Final Print

NSW Youth Parliament

Redefining Mental Health Youth Act 2025

Bill Proposed By: Mental Health Committee

Contents

I certify that this public Bill, which originated in the Youth Legislative Assembly, has finally passed the Youth Legislative Assembly of New South Wales.

Hamani Tanginoa, Youth Parliament Coordinator

NSW Youth Parliament

Redefining Mental Health Youth Act 2025

Act no. 8, 2025

A Bill for

An Act to create positive wellbeing by empowering local communities to redefine mental health, and other purposes.

I have examined this bill and find it to correspond in all respects with the bill as finally passed by the Youth Legislative Assembly.

Lian Sequeira, Youth Governor of the NSW Youth Parliament

Explanatory Note

Summary

The object of this Bill is to create positive wellbeing, empower community-led action, and ultimately redefine mental health for individuals.
This Bill comes at a time where the most prevalent long-term health issues in NSW are mental health related. Marginalised groups face unique challenges shaped by culture, geography, stigma and systemic disadvantage, which the current mental health system fails to rectify.

This Bill aims to empower local communities by leading mental health responses through community-based programs. Improve mental health outcomes for vulnerable and underserved populations via targeted programs. It integrates mental health education, workforce development, and early intervention across schools and public institutions. It has a clear goal of destigmatising mental health by promoting public understanding, shared language, and proactive wellbeing initiatives across New South Wales.

Overall, the Bill closes the gap between individuals and mental health supports, promoting positive wellbeing for all people within NSW

Overview of provisions

Part 1 sets out the short title, commencement, objects and definitions of the Act.
Part 2 establishes mechanisms to promote and empower community-focused mental health care. Community Liaison officers are established to deliver individualised community care and programs, as supported by the state, with the expansion of mentorship programs and training.
Part 3 overhauls the education system to prioritise inclusion of mental health, through curriculum reform, increased mental health professionals in schools, as well as university and workforce partnerships to deliver the professionals needed.
Part 4 establishes a series of strategies to destigmatise mental health across NSW, including an updated definition scale and a public exposure campaign.

Rationale

Introduction

In 2022, the national health survey reported 22.2% of NSW residents were experiencing a long-term mental health or behavioural condition, positioning it as the most prevalent long-term health condition in the state (Australian Bureau of Statistics, 2022). This prolonged struggle with mental health has a variety of complex causes and can affect anybody, but many marginalised groups, including rural or regional, culturally or racially marginalised (CARM), and Aboriginal and Torres Strait Islander communities, are disproportionately affected (Australian Bureau of Statistics, 2024) as their needs are not being adequately met by the current system. Within many of these communities, Mental Health is stigmatised as 'negative' and a sign of weakness due to a lack of access to culturally appropriate education around mental health and wellbeing. Similarly, the inaccessibility of culturally appropriate mental health services within marginalised communities is likely responsible for the disproportionate rates of chronic mental health and behavioural conditions experienced. The stigma surrounding mental health in communities across NSW correlates with the narrowly singular perception of mental health as solely a negative state, when, in reality, mental health exists on a broad spectrum that includes both positive and negative states of well-being. However, the impact of mental health on specific communities and individuals is not uniform; different groups experience individual challenges shaped by their history, geography, and culture. Consequently, standardised approaches to mental health are ineffective in responding to and addressing these issues, and instead, a community-centred and individualised approach is required.

Mental Health as a Widespread Amalgamation of Differing Factors

Mental health treatment typically focuses on the symptoms of mental health conditions, as opposed to considering the socio-economic factors that create well-being issues. A study completed by the US National Library of Medicine found "disadvantaged populations are most affected by mental disorders" (Alegría, NeMoyer, Falgàs Bagué, Wang, & Alvarez, 2018). The study found that a wide range of circumstances, including discrimination, poor familial relations, economic instability, and demographic composition, significantly contribute to an individual's mental health. An estimated 43% of Australians have experienced the adverse effects of mental illness within their lives, while a further unspecified number have felt the symptoms without suffering from a particular condition (Australian Institute of Health and Welfare [AIHW], n.d.). The prevalence of Australians who have experienced poor well-being indicates that, although treatments of particular conditions are required to be individualised, greater attempts to reach and support wider demographics are required in order to mitigate the associated risks.

Stigma and Service Gaps in Vulnerable Groups

Individuals residing in regional centres, remote and rural areas, are faced with similar mental conditions as their metropolitan counterparts but are met with greater challenges in accessing support. Cultural factors, including an emphasis on self-reliance, are key drivers in isolation, due to the reluctance to seek support (RANZCP, 2023). This is exacerbated by limited job opportunities and geographic isolation, hindering the ability to engage in community life, reducing opportunities for social connection. The need for tailored approaches toward mental health is increasingly important as local-level planning for services is key in improving access

for people in regional and remote areas (Australian Government Productivity Commission, 2020).
Those with a Culturally and Racially marginalised (CARM) background can be challenged with further barriers than those with an English-speaking background (ESB). In many CARM communities, mental health is often unrecognised, with psychological medical treatment being a Western concept. The lack of culturally appropriate services that align with individuals' beliefs exacerbates the knowledge gap of mental health in these communities (Swagata Bapat Consulting, 2022).

LGBTQIA+ young people experience some of the highest rates of poor mental health in Australia. Discrimination, social exclusion, family rejection and the ongoing impacts of homophobia and transphobia create serious risks to wellbeing. According to Minus18, 75% of LGBTQIA+ youth experience some form of discrimination, and they are five times more likely to attempt suicide than their heterosexual peers. Too many queer people lack access to inclusive support services that reflect their lived experience.
Nowhere are the daily tolls and struggles of poor mental health more acutely felt than in the prison system. According to an NSW Justice and Forensic Mental Health Networks study, ~20% of NSW prisoners have attempted suicide prior to incarceration (Dapin, 2023), making them the highest risk group in the country when it comes to poor mental health and its consequences. It is apparent that our prison system requires pressing and urgent reform, to ensure high community standards as well as the basic rights of inmates are being protected. Prison life needs to be restructured in such a way that mental health is no longer considered as secondary or else detached from the process of rehabilitation, which underpins the NSW correctional system, but rather as the indispensable bedrock of its success.

Formal Education's Role in Redefining Mental Health
Research suggests most young people with mental health problems do not seek professional help, despite the availability of school wellbeing resources. The Mental Health Commission found only 40 per cent of children with a mental illness used or attended services provided by their school for emotional and behavioural struggles, preferring more informal supports (Marinucci & Grové, 2022). Surveyed young people say schools should place more emphasis on recognising mental health challenges and learning practical coping strategies, instead of rushing through discussions of mental health only in response to crises or stressful times such as exams. There is a need to address this issue through mental health literacy programs and more holistic school education.

Community-based care
While clinical models play a vital role in effective mental healthcare and should not be eliminated, studies suggest that shaping these services to focus more on the needs of individual communities, as well as introducing a higher proportion of informal services, may enhance user participation and community integration (Elstad & Eide, 2009). Orienting mental health services around communities rather than hospitals has consistently been shown to produce improved outcomes and a similar level of clinical effectiveness, while being less expensive to implement (Thornicroft et al., 1998). The lower overall cost of this model of service enables governments to invest more money into the expansion of services, delivering effective care to a larger population for the same price.

A successful example of this type of care is Aboriginal Community-Controlled Health Services (ACCHSs). These services have proven highly effective in improving health outcomes in Aboriginal communities, reducing rates of psychiatric admissions by 58% (Laugharne et al., 2002). This is because they are centred around and run by the local Aboriginal community, allowing them to effectively meet the specific needs of individual communities (Campbell et al., 2017).

Conclusion: Reconceptualising Mental Health as a Foundation for Adaptive Wellbeing Support

The misconception that mental health is a fixed and stable state often conflates good mental health with the permanent state of happiness. Comparatively, shifting the mechanised definition of mental health to a fluid position on a broad spectrum, encapsulates the nuances associated with positive wellbeing, experiencing the range of emotions, in a healthy way (Understanding the Spectrum of Mental Health, n.d.). This approach empowers communities to define and nurture a collective wellbeing by integrating lived experience and co-designed support systems. Embracing the collective perspectives, values, and needs of the community is critical to promoting a state of healthy wellbeing by acknowledging the dynamic relationship between individuals and their socio-cultural environments.

Reference List

Alegría, M., NeMoyer, A., Falgàs Bagué, I., Wang, Y., & Alvarez, K. (2018). Social determinants of mental health: Where we are and where we need to go. Current Psychiatry Reports, 20(11), 95. https://doi.org/10.1007/s11920-018-0969-9

Australian Bureau of Statistics. (2018, December 12). *National Health Survey: State and territory findings, 2017-18 financial year | Australian Bureau of Statistics*. Www.abs.gov.au. https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-state-and-territory-findings/latest-release

Australian Government Productivity Commission. (2020). *Productivity Commission Inquiry Report*. https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf

Australian Institute of Health and Welfare. (n.d.). Prevalence and impact of mental illness. Australian Government. https://www.aihw.gov.au/mental-health/overview/prevalence-and-impact-of-mental-illness

Breakey, W. R. (Ed.). (1996). *Integrated mental health services: Modern community psychiatry*. Oxford University Press.

Campbell, M. A., Hunt, J., Scrimgeour, D. J., Davey, M., & Jones, V. (2017, March 7). Contribution of Aboriginal Community-Controlled Health Services to improving Aboriginal health: evidence reviews. *Australian Health Review*, *42*(2), 218-226. https://doi.org/10.1071/AH16149

Christensen, H., Shand, F., & Tye, M. (n.d.). *LifeSpan trials*. Black Dog Institute. https://www.blackdoginstitute.org.au/research-centres/lifespan-trials/

Dapin, Mark. “Prisoners’ Mental Health – a Contradiction in Terms?” *Law Society Journal*, 15 Nov. 2023, lsj.com.au/articles/prisonersmental-health-a-contradiction-in-terms/.

Elstad, T. A., & Eide, A. H. (2009, November 10). User participation in community mental health services: exploring the experiences of users and professionals. *Scandinavian Journal of Caring Sciences*, *23*(4), 674-681. https://doi.org/10.1111/j.1471-6712.2008.00660.x

Hains, A., Paterson, E., & Lumby, C. (2019). *Report Card*. Illawarra Shoalhaven Suicide Prevention Collaborative. Retrieved May 8, 2025, from https://www.suicidepreventioncollaborative.org.au/assets/SPC_reportcard-2019_FINAL_single.pdf

Health Direct. (2019). *Rural or remote mental health*. Healthdirect.gov.au; Healthdirect Australia. https://www.healthdirect.gov.au/rural-remote-mental-health

Kleinman, A., & Benson, P. (2006). Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. *PLoS Medicine*, *3*(10), e294. https://doi.org/10.1371/journal.pmed.0030294

Lu, W., Todhunter-Reid, A., Mitsdarffer, M. L., Muñoz-Laboy, M., Yoon, A. S., & Xu, L. (2021, March 8). Barriers and Facilitators for Mental Health Service Use Among Racial/Ethnic Minority Adolescents: A Systematic Review of Literature. *Frontiers in Public Health*, *9*(2021). https://doi.org/10.3389/fpubh.2021.641605

Meadows, G. N., Enticott, J. C., Inder, B., Russell, G. M., & Gurr, R. (2015). Better access to mental health care and the failure of the Medicare principle of universality. *Medical Journal of Australia*, *202*(4), 190–194. https://doi.org/10.5694/mja14.00330

Mental Health Commission of New South Wales. (2014). *Rural communities*. Www.nswmentalhealthcommission.com.au. https://www.nswmentalhealthcommission.com.au/content/rural-communities

Rosen, A., Gill, N. S., & Salvador-Carulla, L. (2020, July). The future of community psychiatry and community mental health services. *Current Opinion in Psychiatry*, *33*(4), 375-390. https://journals.lww.com/co-psychiatry/abstract/2020/07000/the_future_of_community_psychiatry_and_community.13.aspx

RANZCP. (2023). *Communities in rural Australia*. RANZCP. https://www.ranzcp.org/college-committees/key-areas-of-focus/rural-psychiatry/about-rural-psychiatry/communities-in-rural-australia

Swagata Bapat. (2022). *National Mental Health Commission Engagement with Culturally and Linguistically Diverse communities to support the development of the National Stigma and Discrimination Reduction Strategy Final Report*.

Thornicroft, G., Deb, T., & Henderson, C. (2016, December 22). Community mental health care worldwide: current status and further developments. *World Psychiatry*, *15*(3), 276-286. https://doi.org/10.1002/wps.20349

Thornicroft, G., Wykes, T., Holloway, F., Johnson, S., & Szmuckler, G. (1998, November). From efficacy to effectiveness in community mental health services: PRiSM Psychosis Study 10. *The British Journal of Psychiatry*, *173*(5), 423-427. https://doi.org/10.1192/bjp.173.5.423

Westerman, T. (2010, December 31). Engaging Australian Aboriginal youth in mental health services. *Australian Psychologist*, *45*(3), 212-222. https://doi.org/10.1080/00050060903451790

Wright, A., McGorry, P. D., Harris, M. G., Jorm, A. F., & Pennell, K. (2006, August 22). Development and evaluation of a youth mental health community awareness campaign – The Compass Strategy. *BMC Public Health*, *6*. https://doi.org/10.1186/1471-2458-6-215

Minus18 Foundation.). *Why do we exist*? https://www.minus18.org.au/about
Minus18 Foundation. *The stats*. https://www.minus18.org.au/articles/the-stats

National LGBTI Health Alliance. *Snapshot of mental health and suicide prevention statistics for LGBTI people*. https://www.lgbtiqhealth.org.au/statistics

Wear It Purple. https://www.wearitpurple.org/about

Young Minds Matter - Survey Results Query Tool. (2025). Youngmindsmatterresults.org.au. https://www.youngmindsmatterresults.org.au/PrevalenceParentReportBS.html#

Kumar, R. K., Aruna, G., Biradar, N., Reddy, K. S., Soubhagya, M., & Sushma, S. A. (2022). The prevalence of depression, anxiety, and stress among high school adolescents' children in public and private schools in Rangareddy district Telangana state: A cross-sectional study. Journal of Education and Health Promotion, 11, 83. https://doi.org/10.4103/jehp.jehp_548_21

NSW Department of Education and Communities. (2015). The Wellbeing Framework for Schools. https://education.nsw.gov.au/content/dam/main-education/student-wellbeing/whole-school-approach/Wellbeing_Framework_for_Schools.pdf

NSW Government. (2015). Wellbeing Framework - Elements of Learning and Achievement. Theelements.schools.nsw.gov.au. https://theelements.schools.nsw.gov.au/introduction-to-the-elements/policy-reforms-and-focus-areas/wellbeing-framework.html

Be You. (2024). *Mental Health in Education Report Building mentally healthy learning communities*.

Kumar, R. K., Aruna, G., Biradar, N., Reddy, K. S., Soubhagya, M., & Sushma, S. A. (2022). The prevalence of depression, anxiety, and stress among high school adolescent's children in public and private schools in Rangareddy district Telangana state: A cross-sectional study. *Journal of Education and Health Promotion*, *11*, 83. https://doi.org/10.4103/jehp.jehp_548_21

Marinucci, A., & Grové, C. (2022, May 24). *"It's almost like a second home": why students want schools to do more about mental health*. The Conversation. https://theconversation.com/its-almost-like-a-second-home-why-students-want-schools-to-do-more-about-mental-health-179644

NSW Department of Education and Communities. (2015). *The Wellbeing Framework for Schools*. https://education.nsw.gov.au/content/dam/main-education/student-wellbeing/whole-school-approach/Wellbeing_Framework_for_Schools.pdf

NSW Government. (2015). *Wellbeing Framework - Elements of Learning and Achievement*. Theelements.schools.nsw.gov.au. https://theelements.schools.nsw.gov.au/introduction-to-the-elements/policy-reforms-and-focus-areas/wellbeing-framework.html

NSW Government. (2022). *Schools and students: 2022 statistical bulletin*. Nsw.gov.au. https://education.nsw.gov.au/about-us/education-data-and-research/cese/publications/statistics/annual-statistical-bulletin/schools-and-students-2022-statistical-bulletin

Victoria University. (2023, October 25). *How to Improve Mental Health in Schools | VU Online*. Online.vu.edu.au. https://online.vu.edu.au/blog/improve-mental-health-in-schools

Young Minds Matter. (2025). *Young Minds Matter - Survey Results Query Tool*. Youngmindsmatterresults.org.au. https://www.youngmindsmatterresults.org.au/PrevalenceParentReportBS.html#

Breakey, W. R. (Ed.). (1996). *Integrated mental health services: Modern community psychiatry*. Oxford University Press.

Campbell, M. A., Hunt, J., Scrimgeour, D. J., Davey, M., & Jones, V. (2017, March 7). Contribution of Aboriginal Community-Controlled Health Services to improving Aboriginal health: evidence reviews. *Australian Health Review*, *42*(2), 218-226. https://doi.org/10.1071/AH16149

Christensen, H., Shand, F., & Tye, M. (n.d.). *LifeSpan trials*. Black Dog Institute. https://www.blackdoginstitute.org.au/research-centres/lifespan-trials/

Elstad, T. A., & Eide, A. H. (2009, November 10). User participation in community mental health services: exploring the experiences of users and professionals. *Scandinavian Journal of Caring Sciences*, *23*(4), 674-681. https://doi.org/10.1111/j.1471-6712.2008.00660.x

Groos, A., Engeler, T., Miller, M., & McDonald, M. A. (1998). *Stories & ideas from around Australia: giving Aboriginal and Torres Strait Islander babies the best start in life: supporting breastfeeding and good food choices for infants*. Department of Social and Preventive Medicine, University of Queensland. https://iats.ent.sirsidynix.net.au/client/en_AU/external/search/detailnonmodal/ent:$002f$002fSD_ILS$002f0$002fSD_ILS:313105/one?qu=

Hains, A., Paterson, E., & Lumby, C. (2019). *Report Card*. Illawarra Shoalhaven Suicide Prevention Collaborative. Retrieved May 8, 2025, from https://www.suicidepreventioncollaborative.org.au/assets/SPC_reportcard-2019_FINAL_single.pdf

Huang, R.-L., Torzillo, P. J., Hammond, V. A., Coulter, S. T., & Kirby, A. C. (2008, October 20). Epidemiology of sexually transmitted infections on the Anangu Pitjantjatjara Yankunytjatjara Lands: results of a comprehensive control program. *Medical Journal of Australia*, *189*(8), 442-445. https://doi.org/10.5694/j.1326-5377.2008.tb02117.x

Laugharne, J., Glennen, M., & Austin, J. (2002, March). The “Maga Barndi” Mental Health Service for Aboriginal People in Western Australia. *Australasian Psychiatry*, *10*(1), 13-17. https://doi.org/10.1046/j.1440-1665.2002.00385.

Lu, W., Todhunter-Reid, A., Mitsdarffer, M. L., Muñoz-Laboy, M., Yoon, A. S., & Xu, L. (2021, March 8). Barriers and Facilitators for Mental Health Service Use Among Racial/Ethnic Minority Adolescents: A Systematic Review of Literature. *Frontiers in Public Health*, *9*(2021). https://doi.org/10.3389/fpubh.2021.641605

Rosen, A., Gill, N. S., & Salvador-Carulla, L. (2020, July). The future of community psychiatry and community mental health services. *Current Opinion in Psychiatry*, *33*(4), 375-390. https://journals.lww.com/co psychiatry/abstract/2020/07000/the_future_of_community_psychiatry_and_community.13.aspx

Su, J.-Y., & Skov, S. (2008, December). An assessment of the effectiveness of the Tiwi Sexual Health Program 2002–2005. *Australian and New Zealand Journal of Public Health*, *32*(6), 554-558. https://doi.org/10.1111/j.1753-6405.2008.00309.x

Thornicroft, G., Deb, T., & Henderson, C. (2016, December 22). Community mental health care worldwide: current status and further developments. *World Psychiatry*, *15*(3), 276-286. https://doi.org/10.1002/wps.20349

Thornicroft, G., Wykes, T., Holloway, F., Johnson, S., & Szmuckler, G. (1998, November). From efficacy to effectiveness in community mental health services: PRiSM Psychosis Study 10. *The British Journal of Psychiatry*, *173*(5), 423-427. https://doi.org/10.1192/bjp.173.5.423

Westerman, T. (2010, December 31). Engaging Australian Aboriginal youth in mental health services. *Australian Psychologist*, *45*(3), 212-222. https://doi.org/10.1080/00050060903451790

Wright, A., McGorry, P. D., Harris, M. G., Jorm, A. F., & Pennell, K. (2006, August 22). Development and evaluation of a youth mental health community awareness campaign – The Compass Strategy. *BMC Public Health*, *6*. https://doi.org/10.1186/1471-2458-6-215

The Youth Legislature of New South Wales enacts—

Part 1 Preliminary

1 Name of Act

This Act is the Redefining Mental Health Youth Act 2025.

2 Commencement

The Act commences upon assent.

3 Objects

The objects of this Act are to—

(a) to empower local communities to lead mental health responses through community-based programs,

(b) to improve mental health outcomes for vulnerable and underserved populations through targeted programs in education, justice, and healthcare,

(c) to integrate mental health education, workforce development, and early intervention across schools and public institutions,

(d) to destigmatise mental health by promoting public understanding, shared language, and proactive wellbeing initiatives across New South Wales.

4 Definitions

In this Act—

Community Wellbeing Liaison Units are entities, designated by the Minister, responsible for communicating and coordinating between local community bodies and government agencies for the purposes of increased service delivery, culturally responsive care, and identification of fluctuating community needs.

Qualified mental health professionals are individuals who hold a recognised certification or accreditation in mental health practice and are qualified to provide mental health support, assessment, or treatment in accordance with relevant jurisdiction

Bonded scholarships are bursaries awarded on the condition that the recipient completes specified service for a period following completion of their studies.

Mental Health Literacy is the understanding and awareness of mental health, including the ability to recognise symptoms of mental distress, seek appropriate support, and engage in positive wellbeing practices.

Culturally and Contextually competent refers to the ability to recognise and respond appropriately to the cultural norms, values, nuances, and specific social contexts of a community.

Risk of harm Refers to the likelihood that an individual may intentionally or unintentionally cause physical or psychological harm to themselves or others, often identified through unusual passive behaviour, and suicidal ideation.

Continuous support refers to timely, consistent, and ongoing assistance that remains connected and responsive to a young person's needs, rather than being fragmented and/or delayed.

Note— The *Interpretation Act 1987* also contains definitions and other provisions that affect the interpretation of this Bill.

Part 2 Community Focused Approaches

Division 1 Allocation of Community Funding

5 Allocation of Community Funding

(1) The Minister must allocate up to 40% of the annual state mental health budget, subject to annual review, to local, community-led mental health services.

a. this may include partnerships with privately funded community-based mental health service providers

(2) Budget allocations must prioritise distribution to vulnerable and underserved populations, including—

a. rural and regional communities; and

b. Culturally and Racially Marginalised (CARM) communities; and

c. Aboriginal and Torres Strait Islander communities; and

d. areas with a proportionately high representation of LGBTQIA+ individuals and services

(3) In accordance with subsection 2a to 2d, funding should be determined using factors such as—

a. population size; and

b. geographic accessibility; and

c. known service gaps, identified through local data and community consultation; and

d. exemptions can be made by the Minister must ensure that budget allocation can be adjusted accordingly to provide appropriate support to populations with escalating concerns, such as natural disaster-affected areas

Division 2 Connecting Communities

6 Bridging Communities and Services

(1) There shall be a Community Wellbeing Liaison unit (CWLU) established in each Local Government Area (LGA) to act as intermediaries between the state and local communities.

a. the allocation and distribution of liaison units is subject to change as decided by the Minister for Mental Health

b. the allocation of liaison units must prioritise populations as outlined in Subsection 2a to 2d

(2) Liaison units shall be decided on factors including but not limited to—

a. trained professionals; and

b. people with lived experience; and

c. Culturally and Linguistically Diverse; and

d. Aboriginal and Torres Strait Islander heritage

(3) Liaison units must be culturally and contextually competent to communicate with and respond to community needs.

a. as such, appointees may be subject to a capability assessment and required background search

7 Role of Liaison Units

(1) The liaison unit shall hold quarterly case coordination meetings with schools, health care providers, police, housing services, and community leaders.

(2) The liaison unit must conduct biannual community forums to identify service gaps and gather live experience feedback.

a. further feedback mechanisms include—

i. drop-in sessions; and

ii. pop-up clinics; and

iii. youth groups; and

iv. school visits; and

v. surveys

b. liaison units shall translate Individualised community needs to state-funded frameworks, the Local government, and the state representative as required

8 Coordinated Action

(1) Each Liaison unit shall be funded by the state to develop and deliver a minimum of two community-based events to promote positive wellbeing, including but not limited to—

a. training sessions; and

b. peer groups; and

c. youth events

(2) Local service providers and community groups shall be partners in event coordination.

(3) Events must appropriately reflect the cultural and Individual mental health needs of the community population

(4) At least one event annually must target youth engagement, marginalised groups or priority populations as identified by the local health district and community needs

9 Accountability

(1) Each liaison unit must submit an annual 'wellbeing action report' to the Minister for Mental Health.

a. the report shall detail anonymous Individualised cases, community Integration, identified community needs, and feedback and evaluation from appropriate parties

b. the report shall focus on documenting qualitative assessments of experiences and only include quantitative data where relevant for explanation

Division 3 Justice System and Service Gaps with Vulnerable Groups

10 Mentorship Program

(1) The Minister for Youth Justice, in consultation with the Minister for Mental Health, shall establish and support mentorship programs within correctional and post-release contexts.

a. this shall be supervised and administered by the NSW Youth Justice Community Offices

(2) Any youth who is or has been previously detained, in the past 18 months, and faces increased vulnerability to mental health illness, may be assigned an adult mentor to—

a. provide opportunities and pathways for personal development; and

b. assist the young person in navigating the youth justice system; and

c. facilitate the young person’s active participation in the community

(3) A mentor must—

a. demonstrate prior training or understanding of relevant cultural, community, and contextual sensitivities; or

i. share lived experience, language, or cultural/community ties with the mentees

b. where this requirement is not initially met, mentors shall receive appropriate cultural competency training prior to commencing mentorship

c. mentor performance and cultural appropriateness shall be evaluated biannually through structured feedback from mentees and may inform continued placement or retraining

(4) Mentors allocated within the program must—

a. hold a valid Working with Children's Check

b. have completed a trauma-informed care training prior to allocation

(5) Where a mentor is allocated during a period of youth detention—

a. the mentor must engage in weekly contact with the youth through any available means; and

b. face-to-face contact must occur no less than once every two weeks; and

i. unless prevented by location or risk, in which case, digital communication shall be used

ii. meetings may be postponed in communication with the NSW Youth Justice Community Offices

c. mentors must provide resources for youth to seek alternative mental health support

d. detention-based mentors must aim to reduce stigma, support identity growth, and normalise wellbeing checks

(6) Where a mentor is allocated to a youth post-detention—

a. mentors must check in with their youth's well-being; and

b. mentors must facilitate and aid with the youth's community engagement; and

c. mentors must provide resources for alternative support services if the youth's mental health requires it; and

d. mentors should promote positive well-being practices for assigned youth through community-led forms of support

(7) All mentors, regardless of the timing of their assignment, shall provide continuous support to youth throughout their engagement with the Youth Justice System, including support during custodial care, community engagement, and reintegration.

11 Mandate of Youth Officer Mental Health Refresher Course

(1) The Minister, in consultation with the Minister for Youth Justice, shall mandate a Mental Health Awareness refresher course for all NSW Youth Officers.

a. refresher courses must be completed no less than every 18 months

b. failure to attend or achieve satisfactory results in the Mental Health Awareness refresher course will render the Youth Officer subject to an employment review

(2) In conjunction with Subsection 1, the Ministers must ensure courses are extensive and encompass a variety of Mental Health frameworks.

(3) The Mental Health awareness program shall be developed with engagement from various youth advisory bodies, young people and mental health professionals.

(4) The course may only be subject to modification to reflect the specific characteristics relevant to the facility and community.

(5) The mental health awareness refresher course shall:

a. maintain and reinforce a positive mental health culture within detention centres; and

b. support the ongoing implementation of rehabilitation-focused practices; and

c. facilitate the preparation of youth for reintegration into the community following release

Part 3 Mental Health in Education

Division 1 Provision of Mental Health Professionals

12 Allocation of Mental Health Professionals

(1) All public schools in New South Wales shall be required to provide access to qualified mental health professionals, including but not limited to—

a. school counsellors; and

b. psychologists; and

c. any other qualified mental health professionals as prescribed by regulation

(2) There shall be a minimum staffing ratio of 1 qualified mental health professional per 250 students.

13 Requirements of Distribution

(1) The Department of Education shall provide sufficient funding to enable compliance with this provision, including recruitment incentives and salary support in cooperation with Division 3.

(2) The Minister for Education and the Minister for Mental Health may determine the starting date of the division unless the supply of Mental Health Professionals meets the required ratio.

(3) If, in any year, there is an insufficient number of qualified mental health professionals available to meet the minimum staffing ratio, the Minister may, after consultation regarding staff availability, prescribe a revised minimum staffing ratio for that year by regulation

Division 2 Curriculum Reform

14 Curriculum Changes

(1) Mental health education shall be a mandatory part within—

a. the Personal Development, Health and Physical Education (PDHPE) curriculum; and

b. relevant cross-curricular areas as prescribed by the New South Wales Education Standards Authority (NESA)

(2) The Department of Education and NESA shall integrate mental health education as a compulsory component of the K–12 curriculum across all public and registered non-government schools in New South Wales. The mental health education component must—

a. be age-appropriate content aligned to child development; and

b. be created in consultation with mental health organisations in Australia; and

c. Include wellbeing education and mental health destigmatisation

(3) The 7–12 Curriculum and NESA syllabuses shall be revised to integrate—

a. mental health-related literature and content within the English syllabus; and

b. mental health-related content within the geography syllabus; and

c. other relevant learning areas as determined by NESA; and

d. mental health literacy; and

e. emotional well-being education; and

f. self-regulation and resilience skills

15 Curriculum Implementation

(1) NESA and the Department of Education must begin implementation of the 7-12 curriculum reform by 2027, and the beginning of the K–12 curriculum reform by 2029, with full integration across K–12 by 2031.

Division 3 Workforce Development and University Partnerships

16 Establishment

(1) The Minister for Education and the Minister for Mental Health shall establish programs of funding for universities and tertiary education institutions intended for the expansion of mental health education qualifications, including—

a. school counselling qualifications; and

b. school psychology qualifications; and

c. other relevant mental health education qualifications as prescribed by regulation

17 Requirements

(2) The Minister for Education and the Minister for Mental Health shall establish programs of funding for universities and tertiary education institutions intended for the expansion of mental health education qualifications, including—

a. school counselling qualifications; and

b. school psychology qualifications; and

c. other relevant mental health education qualifications as prescribed by regulation

Part 4 Destigmatising Mental Health

Division 1 Mental Health as a Spectrum

18 Establishment

(1) There shall be an establishment of a Mental health structure—

a. the structure shall formally be known as the Mental Health Risk Identification Scale (MHRIS), and—

i. the structure shall exist as a spectrum; and

ii. individuals shall be able to self-identify and be identified by others upon this spectrum

(2) The MHRIS is intended to provide a common and consistent method of identifying where individuals sit upon a spectrum of mental health and wellbeing, to enable—

a. early identification of emerging or existing mental health risks; and

b. the provision of timely and appropriate supports and interventions; and

c. the adoption of a shared language and understanding of mental health across sectors, including but not limited to schools, workplaces, hospitals, correctional services and community organisations; and

d. the proactive management of mental health risks, reducing reliance on reactive responses to crises

19 Requirements

(1) The Mental Health Risk Identification Scale shall be divided into 6 subcategories, which will act as specific indicators, these are—

a) risk of harm to self or others; and

b) energy levels and mood regulation; and

c) social engagement and interpersonal functioning; and

d) cognitive and emotional self-regulation; and

e) functional capacity and daily task completion; and

f) other relevant criteria prescribed by regulation

2) These subcategories are to be considered on an individualistic basis, such that the behaviour of an individual identifying within one subcategory may not reflect the identification of an individual with similar behaviours—

a) however, consideration of similar behaviours may be used to support diagnoses and wellbeing supports

3) The specific details of each subcategory are to be determined by the minister after community consultations and parliamentary input—

a) this definition should be updated no less than every three years

20 Integration

(2) The MHRIS shall be integrated, where relevant, into the operation of—

a. schools and educational institutions; and

b. Community Wellbeing Liaison Units; and

c. youth justice and other justice-related mentorship and support programs; and

d. service planning and funding decisions by relevant government and non-government bodies

Division 2 Establishment of Public Exposure Campaign

21 Establishment

(1) There shall be, by an act of the Minister, a series of public campaigns for the purpose of educating individuals in NSW about Mental Health and Wellbeing.

(2) This campaign shall comprise advertisements featuring on televisions, digital platforms, public spaces, and other spaces at the discretion of the Minister for Mental Health.

22 Requirements

(1) The campaigns shall include—

a. accurate representations of diverse experiences regarding mental health, diverse experiences including—

i. individuals within the prison and correctional system, including persons currently incarcerated and those transitioning into the community; and

ii. individuals living in rural and regional areas of New South Wales; and

iii. culturally and linguistically diverse (CALD) communities; and

iv. LGBTQIA+ communities; and

v. Aboriginal and Torres Strait Islander communities.

b. instructions on how to access support; and

c. recognition of individual well-being; and

d. means to boost wellbeing; and

e. destigmatisation education

(2) The campaigns must include targeted messaging, culturally appropriate materials, and community engagement strategies to ensure effective reach and relevance to the communities listed in subsection 1a.

(3) The campaign will be enforced by NSW Health in collaboration with the Department of Education, Department of Communities and Justice and Aboriginal Affairs NSW.

(4) The campaign must be created in consultation with all communities represented.

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