD'[5] nations around the world) has been steadily declining since the early 2010s.[6] Increased uptake of mental health services is therefore not surprising given the concurrent surge in need. Second, a number of recent inquiries and evaluations have revealed the myriad ways the mental health system is currently failing to meet the needs of Australians, including young people.[7] For example, the *Inquiry into Mental Health and Suicide Prevention* found that "many mental health services have long waiting lists...there can be waiting times of up to six months after a young person takes the first step to reach out for help".[8] Findings like this suggest a supply-demand imbalance, where **growing rates of mental ill health among young people, combined with broader eligibility for subsidised services, are straining the system's capacity to provide quality care**. In other words, despite expanded provision and utilisation of subsidised and tailored services through Better Access and headspace, young people's access to quality care is falling short because the system cannot cope with rising demand.

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[1] Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. Journal of Health and Social Behavior, 43(2), 207–222. https://doi.org/10.2307/3090197

[2] Beyond Blue. (2024). What is mental health? https://www.beyondblue.org.au/mental-health/what-is-mental-health

[3] World Health Organization. (2023). Mental health: Promoting and protecting human rights. https://www.who.int/news-room/questions-and-answers/item/mental-health-promoting-and-protecting-human-rights

[4] Jorm, A. F., & Kitchener, B. A. (2021). Increases in youth mental health services in Australia: Have they had an impact on youth population mental health? Australian & New Zealand Journal of Psychiatry, 55(5), 476–484. https://doi.org/10.1177/0004867420976861

[5] 'WEIRD' stands for 'Western, Educated, Industrialised, Rich, Democratic' societies. See:

- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? The Behavioral and Brain Sciences, 33(2–3), 61–83. https://doi.org/10.1017/S0140525X0999152X

[6] McGorry, P. D., Mei, C., Dalal, N., Alvarez-Jimenez, M., Blakemore, S.-J., Browne, V., Dooley, B., Hickie, I. B., Jones, P. B., McDaid, D., Mihalopoulos, C., Wood, S. J., Azzouzi, F. A. E., Fazio, J., Gow, E., Hanjabam, S., Hayes, A., Morris, A., Pang, E., … Killackey, E. (2024). The Lancet Psychiatry Commission on youth mental health. The Lancet Psychiatry, 11(9), 731–774. https://doi.org/10.1016/S2215-0366(24)00163-9

[7] At the national level, pertinent inquiries and evaluations include:

- Parliament of the Commonwealth of Australia. (2021). Mental health and suicide prevention—Final report. https://www.aph.gov.au/Parliamentary_Business/Committees/House/Former_Committees/Mental_Health_and_Suicide_Prevention/MHSP/Report
- Productivity Commission. (2020). Mental Health inquiry report—Actions and findings. https://www.pc.gov.au/inquiries/completed/mental-health/report
- Pirkis, J., Currier, D., Harris, M., Mihalopoulos, C., Arya, V., Banfield, M., Bassilios, B., Buchanan, B., Butterworth, P., Brophy, L., Burgess, P., Chatterton, M. L., Chilver, M., Eagar, K., Faller, J., Fossey, E., Ftanou, M., Gunn, J., Kruger, A., … Williamson, M. (2022). Evaluation of Better Access. The University of Melbourne. https://www.health.gov.au/resources/publications/main-report-evaluation-of-the-better-access-initiative?language=en
- KPMG. (2022). Evaluation of the national headspace program. https://www.health.gov.au/resources/publications/evaluation-of-the-national-headspace-program?language=en

[8] Parliament of the Commonwealth of Australia. (2021). Mental health and suicide prevention—Final report. https://www.aph.gov.au/Parliamentary_Business/Committees/House/Former_Committees/Mental_Health_and_Suicide_Prevention/MHSP/Report

To address these challenges, **there is a need for greater and smarter investment into the mental health system**, including youth mental health services, to improve the system's ability to cope with its volume. **Smarter investment will require understanding key system leverage points where intervention can have the greatest impact.** In this report, we show that workforce shortages are creating a major bottleneck in the system, limiting the capacity of mental health practitioners to deliver affordable, locally-accessible, timely, and continuous care. We also show that service costs are rising rapidly, and are more expensive for children and young people, which may explain why many young people are deciding to delay or not seek help. Without publicly accessible information about the funding flows and fee structures underpinning youth mental health services, or data about how service affordability impacts the behaviours of young people and their parents or caregivers, it is difficult for young people, advocates, practitioners, researchers, and policymakers to make precise recommendations about what smarter investment and reforms look like. Shedding light on these factors is therefore a crucial first step toward implementing policy changes that will improve the workforce capacity and affordability of mental health services for young people. In addition, greater investment into preventative initiatives could ease pressure on mental health services by reducing the number of young people needing psychological and psychiatric support. For example, this might include developing youth-led and evidence-based regulatory frameworks that ensure social media companies put the mental health of young people before profit.

Executive summary

Improving mental health is an urgent priority for young people. Across our extensive review of 60 Australian youth surveys (2020-2024), mental health emerged as by far the most important issue affecting young Australians experiencing disadvantage. Drawing on their expertise and lived experience, our Youth Advisory Board identified a need to understand the challenges and opportunities associated with **accessing high quality mental health services for young people aged 12-25 in Australia**. This report details our resulting program of exploratory research. The program comprised a series of research activities including desk research, consultations with professional and youth experts, and administrative data analysis.

The aim of our exploratory research was firstly to understand:

i) the informal supports and professional services available to young people in Australia who are experiencing mental health challenges and

ii) the psychological and structural barriers that make it hard to ask for or get help from these services.

We constructed a high-level **system map** depicting an overview of our findings, which can be accessed here. It includes the following key barriers limiting access to quality mental health services for young people in Australia:

Psychological barriers *that make it hard to ask for help*		Structural barriers *that make it hard to get the help you ask for*	
	Experiencing mental health symptoms that inhibit help seeking		Crisis management is prioritised
	Having limited bandwidth to prioritise personal mental health during acute crises		Services have workforce shortages
	Having poor mental health literacy		Triaging capabilities are poor
	Feeling skeptical about or distrustful of therapy or therapists		Services are fragmented
	Downplaying the severity of distressing symptoms		Services are expensive
	Preferring to confront challenges alone		Wait times are long

Psychological barriers *that make it hard to ask for help*		Structural barriers *that make it hard to get the help you ask for*	
	Not feeling ready to get help		Travel requirements can be prohibitive
	Experiencing social stigma toward mental ill health		Care is discontinuous
	Holding self stigmatising beliefs about mental ill health		Parental consent is sometimes required
			Diagnosis is emphasised over formulation

We also conducted a **spotlight analysis** of one structural barrier, *services are expensive*, after hearing from professional and youth experts that the cost of accessing services can be particularly prohibitive for young people. Medicare data published in March 2025 revealed that in the financial year 2023-24, young people aged 15-24 paid an average out-of-pocket cost of $68.02 to access a Medicare-subsidised non-inpatient mental health service. This figure represents a 79% increase since 2020-21 (almost 5 times the rate of inflation) and an 18% increase since 2022-23. Moreover, this average out-of-pocket cost of $68.02 was 35% higher than the average out-of-pocket cost paid by people aged 45-64, was nearly double that of 65-79 year olds, and nearly triple that of 80+ year olds.

We used our system map and spotlight analysis to develop **ideas for how we could make the system work more effectively** in providing access to quality mental health services for young people in Australia. We developed and prioritised ideas that aligned closely with System 2's unique approach:

- **Systems-thinking**: Addressing system leverage points.
- **Behavioural science**: Mapping behaviours and using insights from behavioural science about how to encourage behaviour change.
- **Deep collaboration**: Incorporating research methodologies that amplify the voices of young people with relevant lived experience.

We developed detailed proposals for two projects to tackle system leverage points:

Project 1: Illuminating the funding flows, fee structures, and out-of-pocket costs affecting the supply and affordability of youth mental health services in Australia

This project focuses on the **supply-side** and the **demand-side** of the mental health system.

- Rationale: Workforce shortages, which are creating a major bottleneck in the mental health system, are at least partly driven by insufficient financial incentives to attract and retain mental health practitioners in public services such as youth-focussed headspace centres. At the same time, out-of-pocket costs for Medicare-subsidised non-inpatient mental health services are rising rapidly in Australia across all age groups, with young people facing higher costs than those aged over 45. These supply-side and demand-side issues reveal a need for greater and smarter investment into youth mental health services to improve the system's ability to cope with its increasing volume and ensure services are affordable for those who need it.
- Objective: This work will illuminate the funding flows and fee structures affecting the supply and affordability of youth mental health services in Australia, while also examining how affordability influences help-seeking behaviours.
- Impact: These insights will equip young people, advocates, practitioners, researchers, and policymakers with the knowledge needed to drive funding reforms that address the root causes of workforce shortages as well as rising and inequitable service costs. Without a clear understanding of these root causes, funding reform efforts may either be stalled due to uncertainty about where to start, or ineffective due to targeting the wrong drivers.

Project 2: Improving youth mental health by regulating dark patterns in social media

This work focuses on the **demand-side** of the mental health system.

- Rationale: Social media companies must do more to ensure young people are not exposed to unnecessary harm when using their platforms. One way social media companies could improve the safety of their platforms is by removing 'dark patterns', or design features that exploit people's cognitive biases in ways that are not in their best interest. Similarly, social media companies could seek to amplify 'bright patterns' (design features that help users make more informed and intentional choices that align with their interests) and the positive side of 'grey patterns' (design features that have the potential to either help or hinder a person's ability to act in alignment with their interests, depending on how the feature is deployed).
- Objective: Adopting a prevention-focussed lens, this work will produce a set of evidence-based regulatory principles that seek to eliminate dark patterns and the features of grey patterns that may be damaging to mental health, while retaining and amplifying the aspects of social media young people value most through leveraging bright patterns.
- Impact: These principles could be used to guide the development of regulatory frameworks that ensure social media companies put the mental health of young people before profit. Without such regulation, the 'attention economy' will continue to incentivise social media companies to use dark patterns to maximise engagement at all costs.

1. Background

1.1 Rationale

Mental illness is most likely to emerge in youth, with 63%-75% of onsets occurring by age 25 and the peak age of onset being 15 years.[9] The consequences of poor mental health in early life can extend beyond an individual's own life trajectory, producing substantial costs to society.[10] As a result, experts have argued:

> "Early, effective intervention, targeting young people aged 12–25 years...has the capacity to generate greater personal, social and economic benefits than intervention at any other time in the lifespan and is therefore one of the 'best buys' for future reforms."[11]

In the mid 2000s, the Australian Government responded to this call to action by introducing initiatives designed to improve access to mental health services for all Australians, including young people.

In 2006, the Australian Government introduced the **Better Access** initiative to expand the range of mental health service offerings covered under Australia's universal health insurance scheme, Medicare. While psychiatry services were already covered under Medicare and remained unchanged, Better Access introduced coverage for mental health services provided by clinical psychologists, other psychologists, and allied health professionals. The initiative also expanded benefits for mental health services provided by general practitioners (GPs).[12] Under Better Access, Australians can currently access up to 10 subsidised individual sessions with these mental health practitioners per calendar year via a Mental Health Treatment Plan issued by a GP.[13]

Around the same time as Better Access was introduced, a number of Australian Government funded youth-focussed **headspace** centres were opened in 2007. These centres provide young people aged 12-25 access to mental health and other primary care services (physical and sexual health services; alcohol and other drug services; vocational services) at no or low cost.[14] At the time of writing, there are now more than 160 headspace centres around Australia.[15]

Since the introduction of Better Access and headspace in 2006-2007, the proportion of young people accessing a Medicare-subsidised mental health service has increased substantially over time, particularly for services provided by clinical psychologists, other

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[9] McGorry, P. D., Mei, C., Dalal, N., Alvarez-Jimenez, M., Blakemore, S.-J., Browne, V., Dooley, B., Hickie, I. B., Jones, P. B., McDaid, D., Mihalopoulos, C., Wood, S. J., Azzouzi, F. A. E., Fazio, J., Gow, E., Hanjabam, S., Hayes, A., Morris, A., Pang, E., … Killackey, E. (2024). The Lancet Psychiatry Commission on youth mental health. The Lancet Psychiatry, 11(9), 731–774. https://doi.org/10.1016/S2215-0366(24)00163-9

[10] Arias, D., Saxena, S., Verguet, S. (2022). Quantifying the global burden of mental disorders and their economic value. EClinicalMedicine, 54, Article 101675. https://doi.org/10.1016/j.eclinm.2022.101675

[11] McGorry, P. D., Purcell, R., Hickie, I. B., & Jorm, A. F. (2007). Investing in youth mental health is a best buy. Medical Journal of Australia, 187(7). https://doi.org/10.5694/j.1326-5377.2007.tb01326.x

[12] Jorm, A. F., & Kitchener, B. A. (2021). Increases in youth mental health services in Australia: Have they had an impact on youth population mental health? Australian & New Zealand Journal of Psychiatry, 55(5), 476–484. https://doi.org/10.1177/0004867420976861

[13] Australian Government Department of Health and Aged Care. (2024). Better Access fact sheet – patients. https://www.health.gov.au/resources/publications/better-access-fact-sheet-patients?language=en

[14] Rickwood, D., Paraskakis, M., Quin, D., Hobbs, N., Ryall, V., Trethowan, J., & McGorry, P. (2019). Australia's innovation in youth mental health care: The headspace centre model. Early Intervention in Psychiatry, 13(1), 159–166. https://doi.org/10.1111/eip.12740

[15] headspace. (n.d.). Find a centre. https://headspace.org.au/headspace-centres/

psychologists, and GPs.[16] Figure 1 and Figure 2 below depict this trend aggregated across service types from 2013-14 to 2022-23. Young people aged 18-24 are also accessing mental health services at higher rates than any other age cohort, as shown in Figure 3 below.[17]

[16] Jorm, A. F., & Kitchener, B. A. (2021). Increases in youth mental health services in Australia: Have they had an impact on youth population mental health? Australian & New Zealand Journal of Psychiatry, 55(5), 476–484. https://doi.org/10.1177/0004867420976861

[17] Australian Institute of Health and Welfare. (2024). Medicare mental health services 2022-23 [Dataset]. https://www.aihw.gov.au/mental-health/topic-areas/medicare-subsidised-services

Figure 1: Access rates over time for young people aged 12-17

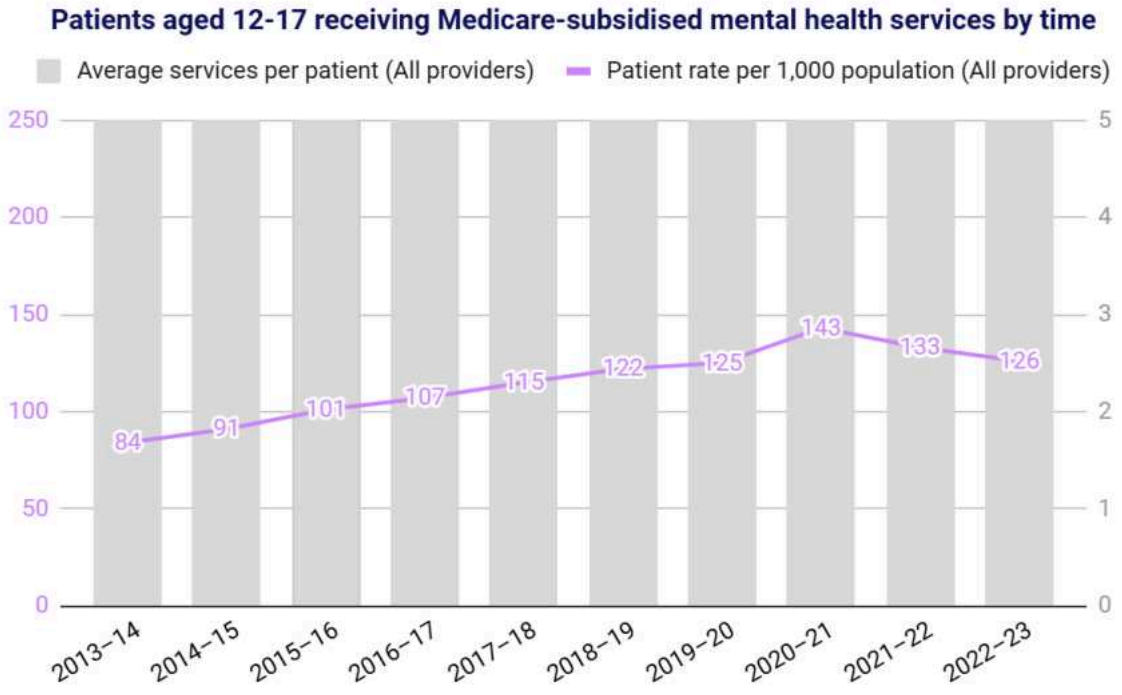


Figure adapted from Table MBS.4 in Medicare mental health services 2022–23 data.

Figure 2: Access rates over time for young people aged 18-24

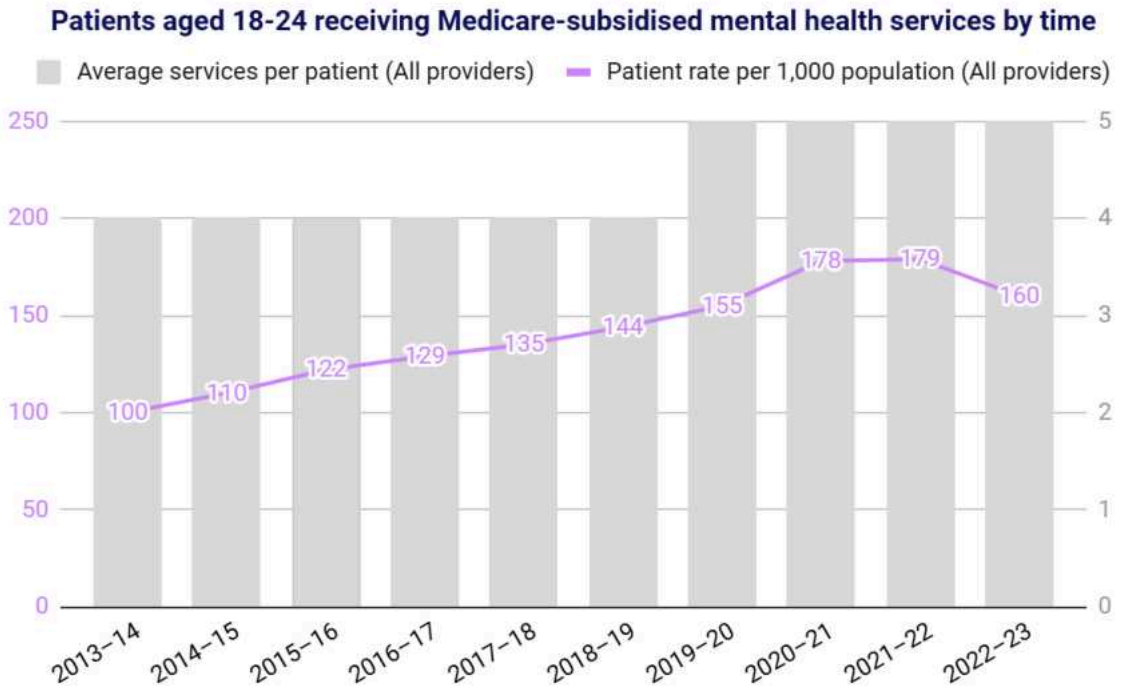


Figure adapted from Table MBS.4 in Medicare mental health services 2022–23 data.

Figure 3: Comparison of access rates in 2022-23 across age cohorts

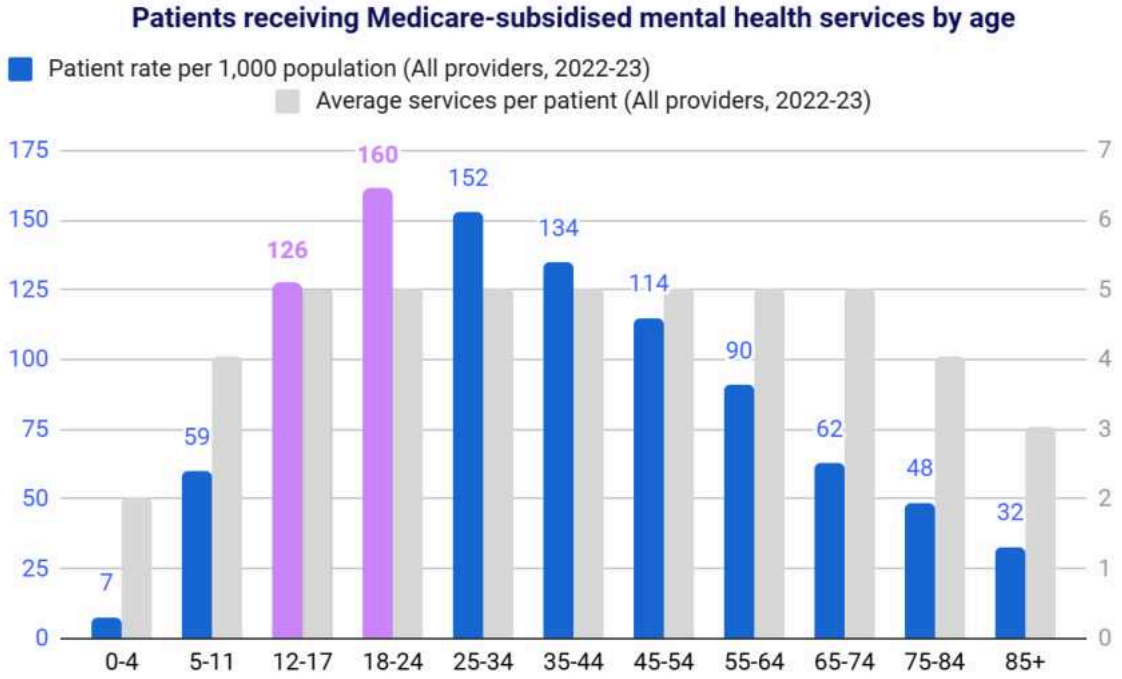


Figure adapted from Table MBS.4 in Medicare mental health services 2022–23 data. Patient rates for young people aged 12-24 are highlighted in pink. Though not depicted here, access rates were higher for young females (17% of 12-17 year olds; 22% of 18-24 year olds) compared to young males (9% of 12-17 year olds; 11% of 18-24 year olds), with 18-24 year old females accessing mental health services at twice the rate of males in the same age group.

On the one hand, young people's growing use of Medicare-subsidised mental health services could be taken as evidence that access has improved for this cohort over time. On the other hand, these trends have coincided with a steady decline in the mental health of young people in Australia (and other 'WEIRD' nations around the world) since the early 2010s (see the box below).[18] The increase in service uptake among young people may therefore simply reflect their growing need for help. A number of recent inquiries into and evaluations of Australia's mental health system have also highlighted a number of ways the system is currently falling short,[19] suggesting increased access to services has not necessarily translated into increased access to quality care.

The state of youth mental health in Australia

In 2022, the Australian Bureau of Statistics released the first national population mental health and wellbeing survey since 2007, called the National Study of Mental Health and Wellbeing. The sample comprised 16 to 85 year-olds:[20]

In 2020-22, an estimated 2 in 5 Australians (38.8%) aged 16-24 had experienced a mental health disorder in the previous 12 months.[21]

- **Mental ill health is increasing among young people**: In 2007, an estimated 1 in 4 Australians (26.4%) had experienced a mental health disorder in the previous 12 months.[22]
- **Mental ill health is more common for young people than any other age group, and the gap between other age groups has widened over time**: Figure 4 below depicts these trends.

[18] McGorry, P. D., Mei, C., Dalal, N., Alvarez-Jimenez, M., Blakemore, S.-J., Browne, V., Dooley, B., Hickie, I. B., Jones, P. B., McDaid, D., Mihalopoulos, C., Wood, S. J., Azzouzi, F. A. E., Fazio, J., Gow, E., Hanjabam, S., Hayes, A., Morris, A., Pang, E., … Killackey, E. (2024). The Lancet Psychiatry Commission on youth mental health. The Lancet Psychiatry, 11(9), 731–774. https://doi.org/10.1016/S2215-0366(24)00163-9

[19] Key access challenges identified in recent inquiries and evaluations include:

- "Within the current mental health and suicide prevention sectors, vital services are not accessible for all who need them" – Inquiry into mental health and suicide prevention, 2021, p. 70
- "To create a person-centred mental health system, Australia needs reforms that…focus on prevention and early help: early in life and early in illness" – Productivity Commission mental health inquiry, 2020, p. 2
- "Better Access is certainly serving some groups better than others, and these gaps are widening. Of most concern, increases in utilisation over time disproportionately favour people on relatively higher incomes in major cities. Affordability was consistently raised as an issue by consumers and providers." – Evaluation of the Better Access initiative, 2022, p. 15
- "While the [headspace] model is associated with positive psychosocial outcomes for young people, the majority do not see a clinically significant change to their outcomes…Young people from 'hard to reach' groups continue to be less well served through the [headspace] model, across outcome areas." – Evaluation of the national headspace program, 2022, p. 27

[20] Data for the 2022 National Study of Mental Health and Wellbeing were gathered via in-person interviews using the World Health Organization's *Composite International Diagnostic Interview (version 3.0)*. This instrument indicates diagnoses, rather than relying on participants' self-reporting of mental illness. Definitions and criteria for the assessed mental disorders were based on the World Health Organization *International Classification of Diseases, Tenth Revision (ICD-10)*. The assessed groups of mental disorders were anxiety disorders, affective disorders, and substance use disorders.

[21] Australian Bureau of Statistics. (2023). National Study of Mental Health and Wellbeing, 2020-2022 [Dataset]. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release

[22] Australian Bureau of Statistics. (2008). National Survey of Mental Health and Wellbeing, 2007 [Dataset]. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2007

Figure 4: Mental health disorders over time across age cohorts

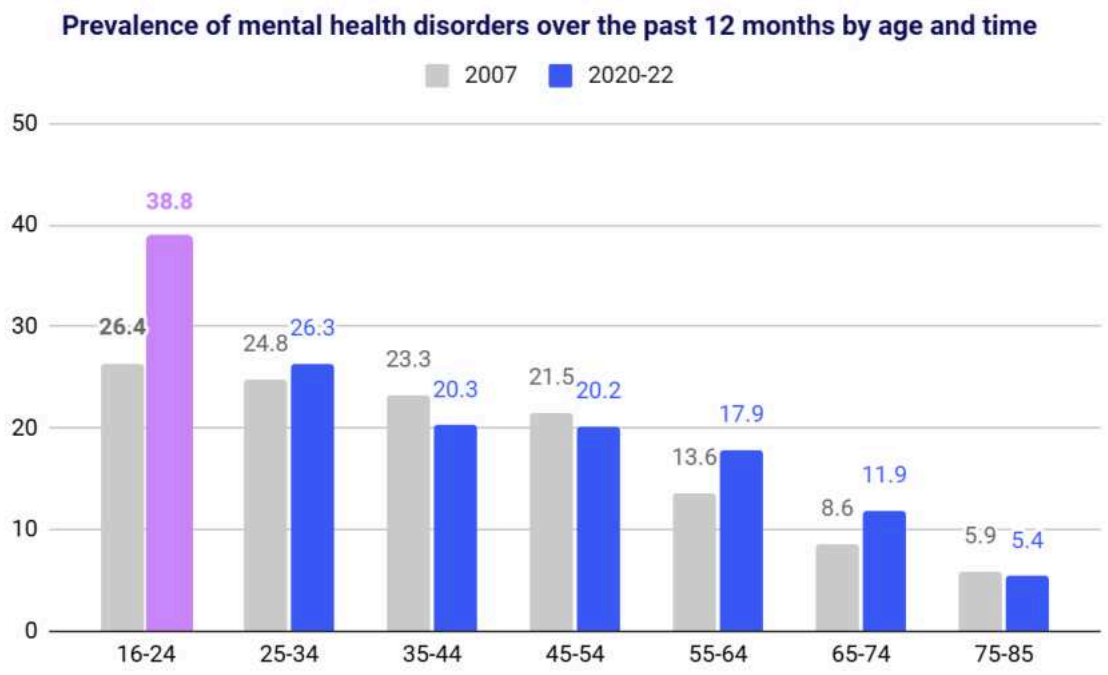


Figure adapted from the National Survey of Mental Health and Wellbeing, 2007 and National Study of Mental Health and Wellbeing, 2020-2022 data. Prevalence rates for young people aged 16-24 are highlighted in pink.

- **Mental ill health is more prevalent among girls**: In 2020-22, an estimated 45.5% of females aged 16-24 had experienced a mental health disorder in the previous 12 months, compared to 32.4% for males.[23]

1.2 Aims

In light of these challenges, improving access to quality youth mental health services is an urgent priority to enable young people experiencing disadvantage to thrive. This report details our program of exploratory research on the **mental health supports and services available to young people aged 12-25 in Australia**. The purpose of the research program was to:

- Build a high-level **system map** to understand the i) informal supports and professional services available to young people experiencing mental health challenges and ii) psychological and structural barriers that make it hard to ask for or get help from these services.
- Use the system map to develop **proposals for impactful projects** we could pursue to improve access to quality mental health services for young people.

1.3 Methodology

Our exploratory research combined desk research, consultations with professional and youth experts, and administrative data analysis.

[23] Australian Bureau of Statistics. (2023). National Study of Mental Health and Wellbeing, 2020-2022 [Dataset]. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release

1.3.1 Desk research

We conducted a rapid evidence review to gain a broad understanding of:

- Access rates for mental health services among young people in Australia
- Mental health trends among young people in Australia
- Available mental health services for young people in Australia

We also used the literature to validate, expand on, and fill gaps in the insights from our consultations with professional and youth experts.

1.3.2 Consultations with professional experts

We conducted a series of 1:1, virtual, one-hour semi-structured interviews with seven mental health practitioners and researchers. The aim of these professional expert interviews was to gain insight into the barriers hindering young people's access to quality mental health services.

The professional experts we consulted included:

- Professor Patrick McGorry AO, Executive Director, Orygen
- Professor Ian Hickie AO, Co-Director, Health and Policy at the Brain and Mind Centre
- Dr Daniel Pellen, Chair, RANZCP Binational Section of Youth Mental Health
- Chris Raine, Mental healthcare founder and executive
- A clinical spokesperson for BeyondBlue
- A practising registered psychologist
- A researcher with expertise in population mental health

1.3.3 Consultation with youth experts

We conducted a one-hour virtual focus group with our Youth Advisory Board. The aim of this focus group was to gather feedback from youth experts on our draft system map.[24] The draft system map summarised findings from our desk research and professional expert interviews, focussing on:

- Mental health supports and services available to young people in Australia
- Psychological and structural barriers inhibiting access to these services

We divided the focus group session into two rounds. In the first round, youth experts were given three minutes to write down as many 1-3 word responses as they could to the following prompt: *Who or where might a young person go to if they wanted mental health support?*

The purpose of this prompting activity was to encourage youth experts to form their thoughts independently before seeing the system map or hearing others' feedback. After writing their responses, youth experts came together to view the relevant section of the

[24] We refer to our Youth Advisory Board members as 'youth experts' to recognise the unique insights they bring based on their lived experiences as young people. Levels of firsthand exposure to the mental health system differed among members, resulting in a diverse representation of perspectives.

system map and provide feedback via an open discussion. The aim of the discussion was to add nuance to, identify gaps in, or challenge the assumptions of the draft system map.

In the second round, youth experts were again given three minutes to respond to a new prompt: *What factors make it hard for young people to access professional mental health services?* As before, after responding to the prompt, youth experts came together to view and provide feedback on the relevant section of the draft system map.

Insights from the focus group discussions were collated by our Youth Mental Health Research Lead (Dr Erin Dakin) and used to refine the system map into its final form.

1.3.4 Administrative data analysis

We conducted a quantitative analysis of the out-of-pocket costs young people pay in Australia to access Medicare-subsidised mental health services. We chose to shine a spotlight on this structural barrier because it was emphasised by the youth and professional experts we spoke to.

Our analysis used the Australian Institute of Health and Welfare *Medicare-subsidised GP, allied health and specialist health care across local areas* datasets. These datasets cover the use of non-inpatient Medicare-subsidised services,[25] including mental health services delivered through GPs, allied health professionals, and specialists. We examined the four most recent datasets – 2020-21,[26] 2021-22,[27] 2022-23,[28] and 2023-24.[29] We focussed on the below service types:

- GP Mental Health[30]
- GP Focussed Psychological Strategies and Family Group Therapy[31]
- Clinical Psychologist
- Other Psychologist
- Other Allied Mental Health[32]
- Psychiatry

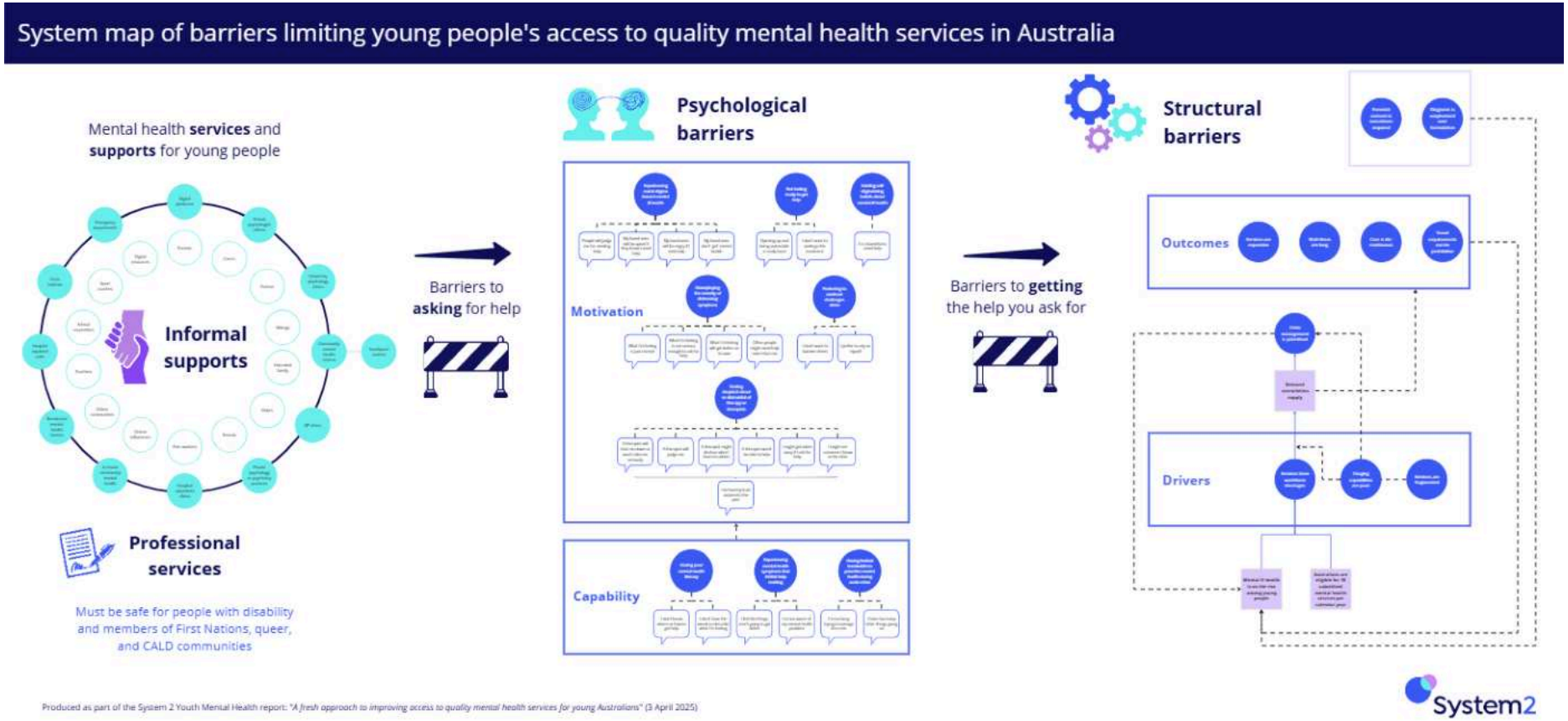
[25] The data excludes: services where no Medicare Benefits Schedule (MBS) benefit was processed, even if the service was eligible for a rebate; services provided to public patients in hospitals; non-hospital services subsidised by private health insurance; services delivered in public outpatient departments or public accident and emergency departments; services provided through other publicly funded programs; services subsidised by the Department of Veterans' Affairs; services for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability; health screening services.
[26] Australian Institute of Health and Welfare. (2021). Medicare-subsidised GP, allied health and specialist health care across local areas: 2019–20 to 2020–21 [Dataset].
https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2021-22/contents/about
[27] Australian Institute of Health and Welfare. (2022). Medicare-subsidised GP, allied health and specialist health care across local areas: 2021–22 [Dataset].
https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-and-specialis/data
[28] Australian Institute of Health and Welfare. (2024). Medicare-subsidised GP, allied health and specialist health care across local areas: 2022-23 [Dataset].
https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/contents/about
[29] Australian Institute of Health and Welfare. (2025). Medicare-subsidised GP, allied health and specialist health care across local areas: 2023-24 [Dataset].
https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-specialist/data
[30] This captures preparation and review of GP Mental Health Treatment Plans as well as extended consultations related to mental health issues, excluding GP Focussed Psychological Strategies and Family Group Therapy.
[31] This captures GP delivered Focussed Psychological Strategies for patients with assessed mental disorders, as well as family group therapy.
[32] This captures mental health services provided by other allied health professionals such as occupational therapists, mental health nurses, Aboriginal health workers, and some social workers.

2. Findings

This section of the report can be viewed in conjunction with our system map. We provide a low-resolution version in Figure 5 below.

The full high-resolution system map can be accessed here.

Figure 5: System map of barriers limiting young people's access to quality mental health services in Australia



2.1 What types of mental health services and supports exist for young people in Australia?

Our system map depicts different types of mental health services and supports available to Australians, including young people. The professional services depicted in the map were identified through desk research,[33] while the informal supports were sourced from our focus group with youth experts (i.e., our Youth Advisory Board) as well as some of the mental health practitioners and researchers (i.e., professional experts) we interviewed.

2.1.1 Professional services

Australia's mental health system comprises a complex web of publicly funded services. For example:

- The Australian Government provides rebates for private practice consultations with GPs, psychiatrists, psychologists, and mental health accredited occupational therapists and social workers.
- State and territory governments fund mental health services through public hospitals and emergency departments.
- The Australian Government and/or state and territory governments co-fund several mental health hotlines and online services such as Lifeline, BeyondBlue, Mindspot, and Kids Helpline.
- The Australian Government funds Australia's National Youth Mental Health Foundation, headspace, which delivers mental health and adjacent services to young people aged 12-25 at low or no cost.

Individuals can also pay fully out-of-pocket, or a subsidised cost through their private health insurance, to access mental health care in private practices or private hospitals.

The full set of professional service types we identified via our desk research are listed in the box below. Notably, this information was difficult to find. There was also limited information about i) the sequencing of and interaction between different service types along a typical care pathway, and ii) what tailored service offerings are available to young people within these generic service types. It is well-established in the behavioural sciences that if you want someone to enact a behaviour, you need to **make it easy**.[34] A first step to 'making it easy' for young people to access quality care could therefore be filling these information gaps via the provision of more centralised, transparent, accessible information about entry points into and care pathways within Australia's mental health system.

[33] Key sources were:
- Australian Institute of Health and Welfare. (2024). Australia's mental health system. https://www.aihw.gov.au/mental-health/overview/australias-mental-health-services
- Department of Parliamentary Services. (2022). Mental health services in Australia: A quick guide. https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/Research/Quick_Guides/2021-22/MentalHealthServices

[34] The Behavioural Insights Team. (2024). EAST Framework: Four simple ways to apply behavioural insights. https://www.bi.team/wp-content/uploads/2014/04/BIT-EAST-handbook.pdf

Professional mental health service types

- Digital platforms
- School psychologist offices
- University psychology clinics
- Community mental health centres (e.g., headspace)
- GP clinics
- Private psychology or psychiatry practices
- Hospital outpatient clinics
- In-home community mental health
- Residential mental health homes
- Hospital inpatient units
- Crisis hotlines
- Emergency departments

Youth experts emphasised the importance of ensuring these mental health services are safe for people with disability and members of First Nations, queer, and CALD communities.

2.1.2 Informal supports

Young people can also access mental health support outside the system through informal channels, listed in the box below. Youth experts emphasised the importance of having support from peers who have lived experience managing mental health challenges. These may include friends (e.g., from school or online communities), peer workers, or even online influencers whose content can provide reassurance and a sense of connection ("I'm not alone") without the young person having to interact with them directly or share their own story.

Informal mental health supports

- Parents
- Carers
- Partner
- Siblings
- Extended family
- Elders
- Friends
- Peer workers
- Online influencers
- Online communities
- Teachers
- School counsellors
- Sport coaches
- Digital resources

Further research mapping young people's journeys from seeking informal mental health support to entering the mental health system — as well as the role these informal supports play once they are within the system — could help identify key opportunities for prevention and early intervention. For an example of such forthcoming work, see doi: 10.1371/journal.pone.0287098.

2.2 What barriers make it hard for young people in Australia to ask for or get help from mental health services?

Our system map depicts different psychological and structural barriers that inhibit young people's access to quality mental health services in Australia. These barriers can be understood through the lens of the COM-B model of behaviour change, which states that behaviours are influenced by internal capability (knowledge and skills) and motivation (attitudes and habits) factors, as well as external opportunity (physical environments and social environments) factors.[35] In this report, psychological barriers capture the capability or motivation factors that make it **hard to reach out for help**, while structural barriers refer to opportunity factors that make it **hard to get the help you asked for**. The gulf between asking for help and getting help was something emphasised by our Youth Advisory Board. In theory, access setbacks caused by structural barriers may further reinforce psychological barriers, making a person less likely to continue seeking help or to reach out for help again in future.

The structural barriers in our system map were identified via a thematic analysis of our interviews with mental health practitioners and researchers (i.e., professional experts), then refined during our focus group with youth experts (i.e., our Youth Advisory Board). The psychological barriers in the map were identified through desk research, then refined during the focus group with youth experts. Key desk research sources drawn on in the psychological barriers section were:[36]

- Gulliver, Griffiths, and Christensen (2010)
- Radez, Reardon, Creswell, Lawrence, Evdoka-Burton, and Waite (2021)
- Carbonell, Georgieva, Navarro-Pérez, and Prades-Caballero (2024)

2.2.1 Psychological barriers

Note: For each psychological barrier, our system map depicts one or more speech bubbles. These speech bubbles do not represent direct quotes, but rather illustrate what the barrier

[35] Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science, 6, Article 42. https://doi.org/10.1186/1748-5908-6-42

[36] The complete references are below:

- Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. BMC Psychiatry, 10(1), 113. https://doi.org/10.1186/1471-244X-10-113
- Radez, J., Reardon, T., Creswell, C., Lawrence, P. J., Evdoka-Burton, G., & Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. European Child & Adolescent Psychiatry, 30(2), 183–211. https://doi.org/10.1007/s00787-019-01469-4
- Carbonell, Á., Georgieva, S., Navarro-Pérez, J.-J., & Prades-Caballero, V. (2024). The hodgepodge reality: A qualitative systematic review of the challenges and barriers in child and adolescent mental health care systems. Adolescent Research Review, 9(3), 563–586. https://doi.org/10.1007/s40894-023-00227-7

might look like through the eyes of a young person based on what we heard and read during our research activities.

Our system map depicts various capability and motivation factors that can make it psychologically challenging for young people in Australia to reach out for help from mental health services. Capability barriers include: experiencing mental health symptoms that inhibit help seeking; having limited bandwidth to prioritise mental health during acute crises; and having poor mental health literacy. Motivation factors include: feeling skeptical about or distrustful of therapy or therapists; downplaying the severity of distressing symptoms; preferring to confront challenges alone; not feeling ready to get help; experiencing social stigma toward mental ill health; and holding self stigmatising beliefs about mental ill health. These barriers are discussed in detail below.

Experiencing mental health symptoms that inhibit help seeking. One professional expert we spoke to noted that feelings of hopelessness — the sense that things won't get better — are a symptom of depression that can make reaching out for help difficult. Another example of a symptom that may hinder help seeking is lack of insight, whereby a person lacks awareness of their mental health problem, which can be seen in schizophrenia.

Having limited bandwidth to prioritise mental health during acute crises. Our youth experts highlighted that sometimes mental ill health can be brought on by external environmental stressors, such as losing a loved one. During these times, it can be difficult for young people to find the time and cognitive space to reach out for mental health support, as energy is instead focussed on managing the immediate crisis or attending to other urgent responsibilities.

Having poor mental health literacy. Given the fragmented nature of Australia's mental health system — which we describe in the structural barriers section — it is unsurprising that youth experts pointed to mental health literacy as a barrier to help seeking. Youth experts explained that this can range from a young person not knowing where or how to get help, to lacking the language or concepts to articulate what they are experiencing.

Feeling skeptical about or distrustful of therapy or therapists. Our desk research revealed a range of concerns young people can have about the trustworthiness of mental health practitioners or services, and these were endorsed by the youth experts we spoke to. These included fears about not being taken seriously, being judged, having confidentiality violated, being taken away, or being seen in the clinic by someone they know. We also heard that some young people can be skeptical that mental health services will help them. Youth experts emphasised that these fears and skepticisms

are often valid, having been formed based on negative experiences with the system in the past.

Downplaying the severity of distressing symptoms. Our desk research and one of the professional experts we spoke to highlighted that young people often minimise their symptoms. This means they may downplay the severity of their distress or wrongly believe it will resolve on its own. Youth experts explained that such downplaying can sometimes arise from a sense of guilt that their situation is less worthy of help relative to peers who may also be struggling.

Preferring to confront challenges alone. Our desk research and one of the professional experts we spoke to noted a tendency for young people to 'individualise' their approach to managing mental ill health. This means many young people express a preference for coping with problems on their own.

Not feeling ready to get help. Youth experts shared that opening up to mental health practitioners requires being extremely vulnerable. As a result, some young people may not feel ready to share their story.

Experiencing social stigma toward mental ill health. Our desk research and one of the professional experts we spoke to identified stigma as a major barrier to help seeking among young people. Youth experts provided several examples of how this stigma can manifest. In addition to fear of being judged by peers, youth experts emphasised the role that loved ones play in fostering stigma around mental ill health. Specifically, youth experts cited fears of upsetting or angering loved ones who may feel responsible or worry about being blamed. They also spoke of loved ones not 'getting' mental health, especially in cultures where there is less awareness or acceptance of the concept.

Holding self stigmatising beliefs about mental ill health. Our desk research and one of the professional experts we spoke to noted that young people can often internalise stigma. Such self-stigma manifests as a perception that help-seeking is a sign of weakness.

Reluctance to reach out for help is not uncommon. One Australian study found that among parents who felt their child had an unmet mental healthcare need, nearly 40% identified their child's refusal to get help as a major barrier.[37] For young people who are suffering from mental health challenges yet hampered by the psychological barriers discussed in

[37] Schnyder, N., Lawrence, D., Panczak, R., Sawyer, M. G., Whiteford, H. A., Burgess, P. M., & Harris, M. G. (2020). Perceived need and barriers to adolescent mental health care: Agreement between adolescents and their parents. Epidemiology and Psychiatric Sciences, 29(Article 60). https://doi.org/10.1017/S2045796019000568

this section, accessing help may be especially unlikely if they are aged over 18 and no longer in the legal care of their parent(s) or caregiver(s).

2.2.2 Structural barriers

Note: Many of the structural barriers in our system map apply to all Australians, not just young people. We have nevertheless included these barriers because they still affect young people as part of the broader population. Where applicable, we call out any instances where a barrier has unique relevance to young people.

Our system map depicts the structural barriers that make it hard for young people in Australia to access the mental health services they need, and the hypothesised relationships between these barriers. These structural barriers can be summarised by a common theme: **supply is not keeping up with demand**. Growing rates of mental ill health among young people, combined with broad eligibility for subsidised services through Better Access, are straining the system's capacity to provide quality care for everyone — including young people. As a result, Australia's mental health system is extremely difficult to navigate, and young people struggle to wade through these complexities without (or even with) a strong advocate.

We discuss each structural barrier in detail below. As depicted in our system map, several of the structural barriers in this section can be conceptualised as either a potential *driver* (services have workforce shortages; services are fragmented; triaging capabilities are poor) or potential *outcome* (services are expensive; wait times are long; travel requirements can be prohibitive; care is discontinuous) of this supply-demand imbalance. In fact, many of these structural barriers can be conceptualised as both potential drivers *and* outcomes of the inability of supply to cope with demand. For example, the neglect of prevention and early intervention efforts are likely to drive up demand due to more people developing mental ill health. At the same time, an undersupplied system is likely to deprioritise prevention and early intervention because it requires less urgent attention than crisis management. In light of these challenges, several of the professional experts we spoke to emphasised a **need for greater and smarter investment into the mental health system**, including youth mental health services, to improve the system's ability to cope with its volume.

Crisis management is prioritised. According to youth and professional experts, Australia's mental health system focuses more on responding to people who are already in crisis to promote their recovery than intervening early to prevent mental health challenges from arising or escalating in the first place. Professional experts told us that young people in the 'missing middle' — who have moderate mental health challenges that render them too unwell for primary care services, but not unwell enough to access overstretched state-based services — [38] are especially under-accessing the system. By the time young people in the missing middle access services, their mental ill health has escalated to crisis levels.

[38] Orygen. (nd). Defining the missing middle. https://www.orygen.org.au/Orygen-Institute/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Defining-the-missing-middle

One professional expert pointed to a need for more preventative initiatives that help to keep young people mentally healthy, such as creating professional accredited mental health promotion practitioners. These practitioners would be embedded in settings where people live, work, and play (e.g., workplaces and schools) and their role would be to curate mentally healthy environments. Other professional experts spoke of the promise of digital platforms for facilitating early intervention via self-directed therapy for individuals presenting with milder mental health challenges. These professional experts noted the importance of ensuring such platforms have strong pathways for stepping-up into blended or face-to-face care if the person's symptoms escalate to more moderate levels.

Services have workforce shortages. Professional experts emphasised that demand on Australia's mental health system exceeds the workforce supply of psychologists, psychiatrists, and other traditional mental health practitioners. They attributed these workforce shortages to factors such as rising rates of mental ill health among young people and insufficient financial incentives to attract and retain mental health practitioners in the public system. Professional experts told us these workforce shortages can be especially pronounced in rural areas where — as highlighted in the *Evaluation of the national headspace program* — GPs, psychologists, and psychiatrists are more limited in number.[39]

In the context of youth mental health services, professional experts told us that headspace struggles to retain clinical staff after training, as government funding does not include any workforce incentives to compete with the high co-payments clinicians can charge in private practice. This sentiment was echoed in the recent *Joint statement on youth mental health priorities by leading mental health organisations*, which called for "sustainable funding for child and youth mental health services, including headspace centres, to boost service capacity [and] retain staff".[40] Professional experts highlighted a particular need to fund more psychiatry positions in headspace to better serve the missing middle. This need has arisen because headspace was designed as a primary care service to support young people with mild to moderate mental health challenges, but young people are increasingly presenting with more complex cases such as psychosis and eating disorders that require specialists like psychiatrists.[41]

The impact of workforce shortages in the mental health system more broadly is currently on full display in the ongoing dispute between public hospital

[39] KPMG. (2022). Evaluation of the national headspace program. https://www.health.gov.au/resources/publications/evaluation-of-the-national-headspace-program?language=en

[40] ARACY, Batyr, Black Dog Institute, headspace, Mission Australia, Orygen, Prevention United, ReachOut, Yourtown, & YouthFocus. (2025). Joint statement on youth mental health priorities. https://www.aracy.org.au/news/joint-statement-on-youth-mental-health-priorities/

[41] Orygen. (nd). Defining the missing middle. https://www.orygen.org.au/Orygen-Institute/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Defining-the-missing-middle

psychiatrists in NSW and the state government over pay and working conditions. Psychiatrists working in NSW public hospitals are earning less than those working in other states, and less than psychiatrists working in NSW private practices. These pay conditions have made it difficult for NSW public hospitals to attract and retain psychiatrists, resulting in a significant staff shortfall of 140 psychiatrists (nearly 1 in 3 unfilled positions). In turn, the psychiatry workforce is overworked and unable to consistently deliver high quality mental health care, further exacerbating staff retention issues.[42] While this example is not specific to young people, it nevertheless impacts them as part of the broader population reliant on public hospital mental health services.

In light of these workforce challenges, one of the professional experts we spoke to advocated for opportunities to unlock new workforces to alleviate the load on traditional mental health practitioners such as psychologists and psychiatrists. They proposed: i) training members of the community to be mental health coaches who can deliver lower intensity interventions for people with more mild-to-moderate concerns; and ii) establishing 24/7 moderated peer networks for people with relevant lived experience.

Triaging capabilities are poor. Some of the professional experts we spoke to criticised the efficiency and effectiveness of client intake and monitoring processes in Australia's mental health system. These professional experts argued that the system operates under a 'take a ticket' approach, meaning it lacks the tools to use information gathered from clients to make 'smart' decisions about appropriate care pathways. Under a smarter system, professional experts highlighted opportunities for a 'stepped-care approach' where interventions can be matched to need: ranging from self-directed care, to early intervention and low intensity Cognitive Behaviour Therapy, to referrals to psychologists and psychiatrists, to management under multi-disciplinary teams. Professional experts highlighted a role for using digital platforms to achieve smarter triaging that helps people get to the right service for them the first time they try. They noted these platforms could include things like i) assessment tools that refer a person to the appropriate specialist and position them in a waiting list based on their level of need, ii) monitoring tools that track outcomes while on the waiting list and while receiving treatment, and iii) self-service interventions for those who do not need to see a clinician, with escalation pathways available if symptoms

[42] For details see:

- Dole, N. (2024, November 18). Half of NSW's public hospital psychiatrists threatening to resign. ABC News. https://www.abc.net.au/news/2024-11-19/nsw-public-hospital-psychiatrists-threaten-resignation-over-pay/104616430;
- May, N. (2025, January 16). Half of the psychiatrists in NSW's public service are preparing to resign. Here's why. The Guardian. https://www.theguardian.com/society/2025/jan/15/half-of-the-psychiatrists-in-nsws-public-service-are-preparing-to-resign-heres-why;
- Ibrahim, T. (2025, January 15). Why the majority of NSW's public psychiatrists plan to resign next week. ABC News. https://www.abc.net.au/news/2025-01-16/nsw-government-planned-public-psychiatrist-exodus-explainer/104820828

worsen. While tools with some of these capabilities already exist, we heard that uptake is low and attrition is high. But for those who do engage, professional experts felt digital platforms hold promise — especially when compared against the counterfactual of not accessing treatment at all.

For young people in particular, one professional expert additionally emphasised the importance of facilitating a 'soft' (i.e., rapid and easy) entry into the mental health system. In addition to using digital platforms, this means creating spaces that do not look and feel too clinical, and recruiting peer workers and clinicians who can build rapport with young people. According to this professional expert, many mental health services currently repel young people away because they do not facilitate a soft entry in these ways.

Another triaging problem raised by some professional experts was the system's reliance on GPs as gatekeepers to accessing Medicare-subsidised services via the Better Access initiative. We heard that not all young people have a GP — as the concept of a 'family GP' is somewhat outdated — rendering it unclear to those young people who they should reach out to first for help. For Australians more generally, we heard that the requirement for a GP referral to see a mental health practitioner under a Mental Health Treatment Plan is wasteful of public funding and inappropriate for two reasons. First, some GPs are not equipped with the skills to handle mental health conversations appropriately or decide whether a person does or does not need help. Second, the use of GPs as gatekeepers adds unnecessary friction — or what behavioural scientists call 'sludge'[43] — that may dissuade people from seeking help. For example, one professional expert shared anecdotal evidence of someone booking the wrong GP appointment type for a Mental Health Treatment Plan and consequently being turned away and asked to rebook. This professional expert was concerned that such a knockback could lead to drop out for people in a psychologically vulnerable state.

Services are fragmented. Some of the professional experts we spoke to noted that Australia's mental health system lacks service integration. As one such professional expert put it, there are many services out there, but they don't necessarily know how to work with or talk to each other. This creates confusion for people seeking mental health support, and inhibits opportunities for coordinated care efforts by practitioners. When it comes to young people in particular, Orygen has called for better integration between headspace and state-funded services to enable smoother care pathways for those who need more specialised care.[44]

[43] Sunstein, C. R. (2022). Sludge audits. Behavioural Public Policy, 6(4), 654–673. https://doi.org/10.1017/bpp.2019.32
[44] Orygen. (nd). Defining the missing middle. https://www.orygen.org.au/Orygen-Institute/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Defining-the-missing-middle

Services are expensive. Youth and professional experts alike emphasised that the costs associated with accessing mental health services in Australia can be prohibitive for young people. We devote a special Spotlight section later in this report to quantifying average out-of-pocket costs paid by young people to access Medicare-subsidised mental health services in Australia. Youth experts felt that mental health care should be free, given it is essential for functioning. This call for free mental health services for young people was echoed in the recent *Joint statement on youth mental health priorities* by leading mental health organisations, given "the cost of mental health support remains a major barrier".[45] For example, in their recent online poll, the Black Dog Institute found that 60% of surveyed young people aged 18-24 who had mental health concerns in the past 12 months either did not seek help or delayed seeking help due to cost.[46]

Regarding Medicare-subsidised services, the professional experts we spoke to expressed differing views about the number of sessions available under a Mental Health Treatment Plan. Many felt the current provision of 10 subsidised sessions per calendar year is insufficient, especially for people with complex needs. Youth experts echoed this sentiment, arguing that many people can't afford care once their 10 sessions expire. Other professional experts cautioned that increasing the number of subsidised sessions for all will result in everyone getting less due to the additional strain placed on the system. These professional experts also noted that such a change would not guarantee higher access rates by people who need help the most. Such comments were grounded in evidence gathered during the COVID-19 pandemic, where the provision of subsidised sessions increased temporarily to 20 per calendar year. During this period, the utilisation of subsidised sessions increased, primarily due to existing users accessing more sessions as opposed to new users entering the system. People living in major cities or more socioeconomically advantaged areas were much more likely to utilise these additional sessions than those in regional, remote, or socioeconomically disadvantaged areas.[47] This trend suggests the increased provision of subsidised sessions during the COVID-19 pandemic may have served to give more help to people who need it less.

Wait times are long. The *Inquiry into Mental Health and Suicide Prevention* found that "many mental health services have long waiting lists...there can be waiting times of up to six months after a young person takes the first step to

[45] ARACY, Batyr, Black Dog Institute, headspace, Mission Australia, Orygen, Prevention United, ReachOut, Yourtown, & YouthFocus. (2025). *Joint statement on youth mental health priorities*. https://www.aracy.org.au/news/joint-statement-on-youth-mental-health-priorities/

[46] Black Dog Institute. (2024). Navigating Australia's mental health system in 2024. https://www.blackdoginstitute.org.au/wp-content/uploads/2024/09/Navigating-Australias-mental-health-system-in-2024-Consumer-Report.pdf

[47] Pirkis, J., Currier, D., Harris, M., Mihalopoulos, C., Arya, V., Banfield, M., Bassilios, B., Buchanan, B., Butterworth, P., Brophy, L., Burgess, P., Chatterton, M. L., Chilver, M., Eagar, K., Faller, J., Fossey, E., Ftanou, M., Gunn, J., Kruger, A., … Williamson, M. (2022). Evaluation of Better Access. The University of Melbourne. https://www.health.gov.au/resources/publications/main-report-evaluation-of-the-better-access-initiative?language=en

reach out for help".[48] The professional experts we spoke to explained that this is the result of workforce shortages and, in the case of headspace, an insufficient number of centres to meet demand. According to the *Evaluation of the national headspace program*, in April to October 2021, the average wait time between making first contact with headspace and being seen for the first time for screening and assessment was 16.3 days, with major cities having shorter wait times (15.7 days) than those in inner regional (16.2 days), outer regional (19.5 days), and remote (19.1 days) areas. The average wait time between being seen for screening and assessment and seeing the recommended service provider was even longer, with an average of 41.2 days.[49] Professional experts noted opportunities for digital platforms to fill the gap while young people are waiting for their first or next appointment.

Travel requirements can be prohibitive. Our youth experts noted that for some young people, finding transport to get to mental health clinics can be challenging. The *Evaluation of the national headspace program* found that this issue is exacerbated for people living outside cities, where public transport options are reduced and travel durations are longer due to the distance between towns.[50]

Major cities tend to be more socioeconomically advantaged than regional and remote communities,[51] suggesting people living in more disadvantaged areas may have less access to public transport options and longer travel durations than people living in more advantaged areas. This would imply a need to ensure socioeconomically disadvantaged areas are not overlooked when deciding where to locate mental health service centres. To explore this, we undertook a quantitative analysis of headspace locations (as of November 2024) mapped against Socio-Economic Indexes for Areas (SEIFA) data to examine the distribution of headspace centres relative to socioeconomic disadvantage.[52] As shown in Figure 6 below, this analysis revealed that headspace centres are more concentrated in areas of higher disadvantage (i.e., lower SEIFA scores) compared to areas of higher advantage (i.e., higher

[48] Parliament of the Commonwealth of Australia. (2021). Mental health and suicide prevention—Final report. https://www.aph.gov.au/Parliamentary_Business/Committees/House/Former_Committees/Mental_Health_and_Suicide_Prevention/MHSP/Report

[49] KPMG. (2022). Evaluation of the national headspace program. https://www.health.gov.au/resources/publications/evaluation-of-the-national-headspace-program?language=en

[50] KPMG. (2022). Evaluation of the national headspace program. https://www.health.gov.au/resources/publications/evaluation-of-the-national-headspace-program?language=en

[51] Australian Bureau of Statistics. (2023). Socio-economic indexes for areas (SEIFA), Australia, 2021. https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release

[52] SEIFA ranks areas according to their relative socioeconomic advantage and disadvantage using Census data. SEIFA combines Census data such as income, education, employment, occupation, housing and family structure to summarise the socioeconomic characteristics of an area. One of the SEIFA indices is the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD). This index summarises information about the economic and social conditions of people and households within an area. An area could have a low score if there are: many households with low incomes, or many people in unskilled occupations, AND a few households with high incomes, or few people in skilled occupations. An area may have a high score if there are: many households with high incomes, or many people in skilled occupations, AND few households with low incomes, or few people in unskilled occupations. The SEIFA data used in this report is from Table 3 of the *2021 Socio-Economic Indexes for Areas (SEIFA) Suburb and Locality (SAL)* dataset, released on 27 April 2023.

SEIFA scores), despite fewer people living in these more disadvantaged areas.[53] At the same time, as shown in Figure 7 below, regions with the lowest SEIFA scores (i.e., below ~750) do not have headspace centres. In summary, headspace centres are more strongly concentrated in more disadvantaged suburbs relative to more advantaged suburbs, but the most highly disadvantaged suburbs (which are few in number) do not have a local headspace centre.

[53] Note that while the population figures shown in the chart include all Australians, the proportion of young people in each state is similar to rates at the whole population level, suggesting these population statistics may be generalisable to young people. See: https://www.aihw.gov.au/reports/children-youth/australias-youth/contents/demographics

Figure 6: Distribution of headspace centre locations across Socio-Economic Indexes for Areas (SEIFA) deciles

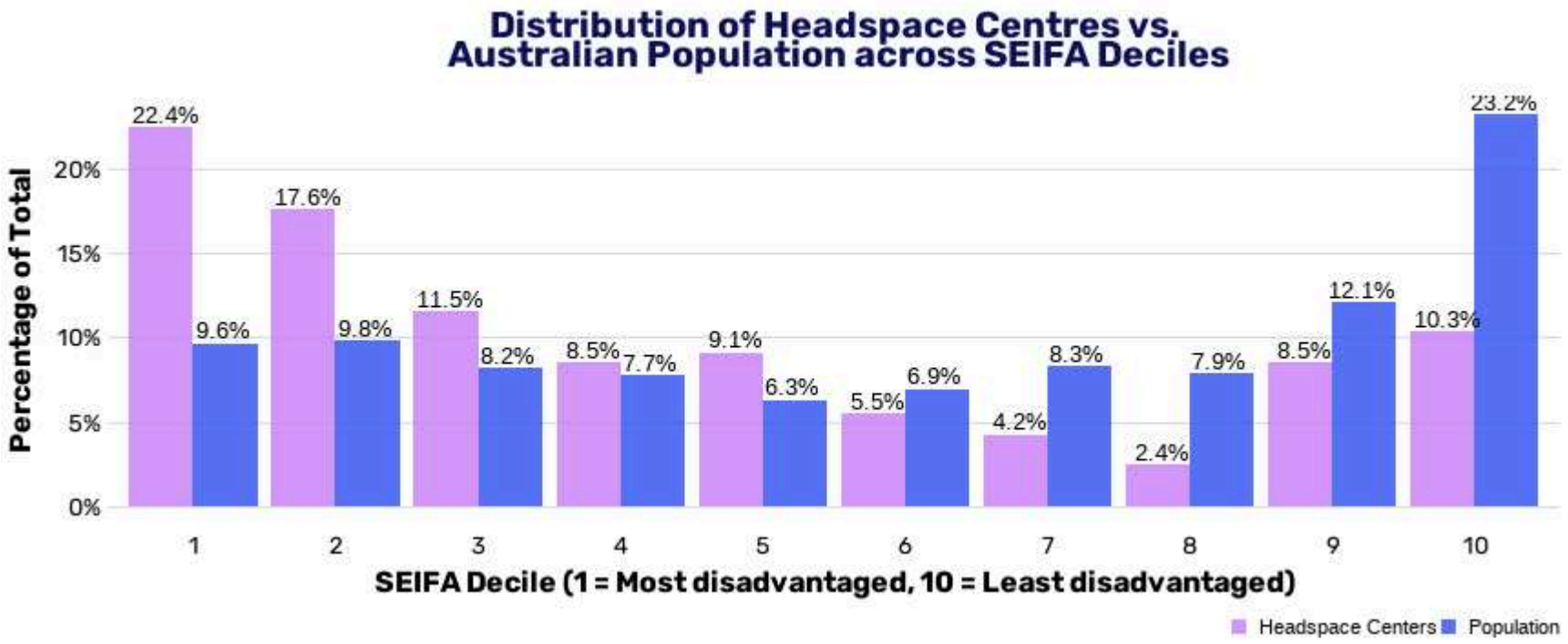
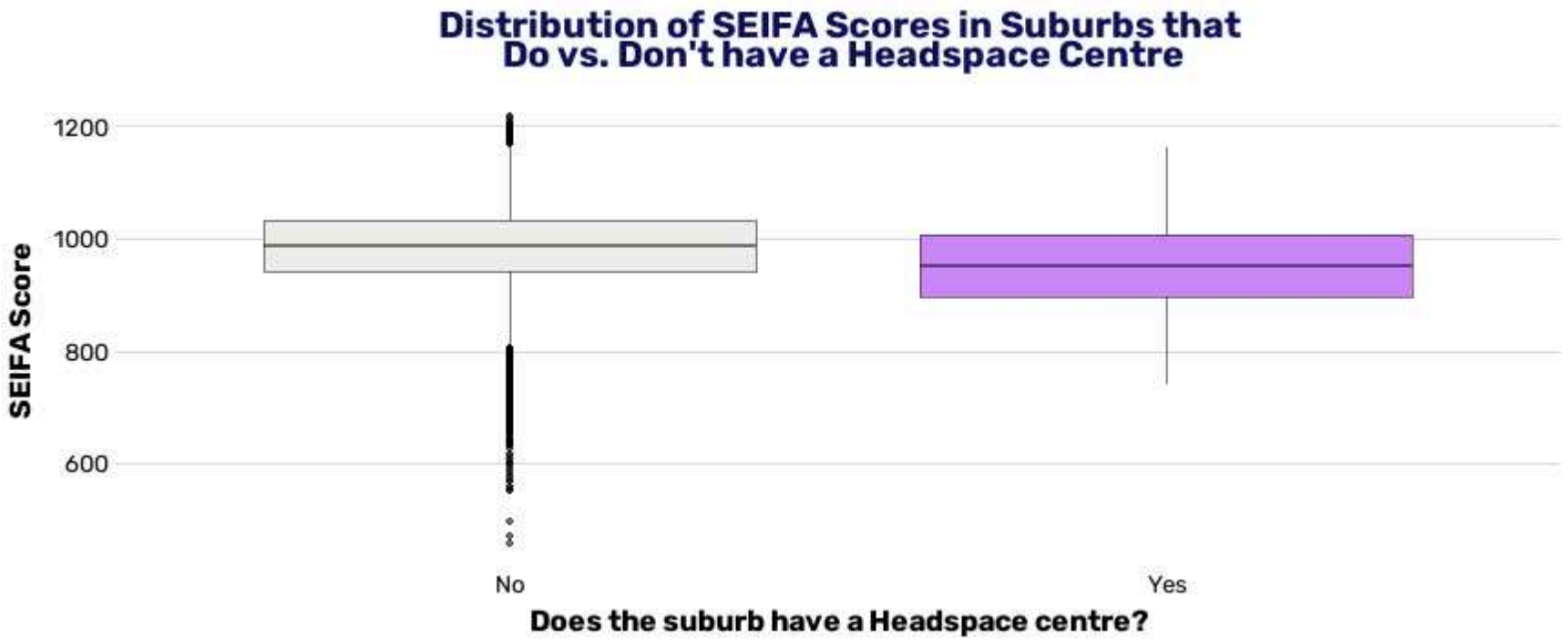


Figure 7: Comparison of Socio-Economic Indexes for Areas (SEIFA) scores for suburbs that do vs. don't have a headspace centre



Note: As of November 2024, there are 15,353 suburbs across Australia,[54] and 165 (roughly 1%) of these have a headspace centre. Among suburbs with a headspace centre, the lowest SEIFA score was 741 while the highest was 1,162. Among suburbs with no headspace centre (of which 891 are missing from this analysis, as SEIFA scores were not available due to low population sizes or high Census non-response rates), the lowest SEIFA score was 457 while the highest was 1,217. There were 139 suburbs with a SEIFA score below 741, corresponding to just under 1% of suburbs.

[54] Australian Bureau of Statistics. (2021). Suburbs and localities. https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/non-abs-structures/suburbs-and-localities

Care is discontinuous. Youth experts advised that being shuffled between different mental health practitioners can be highly disruptive to their care. They explained that being vulnerable with one mental health practitioner is already challenging enough, and becomes even harder when they are asked to repeat the exercise time and again with new people. They also shared that getting passed on to different mental health practitioners can erode their sense of hope that the next person will make any difference.

Discontinuity of care is particularly common for young people, with our youth and professional experts explaining that turning 18 often results in a forced transition from youth-oriented services to adult services. Yet, they argued 18 is an inappropriate age to force people to switch care models and often results in dropout. This is because the majority of mental illnesses have their onset before age 25 and a peak age of onset of 15, meaning the headspace model (which provides care up to age 25) is more evidence-based than service models that use 18 as an arbitrary cutoff.

Parental consent is sometimes required. Youth experts noted that the requirement for parental consent when accessing certain mental health services can restrict young people's autonomy, especially when parents or caregivers lack mental health literacy or react defensively.

Diagnosis is emphasised over formulation. Youth experts as well as one of the professional experts we interviewed spoke of a need to shift the emphasis of therapy away from a disease model. They argued that, currently, therapy is focussed on delivering a diagnosis based on the group of symptoms an individual is experiencing. Instead, they felt the focus should be on developing a strong formulation that explores the unique developmental history and manifestation of symptoms in the individual's life. Youth experts also emphasised that this should include understanding how the young person defines their own recovery.

This section highlighted the many ways young people can be obstructed from asking for or getting the help they need from mental health services in Australia. From a systems-thinking perspective, structural barriers should be prioritised first when determining how to improve access to quality care, as addressing psychological barriers alone will merely drive up demand on an already overstretched system. Nonetheless, efforts to reduce psychological barriers should be considered a vital complement to more comprehensive structural reforms that help the system cope with its demand.

2.3 Spotlight: Services are expensive

This section was adapted from a report we published on our website in December 2024. Please see the full report for methodological details. This Spotlight additionally incorporates new data from the 2023-24 Medicare-subsidised GP, allied health and specialist health care across local areas *dataset, which was not published at the time of our original report.*[55]

Youth experts (i.e., our Youth Advisory Board) and many of the mental health practitioners and researchers (i.e., professional experts) we consulted emphasised that the costs associated with accessing mental health services in Australia can be prohibitive for young people. In this spotlight, we present a quantitative analysis of the out-of-pocket (OOP) costs young people aged 15-24 pay in Australia to access **Medicare-subsidised non-inpatient mental health services**.

About the Medicare rebate

Under Medicare's Better Access initiative, Australians can access up to 10 subsidised sessions with a mental health practitioner per annum via a Mental Health Treatment Plan. Mental health providers set their own fees, which clients pay upfront for each session. The client can then claim a Medicare rebate to recover part of the cost of the session. The size of this rebate will depend on the specific service they received (e.g., type of health professional delivering the service; length of session), as determined by the relevant Medicare Benefits Schedule (MBS) item number. Each item number has a fixed **Schedule Fee** (the fee Medicare deems reasonable on average for that service), **Benefit** (the portion of the schedule fee claimable by the client as a rebate per service), and **Extended Medicare Safety Net Cap** (an annual threshold for OOP costs for a service that, once reached, will trigger a further rebate on any subsequent OOP costs for that service for the remaining calendar year). The **out-of-pocket (OOP) cost** paid by the client for a given session is equal to the remaining portion of the provider's fee after the Medicare benefit has been paid.

The analyses in this spotlight use the Australian Institute of Health and Welfare's *Medicare-subsidised GP, allied health and specialist health care across local areas* datasets.[56]

[55] Australian Institute of Health and Welfare. (2025). Medicare-subsidised GP, allied health and specialist health care across local areas: 2023-24 [Dataset]. https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-specialist/data

[56] Given the raw data are unadjusted for inflation, our analysis includes an examination of whether any growth in average OOP costs in the analysed period exceeded rates of inflation for the same period. For each of the periods (2020-21 to 2021-22, 2021-22 to 2022-23, and 2022-23 to 2023-24), we calculated the OOP cost growth rate, unadjusted for inflation, as: (New average OOP cost - Old average OOP cost / Old average OOP cost) * 100. We then calculated rates of inflation based on published ABS inflation data showing that the Consumer Price Index increased 3.5% in the year from December 2020 to December 2021, 7.8% in the year from December 2021 to December 2022, and 4.1% in the year from December 2022 to December 2023, equivalent to a 16.1% increase over the three years. December data was used as it represents the midpoint of the year for which mental health data were collected.

About OOP cost estimates

The *Medicare-subsidised GP, allied health and specialist health care across local areas* datasets exclude services where no MBS benefit was processed. This means sessions where the client paid fully out-of-pocket, or where they were subsidised by means other than Medicare (e.g., through private health insurance), are not captured in our analyses. While our analyses focus on **Medicare-subsidised** services, OOP costs for accessing mental health services **in general** may therefore be larger once sessions where the client paid fully out-of-pocket are taken into account.

The *Medicare-subsidised GP, allied health and specialist health care across local areas* datasets include bulk-billed services, and there is no way to distinguish services that were bulk-billed from those that were not. This means the average OOP costs calculated in our analysis will be lower than the actual costs for people who had to pay an amount out-of-pocket, as the average will be brought down by services where people were charged $0.

Our analysis builds on the work of Rosenberg, Park, and Hickie (2022),[57] who found that OOP costs rose consistently in Australia between the financial years 2013-14 to 2020-21. We extend their analysis by examining new data from the 2021-22 to 2023-24 financial years and highlighting trends relevant to young people.

We highlight trends relevant to **young people aged 15-24** in **pink** callout boxes.

[57] Rosenberg, S., Park, S. H., & Hickie, I. (2022). Paying the price – out-of-pocket payments for mental health care in Australia. Australian Health Review, 46(6), 660–666. https://doi.org/10.1071/AH22154

Out-of-pocket costs are rising rapidly for all Australians, including young people

In the financial year 2023-24, young people aged 15-24 paid an average OOP cost of **$68.02** to access a Medicare-subsidised non-inpatient mental health service, representing a **79% increase** since 2020-21 and an 18% increase since 2022-23.[Figure 8, Figure 10] This 79% increase was 4.9 times the rate of inflation, as measured by the increase in the Consumer Price Index from December 2020 to December 2023.

In the financial year 2023-24, Australians paid an average OOP cost of $60.72 to access a Medicare-subsidised non-inpatient mental health service. This amount rose from $34.54 in the financial year 2020-21, representing a 75% increase in OOP costs and an acceleration of the 2013-21 trend reported by Rosenberg et al. (2022).[Figure 8; Figure 10]

Over the same period, the average provider fee charged to Australians accessing a Medicare-subsidised non-inpatient mental health service rose from $145.95 in the 2020-21 financial year to $184.11 in the 2023-24 financial year — an increase of 26%. At the same time, the average MBS benefit paid for non-inpatient mental health services rose from $111.41 to $123.38 — an increase of less than 11%.[Figure 11] The increase in the average MBS benefit paid (<11%) is much smaller than the increase in average provider fees charged (26%), resulting in a large increase in OOP costs (75%).

What is driving increases in OOP costs?

One hypothesis is that the proportion of bulk-billed mental health services may be decreasing, in line with recent trends observed for GP services more generally in Australia.[58] While we cannot find publicly available data post 2021 to test this hypothesis, we know from the recent *Evaluation of the Better Access initiative* that the proportion of bulk-billed Better Access services decreased from 63.5% in 2018 to 52.8% in 2021.[59] If this trend continued beyond 2021, we would expect average OOP costs for Medicare-subsidised non-inpatient mental health services to have risen even if providers who have never bulk-billed did not substantially increase their fees.

[58] Australian Institute of Health and Welfare. (2024). Medicare bulk billing and out-of-pocket costs of GP attendances over time, Patterns in GP bulk billing rates between 1984 and October 2024. https://www.aihw.gov.au/reports/medicare/medicare-bulk-billing-of-gp-attendances-over-time/contents/bulk-billing-rates-for-gp-attendances/patterns-in-gp-bulk-billing-between-1984-and-2024

[59] Pirkis, J., Currier, D., Harris, M., Mihalopoulos, C., Arya, V., Banfield, M., Bassilios, B., Buchanan, B., Butterworth, P., Brophy, L., Burgess, P., Chatterton, M. L., Chilver, M., Eagar, K., Faller, J., Fossey, E., Ftanou, M., Gunn, J., Kruger, A., … Williamson, M. (2022). Evaluation of Better Access. The University of Melbourne. https://www.health.gov.au/resources/publications/main-report-evaluation-of-the-better-access-initiative?language=en

Out-of-pocket costs for some service types can be much higher than $68.02

In the financial year 2023-24, young people aged 15-24 paid an average of **$123.49** for a Medicare-subsidised non-inpatient appointment with a psychiatrist, **$73.32** for a clinical psychologist, and **$83.05** for a non-clinical psychologist.[Figure 9]

Average OOP costs for Medicare-subsidised non-inpatient mental health services vary depending on the type of health professional delivering the service. In the financial year 2023-24, Australians paid an average of $103.19 for a Medicare-subsidised non-inpatient appointment with a psychiatrist, $70.02 for a clinical psychologist, and $76.50 for a non-clinical psychologist.[60; Figure 9]

Additional analysis

The above average OOP costs obfuscate variations that occur within each health professional type, as the *Medicare-subsidised GP, allied health and specialist health care across local areas* datasets do not report provider fees charged and MBS benefits paid at the MBS item level. To bridge this gap, we explored item-level data from the 2022-23 financial year for a selection of common psychiatry MBS items via the Medical Costs Finder, managed by the Department of Health and Aged Care. Note that the Medical Costs Finder excludes bulk-billed services from its OOP cost calculations, meaning these averages are not dragged-down by services in which clients were charged $0. Age breakdowns are not available in the Medical Costs Finder, so we do not report on trends for young people.

In the 2022-23 financial year, MBS schedule fees associated with common psychiatry MBS items were not commensurate with provider fees charged, resulting in large OOP costs. For example, the average OOP cost was $243 for the first appointment with a psychiatrist at their rooms lasting more than 45 minutes.[Figure 12]

While the Medical Costs Finder does not include MBS items for psychology, we instead compared the Australian Psychological Society's (APS) 2024-2025 recommended private practice fee for a standard 46 to 60-minute consultation[61] to the corresponding MBS item schedule fees and MBS benefits. Again, the MBS schedule fees were not commensurate with APS recommended fees. If providers charged clients in accordance with the APS recommended fees, OOP costs would be $169.15 for an appointment with a clinical psychologist and $214.35 for an appointment with a non-clinical psychologist (*Note: APS recommended fees are guidelines only, and many providers charge less than the recommended fee, resulting in lower OOP costs for clients*).[Figure 13]

[60] While clinical psychologists typically charge higher fees than non-clinical psychologists, their services also yield a higher MBS benefit.
[61] Australian Psychological Society. (2024). How much does seeing a psychologist cost? https://psychology.org.au/psychology/about-psychology/what-it-costs

Young people are paying higher out-of-pocket costs than those aged over 45

In the financial year 2023-24, young people aged 15-24 paid over **35% more** for a Medicare-subsidised non-inpatient mental health service than those aged 45-64. Young people also paid **double** that of 65-79 year olds, and **triple** that of 80+ year olds.[Figure 8]

In each financial year from 2020-21 to 2023-24, OOP costs for Medicare-subsidised non-inpatient mental health services were higher for people aged under 45 compared to those aged over 45. OOP costs were consistently highest for ages 0-14 (roughly Gen Alpha), followed by ages 15-24 (roughly Gen Z) and ages 25-44 (roughly Millennials). OOP costs declined with each age group from age 45 onward, with those aged 80+ paying $37.72 less per session than the average Australian in the 2023-24 financial year.[Figure 8]

What is driving age differences in OOP costs?

We propose several hypotheses below which we would like to test in future research:

- Are mental health providers more likely to offer bulk-billing (under a mixed-billing model) or other discounted rates to seniors than they are to younger cohorts?
- Are fees higher for psychologists or psychiatrists who specialise in treating children and young people compared to non-specialists or those who specialise in other cohorts?
- Do assessment or treatment services for mental health disorders that typically arise in childhood, adolescence, or early adulthood have higher fees than services for mental health disorders that typically arise later in life?
- Are younger generations more willing to invest in their mental health than older generations?
- Are children and young people more likely to have parents or caregivers who are willing to invest in their mental health than older people are willing to invest in their own mental health?

Figure 8: Average out-of-pocket (OOP) costs over time by age group, collapsed across health professional types

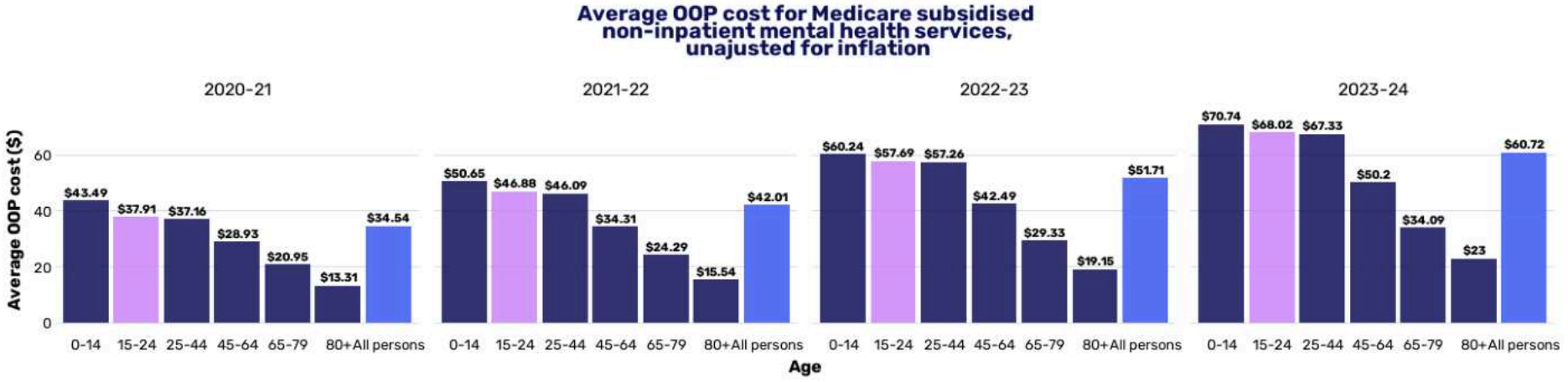


Figure 9: Average out-of-pocket (OOP) costs in the 2023-24 financial year by age group, separated by health professional type

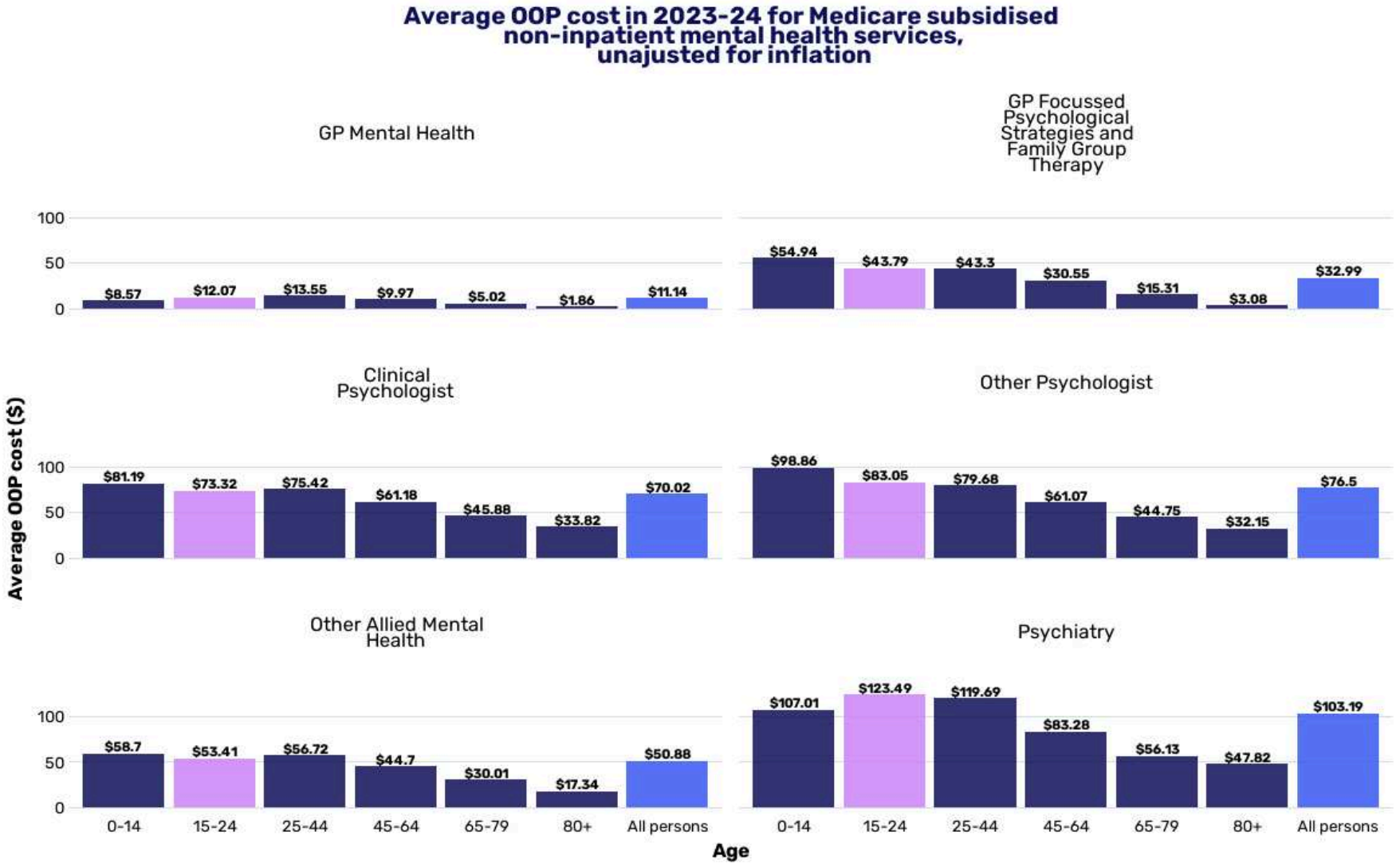


Figure 10: Growth in average out-of-pocket (OOP) costs over time by age group, collapsed across health professional types

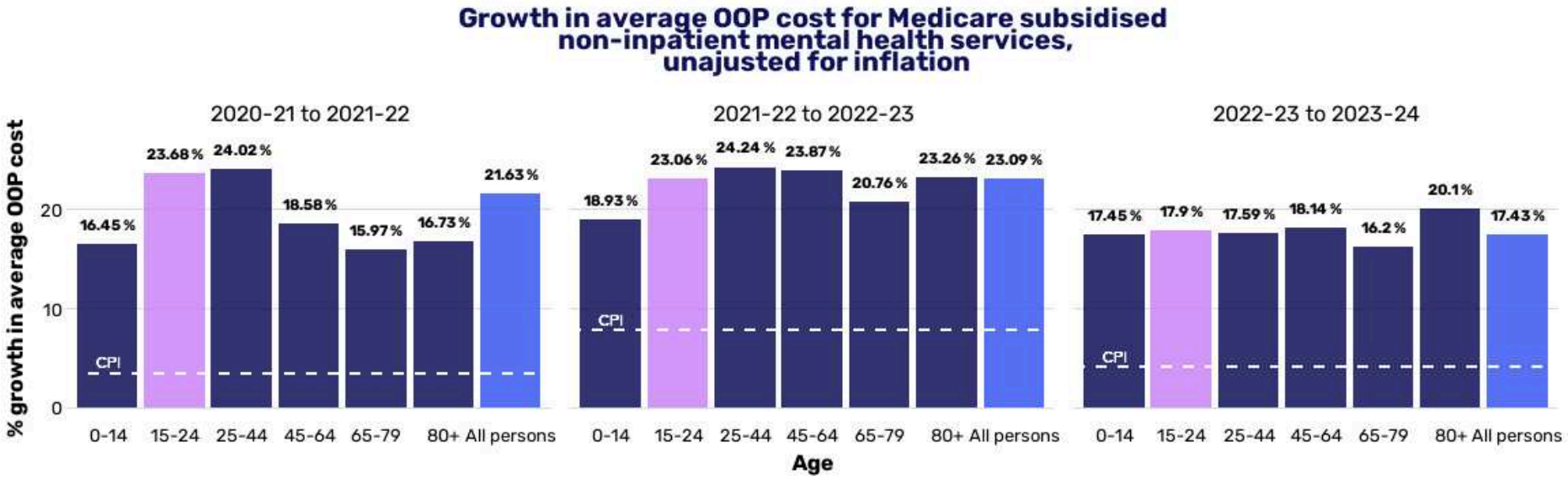


Figure 11: Growth in average provider fees charged and MBS benefits paid over time, collapsed across health professional types

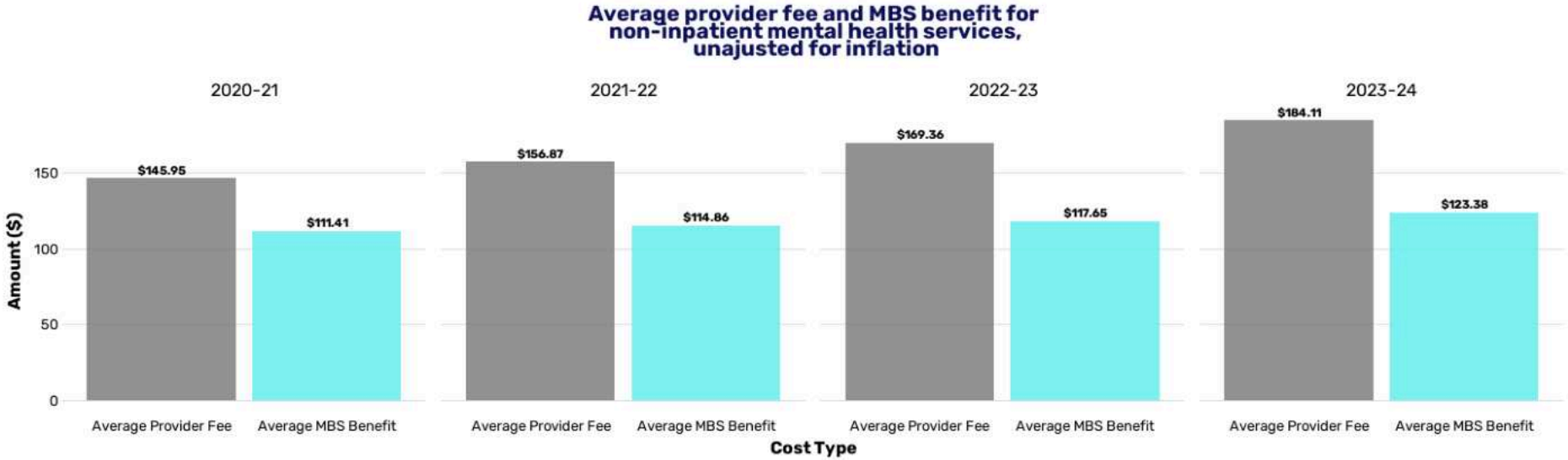
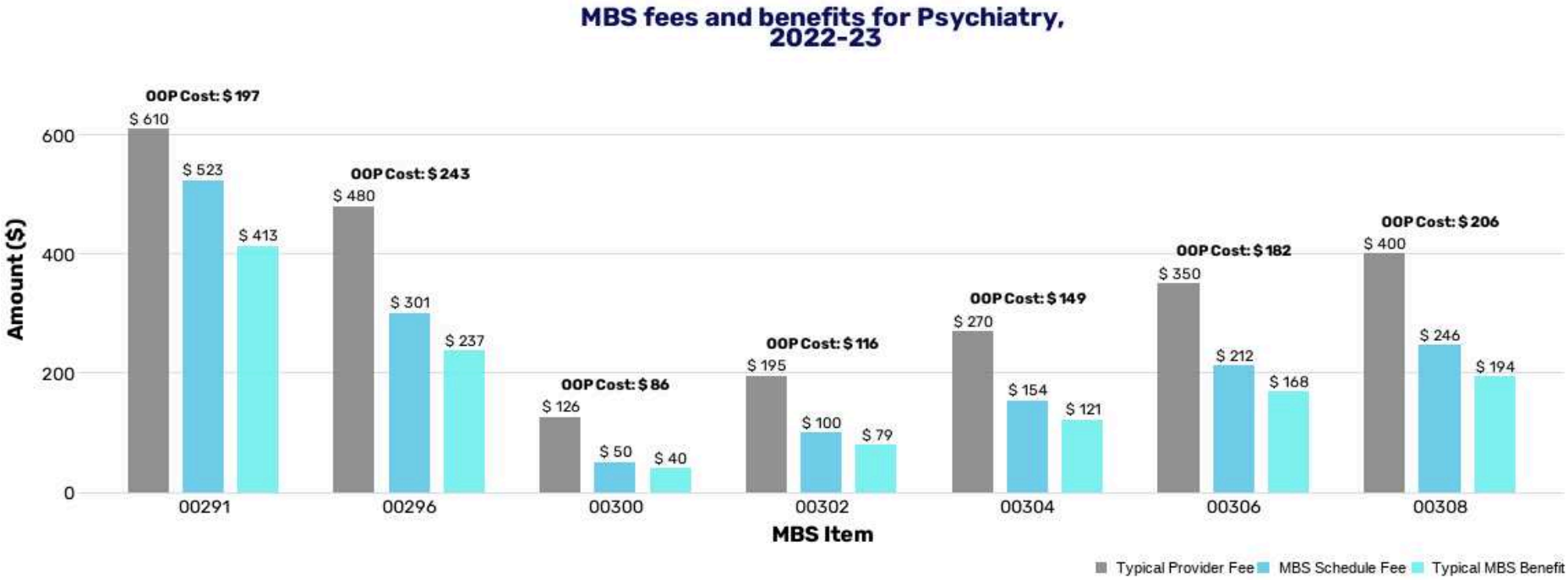
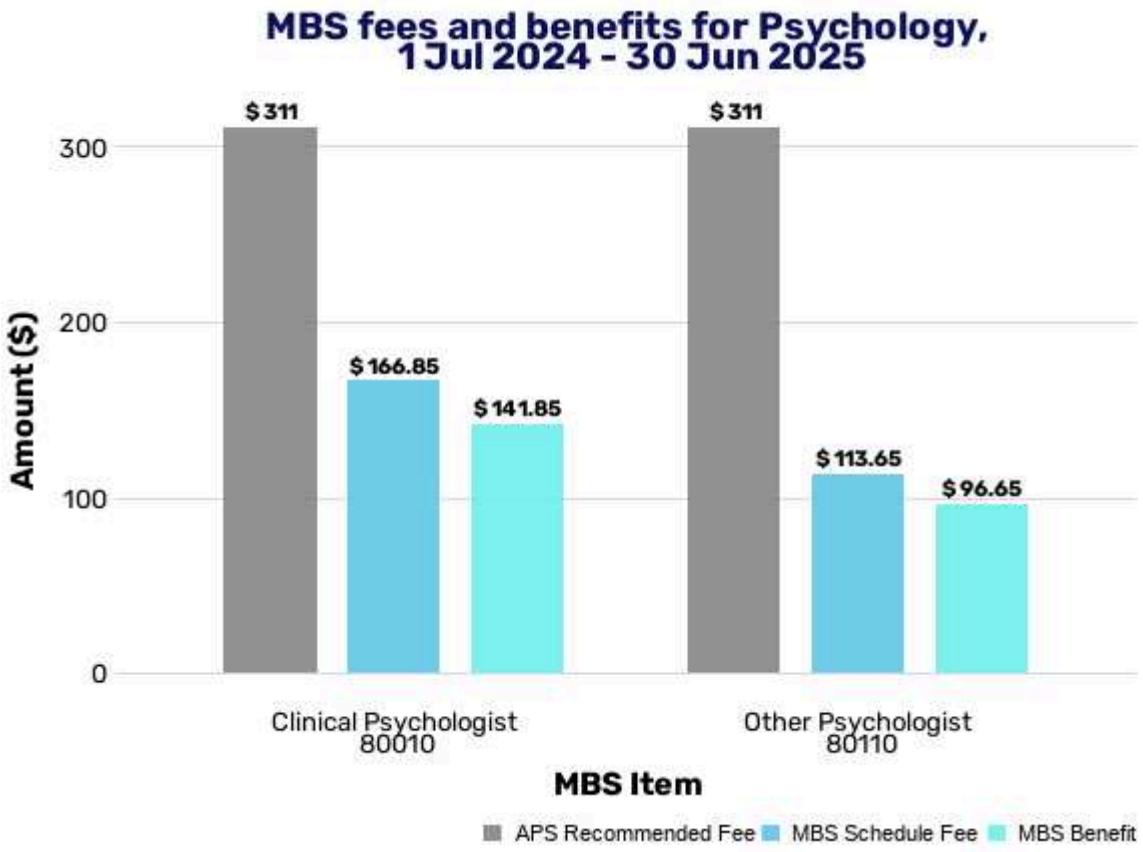


Figure 12: Typical out-of-pocket (OOP) costs for psychiatry[62] in the 2022-23 financial year



[62]
- MBS item 00291: Appointment with a psychiatrist at their rooms lasting more than 45min to develop a 12 month treatment plan for the patient.
- MBS item 00296: First appointment with a psychiatrist at their rooms lasting more than 45min. For new patients or patients who have not seen this specialist in the last 24 months.
- MBS item 00300: Appointment with a psychiatrist at their rooms. The appointment is 15 minutes or less.
- MBS item 00302: Appointment with a psychiatrist at their rooms. The appointment is between 16 and 30 minutes.
- MBS item 00304: Appointment with a psychiatrist at their rooms. The appointment is between 31 and 45 minutes.
- MBS item 00306: Appointment with a psychiatrist at their rooms. The appointment is between 46 and 75 minutes.
- MBS item 00308: Appointment with a psychiatrist at their rooms. The appointment is more than 75 minutes.

Figure 13: MBS benefits for psychology (standard 46 to 60-minute consultation), relative to APS 2024-25 recommended fees



3. Proposed projects

The psychological and structural barriers outlined in this report highlight many of the ways Australia's mental health system is failing to consistently provide young people with access to quality care where and when they need it. At the same time, these barriers present valuable opportunities for reform.

We have identified many potential avenues for research that could support reform efforts, and divided them into two categories.

Firstly, we consider research avenues most closely aligned to System 2's unique approach:

- **Systems-thinking**: Prioritising projects that address 'upstream' system leverage points, rather than tackling 'downstream' barriers in isolation. A key factor underpinning the structural barriers identified in this report is that the supply of youth mental health services is not keeping up with demand. We present one priority project that focusses on both supply-side and demand-side leverage points and one priority project that focuses on the demand-side of the system.
- **Behavioural science**: Prioritising projects that involve one or both of the following: 1) Mapping the different actors, entities, and processes within the system and the behaviours emerging from their interaction; 2) Using insights from behavioural science about how to shift external settings and internal motives and capacities to encourage behaviour change.
- **Deep collaboration**: Prioritising projects that incorporate research methodologies that amplify the voices of young people with relevant lived experience.

In pursuing our research, we also recognise the need to collaborate with a diverse group of stakeholders and engage key decision makers early to ensure support. As an independent charity and research institute, System 2 brings a unique perspective to persistent challenges. We have prioritised projects where decision makers are most likely to be supportive of independent research. This approach will allow us to efficiently move forward with impact-driven initiatives while embracing collaboration where appropriate.

We identified the following potential areas that meet the above criteria, the first two of which we have developed into more detailed plans in the next section:

- **1: Illuminating the funding flows, fee structures, and out-of-pocket costs affecting the supply and affordability of youth mental health services in Australia**
- **2: Improving youth mental health by regulating dark patterns in social media**
- 3: Developing geographical maps that illuminate the Australian regions most in need of youth mental health services (e.g. a heatmap of postcodes colour-coded by the average drive time to the nearest service location)

The second category of promising avenues for research we identified fall outside the criteria we outlined above. Three examples are shown below, with a spotlight on the first idea shown in the box underneath.

- 1: Independently testing whether existing 'digital front doors' to mental health treatment improve mental health outcomes and related process variables

- 2: Identifying and correcting pluralistic ignorance in actual vs. perceived stigma around mental health help-seeking using social norms messaging
- 3: Prompting GPs to consider wait-time data when making mental health referrals

Spotlight - Independently testing whether existing 'digital front doors' to mental health treatment improve mental health outcomes and related process variables

This project would involve undertaking an independent Randomised Controlled Trial (RCT) to test whether digital front doors improve mental health outcomes for young people, as well as process variables such as wait times, service costs, clinician time investment, treatment length, and attrition rate.

'Digital front doors' are digital platforms for people in need of mental health support. They can be used while on the waiting list for, or between appointments with, a mental health practitioner. Features vary across platforms but might include undertaking self-directed interventions, participating in moderated online support communities, or completing dynamic assessments to support triaging. Example digital front doors include MOST and Innowell.

Potential research questions

- Do people who seek mental health treatment via a digital front door have better outcomes than those who seek treatment via a traditional entry point?
- Do any such differences in outcomes persist after excluding people who drop out before receiving a course of treatment (i.e., 'treatment-on-treated' analysis)?
- What type of person benefits from accessing mental health treatment via a digital front door, and what type of person does not?
- Do digital front doors to mental health treatment increase access for individuals who might not have otherwise sought care?

Potential follow-up work

If our independent evaluation yields evidence in favour of the efficacy of digital front doors, follow-up work could test an intervention designed to 'de-sludge' access to and use of these platforms to maximise uptake and retention for people most likely to benefit.

Why was this project not chosen among our two priority projects?

This project lends itself well to System 2's systems-thinking, behavioural science, and deep collaboration approach. However, it could not be undertaken as independent research; it would involve partnering with an organisation who has developed a digital front door platform.

3.1 Project 1

Title: Illuminating the funding flows, fee structures, and out-of-pocket costs affecting the supply and affordability of youth mental health services in Australia

3.1.1 Rationale

This work focuses on the **supply-side** and the **demand-side** of the mental health system.

Supply-side: A key theme from our exploratory research was the finding that supply of youth mental health services is not keeping up with demand. Workforce shortages are creating a major bottleneck in the mental health system, limiting the capacity of mental health practitioners to deliver affordable, locally-accessible, timely, and continuous care for all Australians including young people. These workforce shortages are at least partly driven by insufficient financial incentives to attract and retain mental health practitioners in the public system, including youth-focussed headspace centres.

Demand-side: Our spotlight analysis of administrative data revealed that out-of-pocket costs for Medicare-subsidised non-inpatient mental health services are rising rapidly across all age groups in Australia, with young people facing higher costs than those aged over 45. The reasons behind these rising costs — and why young people are paying more — remain unknown. What is known, however, is that many young people report delaying or not seeking help due to the cost of services.[63] Accordingly, the first priority for action put forward in the recent *Joint statement on youth mental health priorities* by leading youth mental health organisations in Australia was to "provide free access to mental health care for all children and young people."[64]

These supply-side and demand-side issues reveal a need for greater and smarter investment into youth mental health services to improve the system's ability to cope with its increasing volume and ensure services are affordable for those who need it. Indeed, a recent nationally representative survey conducted by Empirica Research and commissioned by Orygen found that while Australians believe around 34% of health expenditure should be allocated to mental health, only 8% currently is, despite mental ill-health contributing to approximately 15% of the national burden of disease.[65] However, without publicly accessible information about the funding flows and fee structures underpinning youth mental health services, or data about how service affordability impacts the behaviours of young people and their parents or caregivers, it is difficult for young people, advocates, practitioners, researchers, and policymakers to make precise recommendations about what smarter investment and reforms look like. Shedding light on these factors is a crucial first step toward implementing policy changes that will improve the workforce capacity and affordability of mental health services for young people.

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[63] Black Dog Institute. (2024). Navigating Australia's mental health system in 2024. https://www.blackdoginstitute.org.au/wp-content/uploads/2024/09/Navigating-Australias-mental-health-system-in-2024-Consumer-Report.pdf

[64] ARACY, Batyr, Black Dog Institute, headspace, Mission Australia, Orygen, Prevention United, ReachOut, Yourtown, & YouthFocus. (2025). Joint statement on youth mental health priorities. https://www.aracy.org.au/news/joint-statement-on-youth-mental-health-priorities/

[65] Orygen. (2025). Youth mental health leaders unite for six-point plan to end inaction. https://www.orygen.org.au/About/News-And-Events/2025/Youth-mental-health-leaders-unite-for-six-point-pl

3.1.2 Aim

Objective

This work will illuminate the funding flows and fee structures affecting the supply and affordability of youth mental health services in Australia, while also examining how affordability influences help-seeking behaviours.

Impact

These insights will equip young people, advocates, practitioners, researchers, and policymakers with the knowledge needed to drive funding reforms that address the root causes of workforce shortages as well as rising and inequitable service costs. Without a clear understanding of these root causes, funding reform efforts may either be stalled due to uncertainty about where to start, or ineffective due to targeting the wrong drivers.

3.1.3 Research questions

- What are the public funding flows into youth mental health services in Australia?
- What fee structures govern the provision of youth mental health services in Australia?
- Why is the cost of accessing mental health services increasing for all Australians, including for young people?
- Why are young people paying more to access mental health services in Australia than older cohorts?
- How do costs factor into young people's use of mental health services in Australia?

3.1.4 Approach

Phase 1: Administrative data analysis

We will update our spotlight analysis of administrative data from the *Medicare-subsidised GP, allied health and specialist health care across local areas* datasets. Specifically, we will request further data from the Department of Health and Aged Care (DoHAC) that distinguishes bulk-billed from non-bulk-billed services. This additional data would allow us to i) better estimate the cost of accessing mental health services *when an out-of-pocket payment is required* and ii) examine whether the proportion of bulk-billed services is declining over time and can account for rising out-of-pocket costs. We will also ask whether out-of-pocket cost breakdowns are available at the Medicare Benefits Schedule (MBS) item level for psychological services, similar to the data provided for psychiatry services in the Medical Costs Finder.

Phase 2: Desk research

We will draft a system map showcasing i) the different types of mental health services

available to young people in Australia (including generic services and youth-specialist services), ii) the agencies responsible for providing or administering public funding for each service, iii) the amount of funding each agency provides, iv) what providers use this funding for, and v) the fee structures providers use to charge patients or clients. This draft system map will be based on publicly available information gathered through desk research, which may be limited. We will stress-test the draft system map and fill knowledge gaps during Phase 3.

Phase 3: Interviews with funders, practice managers, practitioners, researchers, and policymakers

We will conduct 1:1 semi-structured interviews with N = 60 funders, practice managers, practitioners, researchers, and policymakers with expertise in funding flows and fee structures affecting mental health services accessed by young people in Australia. These interviews will be used to stress-test our draft system map and fill knowledge gaps. The interviews will also allow us to explore three hypotheses for why young people pay higher costs to access Medicare-subsidised non-inpatient mental health services:

- Are mental health providers more likely to offer bulk-billing (under a mixed-billing model) or other discounted rates to seniors than they are to younger cohorts?
- Are fees higher for psychologists or psychiatrists who specialise in treating children and young people compared to non-specialists or those who specialise in other cohorts?
- Do assessment or treatment services for mental health disorders that typically arise in childhood, adolescence, or early adulthood have higher fees than services for mental health disorders that typically arise later in life?

Phase 4: Survey of young people, parents and caregivers of young people, and people over 45

We will consult with our Youth Advisory Board to co-design a survey. We will administer the survey to a sample of N = 6,000 young people aged 18-25, parents and caregivers of dependents aged 25 and under, and adults aged over 45. The survey will explore *knowledge* (the accuracy of perceived costs), *attitudes* (the minimum and maximum amounts individuals are willing to pay), and *practices* (the relationship between perceived costs and both self-reported and actual behaviors) regarding access to mental health services for each cohort. To assess practices, we will seek to measure actual access behaviours (e.g., whether any service is accessed at all; how many sessions are accessed; the type of service accessed) by linking our survey data with administrative data held by the Department of Health and Welfare and/or the Australian Bureau of Statistics. Such linkages will be subject to approvals from the relevant agencies and consent from survey participants.

By comparing results across cohorts, the survey will also allow us explore two hypotheses for why young people pay higher costs to access Medicare-subsidised non-inpatient mental health services:

- Are younger generations more willing to invest in their mental health than older generations?

- Are children and young people more likely to have parents or caregivers who are willing to invest in their mental health than older people are willing to invest in their own mental health?

Our sample would aim for approximately:[66]

- 2,000 young people aged 18-25, 2,000 parents or caregivers of dependents aged 25 and under, and 2,000 adults aged over 45.
- Roughly two-thirds metropolitan residents and one-third non-metropolitan residents within each cohort.
- Relative representativeness (in line with Australian population proportions) on gender and state/territory residency within each cohort.

Phase 5: Publication and dissemination of findings

We will synthesise and publish our findings from Phases 1-4 on our website. We will use these findings to advocate for policy reforms that enable greater and smarter investment into the youth mental health system.

[66] Given we are working with large populations, we can expect a margin of error close to 3% at a 95% confidence level for sample sizes of roughly 1,000. We have based our sample sizes on the smallest subgroup we are interested in analysing (e.g., if we want to compare metro to non-metro participants, we would need 1,000 participants in each of these subgroups to ensure a margin of error of 3%).

3.2 Project 2

Title: Improving youth mental health by regulating dark patterns in social media

3.2.1 Rationale

This work focuses on the **demand-side** of the mental health system.

The rise in mental ill health among young Australians in recent years has been accompanied by debate about the potential causal role of social media. In response, the Australian Government passed a bill in November 2024 to implement a social media ban for people aged under 16. The ban is not expected to come into effect until December 2025. There is disagreement among young people, politicians, academics, practitioners, advocacies, and other experts about whether the ban will achieve its aim of protecting young people from harm, with some emphasising the benefits of social media (e.g., for facilitating access to mental health resources and connection to like-minded communities).

Nevertheless, there is a consensus that social media companies must do more to ensure the safety of their platforms for young people. As leading mental health organisations in Australia have put it:

> "We…need social media platforms to step up, and take responsibility for their products and make sure that young people are not exposed to harmful content."[67]

One way social media companies could improve the safety of their platforms is by removing '**dark patterns**', or design features that exploit people's cognitive biases in ways that are not in their best interest (e.g., infinite scroll features, which make it difficult for users to disengage attention). Similarly, social media companies could seek to amplify '**bright patterns**' (design features that help users make more informed and intentional choices that align with their interests) and the positive side of '**grey patterns**' (design features that have the potential to either help or hinder a person's ability to act in alignment with their interests, depending on how the feature is deployed).

[67] ReachOut, Black Dog Institute, Beyond Blue, headspace, Prevention United, ARACY, Project Rockit, Suicide Prevention Australia, Gayaa Dhuwi Australia, & LGBTIQ+ Health Australia. (2024). Press statement: Leading mental health organisations say proposed ban won't make social media safe. https://media.licdn.com/dms/document/media/D561FAQG0dZ5Mt2-rIw/feedshare-document-pdf-analyzed/0/1726008577467?e=1726704000&v=beta&t=LoLy8oZ06Myaj7BSxB7QunJzV1WV7ObTtsjleJ2vo4A

3.2.2 Aim

Objective

Adopting a prevention-focussed lens, this work will produce a set of evidence-based regulatory principles that seek to eliminate dark patterns and the features of grey patterns that may be damaging to mental health, while retaining and amplifying the aspects of social media young people value most through leveraging bright patterns.

Impact

These principles could be used to guide the development of regulatory frameworks that ensure social media companies put the mental health of young people before profit. Without such regulation, the 'attention economy' will continue to incentivise social media companies to use dark patterns to maximise engagement at all costs.

3.2.3 Research questions

- What are the prominent dark, grey, and bright patterns found on the most popular social media platforms used by young people (Instagram, TikTok, Snapchat)?
- How do young people interact with these dark, grey, and bright patterns, and what is their impact on behaviour and wellbeing?
- How can helpful bright patterns be leveraged, the beneficial aspects of grey patterns be amplified, and problematic dark patterns be eliminated, to create an online environment that allows young people to thrive?

3.2.4 Approach

Phase 1: Desk research

Our sister organisation, BIT, are currently undertaking a behavioural audit to catalogue the dark, grey, and bright patterns found on social media platforms. We will review this work to identify a consolidated set of dark, bright, and grey patterns that are most likely to be found on the social media platforms used by young people (Instagram, TikTok, Snapchat).

Phase 2: Survey of young people

We will consult with our Youth Advisory Board to co-design a survey. We will administer the survey to a sample of N = 3,000 young people aged 12-25 who are current or previous users of Instagram, TikTok, or Snapchat. Participants will rate how each dark, grey, and bright pattern impacts their behaviour and wellbeing.

Our sample would aim for approximately:

- 1,000 12-15 year olds and 2,000 16-25 year olds.
- 2,000 metropolitan residents and 1,000 non-metropolitan residents.
- Relative representativeness (in line with Australian population proportions) on gender and state/territory residency.

Phase 3: Interviews with young people

We will invite a subset of N = 45 young people who participated in Phase 2 to participate in a 1:1 semi-structured interview. We will consult with our Youth Advisory Board to co-design the interview guide. During their interview, the young person will explain how they interact with the dark, grey, and bright patterns that were identified as most problematic/helpful in the survey (e.g., strategies they use to resist dark patterns). They will also share how these dark, grey, and bright patterns impact their behaviour and wellbeing and potential design reforms that would help them engage with social media in ways that better align with their goals.

Our sample would aim for approximately:

- 50% gender split.
- 15 Instagram users, 15 TikTok users, and 15 Snapchat users.

Phase 4: Youth Advisory Board co-design workshop

We will present our survey and interview findings to our Youth Advisory Board. Together, we will brainstorm ideas for potential regulatory principles that retain the features of social media that young people value while eliminating problematic dark patterns and leveraging helpful bright patterns.

Phase 5: Interviews with social media companies

We will consolidate the ideas from the Youth Advisory Board co-design workshop into a list of draft regulatory principles. We will conduct a small number of 1:1 interviews with representatives from social media companies to understand how our draft regulatory principles align with any existing initiatives companies are considering, piloting, or implementing.

Phase 6: Digital developer and regulator co-design workshop

We will hold a second co-design workshop, this time with digital developers and regulators, to discuss the feasibility of our draft regulatory principles and ways to ensure they are future-proof.

Phase 7: Publication and dissemination of findings

We will consolidate inputs from the digital developer and regulator co-design workshop into a final list of regulatory principles. We will publish these principles on our website and use them to advocate for regulatory reforms.

Appendix

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Participating in our youth expert focus group	• System 2's Youth Advisory Board
Providing feedback on our project ideas	• System 2's Research Committee
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