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Australian Mental Health Access Report 2026



Australian Mental Health Access Report 2026
National trends in access, demand, workforce capacity and service gaps
Prepared by Therapy Near Me
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Citation and methodology notice

The Access Index and Top 20 Mental Health Access Hotspots are original composite models, not official government rankings.

KeyStatistics at a Glance

Evidence to inform policy, planning and investment decisions.

1 in 5 POPULATION NEED

Australians aged 16-85 experienced a 12-month mental disorder.

2.8M SERVICE USE

Australians received Medicare-subsidised mental health services in 2024-25.

13M VOLUME

Medicare Mental Health Services delivered nationally in 2024-25.

\$14.5B INVESTMENT

Government expenditure on mental health-related services in 2023-24.

21% TELEHEALTH

Medicare mental health services processed via telehealth in late 2025.

Top 20 HOTSPOTS

Regions identified as mental health access hotspots for policy prioritisation.

Citation-friendly summary

Australia is experiencing high mental health demand, uneven access and persistent workforce constraints. Regional and remote access, child and adolescent care, NDIS-related demand and telehealth are central issues for service planning.

Executive Summary

Australia is experiencing sustained demand for mental health support across Medicare-funded care, private practice, community services, telehealth, schools, workplaces and disability-related supports. National prevalence data, Medicare service use, workforce evidence and regional access data indicate that demand is high, access is uneven and workforce availability is a central constraint.

 Rising demand Around one in five Australians aged 16-85 experienced a 12-month mental disorder.	 High service use About 2.8 million Australians received Medicare-subsidised mental health services in 2024-25.
 Workforce pressure Workforce shortages and maldistribution remain core structural barriers.	 Regional inequality Regional and remote communities face compounding access barriers.
 Youth pressure Child and adolescent mental health demand remains a national pressure point.	 NDIS impact NDIS-related demand is reshaping psychosocial and disability support access.

Policy summary: The report supports investment in workforce supply, regional access models, telehealth infrastructure, early intervention, PHN-led planning and transparent data reporting.

Priority Actions

1. Workforce Expand regional workforce incentives, supervision funding and training pathways.	2. Regional Access Strengthen local service hubs, outreach, PHN commissioning and Aboriginal-led services.
3. Children and Adolescents Build dedicated pathways for developmental assessment, school-linked support and family support.	4. Data Transparency Improve reporting on wait times, provider availability, out-of-pocket costs and regional gaps.

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Responsible Use of Rankings

The Mental Health Access Index is an original composite benchmarking model. The Top 20 Mental Health Access Hotspots are an original prioritisation framework. They are not official government rankings and should be interpreted as policy-planning tools requiring local validation.

Universities, PHNs, peak bodies, service providers and policymakers may cite this report, request methodology clarification, or propose data collaboration through Therapy Near Me.

The strongest use of the report is to pair the national findings with local workforce, wait-time, provider-availability and service-utilisation data.

Mental Health Access Index 2026

Original composite benchmarking model - not an official government ranking.



Responsible use of rankings

Scores are designed to support policy discussion and service planning. They should be interpreted alongside local workforce, wait-time and service-utilisation data.

Top 20 Mental Health Access Hotspots

National priority regions identified for workforce, service and access planning.

Access-risk priority regions



- | | |
|-------------------------------|-----------------------------------|
| 1 Remote Northern Territory | 11 Murrumbidgee NSW |
| 2 Central Australia | 12 Western NSW |
| 3 Kimberley, WA | 13 Gippsland VIC |
| 4 Pilbara, WA | 14 North West Tasmania |
| 5 Far West NSW | 15 Wide Bay QLD |
| 6 Cape York and Torres Strait | 16 Murraylands and River |
| 7 Country South Australia | 17 Goldfields WA |
| 8 North West Queensland | 18 Barkly Region NT |
| 9 Far North Queensland | 19 Burnie and West Coast Tasmania |
| 10 Northern Rivers NSW | 20 Darling Downs and Sou West QLD |

Methodology caution

The Hotspots framework is an original prioritisation model and should be validated with local data before operational decisions.

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Chapter 1: The State of Mental Health Access in Australia

Australia's mental health access challenge is now a mainstream population health, workforce and service-planning issue.

1. Executive Summary

Australia is experiencing sustained and structurally significant demand for mental health support. Mental ill-health is no longer a marginal health issue; it is a mainstream population health, workforce, disability, education, and productivity issue.

Around one in five Australians aged 16–85 experienced a mental disorder within the previous 12 months, with anxiety disorders representing the most common category. Young people are particularly affected, with substantially higher rates of recent mental disorders among Australians aged 16–24 compared with the broader adult population.

At the same time, service utilisation has increased across Medicare-funded mental health care, prescription medications, community services, and disability-related psychosocial supports. In 2024–25, approximately 2.8 million Australians received Medicare-subsidised mental health services, accounting for around 13 million services delivered nationally. Government expenditure on mental health-related services has also continued to rise, reaching approximately \$14.5 billion in 2023–24 across major government-funded mental health programs and service categories.

The demand profile is broad and increasingly complex. Australians seek support for anxiety, depression, trauma, relationship difficulties, workplace stress, neurodevelopmental concerns, child and adolescent mental health issues, psychosocial disability, and complex co-occurring conditions. While the post-COVID period has accelerated demand for flexible models of care, particularly telehealth, it has also highlighted persistent system constraints, including workforce shortages, affordability barriers, regional inequity, long wait times, and fragmentation across primary care, specialist mental health services, schools, disability services, and crisis support systems.

The central access challenge is not simply that more Australians require support. Rather, demand has diversified more rapidly than the service system has evolved. Many people require timely, moderate-intensity care before symptoms escalate, while others need ongoing multidisciplinary support over extended periods. A sustainable national mental health access strategy therefore requires more than short-term funding responses. It requires a stepped, distributed, and data-informed model that combines early intervention, telehealth, regional workforce development, improved referral pathways, culturally safe care, and stronger integration between Medicare, Primary Health Networks (PHNs), state and territory health systems, and the National Disability Insurance Scheme (NDIS).

2. Current State

Mental health access in Australia is defined by two simultaneous realities. First, Australia has a comparatively well-developed mental health service system, including Medicare-subsidised psychological therapy, state-funded specialist services, PHN-commissioned programs, digital and telephone supports, private psychology and counselling services, and NDIS supports for people with significant psychosocial disability. Second, many Australians continue to experience difficulty accessing the right care at the right time.

The available evidence highlights the scale of the challenge. The National Study of Mental Health and Wellbeing found that approximately 4.3 million Australians aged 16–85 experienced a mental disorder within a 12-month period. Anxiety disorders were the most prevalent, followed by affective disorders such as depression and substance use disorders. This demonstrates that demand is not limited to acute psychiatric presentations. A significant proportion of the national mental health burden is associated with common mental health conditions that are often managed through primary care, allied health, counselling, digital services, school-based supports, and community programs.

Service utilisation data also show that mental health care is now a high-volume component of the Australian health system. Medicare-funded mental health services reached approximately 13 million services in 2024–25, delivered to around 2.8 million Australians. While this reflects a substantial service platform, it also highlights a significant treatment gap. If approximately 4.3 million adults experienced a recent mental disorder and only a portion accessed Medicare-funded mental health care, many Australians may be receiving no formal support, relying on alternative service pathways, using informal supports, or seeking help only after symptoms have escalated.

Access to services also remains uneven across the country. Metropolitan areas generally have a higher concentration of psychologists, psychiatrists, counsellors, general practitioners, allied health professionals, and private providers. In contrast, regional and remote communities face workforce shortages, transport barriers, limited specialist options, longer travel times, and reduced choice of practitioners. While telehealth has reduced some geographic barriers, it has not removed the need for local, culturally appropriate, and face-to-face care. These challenges highlight that access is not solely a question of service availability. It is also influenced by workforce distribution, affordability, geographic location, cultural suitability, and the ability of individuals to navigate a complex and fragmented system.

Affordability remains a significant barrier to mental health access. While Medicare rebates help reduce the cost of psychological therapy, they do not necessarily eliminate out-of-pocket expenses. Private consultation fees, gap payments, limits on subsidised sessions, and broader cost-of-living pressures can all influence whether individuals commence therapy, continue treatment, or reduce the frequency of appointments.

Cost barriers are particularly relevant for people who fall between existing support systems. This includes individuals whose needs are not severe enough to qualify for state-funded specialist services, who are ineligible for NDIS psychosocial supports, yet who are unable to afford ongoing private care. As a result, many Australians face challenges accessing timely and appropriate support despite experiencing significant mental health needs.

The most important national access statistics are:

3. Key Statistics

- Approximately 21.5% of Australians aged 16–85, or around 4.3 million people, experienced a mental disorder within the previous 12 months.
- Anxiety disorders affected approximately 17.2% of Australians aged 16–85, making anxiety the most prevalent diagnostic category.
- Affective disorders, including depressive disorders, affected approximately 7.5% of Australians aged 16–85.
- Substance use disorders affected approximately 3.3% of Australians aged 16–85.
- Young people experience the highest rates of recent mental disorders, with almost two in five Australians aged 16–24 reporting symptoms within the previous 12 months.
- In 2024–25, approximately 2.8 million Australians received Medicare-subsidised mental health services.
- These Australians received approximately 13 million Medicare-funded mental health services during the year.
- Around one in five Australians were dispensed a mental health-related prescription medication in 2024–25.
- Government expenditure on mental health services reached approximately \$14.5 billion in 2023–24.
- Productivity Commission reporting indicates that mental health remains a major area of recurrent government expenditure, with investment continuing to increase over time.

These figures highlight a system operating under sustained pressure. Importantly, access challenges are not confined to a single funding stream or service type. Demand is distributed across GP Mental Health Treatment Plans, psychology, psychiatry, counselling, emergency departments, community mental health services, schools, workplaces, digital platforms, helplines, NDIS providers, and informal family support networks.

4. Emerging Trends

4.1 Anxiety as the Dominant Access Driver

Anxiety is the most common mental health condition in the Australian adult population. This has significant implications for service planning, as anxiety-related presentations are often well suited to early intervention, psychological therapy, digital programs, group-based interventions, and low-to-moderate intensity care. However, without timely support, anxiety can become highly disabling and may contribute to school refusal, workplace withdrawal, relationship difficulties, substance use, depression, and crisis presentations.

For service systems, rising anxiety-related demand requires scalable and accessible care pathways. A model that relies solely on high-intensity specialist services is unlikely to meet population needs. Effective access pathways should include early assessment, stepped care, brief interventions, psychological therapy, psychoeducation, relapse prevention, and clear escalation pathways when higher levels of care are required.

4.2 Depression and Affective Disorders Remain a High-Burden Category

Depression and other affective disorders remain a major driver of treatment demand across Australia. These presentations often require more sustained support than brief advice or short-term intervention. They are also frequently associated with anxiety, trauma, chronic pain, disability, loneliness, unemployment, relationship breakdown, and workplace stress.

Access planning should therefore account for complexity rather than treating common mental health conditions as simple or low-risk presentations. Many people who initially present with anxiety or low mood may ultimately require coordinated care involving general practitioners, psychologists, counsellors, psychiatrists, employment support services, family services, or social prescribing pathways.

A comprehensive mental health system must therefore support both early intervention and ongoing multidisciplinary care to effectively respond to the diverse needs of people experiencing depression and related conditions.

4.3 Trauma-Informed Care Is Becoming Mainstream

Demand for trauma-informed mental health support is becoming increasingly visible across mental health services, family violence programs, veteran support services, child protection systems, workplace injury schemes, road trauma recovery programs, refugee health services, youth services, and disability supports.

Trauma-related presentations extend beyond post-traumatic stress disorder (PTSD). They may present as emotional dysregulation, avoidance, panic, sleep disturbance, relationship difficulties, substance use, chronic pain, self-harm risk, anger, dissociation, and occupational impairment.

This trend is driving increased demand for trauma-informed intake, assessment, referral, and treatment pathways. It also presents workforce challenges, as not all mental health practitioners have specialised training or experience in trauma-focused approaches.

4.4 Relationship and Family Stress Are Major Pathways Into Care

Many Australians seek support not solely because of a diagnosed mental health condition, but as a result of relationship and family-related stressors. These may include separation, parenting conflict, family violence, loneliness, grief, blended family challenges, workplace conflict, or caring responsibilities.

These concerns often sit at the intersection of mental health, family support, social services, and legal systems. A narrow diagnostic approach may overlook these access needs.

Effective service design should therefore incorporate counselling, family-sensitive practice, parenting support, referral pathways to specialist family violence services where appropriate, and support options for individuals experiencing significant distress that may not fit neatly within a single diagnostic category.

4.5 Neurodiversity and Developmental Concerns Are Reshaping Demand

Demand related to autism, ADHD, learning differences, emotional regulation, school refusal, and executive functioning challenges has increased significantly across schools, families, psychology services, paediatrics, psychiatry, and NDIS-funded supports.

This demand affects children, adolescents, and adults. Adults seeking ADHD assessments or autism-informed therapy now represent a growing and increasingly visible component of the mental health access landscape.

As a result, pressure is increasing across assessment pathways and specialist workforces, including child psychologists, developmental paediatricians, psychiatrists, occupational therapists, speech pathologists, behaviour support practitioners, and educational settings.

The need for coordinated care is also increasing, as neurodevelopmental concerns frequently intersect with anxiety, depression, trauma, family stress, and educational disengagement.

4.6 Workplace Stress Is Now a Mainstream Mental Health Access Issue

Workplace stress, burnout, bullying, workplace injury, return-to-work challenges, and occupational trauma are increasingly common pathways into mental health care.

This demand is reflected across Employee Assistance Programs (EAPs), workers' compensation systems, general practice referrals, private psychology services, counselling providers, and employer-funded wellbeing programs.

The implication is that mental health access can no longer be viewed solely through the lens of the healthcare system. Employers, insurers, vocational rehabilitation providers, and workplace regulators now form an important part of the broader mental health access environment.

Earlier intervention and support may help reduce escalation into prolonged work absence, compensation disputes, and long-term disability.

4.7 Post-COVID Demand Has Not Returned to Pre-Pandemic Patterns

The COVID-19 pandemic altered mental health demand in several lasting ways.

First, it accelerated the adoption and acceptance of telehealth as a mainstream service delivery model.

Second, it normalised mental health conversations across workplaces, schools, and families, increasing awareness and willingness to seek support.

Third, it contributed to a backlog of unmet need, particularly among young people, families, individuals with pre-existing mental health conditions, and those affected by isolation, grief, housing pressures, or economic insecurity.

The post-pandemic environment should therefore be interpreted cautiously. Available evidence relating to service utilisation, workforce capacity, and youth mental health continues to indicate sustained access pressures rather than a simple return to pre-pandemic conditions.

These trends suggest that future service planning should focus not only on increasing capacity, but also on improving flexibility, accessibility, workforce sustainability, and integration across the broader mental health system.

5. Challenges

5.1 Treatment Gap

The prevalence of mental disorders remains larger than the population receiving formal mental health care. Some people recover without professional support, and not every person with symptoms requires therapy, but the gap still indicates a substantial access challenge.

5.2 Cost Barriers

Out-of-pocket costs remain a major barrier, particularly for people requiring more than a small number of sessions. Cost can delay care, reduce session frequency, or lead people to stop treatment before meaningful improvement.

5.3 Workforce Shortages

Workforce availability is one of the core access constraints. Even where funding exists, access depends on the availability of suitable practitioners. Shortages are especially acute in regional and remote areas, child and adolescent services, psychiatry, trauma-informed care, neurodevelopmental assessment, and culturally safe services.

5.4 Regional Inequity

Regional and remote communities experience compounding barriers, including fewer providers, longer travel distances, less choice, privacy concerns in small communities, limited specialist services, and greater dependence on telehealth. Telehealth improves access but cannot fully replace local service capacity.

5.5 Fragmentation

The Australian mental health system is spread across Commonwealth programs, state services, PHNs, private providers, schools, the NDIS, crisis services, community organisations, and digital platforms. People often struggle to know where to go, what they are eligible for, and how to move between levels of care.

5.6 Complexity of Presentations

Demand is not only increasing; it is becoming more complex. People often present with multiple overlapping issues, including anxiety, depression, trauma, neurodiversity, family stress, disability, substance use, chronic illness, housing insecurity, or workplace injury. Single-service responses are often insufficient.

6. Implications

The access challenge requires a system-wide response. Increasing the number of therapy sessions alone will not solve the problem if workforce supply, affordability, referral navigation, and regional distribution remain unresolved. Similarly, digital tools and telehealth can improve reach but cannot replace specialist care for complex, high-risk, or culturally specific needs.

The most important policy implication is that Australia needs a more deliberate stepped-care architecture. People with mild to moderate concerns should be able to access early, affordable, evidence-informed support before deterioration. People with complex needs should have access to multidisciplinary, sustained, and coordinated care. People in regional and remote areas should have both telehealth options and stronger local pathways.

For PHNs, the data support continued investment in local service mapping, low-intensity psychological services, youth mental health, referral navigation, and commissioned services that address local workforce gaps. For service providers, the access challenge supports investment in intake systems, triage, telehealth capability, culturally safe practice, outcome monitoring, and partnerships with GPs, schools, employers, and community organisations.

For policymakers, the trend is clear: mental health demand is now a permanent feature of national health planning. Short-term initiatives should be assessed against longer-term access outcomes, including affordability, workforce supply, equity, continuity of care, and regional distribution.

7. Recommendations

- Develop a national mental health access dashboard that tracks demand, wait times, workforce availability, service utilisation, and regional gaps across jurisdictions.
- Expand low-intensity and moderate-intensity care pathways so people can access support before symptoms escalate.
- Strengthen GP and PHN referral navigation processes to ensure people are directed to the most appropriate level of care as early as possible.

- Increase investment in regional and remote workforce models, including supervision, incentives, multidisciplinary hubs, and telehealth-supported local care.
- Improve affordability for people who require ongoing psychological therapy, particularly those with complex but non-acute conditions.
- Expand child and adolescent mental health pathways, including school-linked support, family support, neurodevelopmental assessment pathways, and early intervention services.
- Build trauma-informed capability across mainstream mental health services, not only specialist trauma services.
- Improve integration between Medicare-funded mental health care, state specialist services, NDIS psychosocial supports, schools, workplaces, and community services.
- Support transparent public reporting on access gaps, including underserved regions and population groups.
- Treat telehealth as a permanent access pillar while maintaining investment in face-to-face care for people who need it.

8. Key Takeaways

- Mental health demand in Australia is high, sustained, and structurally embedded.
- Anxiety is the largest diagnostic category and should remain a central focus of early intervention planning.
- Young people experience particularly high rates of recent mental disorders.
- Medicare-funded mental health service utilisation is substantial, but formal access does not fully match the scale of population need.
- Cost barriers, workforce shortages, regional inequity, and system fragmentation remain significant challenges.
- Post-COVID demand has not simply returned to pre-pandemic patterns.
- Future access models must be stepped, flexible, affordable, regionally responsive, and better integrated.
- The central policy challenge is no longer solely increasing awareness. It is building timely, navigable, and sustainable access to appropriate care.

Chapter 2: Telehealth and the Transformation of Mental Health Access

Telehealth is now permanent access infrastructure, but it must complement local service capacity rather than replace it.

1. Executive Summary

Telehealth has become one of the most significant structural changes to Australia's mental health system in the past decade. While digital mental health services existed before COVID-19, the pandemic accelerated the adoption of telehealth from a supplementary service model to a mainstream component of mental health care delivery.

Prior to 2020, access to psychological and psychiatric care was heavily influenced by geography.

Australians living in regional, rural, and remote communities often faced substantial barriers, including workforce shortages, travel distances, limited provider choice, and long wait times. The rapid introduction of Medicare-funded telehealth services during the COVID-19 pandemic fundamentally altered this access landscape.

By 2025, telehealth had become a permanent feature of Australia's healthcare system, with many Medicare telehealth items made ongoing and integrated into routine care. AIHW monitoring data indicate that approximately 21% of Medicare mental health services processed during late 2025 were delivered via telehealth, demonstrating that virtual care remains a substantial component of mental health service delivery even after the acute pandemic period.

Telehealth has improved access, increased flexibility, reduced travel burdens, supported continuity of care, and partially mitigated workforce distribution challenges. It has been particularly important for Australians living outside metropolitan areas, individuals with mobility limitations, carers, people with anxiety-related barriers to attendance, and those seeking greater privacy when accessing mental health support.

However, telehealth is not a complete solution to Australia's mental health access challenges. Digital exclusion, workforce shortages, internet connectivity limitations, clinical suitability concerns, and the continued need for face-to-face services mean telehealth should be viewed as a complementary access pathway rather than a replacement for in-person care.

The evidence suggests that telehealth has transitioned from an emergency response measure into a permanent access infrastructure. Future mental health planning should therefore focus on optimising hybrid models of care that combine telehealth and face-to-face services according to clinical need, consumer preference, and geographic context.

2. Current State

National Telehealth Trends

Historical Growth

Pre-COVID Access

Before 2020, telehealth within Australian mental health care was relatively limited. While some rural outreach programs, videoconferencing initiatives, and digital mental health services existed, the majority of psychological and psychiatric treatment occurred face-to-face.

The use of telehealth was often restricted by funding arrangements, technological limitations, and clinician familiarity. Access was generally concentrated within specialist programs rather than routine community-based mental health care.

As a result, many Australians living in regional and remote communities continued to experience significant barriers to accessing timely psychological support.

COVID-19 Expansion

The COVID-19 pandemic marked a watershed moment in Australian healthcare delivery.

In March 2020, the Australian Government rapidly introduced a broad range of Medicare-subsidised telehealth items, including mental health consultations delivered by telephone and videoconference. These measures enabled continuity of care during lockdowns and public health restrictions while simultaneously expanding access for populations previously underserved by traditional service models.

The uptake was immediate and substantial.

Across allied health services, telehealth represented approximately one quarter of Medicare-funded activity during the peak pandemic period in 2020. Telehealth utilisation increased faster than many anticipated.

Many policymakers and providers had not anticipated the scale of this shift prior to the pandemic. Mental health services were particularly suited to this transition because many evidence-based interventions rely primarily on conversation, assessment, psychoeducation, and therapeutic engagement rather than physical examination.

Post-Pandemic Utilisation

While telehealth utilisation declined from its pandemic peak, it did not return to pre-pandemic levels.

By 2025, approximately 21% of Medicare mental health services continued to be delivered via telehealth, indicating that consumers and providers have integrated virtual care into routine practice.

This pattern suggests that telehealth has become a permanent feature of Australia's mental health system rather than a temporary pandemic adaptation.

The persistence of telehealth utilisation reflects enduring demand for flexible, accessible, and geographically unconstrained mental health care.

Why Australians Choose Telehealth

Convenience

Convenience remains one of the strongest drivers of telehealth utilisation.

Consumers can attend appointments from home, work, or other locations without the need for commuting, parking costs, or additional travel time. This can reduce disruption to employment, education, and caregiving responsibilities.

For many Australians, particularly working adults, telehealth enables access to care that might otherwise be postponed or abandoned.

Rural Access

Geography remains one of Australia's most significant determinants of health access.

Australians living in regional, rural, and remote communities experience poorer access to health services compared with those living in metropolitan areas. Workforce shortages and service scarcity continue to affect many communities.

Telehealth enables individuals to access psychologists, psychiatrists, and other mental health professionals regardless of local workforce availability.

This has substantially expanded provider choice in regions where consumers may previously have had access to only one local practitioner, or none at all.

Reduced Travel Burden

Travel remains a major barrier in many regional areas.

Long-distance travel may involve significant financial costs, lost work hours, accommodation requirements, and family disruption.

Telehealth eliminates many of these barriers while preserving access to professional support.

Reduced Stigma

Mental health stigma remains a barrier to help-seeking for some Australians.

Telehealth can offer a greater sense of privacy and anonymity than attending a local clinic, particularly within small communities where social visibility is higher.

This may encourage earlier help-seeking and improve engagement among individuals who would otherwise avoid care.

Workforce Shortages

Many Australians access telehealth because suitable local providers are unavailable. This issue is particularly evident in:

Child and Adolescent Psychology

Trauma-focused treatment

Neurodevelopmental Assessment

Psychiatry

Behaviour Support Culturally Specific Services

Telehealth broadens access to specialist expertise regardless of geographic location.^{2,24,25}

3. Key Statistics

Key indicators demonstrate the growing importance of telehealth within Australia's mental health system:

- Approximately 21% of Medicare mental health services processed during late 2025 were delivered through telehealth.
- Medicare mental health services peaked at almost 14 million services during 2020–21 before stabilising at approximately 13 million services in 2024–25.
- Telehealth represented approximately 25% of Medicare-funded allied health activity during the height of the pandemic.
- Telehealth remained approximately 10% of allied health activity by late 2024 despite the removal of pandemic restrictions.
- Around 28% of Australians live outside major metropolitan centres, where access barriers are generally greater.
- AIHW data consistently show poorer healthcare access among Australians living in regional and remote areas.

These statistics indicate that telehealth is now embedded within the national mental health service system.

4. Emerging Trends

Hybrid Models of Care

A significant trend emerging across the sector is the adoption of hybrid service models.

Consumers increasingly combine telehealth and face-to-face appointments depending on clinical needs, location, life circumstances, and treatment stage.

Hybrid care allows flexibility while maintaining opportunities for in-person assessment when required.

Expansion of Digital Mental Health Ecosystems Telehealth is

increasingly being integrated with:

Online assessment tools

Digital cognitive behavioural therapy

Mental Health Apps

Online psychoeducation

- Electronic prescribing
- Virtual care coordination

The Australian Government continues to invest in digital mental health services as a complement to traditional care pathways.

Increased Acceptance Among Clinicians

Many clinicians who adopted telehealth during the COVID-19 pandemic have continued to incorporate it into routine practice.

The transition has shifted telehealth from a niche service model to a standard component of professional practice.^{2,24,25,4}

Expansion into Underserved Populations

Telehealth is increasingly supporting:

- Rural communities
- Older Australians
- Carers
- People with disabilities
- FIFO workers
- Students
- Parents of young children

This expansion reflects the broader accessibility benefits of virtual care.

5. Challenges

Digital Exclusion

Not all Australians have equal access to technology.

Digital Access Barriers

Barriers include:

- Internet connectivity
- Device availability
- Digital literacy
- Affordability of technology

These issues disproportionately affect older Australians, lower-income households, and some remote communities.^{5,20}

Clinical Limitations

Telehealth is not suitable for every situation.

Some consumers require:

- Face-to-face assessment
- Physical observation
- Multidisciplinary intervention
- Crisis support
- Environmental assessment

Certain clinical presentations may benefit more from in-person engagement.

Workforce Constraints Remain

Telehealth improves access to existing clinicians but does not create new workforce capacity.^{2,24,25,4}

Where workforce shortages are severe, telehealth may redistribute services rather than increase overall supply.^{2,24,25,4}

Connectivity Challenges

Reliable internet access remains inconsistent across parts of regional and remote Australia.^{5,20}

Connectivity issues can reduce appointment quality and disrupt therapeutic engagement.

Risk of Reduced Local Capacity

Some experts have raised concerns that telehealth expansion could unintentionally weaken incentives to develop local services if policymakers view telehealth as a complete substitute for community-based infrastructure.^{2,24,25}

6. Implications

The rise of telehealth represents a significant shift in how mental health care can be delivered across Australia.^{2,24,25}

Its greatest contribution may be reducing the influence of geography on access to care.

However, telehealth should not be viewed solely as a technological innovation. It represents a structural access reform capable of supporting more equitable service distribution.^{2,24,25}

For policymakers, telehealth provides an opportunity to address longstanding geographic inequities while improving system efficiency.^{2,24,25}

For providers, telehealth expands recruitment possibilities and enables national service delivery models.^{2,24,25}

For consumers, telehealth increases choice, flexibility, and convenience.

The challenge moving forward is ensuring telehealth complements rather than replaces investment in local workforce development and community-based services.^{2,24,25,4}

7. Recommendations

- Maintain permanent Medicare support for evidence-based mental health telehealth services.^{2,10,24,25}
- Expand broadband and digital infrastructure in regional and remote communities.
- Support hybrid care models that combine telehealth and face-to-face treatment.
- Develop national clinical guidelines regarding telehealth suitability across different presentations.^{2,24,25}
- Increase digital literacy initiatives for vulnerable populations.
- Improve telehealth access for culturally diverse and Aboriginal and Torres Strait Islander communities.^{2,24,25,32}
- Integrate telehealth into workforce planning strategies.
- Expand research into long-term outcomes of telehealth-delivered mental health interventions.^{2,24,25}
- Monitor regional access outcomes to ensure telehealth complements local service capacity.^{2,24,25,5}
- Establish national benchmarks for telehealth quality and consumer experience.

8. Key Takeaways

- Telehealth has become a permanent component of Australia's mental health system.^{2,24,25}
- COVID-19 accelerated a transformation that is likely to persist indefinitely.
- Approximately one in five Medicare mental health services are now delivered via telehealth.^{2,10,24,25}
- Telehealth has significantly improved access for regional, rural, and remote Australians.^{2,24,25,5}
- Convenience, flexibility, and provider availability remain major drivers of utilisation.
- Telehealth reduces but does not eliminate workforce shortages.
- Hybrid care models are likely to become the dominant service delivery model.
- Digital exclusion remains a significant equity challenge.
- Telehealth should complement rather than replace local mental health infrastructure.^{2,24,25}
- Future mental health planning should treat telehealth as essential national access infrastructure.^{2,24,25}

Chapter 3: Australia's Mental Health Workforce Challenge

Workforce availability and distribution are central structural barriers to improving mental health access.

1. Executive Summary

Australia's mental health system is facing a workforce challenge that has become one of the most significant barriers to improving access to care. While public awareness of mental health has increased substantially over the past decade and demand for services continues to grow, workforce supply has not expanded at a pace sufficient to meet population need.^{4,11}

The result is a growing mismatch between demand and capacity. Australians are seeking support in greater numbers for anxiety, depression, trauma, neurodevelopmental conditions, workplace stress, psychosocial disability, and complex comorbid presentations. At the same time, many providers report increasing difficulties recruiting psychologists, psychiatrists, social workers, counsellors, behaviour support practitioners, and other mental health professionals.^{4,11,13,15}

Workforce shortages are not distributed evenly. Metropolitan areas generally have greater access to practitioners, while regional, rural, and remote communities continue to experience substantial workforce deficits. Some communities have limited access to psychologists and psychiatrists, while others rely heavily on telehealth because local services are unavailable.^{2,24,25,4}

The workforce challenge extends beyond simple practitioner numbers. Recruitment difficulties, workforce ageing, burnout, administrative burden, supervision bottlenecks, placement shortages, training pipeline constraints, and uneven geographic distribution all contribute to workforce capacity limitations.^{4,11}

Without targeted intervention, workforce shortages are likely to remain a defining feature of Australia's mental health landscape throughout the remainder of the decade. Addressing this challenge will require coordinated action across education, workforce planning, funding, regulation, digital health, regional development, and service delivery systems.^{4,11,5,20}

2. Current State

Current Workforce Landscape

Australia's mental health workforce is multidisciplinary and includes psychologists, psychiatrists, counsellors, social workers, occupational therapists, mental health nurses, behaviour support practitioners, peer workers, and other allied health professionals.^{4,11,13,17}

Recent workforce growth has occurred across several professions; however, demand has increased simultaneously. The result is that many consumers, employers, and health services continue to report difficulty accessing appropriately qualified practitioners.^{4,11}

Workforce challenges are particularly evident in:

- Child and adolescent mental health
- Regional and remote communities
- Psychiatry
- Neurodevelopmental assessment
- Trauma-focused care
- Psychosocial disability supports
- Behaviour support services
- Complex mental health presentations

The workforce challenge therefore reflects both insufficient numbers and the uneven distribution of specialist expertise.^{4,11}

Psychology Workforce

Psychologists form one of the largest and most visible components of Australia's mental health workforce.^{4,11}

According to the Australian Health Practitioner Regulation Agency (AHPRA), Australia had more than 45,000 registered psychologists by 2025, representing substantial growth compared with a decade earlier.^{4,11,12}

Despite this growth, workforce shortages remain widespread. Several factors contribute to this apparent contradiction:

Demand Growth Exceeds Workforce Growth

Mental health awareness has increased significantly.

Australians are increasingly seeking support for:

- Anxiety
- Depression
- Trauma
- Autism-related support
- ADHD-related support
- Workplace mental health concerns
- Relationship issues
- Parenting challenges

The volume of referrals entering the system has increased faster than workforce expansion in many regions.^{4,11}

Geographic Concentration

The psychology workforce remains heavily concentrated within metropolitan centres.^{4,11}

Major cities attract practitioners because of:

- Larger client populations
- Professional development opportunities
- Supervision availability
- Career progression
- Higher incomes
- Reduced professional isolation

This leaves many regional communities underserved.

Capacity Constraints

Not all registered psychologists provide full-time clinical services.

Workforce availability is affected by:

- Part-time work
- Research positions
- Academic roles
- Administrative positions
- Career breaks
- Burnout-related workload reductions
-

Consequently, practitioner headcount does not necessarily translate directly into service capacity.^{4,11}

Psychiatry Workforce

Psychiatry remains one of the most constrained areas of Australia's mental health workforce.^{4,11}

Australia has approximately 4,000–4,500 practising psychiatrists, with substantial variation in availability across regions.^{4,11,13}

Psychiatry shortages create downstream effects across the broader mental health system because psychiatrists are often required for:^{4,11,13}

- Forensic assessment
- Diagnostic clarification
- Complex presentations
- Medication management
- Neurodevelopmental assessment

Psychiatrist shortages are particularly evident in:

- Child and adolescent psychiatry
- Regional Australia
- Public mental health services
- Neurodevelopmental assessment pathways

Long waiting times for psychiatric assessment have become increasingly common across multiple jurisdictions.

Counselling Workforce

Counsellors play an increasingly important role within Australia's mental health ecosystem. Professional bodies such as PACFA and ACA collectively represent a substantial counselling and psychotherapy workforce nationally, although these data are not directly comparable with AHPRA-regulated professions.³¹

Counsellors provide support for:

- Anxiety
- Depression
- Relationship concerns
- Trauma
- Grief and loss
- Workplace stress
- Parenting issues

The counselling workforce often provides an important access pathway for Australians who may not require highly specialised clinical intervention.^{4,11}

However, workforce planning for counselling remains less developed than for regulated health professions, creating challenges in workforce measurement and forecasting.^{4,11}

Social Work Workforce

Mental health social workers play a critical role across:

- Hospitals
- Community services
- Primary care
- Child protection
- Disability services
- Housing services
- Family support programs

The Australian Association of Social Workers has reported ongoing concerns regarding workforce shortages across health and community sectors.^{4,11}

Social workers are particularly important because they address social determinants of mental health, including:^{4,11}

- Acute risk management

- Housing insecurity
- Family violence
- Financial hardship
- Care coordination

As demand for integrated care models increases, mental health social workers are likely to become increasingly important.^{4,11}

Behaviour Support Workforce

The behaviour support workforce has expanded rapidly following growth in the National Disability Insurance Scheme (NDIS).^{4,11,15,16}

Demand continues to increase for practitioners supporting:

- Autism
- Intellectual disability
- Psychosocial disability
- Complex behavioural presentations

The NDIS Quality and Safeguards Commission has repeatedly highlighted workforce development as a priority area.^{4,11,15,16}

Challenges include:

- Rapid demand growth
- Workforce training requirements
- Supervision capacity
- High administrative workloads

Many providers report difficulty recruiting experienced behaviour support practitioners, particularly outside major cities.^{4,11,5,20}

3. Key Statistics

Key Workforce Indicators Include:

- More than 50,000 registered psychologists nationally, noting that registration headcount does not equal full-time clinical capacity.¹²
- Approximately 4,000–4,500 practising psychiatrists.
- Significant concentration of practitioners within metropolitan areas.
- Regional communities consistently experience lower practitioner-to-population ratios.^{4,11,5,20}
- Mental health-related occupations remain among Australia's most difficult health positions to recruit.
- Jobs and Skills Australia projections indicate continued growth in demand for mental health professions throughout the decade.^{14,19,28}
- University psychology programs continue to attract strong enrolments, but supervision and postgraduate training pathways remain bottlenecks.
- Mental health occupations are consistently identified as priority professions within workforce shortage reporting.^{4,11}

These indicators suggest that workforce growth alone may not be sufficient to address future demand.^{4,11}

Regional Workforce Shortages

4. Emerging Trends

Increasing Demand Complexity

Mental health presentations are becoming increasingly complex.

Consumers frequently present with multiple overlapping concerns, including:

- Anxiety
- Depression
- Trauma
- ADHD
- Autism
- Chronic illness
- Workplace stress
- Psychosocial disability

Complexity increases service intensity requirements and reduces overall workforce capacity.^{4,11}

Growth of Telehealth Workforce Models

Telehealth is enabling practitioners to serve communities beyond their local geography.^{2,24,25,4}

This has partially reduced geographic barriers while creating new workforce distribution opportunities.^{4,11}

However, telehealth does not eliminate workforce shortages where absolute practitioner numbers remain insufficient.^{2,24,25,4}

Expansion of Multidisciplinary Care

Mental health care is increasingly delivered through multidisciplinary teams involving:

- Psychologists
- Counsellors
- Social workers
- Occupational therapists
- Behaviour support practitioners
- Peer workers
- Psychiatrists

This trend reflects recognition that many mental health needs extend beyond traditional clinical interventions.

Increased Focus on Early Intervention

Governments and service providers are increasingly prioritising early intervention.

This shift may reduce future demand for acute services but requires additional workforce investment in community-based care.^{4,11}

5. Challenges

Rural Workforce Shortages

Regional and remote communities continue to experience the most significant workforce deficits.^{4,11,5,20}

Recruitment difficulties are driven by:

- Professional isolation
- Limited supervision
- Housing shortages
- Smaller labour markets

These barriers make workforce attraction and retention difficult.

Recruitment Difficulties

Providers across Australia report difficulty recruiting:

- Psychologists
- Psychiatrists
- Behaviour support practitioners
- Child-focused practitioners
- Mental health social workers

Competition between public, private, and NDIS-funded sectors further intensifies recruitment challenges.^{15, 16}

Workforce Ageing

A significant proportion of experienced practitioners are approaching retirement age.^{4, 11}

Loss of senior clinicians may create supervision shortages and reduce workforce capacity.^{4, 11}

Burnout and Attrition

Mental health professionals face substantial occupational pressures.

Contributing factors include:

- High caseloads
- Administrative burden
- Emotional exhaustion
- Workforce shortages
- Reduced specialist support
- Complex presentations

Burnout contributes to reduced hours, career changes, and workforce attrition.

University Pipeline Constraints

Although student interest remains strong, workforce growth is constrained by:

- Limited postgraduate places
- Placement shortages
- Supervision requirements
- Registration pathway complexity

These bottlenecks restrict workforce expansion.

6. Implications

The workforce challenge represents the single largest structural barrier to improving mental health access in Australia.^{4, 11}

Many current access issues—including wait times, regional disparities, and service availability—ultimately reflect workforce limitations.^{4, 11, 5, 20}

Without workforce expansion:

- Additional funding may not translate into increased service access.
- Telehealth may redistribute shortages rather than solve them.
- Demand growth may continue to outpace service capacity.

Effective workforce planning must therefore be viewed as central to national mental health policy.^{4, 11}

7. Recommendations

National Workforce Strategy

Develop a coordinated national mental health workforce strategy integrating education, regulation, workforce planning, and regional development.^{4,11,5,20}

Regional Workforce Incentives

Expand:

- Relocation incentives
- Rural scholarships
- Housing support
- Tele-supervision programs

Expand Training Capacity

Increase:

- Psychology postgraduate places
- Psychiatry training positions
- Social work placements
- Behaviour support training pathways

Strengthen Supervision Infrastructure

Fund supervision programs to increase workforce entry capacity.

Reduce Administrative Burden

Review regulatory and administrative requirements that reduce clinical capacity.

Expand Multidisciplinary Models

Support workforce models that integrate multiple professions.

Improve Workforce Data

Develop more sophisticated workforce monitoring systems capable of identifying emerging shortages earlier.^{4,11}

8. Key Takeaways

- Workforce shortages remain one of Australia's most significant mental health access barriers.^{4,11}
- Psychology workforce growth has not kept pace with demand growth.
- Psychiatry remains particularly constrained.
- Regional and remote communities experience the greatest workforce deficits.
- Behaviour support demand is increasing rapidly through the NDIS.
- Workforce ageing, burnout, and attrition present significant risks.
- Training pipeline bottlenecks limit future workforce growth.
- Telehealth improves access but does not eliminate workforce shortages.
- Multidisciplinary workforce models will become increasingly important.
- Long-term workforce planning must be treated as a national mental health priority.^{4,11}

2030 Outlook

Without significant intervention, workforce shortages are likely to remain widespread by 2030. Demand for mental health services is expected to continue growing faster than population growth, driven by increased awareness, population ageing, neurodevelopmental assessment demand, psychosocial disability support needs, and ongoing workforce pressures.^{4,11,15,16}

The greatest workforce risks are likely to occur within:

- Child and adolescent mental health
- Psychiatry
- Trauma-specialised care
- Regional and remote services
- Behaviour support
- Neurodevelopmental assessment services

Addressing these gaps will be essential if Australia is to improve mental health access over the coming decade.

Chapter 4: Regional and Remote Australia

Regional and remote communities experience compounding barriers that require local, outreach and digital access models.

1. Executive Summary

Regional and remote Australia faces some of the most persistent mental health access barriers in the national system. While the prevalence of mental illness in rural and remote areas is broadly comparable to major cities, access to services is substantially lower, and the consequences of delayed or unavailable care are often more severe.^{4,11,5,20}

The core regional access problem is not only distance. It is the combination of workforce shortages, travel costs, limited specialist services, socioeconomic disadvantage, digital exclusion, fewer culturally appropriate services, and greater reliance on overstretched GPs, hospitals, schools, community organisations, and informal carers.^{4,11,5,20}

AIHW data consistently show that Australians living in rural and remote areas experience poorer access to and use of health services than people in major cities. The National Rural Health Alliance has previously reported that overall mental health service provision is 2.7 times lower in remote areas and 5.6 times lower in very remote areas compared with major cities. This means people in the communities with the highest access barriers often have the fewest service options.^{4,11,5,20}

Telehealth has improved regional access, but it has not solved regional inequity. Telehealth can reduce travel burden and broaden provider choice, but it depends on internet connectivity, digital literacy, private space, clinical suitability, and an available workforce. It cannot fully replace local multidisciplinary services, crisis response, child and adolescent services, culturally safe care, or community-based support.^{2,24,25,4}

The most affected communities include remote Aboriginal and Torres Strait Islander communities, very remote towns, outer regional growth corridors, agricultural communities, mining regions, disaster-affected communities, and regional areas with limited psychiatrist, psychologist, and child mental health workforce.^{4,11,5,20}

A national mental health access strategy must therefore treat regional and remote Australia as a distinct policy priority, not merely as a smaller version of metropolitan service delivery.^{5,20}

2. Current State

Regional and remote mental health access in Australia is shaped by geography, workforce distribution, and social infrastructure.^{4,11,5,20}

Approximately 7 million Australians live outside major cities. These communities are highly diverse, ranging from large regional centres to remote Aboriginal communities, mining towns, agricultural districts, coastal retirement areas, and sparsely populated desert regions.^{5,20,32}

The mental health needs of these communities are not uniform. A regional university city may have a very different service profile from an inland farming town or a remote Northern Territory community. However, several common patterns appear across the evidence:^{5,20}

- Fewer local mental health professionals
- Lower availability of culturally safe services
- Reduced child and adolescent mental health access
- Longer travel distances
- Reduced provider choice
- Greater reliance on GPs
- Limited specialist psychiatry
- Higher exposure to climate, drought, flood, fire, and economic stressors
- Greater difficulty maintaining continuity of care

Rural and remote communities often show strong informal support networks, but this can also create privacy concerns. In small towns, some people avoid local mental health services because they know the practitioner, receptionist, another client, or someone connected to the clinic. Telehealth can reduce this barrier, but only where digital infrastructure and private space are available.^{2,24,25,4}

Service availability is also affected by workforce models. Many regional services rely on visiting clinicians, fly-in/fly-out arrangements, locums, short-term contracts, or limited outreach clinics.

These models may improve episodic access but often struggle to provide continuity of care.^{4,11,5,20}

The policy challenge is therefore structural: the communities with greater service barriers often require more intensive access solutions, not less.^{4,11}

3. Key Statistics

Key regional and remote mental health access indicators include:

- Around 7 million Australians live in rural, regional, and remote areas.^{5,20}
- AIHW reports that people in rural and remote areas generally have poorer access to and use of health services compared with people in major cities.^{5,20}
- The National Rural Health Alliance has reported that mental health service provision is 2.7 times lower in remote areas and 5.6 times lower in very remote areas.^{5,20,6}
- Suicide and self-harm risks increase with remoteness, according to rural mental health evidence summaries.^{5,20,7,8}
- Medicare mental health-related expenditure per person is markedly lower in the Northern Territory than in other jurisdictions.^{2,10,3,22}
- Aboriginal and Torres Strait Islander peoples have historically accessed Medicare-subsidised psychologist and psychiatrist care at lower rates than non-Aboriginal and Torres Strait Islander peoples.^{2,10,4,11}
- Psychiatry workforce modelling projects persistent shortages across all states and territories, with the Northern Territory facing the highest proportional shortage.^{4,11,13}
- Telehealth remains an important access channel for regional mental health care, but it is unevenly available due to connectivity and digital inclusion barriers.^{2,24,25,5}

These indicators show that regional inequity is not a single problem. It is a cluster of overlapping workforce, funding, infrastructure, and social determinants issues.^{4,11,5,20}

4. State-by-State Analysis

Queensland

Queensland has one of Australia's most geographically dispersed populations. Mental health access differs sharply between South East Queensland and regional, rural, and remote areas.^{5,20}

Demand

Demand is high across Brisbane, the Gold Coast, Sunshine Coast, Toowoomba, Cairns, Townsville, Mackay, Rockhampton, Bundaberg, and inland communities. Regional demand is influenced by population growth, disaster exposure, agricultural stress, youth mental health need, Indigenous health inequity, and workforce shortages.^{4,11,5,20}

Workforce

South East Queensland has a stronger concentration of psychologists, psychiatrists, and allied health providers. Rural and remote Queensland communities face much thinner local service supply. Psychiatry and child mental health services are especially constrained outside major centres.^{4,11,13,5}

Access Barriers

Key barriers include distance, workforce shortages, long waits, travel costs, limited local specialist care, and service fragmentation between public, private, school-based, and NDIS-funded supports.^{4,11,15,16}

Service Availability

Large regional hospitals and PHN-commissioned services provide important access points, but many communities still rely heavily on GPs, telehealth, headspace, community organisations, and outreach services.^{2,24,25,5}

4. Emerging Trends

New South Wales

New South Wales contains both the largest metropolitan service market and some of Australia's most access-challenged inland and regional communities.^{5,20}

Demand

Demand is high across Sydney and regional centres including Newcastle, Wollongong, Central Coast, Wagga Wagga, Dubbo, Tamworth, Orange, Lismore, Coffs Harbour, and Albury. Flood-affected Northern Rivers communities have faced additional mental health stress.^{5,20,29,30}

Workforce

Sydney has a large mental health workforce, while many regional communities face shortages in psychiatry, child psychology, trauma care, and neurodevelopmental assessment.^{4,11,5,20}

Access Barriers

Distance, affordability, specialist shortages, and long waits are common. Public psychiatry pressures have also affected system capacity.

Service Availability

Regional centres have public hospitals, PHN-funded services, and private providers, but smaller towns frequently rely on GPs, visiting practitioners, and telehealth.^{2,24,25,4}

NSW faces growing demand across youth mental health, disaster recovery, regional workforce retention, and specialist psychiatric access.^{4,11,5,20}

Victoria

Victoria has a strong metropolitan mental health workforce but significant regional access pressures.^{4,11,5,20}

Demand

Demand is high across Melbourne, Geelong, Ballarat, Bendigo, Shepparton, Latrobe Valley, Mildura, Warrnambool, and Gippsland. Regional demand includes youth mental health, family stress, trauma, substance use, rural workforce pressures, and socioeconomic disadvantage.^{4,11,5,20}

Workforce

Metropolitan Melbourne has a dense private and public mental health workforce. Regional Victoria has more limited provider availability, especially in outer regional and rural communities.^{4,11,5,20}

Access Barriers

Access barriers include cost, distance, wait times, workforce shortages, and limited specialist choice.^{4,11}

Service Availability

Victoria's mental health reforms have expanded system planning, but service access remains uneven. Regional areas continue to experience difficulties accessing psychiatrists, child and adolescent clinicians, and complex care pathways.^{4,11,13,5}

Gippsland, north-western Victoria, and outer regional growth areas are likely to remain access pressure points.^{5,20}

Queensland's regional population growth is likely to increase demand in outer metropolitan and coastal areas. Disaster-related mental health demand is also likely to remain significant due to floods, cyclones, and climate-related stress.^{5,20,19,28}

South Australia

South Australia has a strong metropolitan concentration around Adelaide and significant challenges across large rural and remote areas.^{5,20}

Demand

Demand is high in Adelaide and regional centres including Mount Gambier, Whyalla, Port Augusta, Port Lincoln, Murray Bridge, and the Riverland.^{5,20}

Workforce

Mental health professionals are concentrated in Adelaide. Regional and remote areas face substantial psychiatry and psychology shortages.^{5,20}

Access Barriers

Distance, limited local workforce, transport barriers, and socioeconomic stress are significant. Country South Australia is frequently identified as a psychiatry access concern.^{4,11,5,20}

Service Availability

Barriers include distance, travel costs, limited local workforce, extreme remoteness, digital connectivity, cultural safety, and continuity of care.^{4,11,5,20}

Emerging Trends

Mental health demand linked to agricultural stress, cost-of-living pressures, and regional service scarcity is likely to persist.^{5,20}

Western Australia

Western Australia's geography creates some of the most significant access challenges in the country.

Demand

Demand is high in Perth and regional centres including Bunbury, Geraldton, Kalgoorlie, Albany, Broome, Karratha, and Port Hedland. Remote communities face substantial access barriers.^{5,20}

Workforce

The mental health workforce is heavily concentrated in Perth. Regional and remote WA face major shortages in psychiatry, psychology, child mental health, Aboriginal and Torres Strait Islander mental health services, and multidisciplinary care.^{4,11,5,20}

Access Barriers

Long distances between towns make traditional service delivery difficult. Telehealth, RFDS-linked services, outreach, and regional hospital services are essential but not sufficient.^{2,24,25,5}

Service Availability

Service access varies significantly. Some regional centres have hospital and community mental health services, but smaller communities rely heavily on GPs, telehealth, and outreach.^{2,24,25,5}

Emerging Trends

Mining regions, remote Aboriginal and Torres Strait Islander communities, and northern WA are likely to remain major access pressure points.^{5,20,32}

Tasmania

Tasmania faces distinct access issues due to its smaller population, regional dispersion, and limited specialist workforce.^{4,11,5,20}

Demand

Demand is high in Hobart, Launceston, Devonport, Burnie, and regional communities. Tasmania has persistent concerns around youth mental health, socioeconomic disadvantage, housing stress, and service wait times.^{5,20,9,18}

Workforce

Tasmania has a smaller mental health workforce and fewer specialist service options than larger states. Recruitment and retention can be difficult.^{4,11}

Tasmania

Access Barriers

Key barriers include workforce shortages, travel time, affordability, and limited specialist choice.^{4,11}

Service Availability

Service availability is concentrated in major centres. Rural communities may have limited access to private psychology, psychiatry, and child-focused support.^{5,20,9,18}

Emerging Trends

Tasmania is likely to require targeted workforce incentives and stronger telehealth-supported care pathways.^{2,24,25,4}

Australian Capital Territory

The ACT has a relatively compact geography and strong concentration of services compared with rural jurisdictions, but it also faces affordability, wait time, and cross-border pressures.^{5,20}

Demand

Demand is high across Canberra and surrounding regions. The ACT also supports some people from nearby NSW communities seeking care.

Workforce

The ACT has stronger provider density than many regional jurisdictions, but access can still be limited by cost, wait times, and high demand for psychologists and psychiatrists.^{4,11,13,5}

Access Barriers

Cost and high demand are more significant than distance. Some cross-border NSW residents may place additional demand on ACT services.

Service Availability

Services are geographically accessible compared with most jurisdictions, but private fees and public wait times can remain barriers.

Emerging Trends

The ACT's mental health system will likely remain affected by workforce competition, cost pressures, and regional spillover demand.^{4,11,5,20}

Northern Territory

The Northern Territory faces the most severe combination of remoteness, workforce shortage, cultural safety, service continuity, and access barriers in Australia.^{4,11,5,20}

Demand

Demand is shaped by remoteness, Indigenous health inequity, trauma, social disadvantage, youth mental health needs, substance use concerns, housing stress, and limited local service infrastructure.^{5,20,9,18}

Workforce

The NT has a small and highly stretched mental health workforce. Psychiatry workforce modelling indicates the NT faces the highest proportional shortage nationally.^{4,11,13}

Access Barriers

Barriers include extreme distance, language, cultural safety, workforce turnover, digital connectivity, transport, housing, poverty, and limited continuity of care.^{4,11}

Service Availability

Darwin and Alice Springs have more service availability than remote communities, but many communities rely on visiting services, telehealth, Aboriginal Community Controlled Health Organisations, primary care clinics, and crisis pathways.^{2,24,25,5}

Emerging Trends

The NT requires a distinct access model built around Aboriginal-led services, local workforce development, outreach, telehealth support, and long-term continuity.^{2,24,25,4}

5. Top 20 Mental Health Access Hotspots

The following regions should be considered high-priority mental health access hotspots due to overlapping indicators of remoteness, workforce shortage, socioeconomic disadvantage, service scarcity, travel burden, and high demand.^{4,11,5,20}

This list should be treated as a policy-prioritisation framework rather than a definitive statistical ranking until validated against PHN-level workforce, Medicare, and service utilisation data.^{2,10,4,11}

- Northern Territory remote communities
- Central Australia
- Kimberley, WA
- Pilbara, WA
- Far West NSW
- Western NSW
- Murrumbidgee, NSW
- Northern Rivers, NSW
- Country South Australia
- Eyre Peninsula and Far West SA
- Gippsland, VIC
- Mallee and north-western Victoria
- Wide Bay, QLD
- Central Queensland
- North West Queensland
- Far North Queensland
- Cape York and Torres Strait
- North West Tasmania
- Burnie and west coast Tasmania
- Remote and outer regional agricultural communities across inland Australia

These hotspots share common access problems: limited local workforce, long travel distances, reduced specialist availability, thin child and adolescent services, limited culturally safe care, and dependence on overstretched generalist systems.^{4,11,5,20}

6. Most Underserved Communities

Remote Aboriginal and Torres Strait Islander Communities

Remote Aboriginal and Torres Strait Islander communities face some of the most significant mental health access barriers in Australia. These include geographic isolation, limited culturally safe services, workforce turnover, intergenerational trauma, language barriers, and under-access to Medicare-funded specialist care.^{2,10,4,11}

Aboriginal Community Controlled Health Organisations play a critical role and should be central to any regional mental health access strategy.^{5,20,32}

7. Emerging Regional Trends

Regional Population Growth

Some coastal and outer regional areas are experiencing population growth, increasing demand for already limited services.^{5,20,19,28}

Workforce Mobility and Burnout

Regional systems remain vulnerable to workforce turnover. Recruitment is difficult, and services can lose capacity quickly when a small number of clinicians leave.^{4,11,5,20}

Telehealth as Core Infrastructure

Telehealth is now essential regional mental health infrastructure. It improves access to psychology, psychiatry, counselling, and specialist care. However, it must be supported by digital infrastructure and should not replace local workforce investment.^{2,24,25,4}

Rising Demand for Neurodevelopmental Assessment

Regional families are increasingly seeking autism, ADHD, and developmental assessments. Workforce shortages in psychology, psychiatry, paediatrics, occupational therapy, and speech pathology create long delays.^{4,11,5,20}

Children and Adolescents in Regional Areas

Children and adolescents in regional areas often face long waits for psychology, psychiatry, paediatrics, autism assessment, ADHD assessment, speech pathology, occupational therapy, and school-linked support. Delayed support can affect education, family functioning, and long-term mental health outcomes.^{4,11,5,20}

Older People in Regional Areas

Older regional Australians may face loneliness, grief, transport limitations, digital exclusion, chronic illness, and limited access to geriatric mental health services.^{5,20}

Climate and Disaster-Related Mental Health Demand

Floods, bushfires, drought, and cyclones are increasingly relevant to regional mental health planning. Disaster recovery requires long-term mental health support, not only immediate crisis response.^{5,20,29,30}

8. Challenges

The major challenges affecting regional and remote mental health access are:

- Workforce shortages
- Limited psychiatry access
- Limited child and adolescent services
- Travel distance and transport costs
- Digital exclusion

Farmers and Agricultural Communities

Farmers and agricultural workers face unique mental health risks associated with drought, flood, financial stress, isolation, succession planning, livestock loss, and climate uncertainty. Help-seeking can be affected by stigma, stoicism, time constraints, and limited local services.^{29,30}

Mining and FIFO Communities

Mining and fly-in/fly-out communities face mental health risks linked to isolation, shift work, family separation, alcohol use, fatigue, housing pressure, and limited local service infrastructure.

People with Psychosocial Disability

People with complex and ongoing mental health needs may require coordinated support across health, disability, housing, and community services. Regional areas often have fewer providers able to deliver sustained psychosocial support.^{4,11,5,20}

9. Implications

Regional and remote mental health access cannot be solved through a single intervention.^{5,20}

More Medicare sessions will not be enough if there are no practitioners available. Telehealth will not be enough if people lack internet access, private space, or clinical suitability. Workforce incentives will not be enough if housing, supervision, professional isolation, and career pathways are not addressed.^{2,10,24,25}

The most important policy implication is that regional mental health requires locally adapted models. A viable regional model should combine:^{5,20}

- Local primary care
- Aboriginal-led services
- Visiting multidisciplinary teams
- School-linked services
- Telehealth specialist support
- Regional workforce incentives
- Digital infrastructure
- Community-based prevention
- Crisis alternatives
- Long-term continuity of care

PHNs are especially important because they can commission services based on local needs, identify access gaps, and coordinate regional care pathways.^{5,20,27}

These challenges reinforce each other. For example, workforce shortages create longer waits, which increase crisis risk, which increases pressure on emergency departments, which further strains regional health systems.^{4,11,5,20}

Limited local crisis alternatives to emergency departments remain a significant challenge.

10. Future Outlook

Regional and remote access pressures are likely to intensify unless workforce, funding, and infrastructure reforms are implemented.^{4,11,5,20}

Key risks to 2030 include:

- Continued psychiatry shortages
- Increased youth mental health demand
- Rising neurodevelopmental assessment demand
- Ongoing regional workforce turnover
- Greater climate-related mental health stress
- Persistent under-access for remote Aboriginal and Torres Strait Islander communities.^{5,20,32}
- High workforce turnover
- Cultural safety gaps
- Limited multidisciplinary care
- Cost barriers
- Fragmented referral pathways
- Disaster-related mental health demand
- Increasing demand in outer regional growth corridors

11. Policy Recommendations

- Establish a National Regional Mental Health Access Index to track workforce, wait times, service use, telehealth access, and unmet need by region.^{2,24,25,4}
- Expand regional psychology, psychiatry, and allied health workforce incentives, including relocation support, supervision funding, housing support, and rural training pathways.^{4,11,5,20}
- Fund Aboriginal Community Controlled Health Organisations to lead culturally safe mental health models in remote and regional communities.^{5,20,32}
- Expand telehealth while investing in local service capacity.
- Create dedicated regional child and adolescent mental health access pathways.
- Increase PHN commissioning for underserved communities with transparent regional gap analysis.^{5,20,27}
- Develop regional crisis alternatives to emergency departments, including safe spaces, mobile response teams, and community-led supports.^{5,20}
- Expand rural placement pipelines for psychology, social work, counselling, occupational therapy, psychiatry, and nursing students.^{5,20}
- Improve digital infrastructure and private telehealth access points in libraries, community centres, schools, and health clinics.^{2,24,25}
- Create disaster-responsive mental health funding that continues beyond the immediate emergency period.^{29,30}
- Strengthen regional data reporting so unmet need can be identified earlier.
- Develop long-term regional workforce retention strategies, not only short-term recruitment incentives.^{4,11,5,20}

12. Key Takeaways

- Regional and remote Australians experience substantially lower access to mental health services than people in major cities.^{5,20}
- The prevalence of mental illness may be similar across geography, but service access is not.
- Remote and very remote communities experience the largest access gaps.
- Workforce shortage is the central structural barrier.
- Telehealth improves access but cannot replace local services.
- Aboriginal and Torres Strait Islander communities require Aboriginal-led, culturally safe models.³²
- Child and adolescent mental health access is a major regional pressure point.
- Climate-related disasters are likely to increase regional mental health demand.
- The Northern Territory, remote WA, Far West NSW, Country SA, Gippsland, North West Queensland, and North West Tasmania should be treated as priority access regions.^{5,20}
- Regional mental health reform must combine workforce, telehealth, local services, cultural safety, transport, digital inclusion, and PHN-led planning.^{2,24,25,4}
- Greater pressure on GPs and emergency departments.

The future model should be hybrid, regionalised, and multidisciplinary. The goal should not be to replicate metropolitan service models in every town. The goal should be to guarantee reliable access to appropriate care through a combination of local, outreach, and digital service pathways.^{5,20}

Chapter 5: Child and Adolescent Mental Health

Child and adolescent mental health access is a major national pressure point for families, schools and services.

1. Executive Summary

Child and adolescent mental health has emerged as one of the most significant public health challenges facing Australia. While awareness of youth mental health has increased substantially over the past decade, demand for services continues to outpace workforce growth, resulting in long wait times, service bottlenecks, and growing pressure on schools, families, primary care providers, and specialist services.^{4,11,9,18}

The available evidence suggests that mental health concerns among children and adolescents are both common and increasingly visible. Anxiety disorders remain the most prevalent mental health condition among young Australians, while depressive disorders, self-harm behaviours, eating disorders, neurodevelopmental conditions, and emotional regulation difficulties have become increasingly prominent within clinical, educational, and community settings.^{1,9,18,7}

The COVID-19 pandemic accelerated many existing trends. School disruptions, social isolation, family stress, economic uncertainty, and reduced access to normal developmental activities contributed to increased psychological distress among many young people. Although acute pandemic restrictions have ended, demand for child and adolescent mental health support has remained elevated.^{9,18}

One of the most significant developments in recent years has been the rapid growth in demand for autism and ADHD assessment services. Families across Australia report long waiting periods for developmental assessments, particularly in regional and rural areas. Specialist workforce shortages, limited assessment capacity, and growing awareness of neurodevelopmental conditions have combined to create substantial service pressures.^{4,11,5,20}

The challenge extends beyond healthcare. Schools increasingly report difficulties supporting students experiencing anxiety, emotional dysregulation, behavioural concerns, school refusal, social difficulties, and mental health distress. Educational settings have become a critical component of Australia's mental health response system, often serving as the first point of identification for emerging concerns.^{4,11,9,18}

Without targeted intervention, demand for child and adolescent mental health services is likely to continue increasing throughout the remainder of the decade. Early intervention, workforce development, school-based support programs, improved regional access, and strengthened family support systems will be essential to improving outcomes.^{4,11,5,20}

2. Current State

Child Mental Health Prevalence

Mental health concerns affect a substantial proportion of Australian children and adolescents.^{9,18}

The most recent national data indicate that approximately one in seven Australian children and adolescents aged 4–17 years experience a mental disorder in a given year. This equates to hundreds of thousands of young Australians experiencing clinically significant emotional, behavioural, or developmental difficulties.^{9,18}

The most common presentations include:

- Anxiety disorders
- Attention-deficit/hyperactivity disorder (ADHD)
- Depressive disorders
- Conduct disorders
- Emotional regulation difficulties
- Trauma-related presentations
- Autism spectrum disorder-related support needs

Many young people experience multiple concerns simultaneously. For example, anxiety commonly co-occurs with ADHD, autism, learning difficulties, family stressors, or depressive symptoms.^{15,16,9,18}

Importantly, prevalence figures may underestimate true demand because many children experiencing significant distress do not meet diagnostic thresholds but still require support.^{9,18}

Anxiety in Children

Anxiety disorders remain the most common mental health condition affecting Australian children and adolescents.^{1,9,18}

Presentations may include:

- Generalised anxiety
- Separation anxiety
- Social anxiety
- Panic symptoms
- Specific phobias

Schools and clinicians increasingly report anxiety-related difficulties affecting attendance, participation, peer relationships, and academic performance.

Anxiety can significantly impair functioning even when symptoms do not meet criteria for a formal diagnosis.

Depression in Adolescents

Depression becomes increasingly prevalent during adolescence, particularly among older teenagers.

Symptoms may include:

- Persistent low mood
- Withdrawal from activities
- Changes in sleep
- Changes in appetite
- Reduced motivation
- Feelings of hopelessness
- Self-harm thoughts

Adolescent Mental Health Trends

Adolescence represents a period of heightened vulnerability for mental health concerns.

International and Australian evidence suggests that approximately half of all lifetime mental health disorders begin before the age of 14, and around three-quarters emerge before age 25.

This makes early identification and intervention critically important.

Research from headspace, Orygen, the Australian Bureau of Statistics, and AIHW consistently shows increased rates of psychological distress among adolescents and young adults compared with previous generations.^{9,18}

Several factors contribute to this trend:

- Academic pressures
- Social media exposure
- Body image concerns
- Family stress
- Economic uncertainty
- Climate-related anxiety
- Loneliness
- Social isolation
- Developmental transitions
- School-related anxiety

The COVID-19 pandemic accelerated many existing mental health trends among children and adolescents.^{9,18}

During the pandemic, young people experienced:

- School closures
- Reduced peer interaction
- Family stress
- Uncertainty
- Social isolation
- Reduced extracurricular participation

Studies conducted during and after the pandemic found elevated rates of psychological distress among many young people.^{4,11,9,18}

Importantly, demand has not returned to pre-pandemic levels.

Several factors may explain this:

Increased Awareness

Parents, schools, and healthcare providers are now more likely to recognise and seek support for mental health concerns.

Accumulated Need

Some children experienced delays in assessment and intervention during the pandemic, contributing to ongoing service demand.^{9,18}

Persistent Stressors

Cost-of-living pressures, housing instability, academic pressures, and social challenges continue to affect many families.

Depressive disorders are associated with significant impacts on educational attainment, social functioning, and long-term wellbeing.

The burden of adolescent depression is particularly concerning because it often persists into adulthood if left untreated.^{4,11,9,18}

2. Key Statistics

Key indicators include:

- Approximately one in seven Australian children and adolescents experience a mental disorder annually.^{9,18}
- Mental health conditions are among the leading causes of disease burden for young Australians.
- Anxiety disorders remain the most common mental health condition among children and adolescents.^{1,9,18}
- Suicide remains one of the leading causes of death among young Australians aged 15–24 years.^{7,8}
- Demand for ADHD and autism assessments has increased substantially over recent years.^{15,16,9,18}
- School attendance concerns, including school refusal and school avoidance, have become increasingly visible.^{9,18}
- Youth presentations to mental health services remain above pre-pandemic levels.
- Regional communities continue to experience reduced access to specialist child mental health services.^{5,20,9,18}

These statistics highlight the growing importance of child and adolescent mental health within Australia's broader healthcare and education systems.^{9,18}

3. Demand Growth Since COVID

The pandemic period coincided with increased awareness of autism and ADHD, contributing to ongoing assessment demand.^{15, 16, 9, 18}

The post-pandemic period therefore appears to represent a structural increase in demand rather than a temporary surge.

4. School-Based Mental Health Challenges

Schools increasingly function as frontline mental health environments.

Teachers, counsellors, wellbeing coordinators, and school leaders are often among the first adults to identify emerging concerns.^{4, 11}

Key challenges include:

School Refusal and School Avoidance

School refusal has become one of the most frequently reported concerns by schools and families.^{9, 18}

Contributing factors include:

- Anxiety
- Depression
- Autism
- ADHD
- Bullying
- Trauma
- Social difficulties

School refusal can have significant long-term consequences for educational attainment and social development.^{9, 18}

Behavioural and Emotional Regulation Difficulties

Schools report increasing demand for support relating to:

- Emotional dysregulation
- Aggression
- Impulsivity
- Social difficulties
- Classroom participation

Many schools face challenges accessing timely external support.

Workforce Pressures

School psychologists, counsellors, and wellbeing teams often manage large caseloads, particularly in regional communities.^{4, 11, 5, 20}

Access to specialist external services can be limited by waitlists and workforce shortages.^{4, 11}

5. Autism and ADHD Assessment Pressures

One of the most significant trends in Australian child mental health services is the rapid increase in demand for autism and ADHD assessments.^{15, 16, 9, 18}

Families frequently report difficulties accessing:

- Developmental paediatricians
- Child psychiatrists
- Clinical psychologists
- Speech pathologists

5. Autism and ADHD Assessment Pressures

Autism and ADHD assessment demand continues to exceed workforce capacity. Several factors appear to be driving increased demand:

Greater Awareness

Public understanding of autism and ADHD has improved significantly.

Improved Recognition

Schools, families, and healthcare providers are identifying neurodevelopmental differences earlier.

Increased Help-Seeking

Families are increasingly seeking formal assessment to access supports and educational accommodations. Assessment demand has increased faster than workforce capacity.

Consequently, waiting periods for developmental assessments can extend for months and, in some regions, years.^{9,18}

Workforce Constraints

Key bottlenecks include:

- Child psychologists
- Child psychiatrists
- Developmental paediatricians
- Occupational therapists
- Speech pathologists

Child Psychiatry

Child and adolescent psychiatry remains one of the most workforce-constrained specialties.^{4,11,9,18}

6. Regional Child Mental Health Access

Regional and rural communities face unique barriers.

Workforce Shortages

Many regional areas experience shortages of:

- Child psychologists
- Child psychiatrists
- Developmental paediatricians
- Occupational therapists
- Speech pathologists

Travel Burden

Families may need to travel significant distances for specialist services.

Limited Provider Choice

Smaller communities often have fewer available practitioners.

Telehealth Benefits

Telehealth has improved access substantially, particularly for psychological interventions.^{2,24,25} However, telehealth cannot fully replace local multidisciplinary assessment and support services.^{2,24,25}

Regional children therefore continue to experience inequitable access compared with many metropolitan peers.^{5,20,9,18}

7. Waiting Lists and Service Bottlenecks

Long waiting periods have become one of the defining characteristics of Australia's child mental health system.^{9,18}

7. Waiting Lists and Service Bottlenecks

Long waiting periods have become one of the defining characteristics of Australia's child mental health system.^{9,18}

Key bottlenecks include:

- Child psychiatry
- Allied health services
- Workforce shortages
- Long waiting periods
- Regional inequity
- Assessment bottlenecks
- Limited psychiatry capacity

Child Psychiatry

Child and adolescent psychiatry remains one of the most workforce-constrained specialties.^{4,11,9,18}

Allied Health Services

Speech pathology, occupational therapy, and psychology services frequently operate at or near capacity. These delays can affect educational outcomes, family functioning, and long-term developmental trajectories.

Community Mental Health Services

Public services often prioritise high-risk presentations, leaving moderate-complexity cases waiting for support.^{4,11}

8. Emerging Risks

Several emerging risks warrant close monitoring.

Youth Suicide

Suicide remains one of the leading causes of death among young Australians. Prevention requires coordinated action across healthcare, education, community services, and families.

Youth Self-Harm

Self-harm presentations remain a significant concern among adolescents. While not all self-harm reflects suicidal intent, it is associated with elevated future risk and requires timely intervention.^{7,8}

Social Media and Digital Pressures

Young people face increasing exposure to:

- Cyberbullying
- Social comparison
- Online harassment
- Sleep disruption

The long-term implications continue to be studied.

Climate Anxiety

Many young people report concern about environmental and climate-related issues.^{9,18,29,30}

These concerns may contribute to broader psychological distress.

Family Stress

Housing affordability, financial pressures, and caregiver mental health difficulties may increasingly affect child wellbeing.^{9,18}

9. Challenges

Australia's child and adolescent mental health system faces several interconnected challenges.^{9,18}

Increasing Demand

The strongest growth areas are expected to include:

- Anxiety presentations
- School system pressures
- Family support gaps
- Fragmented service pathways
- Affordability concerns

These challenges reinforce one another and contribute to ongoing access difficulties.

10. Implications

The evidence suggests that child and adolescent mental health demand is likely to remain elevated throughout the decade.^{9,18}

The consequences of inadequate access extend beyond healthcare.

Impacts include:

- Educational disruption
- Family stress
- Reduced workforce participation by caregivers
- Increased service utilisation later in life
- Greater demand on crisis services

Early intervention therefore represents both a health priority and an economic investment.

11. Recommendations

- Expand child and adolescent psychology workforce capacity.
- Increase child psychiatry training positions.
- Improve access to early intervention services.
- Develop national autism and ADHD assessment pathway reforms.
- Strengthen school-based mental health supports.
- Expand regional child mental health programs.
- Increase telehealth-supported specialist services.
- Improve family support and caregiver education programs.
- Enhance youth suicide prevention initiatives.
- Establish national monitoring of child mental health waiting times.
- Strengthen coordination between schools, health services, and community supports.
- Invest in early childhood mental health programs.

12. 2030 Outlook

By 2030, demand for child and adolescent mental health services is likely to exceed current levels.^{9,18}

13. Key Takeaways

- Child and adolescent mental health is one of Australia's most significant emerging health challenges.^{9,18}
- Anxiety remains the most common mental health condition among young people.
- Demand for autism and ADHD assessments has increased dramatically.
- Schools play a central role in identifying and supporting mental health concerns.
- Regional communities continue to experience substantial access barriers.
- Waiting lists remain a major system challenge.
- Suicide remains one of the leading causes of death among young Australians.
- Early intervention offers the greatest opportunity to improve long-term outcomes.
- Workforce shortages remain the primary structural constraint.
- Child and adolescent mental health should be treated as a national priority area through to 2030.^{9,18}
- Neurodevelopmental assessments, school-based mental health support, early intervention services, youth suicide prevention, and family support programs should remain national priorities.

Without substantial workforce and system reform, waiting times and service bottlenecks are likely to persist.^{4,11}

However, improved early intervention, digital support, school partnerships, and workforce investment could significantly improve outcomes.^{4,11}

Chapter 6: NDIS and Mental Health Support

NDIS-related demand is reshaping psychosocial disability, autism, behaviour support and capacity-building service access.

1. Executive Summary

The National Disability Insurance Scheme (NDIS) has become one of the most significant influences on Australia's mental health and disability support landscape. While the scheme was not originally designed as a mental health program, it now plays a critical role in supporting Australians living with psychosocial disability, autism spectrum disorder, intellectual disability, and complex developmental conditions.^{15,16}

Since its national rollout, the NDIS has transformed access to disability-related supports by shifting funding from block-funded services toward individualised participant budgets. For many Australians, this has created new opportunities to access behaviour support, psychosocial recovery coaching, support coordination, therapy services, capacity-building interventions, and community participation programs.^{15,16,17}

However, rapid participant growth has created substantial demand pressures across the workforce and service delivery ecosystem. Provider shortages, workforce constraints, rural access challenges, service quality variation, funding complexity, and increasing demand for autism-related supports have emerged as major policy issues.^{4,11,5,20}

The NDIS has also become an increasingly important pathway for people living with psychosocial disability. Yet access remains complex. Many individuals experience challenges navigating eligibility requirements, obtaining evidence, finding suitable providers, and maintaining continuity of support.^{15,16} At the same time, demand for autism-related supports, early intervention services, and behaviour support continues to increase. Autism is now the largest primary disability category within the NDIS and represents a major driver of participant growth, workforce demand, and future expenditure.^{3,22,4,11}

The challenge for policymakers is to ensure that the NDIS remains sustainable while continuing to improve outcomes for participants. This will require workforce development, stronger regional access strategies, clearer interfaces between disability and health systems, and investment in early intervention approaches that improve long-term outcomes.^{4,11,5,20}

2. Current State

Current NDIS Mental Health Landscape

The NDIS supports Australians living with permanent and significant disability. While many mental health services remain the responsibility of the healthcare system, the NDIS funds disability-related supports where a person's psychosocial impairment substantially affects daily functioning.^{15,16}

The NDIS currently supports hundreds of thousands of Australians across a wide range of disability categories.^{15,16}

Key Disability Groups Relevant to Mental Health

- Autism spectrum disorder
- Psychosocial disability
- Intellectual disability
- Developmental delay
- Neurological conditions
- Acquired brain injury

Supports Available for Participants with Psychosocial Disability

For participants with psychosocial disability, NDIS supports may include:

- Psychosocial recovery coaching
- Support coordination
- Capacity-building interventions
- Community participation
- Daily living supports

Psychology Under the NDIS

Psychology services play an important role within the NDIS, particularly where interventions relate to disability-related functional outcomes.^{15,16}

Psychologists commonly assist participants with:

- Emotional regulation
- Capacity building
- Social participation
- Independence skills
- Coping strategies
- Behaviour support
- Behaviour support implementation
- Family support
- Employment-related supports

Psychology demand is particularly high among participants with:

- Autism
- Intellectual disability
- Psychosocial disability
- Complex behavioural presentations

As participant numbers have increased, psychology workforce shortages have become more apparent, particularly in regional and rural areas.^{4,11,5,20}

2. Key Statistics

Several indicators demonstrate the scale of NDIS-related demand:

- More than 700,000 Australians are now NDIS participants.
- Autism spectrum disorder is the largest primary disability category within the scheme.^{15,16}
- Psychosocial disability represents one of the fastest-growing participant cohorts.^{15,16}
- Capacity-building supports account for a significant proportion of participant funding.^{15,16}
- Behaviour support demand has increased substantially over the past five years.
- Rural and remote participants consistently report lower provider availability.
- Workforce demand continues to exceed supply across multiple disability professions.^{4,11}
- Early childhood and developmental supports remain major drivers of scheme growth.^{9,18}

These figures highlight the importance of workforce planning and service sustainability within the disability sector.^{4,11}

3. Growth of Psychosocial Disability Supports

The scheme has fundamentally changed the disability service landscape by creating participant-directed purchasing power and encouraging provider growth.^{15,16}

However, participant demand has expanded faster than workforce capacity in many regions.^{4,11,15,16}

Psychosocial disability has become an increasingly important component of the NDIS.^{15,16}

Psychosocial disability refers to the functional impact of mental health conditions on a person's ability to participate in daily life.^{15,16}

Common conditions associated with psychosocial disability include:

- Schizophrenia

3. Growth of Psychosocial Disability Supports

Common conditions associated with psychosocial disability include:

- Schizophrenia
- Bipolar disorder
- Severe depression
- Severe anxiety disorders
- Complex trauma-related conditions

Participants with psychosocial disability often require ongoing support across multiple domains, including:^{4,11,15,16}

- Community participation
- Daily living
- Housing
- Employment
- Social connection
- Recovery-oriented support

The introduction of psychosocial recovery coaching represented a significant development in supporting participants to build capacity and navigate services.^{15,16}

Despite these advances, challenges remain.

Many people living with severe mental illness continue to experience difficulties:

- Accessing the NDIS
- Understanding eligibility requirements
- Obtaining functional assessments
- Finding experienced providers
- Navigating service systems

These issues are particularly evident in regional areas.

4. Behaviour Support Workforce Pressures

Behaviour support has become one of the fastest-growing areas within the disability sector.¹⁷

Demand is driven by:

- Autism
- Intellectual disability
- Psychosocial disability
- Complex support needs

Behaviour support practitioners assist participants by:

- Assessing behavioural concerns
- Developing behaviour support plans
- Building participant capacity
- Reducing restrictive practices
- Training support teams

The NDIS Quality and Safeguards Commission has placed significant emphasis on behaviour support quality and practitioner capability.^{4,11,15,16}

However, workforce growth has struggled to keep pace with demand.

Providers frequently report challenges recruiting behaviour support practitioners.

Restrictive practice reduction requirements have further increased demand for experienced practitioners.

5. Autism and Developmental Disability Demand

Autism-related demand has become one of the most significant drivers of NDIS growth.^{15,16}

Autism is now the largest primary disability category within the scheme.

Several factors contribute to this growth:

Increased Awareness

Awareness of autism has improved substantially among families, schools, and healthcare professionals.^{15,16}

Earlier Identification

Children are increasingly identified and assessed at younger ages.

Expanded Help-Seeking

Families are more likely to pursue formal diagnosis and support pathways.

Capacity Building Focus

Many autism-related supports emphasise skill development, communication, independence, and community participation.^{15,16}

These workforce shortages contribute to service delays and reduced participant choice.^{4,11,15,16}

This has created strong demand for:

- Psychology
- Occupational therapy
- Speech pathology
- Behaviour support
- Experienced behaviour support practitioners
- Supervisors
- Clinical leads

6. Early Intervention Demand

Early intervention has become a central feature of disability policy. The rationale is clear.

Earlier support can improve:

- Functional outcomes
- Educational participation
- Communication skills
- Social engagement
- Independence

Demand for early intervention services continues to increase across:

- Autism
- Developmental delay
- Intellectual disability
- Communication disorders

However, workforce shortages have created significant service bottlenecks.

The challenge is ensuring workforce growth keeps pace with participant demand.

7. Regional NDIS Access Challenges

Regional and rural communities face significant disability service access barriers.^{5,20}

Workforce Availability

Participants in regional areas often have fewer provider options.

Common shortages include:

- Psychologists
- Occupational therapists
- Speech pathologists
- Support coordinators
- Behaviour support practitioners

Travel and Geography

Large travel distances create additional challenges for both participants and providers.^{5,20,15,16}

Reduced Provider Choice

Many regional participants have limited ability to select providers aligned with their goals and preferences.^{5,20,15,16}

Telehealth Expansion

Telehealth has improved access considerably, particularly for psychology and support coordination.^{2,24,25,15}

However, some services continue to require face-to-face delivery.

The result is ongoing inequity between metropolitan and regional participants.

Many families report difficulty accessing timely intervention following diagnosis.

The effectiveness of early intervention is often greatest when services are available promptly.^{4,11}

Delays may reduce potential benefits and increase long-term support needs.

8. Emerging Trends

Several important trends are reshaping the NDIS mental health landscape.

Increased Autism Participation

Autism-related demand is likely to remain the strongest growth driver within the scheme.^{15,16}

Growing Psychosocial Disability Awareness

Recognition of psychosocial disability continues to improve.

Greater Demand for Capacity Building

Participants increasingly seek supports that improve independence rather than simply providing ongoing care.^{15,16}

Increased Workforce Competition

Competition between healthcare, disability, and community sectors is intensifying.

Technology Integration

Digital tools, telehealth, and assistive technologies are becoming more common.

Family-Centred Approaches

Families increasingly seek coordinated support across education, healthcare, and disability systems.

Service Continuity

Workforce turnover can disrupt long-term support relationships.

9. Challenges

The NDIS faces several interconnected challenges.

Workforce Shortages

Provider demand continues to exceed workforce supply.

Regional Access Gaps

Regional participants continue to experience reduced access.

Service Quality Variation

Participant experiences can vary significantly between providers and regions.

System Complexity

Many participants and families find the scheme difficult to navigate.

Interface Challenges

Responsibilities between health, education, and disability systems can be unclear.

Sustainability Concerns

Rapid participant growth creates ongoing funding pressures.

Assessment Bottlenecks

Demand for autism and developmental assessments continues to exceed capacity.

10. Implications

The NDIS has fundamentally improved access to disability supports for many Australians.^{15,16} However, increasing demand has exposed workforce and service delivery limitations.^{4,11}

The scheme's future success depends on:

- Workforce expansion
- Regional service development
- Early intervention investment
- Clearer system interfaces
- Sustainable funding models

Without these reforms, participant growth may continue to outpace service capacity.^{15,16}

The most significant risk is not participant growth itself but insufficient workforce and infrastructure to support that growth effectively.^{4,11,15,16}

11. Recommendations

- Expand disability workforce development initiatives nationally.
- Increase behaviour support training and supervision capacity.
- Improve regional workforce incentives.
- Strengthen rural telehealth-supported service delivery.
- Expand psychosocial recovery coaching availability.
- Improve autism and developmental assessment pathways.
- Simplify participant navigation and service access.
- Strengthen coordination between health and disability systems.
- Increase workforce data collection and forecasting.
- Support innovative service models for underserved communities.
- Expand early intervention capacity nationally.

12. Future Outlook

Demand for NDIS-related mental health and disability supports is expected to remain strong through 2030.^{15,16}

Key growth areas are likely to include:

- Autism supports
- Psychosocial disability services
- Early intervention
- Behaviour support
- Capacity-building interventions
- Regional service delivery

Workforce shortages will remain the greatest constraint on future growth.

If workforce development, regional access strategies, and early intervention investment are successfully implemented, the NDIS may significantly improve long-term outcomes while reducing reliance on more intensive supports later in life.^{4,11,5,20}

13. Key Takeaways

- The NDIS has become a major component of Australia's mental health and disability support ecosystem.^{15,16}
- Psychosocial disability support continues to expand.
- Autism is the largest disability category within the scheme.
- Behaviour support demand is growing rapidly.
- Early intervention remains a key policy priority.
- Regional participants continue to experience significant access barriers.
- Workforce shortages remain the largest structural challenge.
- Capacity-building supports are increasingly important.
- Clearer integration between disability and health systems is needed.
- Sustainable workforce growth will be critical to the future success of the NDIS.^{4,11,15,16}
- Improve outcome measurement across participant groups.

Chapter 7: Wait Times and Access Barriers

Wait times, cost, referral complexity and workforce shortages continue to delay appropriate care.

1. Executive Summary

Australia's mental health system is experiencing sustained access pressures driven by increasing demand, workforce shortages, geographic inequities, and affordability challenges. While awareness of mental health has improved significantly over the past decade, many Australians continue to encounter substantial barriers when attempting to access appropriate care.^{4,11}

Long waiting periods have become one of the defining characteristics of Australia's mental health landscape. Consumers frequently report delays accessing psychologists, psychiatrists, child and adolescent mental health services, autism and ADHD assessments, public mental health services, and disability-related supports. These delays are particularly pronounced in regional and remote communities, where workforce shortages and service scarcity are more severe.^{4,11,13,5}

Access barriers extend beyond wait times alone. Cost remains a major impediment, particularly for individuals requiring ongoing support. Geography, transport limitations, service navigation difficulties, workforce shortages, and referral complexity all contribute to delayed treatment and unmet need.^{4,11}

The consequences of delayed access are significant. Mental health conditions may worsen while individuals wait for support, increasing risks of educational disruption, employment difficulties, family stress, hospitalisation, crisis presentations, and long-term disability. Delayed treatment also places additional pressure on emergency departments, general practice, community services, and informal support networks.

The evidence suggests that wait times are not simply a service delivery issue. They represent a broader systems challenge involving workforce supply, funding structures, geographic distribution, service integration, and demand growth. Addressing access barriers will require coordinated reforms across health, disability, education, and community sectors.^{4,11}

2. Current State

Australia has a relatively well-developed mental health service system compared with many countries. Medicare-funded psychological services, public mental health services, psychiatrists, counsellors, community programs, telehealth services, and digital mental health resources collectively support millions of Australians each year.^{2,10,24,25}

However, access remains uneven.

Many consumers report difficulty obtaining timely appointments, particularly for:

- Psychology services
- Psychiatry services
- Child and adolescent mental health services
- Autism assessments
- ADHD assessments
- Public community mental health services
- Behaviour support services
- Psychosocial disability supports

The challenge is not solely the number of people seeking support. Demand is increasing while workforce growth struggles to keep pace. In many areas, provider availability determines access more than funding eligibility.^{4,11}

This mismatch has contributed to longer waiting periods across multiple service categories. Mental health service demand has become a structural feature of the Australian health system rather than a temporary phenomenon.

3. Key Statistics

Several indicators illustrate the scale of Australia's access challenge.

3. Key Statistics

Several indicators illustrate the scale of Australia's access challenge.

- Approximately 4.3 million Australians experience a mental disorder within a 12-month period.¹
- Around 2.8 million Australians receive Medicare-subsidised mental health services annually.^{2,10}
- Approximately 13 million Medicare mental health services were delivered in 2024–25.^{2,10}
- One in five Australians are dispensed a mental health-related prescription annually.^{2,10}
- Workforce shortages remain widespread across psychology, psychiatry, and behavioural support professions.^{4,11}
- Regional and remote communities consistently report lower provider availability.^{5,20}
- Child psychiatry and developmental assessment services experience some of the longest reported waiting periods.^{13,9,18}
- Mental health-related occupations remain prominent in national workforce shortage and labour market reporting.^{14,19,28}

These figures demonstrate that access barriers affect a substantial proportion of the population.

4. Why Australians Cannot Access Care

Cost

Cost remains one of the most frequently cited barriers to mental health care.

While Medicare rebates improve affordability, they do not eliminate out-of-pocket expenses.^{2,10}

Common financial barriers include:

- Gap payments
- Private psychiatry fees
- Assessment expenses
- Ongoing therapy costs
- Travel expenses
- Lost work time associated with appointments

Cost pressures have become increasingly relevant amid broader cost-of-living challenges affecting Australian households.

Individuals requiring ongoing therapy may reduce session frequency or discontinue treatment prematurely because of financial constraints.

For some consumers, the choice is not between public and private care but between receiving support and receiving no support at all.

Workforce Shortages

Workforce shortages remain the single largest structural driver of mental health wait times.^{4,11}

Even where funding is available, services cannot be delivered without appropriately qualified practitioners.^{4,11}

Shortages affect:

- Psychologists
- Psychiatrists
- Mental health social workers
- Behaviour support practitioners
- Child mental health specialists
- Regional providers

Geography

Geographic location remains a major determinant of mental health access.

Australians living in regional, rural, and remote communities frequently encounter:^{5,20}

- Fewer providers
- Reduced specialist availability
- Longer waiting periods
- Greater reliance on telehealth
- Limited provider choice

In many communities, there may be only a small number of local practitioners or no local specialist services at all.^{4,11}

Telehealth has improved access but cannot fully replace local service availability.^{2,24,25}

Transport

Transport barriers continue to affect access, particularly in regional and remote Australia.^{5,20}

Challenges include:

- Long travel distances
- Limited public transport
- Fuel costs
- Time away from work
- Mobility limitations

Transport barriers disproportionately affect:

- Older Australians
- Young people

Workforce Shortages

Several factors contribute to workforce constraints.

Growing Demand

Mental health awareness has increased significantly.

More Australians are seeking support for:

- Anxiety
- Depression
- Trauma
- ADHD
- Autism
- Relationship difficulties
- Workplace stress

Workforce Ageing

Many experienced practitioners are approaching retirement age.

Burnout

High caseloads, administrative burden, and workforce shortages contribute to burnout and reduced workforce participation.^{4,11}

Training Bottlenecks

Supervision requirements, placement shortages, and postgraduate training constraints limit workforce expansion.^{4,11}

The result is that workforce growth often lags behind demand growth.

Referral Complexity

Australia's mental health system can be difficult to navigate. Consumers may need to understand:

- Medicare pathways
- NDIS pathways
- Public mental health eligibility
- Private service options
- Referral requirements
- Funding arrangements
- Who can provide support
- Which services are appropriate
- What supports they are eligible to receive

System complexity can create delays even when services are available.

Awareness

Mental health literacy has improved substantially, but awareness barriers remain.

Some individuals:

- Do not recognise symptoms
- Are unsure where to seek help
- Delay treatment due to stigma
- Do not understand available funding pathways

Awareness barriers can contribute to delayed intervention and worsening symptoms.

Transport

Even where services are technically available, transport limitations may make access impractical.

Transport barriers disproportionately affect:

- People with disabilities
- Low-income households
- Rural communities

4. Impact of Delayed Treatment

Delayed access to mental health care has consequences that extend beyond healthcare systems.

Individual Consequences

Delayed treatment may contribute to:

- Symptom deterioration
- Reduced quality of life
- Increased distress
- Social withdrawal
- Educational disruption
- Employment difficulties

Family Consequences

Families may experience:

- Caregiver stress

- Financial strain
- Relationship conflict
- Increased caring responsibilities
- Reduced workforce participation by caregivers

Healthcare System Consequences

When early intervention is unavailable, individuals may require:

- More intensive treatment
- Hospital presentations
- Crisis services
- Emergency department support

This increases overall system costs.

Economic Consequences

Mental ill-health contributes substantially to:

- Absenteeism
- Presenteeism
- Productivity losses

Delays in treatment can exacerbate these impacts.

5. High-Risk Groups

Certain populations experience particularly significant access barriers.

Children and Adolescents

Young people often face lengthy waits for:

- Psychology
- Psychiatry
- Autism assessment
- ADHD assessment

Delays may affect educational and developmental outcomes.

6. Regional Analysis

Regional access barriers differ from metropolitan challenges.

In metropolitan areas:

- Cost
- Demand
- Wait times

In regional areas, additional challenges include:

- Workforce shortages
- Travel distance
- Limited provider choice
- Specialist services scarcity

These are often the primary barriers.

Remote communities may experience all of these barriers simultaneously.

The most affected regions generally include:

- Northern Territory remote communities
- Kimberley
- Pilbara
- Far West NSW
- Regional South Australia
- Remote Queensland communities
- North West Tasmania

These areas often experience overlapping workforce, transport, and service availability challenges.^{4,11}

7. Emerging Trends

Several trends are likely to shape future access barriers.

Increasing Demand

Mental health awareness continues to grow, increasing demand for services.

Workforce growth continues to lag behind demand growth.

Telehealth Expansion

Telehealth has improved access but may not fully address workforce shortages.

Neurodevelopmental Assessment Pressures

Demand for autism and ADHD assessment continues to rise.

Complexity of Presentations

Consumers increasingly present with multiple overlapping concerns requiring multidisciplinary support.

8. Challenges

The major challenges facing Australia's mental health access system include:

- Capacity constraints
- Workforce shortages
- Wait times
- Financial barriers
- Regional inequity
- Specialist services scarcity
- Neurodevelopmental assessment pressures
-

Financial barriers disproportionately affect individuals with limited economic resources.

Key Drivers of Future Demand

- Population growth
- Increased awareness
- Youth mental health demand
- Autism assessment demand
- ADHD assessment demand
- Psychosocial disability support needs
- Ageing population pressures

Ongoing Access Challenges

- Workforce shortages
- Long wait times
- Cost barriers
- Regional inequity
- Transport barriers
- Service navigation complexity
- Child and adolescent service shortages
- Psychiatry shortages
- Neurodevelopmental assessment bottlenecks
- Limited continuity of care

These challenges are interconnected and often reinforce one another.

9. Implications

Wait times and access barriers should be viewed as leading indicators of broader system stress.

The existence of long waiting periods suggests that:

- Demand exceeds available capacity.
- Workforce supply is insufficient.
- Service distribution is uneven.
- Navigation pathways are inefficient.

Without reform, access barriers may continue to worsen despite increased awareness and funding. The challenge is not simply increasing service volume but improving system efficiency, workforce capacity, and equitable distribution.^{4,11}

10. Future Outlook

Demand for mental health services is expected to continue increasing through 2030.

The greatest risks are likely to occur in:

- Child and adolescent services
- Psychiatry
- Regional Australia
- Neurodevelopmental assessment pathways
- Psychosocial disability services

Future reforms should focus on reducing delays before they become crises.

Without substantial workforce expansion, wait times are likely to remain a significant challenge.^{4,11}

11. Recommendations

Develop a National Mental Health Wait Time Monitoring Framework.
Increase psychology and psychiatry workforce capacity.
Expand child and adolescent mental health services.
Improve regional workforce incentives.
Expand telehealth-supported access pathways.
Simplify referral and navigation systems.
Improve affordability through targeted funding mechanisms.
Increase public reporting of service availability and wait times.
Expand multidisciplinary care models.
Improve coordination between health, disability, and education systems.
Support earlier intervention pathways.
Invest in digital navigation and triage systems.

12. Key Takeaways

Wait times are one of Australia's most significant mental health access challenges.
Workforce shortages are the primary structural cause of delays.
Cost remains a major barrier despite Medicare support.
Regional and remote communities experience the greatest access inequities.
Child mental health and psychiatry services face particularly severe capacity pressures.^{9,18}
Delayed treatment can worsen health, educational, social, and economic outcomes.
Service navigation complexity contributes to access barriers.
Demand for autism and ADHD assessments continues to increase.
Telehealth improves access but does not eliminate workforce shortages.
National workforce and access reforms will be essential to improving mental health outcomes through 2030.^{4,11}

Chapter 8: Australian Mental Health Access Index 2026

The Access Index provides an original composite lens for comparing state and territory access risk.

Executive Summary

The Australian Mental Health Access Index 2026 has been developed to provide a comparative assessment of mental health access across Australia's states and territories.

The Index recognises that mental health access is influenced by multiple interacting factors rather than a single measure. Workforce availability, telehealth utilisation, service density, regional accessibility, expenditure, socioeconomic conditions, and population need all contribute to whether individuals can obtain timely mental health support.^{3,22,2,24}

While Australia maintains a nationally funded healthcare system, access to mental health services varies considerably between jurisdictions. Geographic distribution of services, population density, workforce concentration, and regional infrastructure create substantial differences in access experiences.^{4,11,5,20}

The Index identifies the Australian Capital Territory, Victoria, and New South Wales as the strongest-performing jurisdictions overall. These jurisdictions benefit from relatively high provider density, strong telehealth adoption, greater workforce availability, and larger metropolitan service networks.^{2,24,25,4}

At the opposite end of the scale, the Northern Territory faces the most significant structural access challenges due to extreme remoteness, workforce shortages, service scarcity, and high levels of unmet need.^{4,11,5,20}

The purpose of this Index is not to rank states for political comparison. Rather, it provides a framework for identifying strengths, weaknesses, and future priorities for mental health access improvement.

1. Methodology

Overview

The Australian Mental Health Access Index 2026 is based on eight weighted domains that influence mental health service accessibility.

Each jurisdiction is scored out of 100.

Scores are derived from available national evidence, including:

- AIHW mental health reports
- ABS demographic and health data
- National Mental Health Workforce Strategy
- Medicare service utilisation data
- Rural Health and PHN reporting
- Government expenditure reports

Measures

Psychologist density

Psychiatrist density

Allied mental health workforce availability

Workforce growth trends

Weighting Framework

Workforce Availability (25%)

Service Density (15%)

Population Need (10%)

Measures:

- Mental illness prevalence
- Suicide burden
- Service utilisation
- Housing pressures

Regional Access (15%)

Measures:

- Population outside major cities
- Population distribution
- Service delivery complexity
- Regional telehealth capability

Mental Health Expenditure (10%)

Measures:

- Public investment
- Mental health services per capita
- Community mental health availability
- Specialist service access
- Funding distribution

Telehealth Access (10%)

Measures:

- Telehealth utilisation
- Travel burden
- Geographic equity
- Digital infrastructure

Socioeconomic Disadvantage (10%)

Measures:

- SEIFA indicators
- Employment
- Social determinants

Rurality and Remoteness (5%)

Measures:

- Remoteness profile
- Psychological distress indicators

Methodology Note

The Index is an original composite benchmarking model developed for this report using publicly available indicators and risk scoring. It is not an official government ranking, and the scores should be read as indicative comparative benchmarks rather than precise measurements of individual service availability.

2. National Ranking Table

Rank	State/Territory	Score
1	ACT	84
2	Victoria	81
3	New South Wales	79
4	South Australia	74
5	Queensland	72
6	Tasmania	69
7	Western Australia	66
8	Northern Territory	52

3. State Report Cards

1. Australian Capital Territory

Overall Score: 84/100

Strengths

- Highest provider density nationally
- Strong specialist access
- Compact geography
- Strong telehealth integration

Weaknesses

- High concentration of psychologists and psychiatrists
- Cost barriers
- Workforce competition
- Child psychiatry bottlenecks

Future Risks

- Population growth
- Specialist demand pressures
- Rising youth mental health demand

Access Outlook

The ACT is expected to maintain Australia's strongest overall access profile through 2030.

2. Victoria

Overall Score: 81/100

Strengths

- Large mental health workforce
- Strong metropolitan service density
- Significant public investment
- Strong university pipeline

Weaknesses

- Regional workforce shortages
- High service demand
- Cost barriers
- Workforce competition

3. New South Wales

Overall Score: 79/100

Strengths

- Largest mental health workforce
- Strong metropolitan service infrastructure
- Extensive telehealth uptake

Weaknesses

- Large regional disparities
- Long specialist wait times

Future Risks

- Disaster recovery pressures
- Northern Rivers demand
- Regional workforce turnover

Access Outlook

NSW is likely to maintain strong overall access but continue to face regional inequities.^{5,20}

4. South Australia

Overall Score: 74/100

Strengths

- Strong Adelaide service network
- Growing telehealth utilisation
- Moderate workforce stability

Weaknesses

- Significant regional shortages
- Rural psychiatry constraints

Future Risks

- Ageing workforce
- Regional population shifts

Access Outlook

Access is expected to remain stable but uneven.

5. Queensland

Overall Score: 72/100

Strengths

(No strengths listed in the source text.)

Weaknesses

- Rural psychiatrist shortages

Future Risks

- Demand growth exceeding workforce growth
- Increasing developmental assessment demand

Access Outlook

Victoria remains well positioned but will require continued investment in regional access.^{5,20}

5. Queensland

Overall Score: 69/100

Strengths

- Growing workforce
- Expanding telehealth services
- Strong metropolitan growth

Weaknesses

- Large geographic spread
- Significant rural access barriers

Future Risks

- Disaster-related demand
- Population growth outpacing service growth
- Workforce shortages in northern regions

Access Outlook

Queensland's challenge is less about demand and more about distribution.

6. Tasmania

Overall Score: 66/100

Strengths

- Strong community service networks
- High telehealth potential

Weaknesses

- Limited specialist workforce
- Recruitment challenges
- Smaller provider base

Future Risks

- Workforce retention
- Ageing population

Access Outlook

Tasmania requires targeted workforce development to improve rankings.

7. Western Australia

Strengths

- Strong Perth workforce
- Growing telehealth integration

Weaknesses

- Extreme geographic challenges

7. Western Australia

Access Outlook

WA's access challenges are primarily geographic rather than funding-related.

Future Risks

- Remote workforce shortages
- Growing demand in regional centres
- Remote community access issues
- Significant workforce concentration in Perth

8. Northern Territory

Overall Score: 52/100

Strengths

- Strong Aboriginal community-controlled sector
- High telehealth potential

Weaknesses

- Extreme remoteness
- Psychiatry shortages
- Workforce turnover
- Limited service density

Future Risks

- Workforce instability
- Rising demand
- Service continuity challenges

Access Outlook

The NT faces Australia's most significant structural mental health access challenges.

4. National Findings

Finding 1: Geography Remains the Strongest Predictor of Access

States with large metropolitan populations consistently outperform jurisdictions with highly dispersed populations.

Finding 2: Workforce Distribution Matters More Than Workforce Numbers

Several jurisdictions have adequate workforce numbers overall but poor regional distribution.^{4,11,5,20}

Finding 3: Telehealth Has Reduced But Not Eliminated Inequity

Telehealth improves access but does not replace local workforce availability.

Finding 4: Regional Australia Remains Underserved

Every jurisdiction experiences a substantial decline in access outside metropolitan centres.

Finding 5: Child and Adolescent Services Represent a National Weak Point

No jurisdiction performs strongly across all child mental health access indicators.^{9,18}

Finding 6: Psychiatry Is the Most Constrained Workforce

Psychiatry shortages affect every state and territory.

5. Policy Implications

The Index highlights several national priorities.

Workforce Development

- Increasing workforce supply remains the single most important access reform.

Regional Access

- Regional and remote access gaps require targeted investment rather than uniform national approaches.^{5,20}

Telehealth Infrastructure

- Digital mental health infrastructure should be treated as essential healthcare infrastructure.^{2,24,25}

Child and Adolescent Services

- Additional investment is required across assessment, intervention, and specialist pathways.

Aboriginal and Torres Strait Islander Mental Health

- Community-controlled and culturally safe models should remain a national priority.

National Monitoring

- Australia would benefit from an ongoing Mental Health Access Index updated annually.

Index Summary

Top Tier Access

- ACT
- Victoria
- NSW

Middle Tier Access

- South Australia
- Queensland
- Tasmania

Higher-Risk Access Environments

- Western Australia
- Northern Territory

These rankings should be viewed as a strategic benchmarking tool designed to inform future policy development, workforce planning, and regional investment priorities.^{4,11,5,20}

6. Key Takeaways

- Access to mental healthcare varies substantially across Australia.
- The ACT currently demonstrates the strongest overall access profile.
- The Northern Territory faces the most significant structural access barriers.
- Workforce shortages remain the largest determinant of access.
- Telehealth has improved access but has not solved regional inequity.
- Child and adolescent services are under pressure nationally.
- Psychiatry shortages affect all jurisdictions.
- Regional communities remain consistently underserved.
- Future reforms should prioritise workforce, regional access, and service integration.^{4,11,5,20}
- National benchmarking can support more targeted mental health planning.

Chapter 9: Australia's Top 20 Mental Health Access Hotspots

The Hotspots framework identifies regions where service gaps, workforce risk and population need overlap.

Executive Summary

Mental health access challenges are not distributed evenly across Australia. While every state and territory experiences workforce shortages and service pressures, some regions face a combination of disadvantages that create particularly severe barriers to care.^{4,11,21}

These barriers include:

Workforce shortages
Geographic isolation
Socioeconomic disadvantage
Youth mental health demand
Limited psychiatry access
Poor transport infrastructure
Digital connectivity limitations
Child mental health shortages

The Mental Health Access Hotspot Rankings identify regions where these challenges overlap most significantly.

Importantly, the rankings do not necessarily identify regions with the highest prevalence of mental illness. Rather, they identify areas where obtaining timely and appropriate mental health care is likely to be most difficult.

The findings reveal a strong geographic pattern. Remote and very remote communities consistently experience the most severe access barriers, followed by outer regional communities experiencing workforce shortages, population growth, and limited specialist services.^{4,11,5,20}

Many hotspot regions are also experiencing increasing demand due to population growth, economic change, climate-related disasters, youth mental health pressures, and rising demand for autism and ADHD assessment services.^{15,16,9,18}

These findings suggest that future mental health investment should prioritise workforce attraction, regional service development, telehealth infrastructure, Aboriginal-led care models, and child and adolescent mental health pathways.^{2,24,25,4}

1. Ranking Methodology

The Australian Mental Health Access Hotspot Rankings were developed using a composite assessment framework.

Regions were evaluated across eight domains.

Workforce Availability (25%)

Measures:

- Psychologist availability
- Psychiatrist availability
- Allied mental health workforce density
- Recruitment difficulty
- Geographic Access (20%)
- Measures:
- Travel burden
- Remoteness
- Indigenous health inequities
- Natural disaster exposure

Socioeconomic Vulnerability (15%)**Measures:**

- Socioeconomic disadvantage
- Employment conditions
- Housing pressures
- Population growth
- Workforce projections
- Emerging service demand

Telehealth and Digital Access (5%)**Measures:**

- Connectivity
- Digital infrastructure
- Telehealth capability

Youth Mental Health Pressure (10%)**Measures:**

- Child mental health demand
- School-based mental health concerns
- Developmental assessment demand

Indigenous Mental Health Access (10%)**Measures:**

- Indigenous population size
- Availability of Aboriginal-led services
- Cultural safety considerations
- Social determinants

Disaster Exposure (5%)**Measures:**

- Floods
- Bushfires
- Cyclones
- Drought

Future Demand Pressure (10%)**Measures:**

- Distance to specialist services
- Service concentration

Scores were used to identify regions with the greatest unmet mental health access need.

Methodology Note

The Hotspot Rankings are an original composite prioritisation framework. They are intended to identify regions where multiple access barriers overlap, not to provide an official government ranking of mental illness prevalence or local service performance.

3. Kimberley (WA)

Why Included

High Indigenous population, extreme remoteness, and workforce shortages.

Access Challenges

Distance

Transport

Cultural safety

Workforce Situation

Persistent psychiatry shortages

Difficulty attracting and retaining practitioners

Future Outlook

Moderate deterioration risk.

Recommended Actions

- Expand telepsychiatry and rural incentives.
- Strengthen Aboriginal community-controlled mental health services.
- Increase long-term workforce attraction and retention initiatives in remote communities.

4. Pilbara (WA)

Why Included

Rapid economic activity with limited mental health infrastructure.

Access Challenges

- FIFO workforce pressures

Workforce Situation

- Limited specialist workforce
- Persistent psychiatry shortages
- Difficulty attracting and retaining practitioners

Future Outlook

- Moderate deterioration risk.
- Recommended Actions
- Expand telepsychiatry and rural incentives.

5. Far West NSW

Why Included

Large geographic area with limited workforce.

Access Challenges

- Cultural safety
- Recruitment difficulties

Workforce Situation

- Limited specialist workforce.
- Future Outlook
- Access risks remain substantial.
- Recommended Actions
- Increase Aboriginal community-controlled mental health services.

6. Cape York and Torres Strait

Why Included

Remote communities with substantial service access challenges.

Access Challenges

- Remoteness
- Service scarcity

Workforce Situation

Workforce shortages and limited specialist availability.

Future Outlook

Growing demand likely.

Recommended Actions

- Develop regional specialist outreach programs.

7. Country South Australia

Why Included

Significant regional workforce shortages outside Adelaide.

Access Challenges

- Distance
- Child mental health shortages
- Long travel distances

Workforce Situation

- Reliance on visiting providers
- Specialist shortages remain common

Future Outlook

Stable but constrained.

Recommended Actions

- Expand regional workforce incentives.

8. North West Queensland

Why Included

Large service catchments and workforce scarcity.

Access Challenges

- Geographic isolation
- Indigenous health inequity
- Connectivity limitations

Workforce Situation

- Limited psychiatry and psychology availability

Future Outlook

Demand expected to remain high.

Recommended Actions

- Expand culturally safe regional service models.

9. Far North Queensland

Why Included

Rapid population growth and disaster exposure.

Access Challenges

- Long travel distances
- Geographic isolation
- Disaster-related service disruption

Workforce Situation

- Workforce shortages across psychology and psychiatry
- Difficulty attracting and retaining specialists

Future Outlook

Growing population pressures.

Recommended Actions

- Develop permanent multidisciplinary hubs.

10. Northern Rivers (NSW)

Why Included

Significant disaster recovery burden following floods.

Access Challenges

- Disaster-related trauma
- Housing stress
- Workforce shortages

Workforce Situation

- Chronic shortages

Future Outlook

Continued recovery pressures.

Recommended Actions

- Long-term recovery funding.

11. Murrumbidgee (NSW)

Why Included

Large rural catchment with workforce challenges.

Access Challenges

- Distance
- Service scarcity

Workforce Situation

- Demand exceeds workforce growth.
- Recruitment difficulties across multiple disciplines.

Future Outlook

Persistent workforce pressure.

Recommended Actions

- Expand rural placement pathways.

12. Western NSW

Why Included

High remoteness and low specialist density.

Access Challenges

- Distance
- Workforce shortages

Workforce Situation

- Limited specialist availability
- Recruitment challenges across rural communities

Future Outlook

Increasing demand.

Recommended Actions

- Expand youth mental health services.

13. Gippsland (VIC)

Why Included

Large regional population and specialist workforce pressures.

Access Challenges

- Transport barriers
- Long waits

Workforce Situation

- Child mental health shortages
- Provider demand exceeds supply

Future Outlook

Demand growth expected.

Recommended Actions

- Increase regional specialist capacity.

14. North West Tasmania

Why Included

Limited specialist workforce and recruitment difficulties.

Access Challenges

- Geography
- Workforce retention

Workforce Situation

- Small provider base

Future Outlook

Ongoing access concerns.

Recommended Actions

- Strengthen regional service networks.

15. Wide Bay (QLD)

Why Included

Rapid population growth and service pressure.

Access Challenges

- Workforce shortages
- Service concentration

Workforce Situation

- Growing demand exceeds local workforce capacity

Future Outlook

Moderate deterioration risk.

Recommended Actions

- Expand telehealth-supported services.

16. Murraylands and Riverland (SA)

Why Included

Regional workforce constraints and travel burden.

Access Challenges

- Distance
- Psychiatry shortages
- Travel burden

Workforce Situation

- Limited specialist availability
- Recruitment challenges

Future Outlook

Growing access pressure.

Recommended Actions

- Expand child and adolescent services.

17. Goldfields (WA)

Why Included

Remote mining communities and workforce scarcity.

Access Challenges

- FIFO workforce impacts
- Distance

Workforce Situation

- Very low workforce density
- Persistent service gaps

Future Outlook

Continued workforce pressure.

Recommended Actions

- Improve permanent workforce retention.

18. Barkly Region (NT)

Why Included

Extremely remote communities with limited services.

Access Challenges

- Workforce shortages
- Youth demand

Workforce Situation

- Limited specialist availability
- Very low workforce density

Future Outlook

Persistent service gaps.

Recommended Actions

- Expand outreach psychiatry.

19. Burnie and West Coast Tasmania

Why Included

Socioeconomic disadvantage and workforce shortages.

Access Challenges

- Access inequity
- Transport
- Service continuity

Workforce Situation

- Limited provider availability

Future Outlook

Moderate risk.

Recommended Actions

- Increase regional service investment.

20. Darling Downs and South West Queensland

Why Included

Large catchment area with increasing demand.

Access Challenges

- Distance
- Workforce limitations

Workforce Situation

- Growing shortages in child and youth services

Future Outlook

Demand likely to increase.

Recommended Actions

- Expand multidisciplinary care models.
- Expand local workforce pathways.

3. National Findings

Finding 1: Remoteness Remains the Strongest Driver of Access Inequity

The highest-ranked hotspots are overwhelmingly located in remote and very remote Australia.^{5,20}

Finding 2: Child and Adolescent Services Are Under Severe Pressure

Many hotspot regions experience significant shortages of child psychologists, psychiatrists, and developmental assessment services.^{4,11,13,9}

Finding 3: Psychiatry Access Is a National Weakness

Every hotspot region experiences psychiatrist shortages.

4. Policy Implications

The Hotspot Rankings suggest several national priorities.

Workforce Incentives

Regional workforce attraction and retention should remain a national priority.

Telehealth Infrastructure

Telehealth should be treated as essential mental health infrastructure.

Child Mental Health Expansion

Regional child and adolescent mental health services require significant capacity growth.^{5,20,9,18}

Aboriginal-Led Models

Community-controlled mental health services should receive ongoing investment.

Regional Data Monitoring

Access gaps should be tracked using region-level indicators rather than state-level averages.

Long-Term Disaster Recovery

Mental health recovery programs should extend beyond short-term disaster response periods.^{29,30}

5. Priority Regions for Investment

Based on the composite hotspot rankings, the highest priority investment regions are:

Tier 1 Priority

- Remote Northern Territory
- Central Australia
- Kimberley
- Pilbara
- Far West NSW

Tier 2 Priority

- Cape York and Torres Strait
- Country South Australia
- North West Queensland
- Far North Queensland
- Northern Rivers

Tier 3 Priority

- Murrumbidgee
- Western NSW
- Gippsland
- North West Tasmania
- Wide Bay

6. National Findings

Finding 4: Indigenous Communities Face Disproportionate Barriers

Regions with large Aboriginal and Torres Strait Islander populations consistently face greater access challenges.³²

Finding 5: Disaster-Affected Communities Experience Sustained Demand

Flood, drought, bushfire, and cyclone impacts create long-term mental health service pressures.^{29,30}

Finding 6: Workforce Distribution Is More Important Than Workforce Numbers

The challenge is not only workforce supply but workforce location.

These regions represent the areas where targeted investment is most likely to improve mental health access outcomes over the remainder of the decade.

6. Key Takeaways

- Mental health access challenges are concentrated in identifiable geographic hotspots.
- Remote and very remote Australia experiences the greatest barriers.
- Child and adolescent mental health shortages are widespread.
- Psychiatry shortages affect every hotspot region.
- Aboriginal and Torres Strait Islander communities remain disproportionately impacted.³²
- Workforce shortages underpin most access challenges.
- Telehealth improves access but cannot replace local workforce capacity.
- Disaster-affected communities require long-term support.
- Regional investment should be targeted rather than uniform.
- Addressing hotspot regions offers one of the largest opportunities to improve national mental health access outcomes.

Chapter 10: Mental Health Access to 2030

Australia's access challenge to 2030 will be shaped by workforce supply, youth demand, telehealth and regional service design.

Executive Summary

Australia's mental health system is entering a period of significant transformation. Between now and 2030, demand for mental health support is expected to continue increasing, driven by population growth, workforce shortages, youth mental health needs, neurodevelopmental assessment demand, psychosocial disability support requirements, and broader social and economic pressures.^{4,11,15,16}

The central challenge facing Australia is not whether demand will increase—it almost certainly will. The challenge is whether mental health service capacity can expand quickly enough to meet that demand while maintaining quality, accessibility, and sustainability.

Several forces are likely to shape the next five years:

- Continued population growth
- Growing demand for child and adolescent mental health services
- Increasing autism and ADHD assessment demand
- Expansion of NDIS-related mental health supports
- Ongoing workforce shortages
- Greater telehealth utilisation
- Emergence of AI-assisted mental health technologies
- Climate-related mental health pressures
- School-based initiatives
- Regional workforce challenges

The evidence suggests that mental health access will increasingly depend on the ability of governments, providers, and communities to adopt new models of care. Traditional service expansion alone is unlikely to meet future demand. Workforce growth, digital innovation, early intervention, and integrated care models will become increasingly important.^{4,11}

By 2030, Australia could either experience a more connected, technology-enabled, and accessible mental health system or face worsening workforce shortages, increasing wait times, and greater inequity between metropolitan and regional communities.^{4,11,5,20}

The choices made during the remainder of this decade will determine which of these futures emerges.

1. Current State

Australia currently faces a substantial mismatch between demand for mental health services and available workforce capacity.^{4,11}

Approximately 4.3 million Australians experience a mental disorder each year, while millions more experience psychological distress that may not meet diagnostic thresholds but still affects wellbeing, productivity, and quality of life.¹

Mental health services have expanded significantly over the past decade through:

- Medicare-funded psychology
- Telehealth
- NDIS supports
- Digital mental health services
- Community mental health programs

Despite this expansion, wait times remain common across psychology, psychiatry, child mental health services, and developmental assessment pathways.^{9,18}

Workforce shortages remain the most significant structural barrier to improved access.^{4,11}

2. Key Statistics

Several indicators provide insight into future pressures.

- Australia's population is projected to exceed 30 million people before the end of the decade.^{19,28}
- Mental health remains a major contributor to national disease burden and health service demand.²³
- Approximately one in five Australians aged 16–85 experienced a 12-month mental disorder in the most recent national survey period.¹
- Youth psychological distress remains significantly elevated compared with historical levels.^{9,18}
- Autism-related demand continues to grow across health, disability, and education systems.^{15,16}
- More than 700,000 Australians now participate in the NDIS.¹⁵
- Telehealth remains responsible for approximately one in five Medicare mental health services.^{2,10,24,25}
- Mental health-related occupations remain prominent in national workforce shortage and labour market reporting.^{14,19,28}

These indicators suggest that future demand is likely to increase faster than overall population growth.^{19,28}

3. Demand Forecast

Population Growth

Population growth is expected to be strongest in:

- South East Queensland
- Greater Melbourne
- Western Sydney
- Perth
- Major regional centres

Population growth alone will increase demand for mental health services. Even if prevalence rates remain stable, a larger population will require:

- More psychologists
- More psychiatrists
- More counsellors
- More social workers
- More behaviour support practitioners
- More community mental health services

These areas are likely to experience increasing pressure on existing services.

Youth Mental Health Demand

Youth mental health demand is expected to remain one of the fastest-growing areas of the system.^{9,18}

Key drivers include:

- Anxiety
- Depression

The next five years will determine whether Australia can successfully adapt its mental health system to rising demand.

4. Workforce Forecast

Psychology Workforce

Psychologist numbers are likely to continue increasing.

However, demand is expected to increase simultaneously.

The major challenge will remain workforce distribution rather than total workforce numbers.^{4,11}

Psychiatry Workforce

Psychiatry is likely to remain the most constrained workforce group.

Child psychiatry, regional psychiatry, and complex mental health assessment services face the greatest risks.^{13,5,20,9}

Behaviour Support Workforce

Demand is expected to continue growing due to NDIS expansion and autism-related supports.^{15,16}

Workforce shortages may persist without targeted investment.

Regional Workforce

Regional recruitment challenges are likely to remain significant.

Competition between public, private, and disability sectors may intensify.

Neurodevelopmental Demand

Autism- and ADHD-related demand is expected to remain one of the strongest growth drivers through 2030.^{15,16,9,18}

Assessment pathways are already under pressure and may face further bottlenecks.

Demand for child and adolescent services is likely to exceed workforce growth unless substantial reforms occur.^{4,11,9,18}

Key drivers include:

- School refusal
- Autism assessments
- ADHD assessments
- Educational pressures
- Social media-related concerns

Psychosocial Disability Demand

NDIS-related psychosocial disability demand is expected to continue growing as awareness and service engagement increase.^{15,16}

This will place additional pressure on:

- Psychology services
- Behaviour support
- Support coordination
- Recovery coaching

5. Telehealth Forecast

Telehealth is expected to become a permanent and increasingly sophisticated component of Australia's mental health system.^{2,24,25}

By 2030:

- Hybrid care models are likely to dominate.
- Telehealth utilisation is likely to remain well above pre-pandemic levels.
- The future mental health system will depend heavily on workforce availability.

6. Regional Forecast

Regional and remote Australia will remain a major policy challenge.

Key trends include:

Population Growth in Regional Centres

Many regional centres are experiencing population growth faster than workforce growth.^{4,11,5,20}

Workforce Shortages

Workforce shortages are expected to persist in:

- Psychiatry
- Child mental health
- Behaviour support
- Developmental assessment

Disaster Recovery Demand

Climate-related disasters are expected to increase demand for regional mental health support.^{5,20,29,30}

Indigenous Mental Health Access

Aboriginal and Torres Strait Islander communities will continue to require culturally safe, community-controlled models.³²

Rural communities will rely increasingly on telehealth-supported specialist care.^{2,24,25,5}

Telehealth is unlikely to replace face-to-face services entirely but will continue reducing geographic barriers.^{2,24,25}

7. Emerging Technologies

Artificial intelligence is likely to become increasingly integrated into mental health systems.

AI-Assisted Mental Health Technologies

Potential applications include:

- Early screening
- Symptom monitoring
- Appointment navigation
- Digital triage
- Psychoeducation
- Administrative support

AI is unlikely to replace clinicians but may improve efficiency and accessibility.

Digital Mental Health Platforms

Digital assessment tools will become more common.

Digital platforms are expected to become more sophisticated and integrated with traditional services.

Virtual Care Ecosystems

Consumers may increasingly move between:

- Self-guided digital support
- AI-assisted tools
- Telehealth
- Face-to-face care

within a single integrated system.

8. Emerging Trends

Several trends are likely to define the remainder of the decade.

Greater Mental Health Literacy

Continued improvement in awareness and help-seeking.

Telehealth Expansion

Continued telehealth growth offers substantial access benefits.

Integrated Care Models

Closer integration between:

- Health
- Disability
- Education
- Community sectors

Outcome Measurement

Greater emphasis on measurable outcomes and service quality.

Consumer-Centred Care

Increasing emphasis on personalised support pathways.

9. Future Risks

Workforce Supply Fails to Keep Pace

The greatest risk is that demand grows faster than workforce capacity.

Assessment and treatment delays may continue to worsen.

Child Mental Health Bottlenecks

Growing demand could create funding and workforce pressures.

Regional Inequity

Access disparities between metropolitan and regional communities may increase.

NDIS Sustainability Pressures

New workforce models may improve access.

Climate-Related Mental Health Impacts

Natural disasters, droughts, and environmental stressors may increase psychological distress.^{29,30}

Technology Exclusion

Digital innovation could unintentionally widen inequities if vulnerable groups are excluded.

10. Future Opportunities

Early Intervention Expansion

Increasing focus on prevention and early support.

AI-Enabled Efficiency

Technology may improve system navigation and reduce administrative burden.

Workforce Innovation

New workforce models may improve access.

Prevention and Early Intervention

Earlier support may reduce long-term demand.

Community-Based Care

Strengthening local supports may improve outcomes while reducing system pressure.

11. Best Case Scenario

By 2030:

- Workforce growth exceeds demand growth.
- Telehealth becomes fully integrated.
- Child mental health waiting times decrease.
- Regional access improves substantially.
- AI improves efficiency without compromising quality.
- NDIS workforce capacity expands.
- Early intervention reduces future burden.

In this scenario, access improves across most regions and population groups.

12. Worst Case Scenario

By 2030:

- Workforce shortages worsen.
- Psychiatry access deteriorates.
- Child assessment waiting times increase.
- Regional inequities expand.
- NDIS demand exceeds workforce capacity.
- Climate-related events increase service pressure.
- Costs continue rising.

In this scenario, wait times and unmet need increase substantially.

13. Challenges

Australia faces several major strategic challenges:

- Workforce shortages
- Child mental health demand
- Regional inequity
- NDIS growth pressures
- Funding sustainability
- Workforce burnout
- Service fragmentation
- Psychiatry shortages
- Technology integration
- Climate-related mental health impacts

14. Implications

The next five years will determine whether Australia can transition from a reactive mental health system toward a proactive, prevention-focused model.

The evidence suggests that increasing workforce numbers alone will not be sufficient.^{4,11}

Future success will depend on:

- Workforce expansion
- Technology integration
- Early intervention
- Integrated models of care
- Sustainable funding
- Regional workforce development
- Digital innovation
- Cross-sector collaboration

15. Recommended National Strategy

Develop a National Mental Health Access Strategy to 2030.

Pillar 1: Workforce Growth

- Expand mental health workforce training capacity.
- Expand psychology, psychiatry, social work, and behaviour support training pathways.¹⁷

Pillar 2: Regional Access

- Strengthen regional workforce incentives.
- Expand telehealth infrastructure nationally.
- Invest in regional workforce incentives and telehealth infrastructure.

Pillar 3: Child and Youth Mental Health

- Prioritise child mental health as a national reform area.
- Create a National Child Mental Health Action Plan.

Pillar 4: Digital and AI Integration

- Adopt technology to improve access, triage, and efficiency.
- Invest in AI-supported navigation tools.

Pillar 5: NDIS Sustainability

- Improve integration between health and disability systems.

Pillar 6: Prevention and Early Intervention

- Shift investment toward earlier support models.
- Increase early intervention funding.

Pillar 7: Aboriginal and Torres Strait Islander Mental Health

- Support community-controlled and culturally safe services.
- Expand Aboriginal-led mental health services.

Pillar 8: National Data Monitoring

- Establish annual Mental Health Access Index reporting.
- Develop national access, workforce, and wait-time dashboards.

16. Recommendations

- Expand workforce capacity while maintaining participant outcomes.
- Strengthen service coordination.
- Increase regional investment.
- Expand early intervention initiatives.

The jurisdictions that successfully integrate these elements are likely to achieve the strongest access outcomes.

17. Key Takeaways

- Mental health demand is expected to continue increasing through 2030.
- Workforce shortages remain the largest strategic risk.
- Child and adolescent mental health demand will continue to grow.
- Telehealth will remain a core access pathway.
- AI technologies may improve efficiency but will not replace clinicians.
- Regional access inequities remain a major challenge.

Conclusion: Access to 2030

Australia's mental health access challenge is now a long-term system design issue rather than a short-term demand spike. The evidence reviewed in this report indicates that access will depend on whether workforce supply, regional service distribution, telehealth, child and adolescent pathways, psychosocial disability supports, and data transparency improve together.^{4, 11, 15, 16}

For policymakers and service planners, the key message is practical: mental health access should be measured, funded, and improved at the level where people seek care. National averages are useful, but local workforce availability, wait times, gap fees, provider capacity, and culturally safe service options determine whether Australians can obtain timely support.

The most credible path to improvement is a mixed model: stronger local services where face-to-face and culturally safe care are essential, supported by telehealth, digital navigation, multidisciplinary workforce models, and PHN-led local commissioning. This approach is especially important for regional and remote communities, Aboriginal and Torres Strait Islander communities, children and adolescents, people with psychosocial disability, and communities affected by disasters.^{2, 24, 25, 5}

NDIS-related demand will continue increasing.

Climate-related mental health impacts are likely to become more important.

Early intervention offers the strongest opportunity to reduce future burden.

The decisions made during the next five years will shape Australia's mental health access outcomes for the next generation.

Appendix A - State-by-State Workforce Tables

State-by-state workforce tables supporting the report's access analysis.

Appendix A.1 Methodological Notes

This appendix provides a workforce evidence base for the Australian Mental Health Access Report 2026. It summarises available data on specialist mental health workforce availability across Australian states and territories, with particular attention to psychologists, clinical psychologists, psychiatrists, mental health nurses, mental health occupational therapists, accredited mental health social workers, counsellors, behaviour support practitioners, and support coordination-related roles.^{4,11,13,15}

The appendix uses a combination of confirmed public data and derived indicators. Where exact state-level headcount or full-time equivalent data are unavailable, this is stated clearly.

Regulated and Non-Regulated Workforce Categories

The following workforce groups are regulated through AHPRA or specialist medical regulation:^{4,11,12}

- Psychologists
- Provisional psychologists
- Psychiatrists
- Nurses, including registered nurses working in mental health
- Occupational therapists

The following groups are not regulated by AHPRA in the same way:

- Counsellors
- Psychotherapists
- Support coordinators
- Psychosocial recovery coaches

Primary Data Types Used

Confirmed Registration Data

These include AHPRA and Psychology Board of Australia registrant data, such as registered psychologists, provisional psychologists, non-practising psychologists, area-of-practice endorsements, and board-approved supervisors.^{4,11,12}

Confirmed National Workforce Data

These include AIHW mental health workforce data drawn from the National Health Workforce Dataset, Australian Association of Social Workers data, and specialised mental health facilities data.^{4,11}

Derived FTE Estimates

AIHW provides full-time equivalent rates per 100,000 population by state and territory for psychologists, psychiatrists, mental health nurses, and mental health occupational therapists. In this appendix, these rates have been multiplied by ABS September 2025 Estimated Resident Population to create approximate workforce FTE counts by jurisdiction.^{4,11,13}

Self-Regulated Workforce Data

Counsellors and psychotherapists are not registered under AHPRA. Workforce figures rely on professional body membership and registration data from organisations such as the Australian Counselling Association and PACFA.^{4,11,12}

Qualitative Workforce Risk Indicators

Behaviour support practitioners, support coordinators, and psychosocial recovery coaches are not consistently reported in a nationally comparable public workforce dataset. Their availability is therefore assessed qualitatively using NDIS Commission materials, disability sector evidence, and regional access indicators.^{4,11,5,20}

The tables use the following data categories.

Interpreting Workforce Density

Workforce density is usually expressed as practitioners or FTE per 100,000 population.^{4,11}

This is useful for comparing jurisdictions, but it should be interpreted cautiously. A high statewide workforce density does not guarantee timely access. For example, a state may have strong overall psychologist numbers but still experience severe shortages in regional areas, child mental health, psychiatry, or autism assessment.^{4,11,5,20}

Headcount Versus Clinical Capacity

Headcount does not equal clinical service capacity.

A registered practitioner may:

- Work part-time.
- Work in education, research, policy, or administration.
- Be non-practising.
- Focus on a specialised population or presentation.
- Work in private practice with limited availability.
- Be unavailable to Medicare, NDIS, or public-sector clients.

For this reason, FTE rates and clinical FTE are stronger indicators of practical access than registration totals alone.^{4,11}

Data Limitations

The main data limitations are:

- Limited real-time workforce availability data.
- Limited PHN-level practitioner capacity data.
- Limited child and adolescent workforce data.
- Limited regional breakdowns for some professions.
- State-level averages masking local shortages.
- Inconsistent public reporting across professions.
- Limited public data on counsellors, behaviour support practitioners, and support coordinators.^{4,11,17}
- Limited visibility of waitlists, closed books, and appointment availability.

Behaviour Support Practitioners

Behaviour support practitioners are subject to NDIS Quality and Safeguards Commission suitability processes when delivering specialist behaviour support under the NDIS. However, this is not the same as AHPRA professional registration.^{4,11,12,15}

Appendix A.2 National Workforce Summary Table

The table below summarises relative workforce access risk by jurisdiction. Ratings are interpretive and based on available workforce density, remoteness, known distribution issues, child and adolescent pressures, psychiatry constraints, and regional service availability.^{4, 11, 5, 20}

Jurisdiction	Psychologist Access	Psychiatrist Access	Allied Mental Health Workforce	Regional Workforce Risk	Child Mental Health Workforce Risk	Overall Workforce Risk
ACT	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk
New South Wales	Moderate risk	Moderate risk	Moderate risk	High risk	High risk	Moderate risk
Victoria	Moderate risk	Moderate risk	Moderate risk	Moderate risk	High risk	Moderate risk
Queensland	Moderate risk	Moderate risk	High risk	High risk	High risk	Moderate risk
South Australia	High risk	Moderate risk	High risk	High risk	High risk	High risk
Western Australia	Moderate risk	Moderate risk	Moderate risk	Very high risk	High risk	Moderate risk
Tasmania	High risk	Moderate risk	High risk	High risk	High risk	High risk
Northern Territory	Very high risk	High risk	Very high risk	Very high risk	Very high risk	Very high risk

Data Notes for Tables

- Population figures use ABS September 2025 Estimated Resident Population.
- Psychologist, psychiatrist, mental health nurse, and mental health occupational therapist figures are derived FTE estimates based on AIHW 2024 FTE rates per 100,000 population.^{4,11}
- Registered psychologist and clinical psychology endorsement figures are from AHPRA/Psychology Board of Australia December 2025 data.^{4,11,12}
- Clinical psychology figures refer to area-of-practice endorsements, not necessarily unique individual clinical psychologists, because some psychologists may hold more than one endorsement.^{4,11,12}
- Accredited mental health social worker figures are derived from AIHW/AASW 2024 rates per 100,000 population.^{4,11}
- Counsellor, behaviour support practitioner, support coordinator, and psychosocial recovery coach data are not available in a consistent, state-level public dataset.^{4,11,15,16}

Summary Interpretation

The ACT has the strongest workforce density profile, but its small size and high demand still create access pressures.

Victoria and New South Wales have large workforces, but both experience regional and child mental health bottlenecks.

Queensland and Western Australia face significant geographic distribution challenges.

South Australia and Tasmania have smaller workforce bases and notable regional constraints.

The Northern Territory has the most severe workforce access risk due to low specialist workforce density, remoteness, cultural access requirements, and high service delivery complexity.^{4,11,5,20}

Appendix A.3 State and Territory Workforce Tables

National Specialist Workforce Rate Table

Jurisdiction	Population (Sep 2025)	Psychologist FTE Rate / 100k	Estimated Psychologist FTE	Psychiatrist FTE Rate / 100k	Estimated Psychiatrist FTE	Mental Health Nurse FTE Rate / 100k	Estimated MH Nurse FTE	MH OT FTE Rate / 100k	Estimated MH OT FTE	Accredited MH Social Worker Rate / 100k	Estimated AMHSW Headcount
ACT	486,231	171	831	16	78	113	549	7	34	17	83
NSW	8,624,534	116	10,004	14	1,207	89	7,676	7	604	13	1,121
Victoria	7,104,349	124	8,809	16	1,137	114	8,099	15	1,066	10	710
Queensland	5,692,642	107	6,091	16	911	94	5,351	11	626	16	911
South Australia	1,908,182	80	1,527	15	286	96	1,832	10	191	7	134
Western Australia	3,061,672	110	3,368	14	429	116	3,552	11	337	13	398
Tasmania	576,659	94	542	14	81	106	611	5	29	20	115
Northern Territory	265,457	70	186	9	24	80	212	6	16	15	40

Notes

- Population figures are based on ABS Estimated Resident Population (September 2025).
- FTE estimates are derived from AIHW workforce rates per 100,000 population.^{4,11,13}
- AMHSW = Accredited Mental Health Social Worker.
- Figures are estimates intended for comparative workforce planning and should not be interpreted as exact practitioner headcounts.^{4,11}

AHPRA Psychology Registration and Clinical Psychology Endorsement Table

Jurisdiction	General Registered Psychologists	General Psychologists / 100k	Clinical Psychology Endorsements	Clinical Psychology Endorsements / 100k	Board-Approved Supervisors
ACT	1,039	214	442	91	401
New South Wales	13,271	154	4,120	48	4,271
Northern Territory	227	86	58	22	66
Queensland	7,730	136	2,427	43	2,442
South Australia	2,048	107	923	48	702
Tasmania	778	135	283	49	249
Victoria	11,784	166	3,809	54	3,672
Western Australia	4,416	144	1,595	52	1,398

Notes

- Figures are based on AHPRA / Psychology Board of Australia (December 2025) registration data.^{4,11,12}
- Clinical Psychology Endorsements represent area-of-practice endorsements and do not necessarily equal the number of unique clinical psychologists, as some practitioners may hold multiple endorsements.^{4,11,12}
- Board-Approved Supervisors are psychologists approved by the Psychology Board of Australia to supervise registration pathways and area-of-practice endorsement programs.^{4,11,12}

State and Territory Commentary

Australian Capital Territory (ACT)

Commentary

The ACT has the strongest psychologist access profile in Australia by FTE rate. Its compact geography reduces travel barriers and allows services to be geographically concentrated. However, the ACT still experiences access constraints related to cost, demand, specialist wait times, and cross-border service use from surrounding NSW communities.^{4,11}

The ACT's key risks are not primarily geographic. They relate to specialist bottlenecks, child and adolescent demand, psychiatry wait times, and high private-sector costs.^{9,18}

Workforce Indicator	Data / Assessment
Estimated psychologist FTE	831
Psychologist FTE rate	171 per 100,000
General registered psychologists	1,039
Clinical psychology endorsements	442
Estimated psychiatrist FTE	78
Psychiatrist FTE rate	16 per 100,000
Estimated mental health nurse FTE	549
Estimated mental health OT FTE	34
Estimated accredited mental health social workers	83
Regional distribution risk	Low
Child mental health pressure	Moderate
Overall workforce risk	Moderate

New South Wales

Commentary

New South Wales has the largest absolute psychology workforce in Australia, but its workforce is unevenly distributed.

Sydney and major coastal centres have much greater provider density than inland, rural, and remote areas.^{4,11,5,20}

The main workforce risks are psychiatry access, child and adolescent mental health access, developmental assessment bottlenecks, and regional workforce shortages across Western NSW, Far West NSW, Murrumbidgee, and disaster-affected regions such as the Northern Rivers.^{4,11,5,20}

Workforce Indicator	Data / Assessment
Estimated psychologist FTE	10,004
Psychologist FTE rate	116 per 100,000
General registered psychologists	13,271
Clinical psychology endorsements	4,120
Estimated psychiatrist FTE	1,207
Psychiatrist FTE rate	14 per 100,000
Estimated mental health nurse FTE	7,676
Estimated mental health OT FTE	604
Estimated accredited mental health social workers	1,121
Regional distribution risk	High
Child mental health pressure	High
Overall workforce risk	High

Victoria

Commentary

Victoria has one of the strongest workforce density profiles among the states. It has comparatively high psychologist and mental health nurse FTE rates and a large mental health occupational therapy workforce.^{4,11}

However, Victoria still faces significant regional access challenges. Gippsland, north-western Victoria, the Mallee, and outer regional growth corridors are more exposed to workforce shortages than metropolitan Melbourne.^{4,11,5,20}

Child and adolescent mental health, developmental assessment demand, and specialist psychiatry remain high-risk service categories.^{9,18}

Workforce Indicator	Data / Assessment
Estimated psychologist FTE	8,809
Psychologist FTE rate	124 per 100,000
General registered psychologists	11,784
Clinical psychology endorsements	3,809
Estimated psychiatrist FTE	1,137
Psychiatrist FTE rate	16 per 100,000
Estimated mental health nurse FTE	8,099
Estimated mental health OT FTE	1,066
Estimated accredited mental health social workers	710
Regional distribution risk	Moderate
Child mental health pressure	High
Overall workforce risk	Moderate

Queensland

Commentary

Queensland's main workforce challenge is distribution. South East Queensland has relatively stronger access, while northern, western, and remote Queensland face substantial workforce constraints.^{4,11,5,20}

Despite strong overall workforce growth, Queensland continues to experience significant regional inequities. Population growth, disaster-related demand, child and adolescent mental health pressures, and limited specialist availability in regional and remote communities are expected to remain key workforce challenges through 2030.^{4,11,5,20}

Workforce Indicator	Data / Assessment
Estimated psychologist FTE	6,091
Psychologist FTE rate	107 per 100,000
General registered psychologists	7,730
Clinical psychology endorsements	2,427
Estimated psychiatrist FTE	911
Psychiatrist FTE rate	16 per 100,000
Estimated mental health nurse FTE	5,351
Estimated mental health OT FTE	626
Estimated accredited mental health social workers	911
Regional distribution risk	High
Child mental health pressure	High
Overall workforce risk	Moderate

Summary

Despite strong absolute workforce numbers, New South Wales remains a high-risk jurisdiction because large state averages obscure significant regional gaps.^{4,11,5,20}

South Australia

Commentary

South Australia has a comparatively low psychologist FTE rate and a strong concentration of services in Adelaide. Rural and remote areas, including Country SA, the Eyre Peninsula, Far North, and the Riverland, face more significant access constraints.^{4,11,5,20}

Psychiatry access is a major risk, particularly outside Adelaide. Regional travel distances, limited specialist availability, and smaller provider markets contribute to ongoing workforce vulnerability.^{4,11,5,20}

South Australia requires targeted regional workforce development, telepsychiatry support, and investment in child and adolescent pathways.^{4,11,5,20}

Workforce Indicator	Data / Assessment
Estimated psychologist FTE	1,527
Psychologist FTE rate	80 per 100,000
General registered psychologists	2,048
Clinical psychology endorsements	923
Estimated psychiatrist FTE	286
Psychiatrist FTE rate	15 per 100,000
Estimated mental health nurse FTE	1,832
Estimated mental health OT FTE	191
Estimated accredited mental health social workers	134
Regional distribution risk	High
Child mental health pressure	High
Overall workforce risk	High

Western Australia

Commentary

Western Australia faces some of Australia's greatest workforce distribution challenges because of its vast geography. Although Perth has a comparatively strong mental health workforce, regional and remote communities experience substantial shortages in psychology, psychiatry, child mental health, and multidisciplinary services.^{4,11,5,20}

The state's size, regional population growth, and exposure to disaster-related mental health demand increase workforce pressure. North West Queensland, Far North Queensland, Wide Bay, Cape York, and the Torres Strait should be treated as priority workforce risk regions.^{4,11,5,20}

Queensland also faces growing child and adolescent demand, neurodevelopmental assessment pressures, and behaviour support workforce shortages.^{4,11,17,9}

Workforce Indicator	Data / Assessment
Estimated psychologist FTE	3,368
Psychologist FTE rate	110 per 100,000
General registered psychologists	4,416
Clinical psychology endorsements	1,595
Estimated psychiatrist FTE	429
Psychiatrist FTE rate	14 per 100,000
Estimated mental health nurse FTE	3,552
Estimated mental health OT FTE	337
Estimated accredited mental health social workers	398
Regional distribution risk	Very high
Child mental health pressure	High
Overall workforce risk	High

Western Australia

Commentary

Western Australia has reasonable workforce density in Perth but severe geographic access challenges across the state. The Kimberley, Pilbara, Goldfields, and remote Aboriginal communities experience major workforce and service continuity risks.^{4,11,5,20}

The state's mental health workforce is heavily concentrated in Perth, while regional and remote communities rely on outreach, telehealth, visiting clinicians, and local primary care.^{2,24,25,4}

The major workforce risks are psychiatry, child mental health, culturally safe care, behaviour support, and remote multidisciplinary access.^{4,11,5,20}

Workforce Indicator	Data / Assessment
Estimated psychologist FTE	3,368
Psychologist FTE rate	110 per 100,000
General registered psychologists	4,416
Clinical psychology endorsements	1,595
Estimated psychiatrist FTE	429
Psychiatrist FTE rate	14 per 100,000
Estimated mental health nurse FTE	3,552
Estimated mental health OT FTE	337
Estimated accredited mental health social workers	398
Regional distribution risk	Very high
Child mental health pressure	High
Overall workforce risk	High

Tasmania

Commentary

Tasmania has a small workforce base and limited specialist depth. While the accredited mental health social worker rate is comparatively high, the state faces broader workforce constraints due to scale, recruitment difficulty, and limited specialist availability.^{4,11,14}

North West Tasmania and the West Coast face particular access challenges. Key risks include psychiatry, child and adolescent mental health, developmental assessment, rural travel burden, and workforce retention.^{4,11,5,20}

Tasmania's workforce strategy should focus on retention, training placements, telehealth-supported specialist access, and regional multidisciplinary service development.^{2,24,25,4}

Workforce Indicator	Data / Assessment
Estimated psychologist FTE	542
Psychologist FTE rate	94 per 100,000
General registered psychologists	778
Clinical psychology endorsements	283
Estimated psychiatrist FTE	81
Psychiatrist FTE rate	14 per 100,000
Estimated mental health nurse FTE	611
Estimated mental health OT FTE	29
Estimated accredited mental health social workers	115
Regional distribution risk	High
Child mental health pressure	High
Overall workforce risk	High

Workforce Indicator	Data / Assessment
Estimated psychologist FTE	186
Psychologist FTE rate	70 per 100,000
General registered psychologists	227
Clinical psychology endorsements	58
Estimated psychiatrist FTE	24
Psychiatrist FTE rate	9 per 100,000
Estimated mental health nurse FTE	212
Estimated mental health OT FTE	16
Estimated accredited mental health social workers	40
Regional distribution risk	Very high
Child mental health pressure	Very high
Overall workforce risk	Very high

Northern Territory

Commentary

The Northern Territory has the most significant workforce access risk in Australia. It has the lowest psychiatrist FTE rate and one of the lowest psychologist access profiles. These workforce constraints are compounded by extreme remoteness, high travel burden, workforce turnover, cultural safety requirements, and limited service continuity.^{4,11,5,20}

Remote Aboriginal communities face particular access barriers. Local workforce development, Aboriginal Community Controlled Health Organisation-led models, telehealth infrastructure, multidisciplinary outreach, and long-term workforce retention strategies are essential.^{2,24,25,4}

The NT should be treated as a separate national priority rather than compared only through conventional state-level workforce indicators.^{4,11}

Behaviour Support Practitioner and NDIS Workforce Notes

Behaviour support practitioners are central to NDIS-funded support for people with autism, intellectual disability, psychosocial disability, and complex support needs. However, nationally consistent public data on behaviour support practitioner numbers by state and territory are limited.^{4,11,15,16}

The NDIS Commission requires practitioners delivering specialist behaviour support under the NDIS to be considered suitable under its Positive Behaviour Support Capability Framework. This framework includes capability levels and suitability processes, but it does not provide a public workforce dataset equivalent to AHPRA registration data.^{4,11,12,15}

Behaviour support workforce risk is assessed qualitatively in this appendix based on:^{4,11,17}

- NDIS demand growth
- Autism support demand
- Workforce supervision needs
- Regional provider thin markets
- Restrictive practice requirements
- Specialist provider availability

Support coordinators and psychosocial recovery coaches are similarly important but not consistently captured in publicly comparable state-level workforce datasets.^{4,11,15,16}

Counselling Workforce Notes

Counsellors and psychotherapists are an important part of the Australian mental health workforce, particularly for mild-to-moderate distress, relationship concerns, grief, life transitions, trauma-informed support, and early intervention.^{4,11}

However, counsellors are not currently regulated through AHPRA. The Australian Counselling Association reports more than 23,000 registered counsellors and psychotherapists nationally, while PACFA reports more than 6,000 registrants and 11,000 members as at 30 June 2025. These figures are not directly comparable with AHPRA registration data because professional-body membership and self-regulation operate differently from statutory registration.¹²

For this appendix, counselling workforce availability is therefore treated as a supplementary national workforce indicator rather than a state-level comparable metric.^{4,11}

Metropolitan Versus Regional Distribution

AIHW workforce data show that workforce supply is highest in major cities across all specialist mental health professions, with the most pronounced concentration among psychiatrists and psychologists.^{4,11,13,5}

The 2024 remoteness pattern is clear:

Workforce Group	Major Cities FTE Rate / 100,000	Inner Regional	Outer Regional	Remote	Very Remote
Psychiatrists	18	9	7	7	2
Mental health nurses	107	94	64	56	40
Psychologists	130	78	56	43	28
Mental health occupational therapists	12	7	6	6	2
Accredited mental health social workers	12	16	13	8	2

Interpretation

The table demonstrates a consistent decline in workforce availability with increasing remoteness. Psychiatrists and psychologists show the greatest concentration in major cities, while remote and very remote communities experience substantially lower workforce density across all specialist mental health professions.^{4,11,13,5}

These findings reinforce the importance of targeted regional workforce strategies, telehealth-supported care, multidisciplinary service models, and long-term workforce retention initiatives to improve access outside metropolitan Australia.^{4,11,5,20}

Interpretation

Psychiatry and psychology show the sharpest metropolitan concentration. Mental health nurses are more evenly distributed than psychologists and psychiatrists, but even nursing supply declines in very remote areas.

Accredited mental health social workers have comparatively strong representation in inner regional areas, but access falls sharply in very remote communities.^{4,11,13,5}

These findings demonstrate that remoteness remains a major determinant of workforce availability. While some professions are more evenly distributed than others, every specialist mental health workforce group experiences reduced availability as remoteness increases, reinforcing the need for targeted regional workforce investment, telehealth, and multidisciplinary service models.^{4,11,5,20}

Appendix A.4 Workforce Shortage Risk Matrix

Jurisdiction	Psychology	Psychiatry	Child & Adolescent Services	Behaviour Support	Regional Workforce	Aboriginal & Torres Strait Islander Mental Health Workforce
ACT	Low	Moderate	Moderate	Moderate	Low	Moderate
New South Wales	Moderate	High	High	High	High	High
Victoria	Moderate	Moderate	High	Moderate	Moderate	Moderate
Queensland	Moderate	High	High	High	High	Very high
South Australia	High	High	High	High	High	High
Western Australia	Moderate	High	High	High	Very high	Very high
Tasmania	High	High	High	Moderate	High	Moderate
Northern Territory	Very high	Very high	Very high	Very high	Very high	Very high

Interpretation

The matrix highlights substantial variation in workforce risk across Australia's jurisdictions. The ACT demonstrates the lowest overall workforce risk, reflecting its strong specialist workforce density and compact geography. Victoria also performs relatively well overall but continues to experience regional and child mental health workforce pressures.

Queensland, South Australia, Western Australia, and Tasmania face higher workforce risks due to combinations of regional workforce shortages, specialist service constraints, and child and adolescent mental health demand.

The Northern Territory records very high risk across every workforce domain, reflecting the combined impacts of extreme remoteness, workforce scarcity, cultural safety requirements, and ongoing recruitment and retention challenges.^{4, 11, 5, 20}

Risk Matrix Interpretation

The highest-risk workforce domains nationally are:

- Psychiatry
- Child and adolescent mental health
- Regional and remote workforce access
- Behaviour support

The Northern Territory, remote Western Australia, regional Queensland, Country South Australia, Western NSW, and rural Tasmania should be treated as priority workforce planning areas.^{4,11,5,20}

Recommended Data Improvements for Future Reports

Future versions of this appendix should seek to include:

- PHN-level psychologist and psychiatrist availability
- Real-time provider availability
- Aboriginal and Torres Strait Islander mental health workforce availability

Appendix A.5 Key Findings

Australia's specialist mental health workforce has grown over the past decade, but workforce growth has not removed access pressures.^{4,11}

Workforce distribution is a larger access problem than national headcount alone.^{4,11}

Psychologists and psychiatrists remain strongly concentrated in major cities.

The ACT has the highest psychologist workforce density, while the Northern Territory has the lowest specialist access profile.^{4,11}

South Australia, Tasmania, and the Northern Territory have comparatively smaller psychology workforce bases.^{4,11}

Psychiatry remains the most constrained specialist workforce nationally.

Child and adolescent mental health workforce shortages affect every jurisdiction.^{4,11,9,18}

Regional and remote communities rely more heavily on mental health nurses, GPs, telehealth, outreach, and community services.^{2,24,25,4}

Counsellors represent a substantial potential workforce, but public workforce data are less comparable because counselling is self-regulated rather than AHPRA-regulated.^{4,11,12}

Behaviour support practitioner availability is a significant NDIS access issue, particularly in regional and remote areas.^{4,11,5,20}

State-level data can mask local shortages; PHN-level and regional workforce mapping would provide a more accurate access picture.^{4,11,5,20}

Future workforce planning should integrate health, disability, education, regional development, and telehealth infrastructure rather than treating mental health workforce supply as a narrow clinical issue.^{2,24,25,4}

Additional recommended data improvements include:

- Appointment wait-time data
- Child and adolescent workforce counts
- Autism and ADHD assessment workforce capacity
- Counselling workforce distribution by jurisdiction
- NDIS behaviour support practitioner counts by region
- Support coordinator and psychosocial recovery coach availability
- Aboriginal and Torres Strait Islander mental health workforce data
- Public/private sector workforce distribution
- Cost and gap-fee data by profession and region

These improvements would allow future versions of the Australian Mental Health Access Report to move from state-level benchmarking toward more precise regional workforce planning.^{4,11,5,20}

Appendix B - Mental Health Access Index Methodology

Methodology for the Mental Health Access Index.

Appendix B.1 Purpose of the Index

The **Australian Mental Health Access Index 2026** is an original composite benchmarking model developed for the **Australian Mental Health Access Report 2026**.

The purpose of the Index is to compare the relative accessibility of mental health services across Australian states and territories using a structured set of indicators. The Index is designed to support policy discussion, regional planning, media interpretation, and further research.^{5,20}

The Index is not an official government ranking. It should not be interpreted as a definitive measure of all mental health system performance. Instead, it provides a transparent comparative framework for assessing how different access conditions interact across jurisdictions.

Mental health access is multidimensional. A person's ability to obtain timely support may depend on workforce availability, geography, service density, affordability, telehealth access, population need, socioeconomic conditions, and the distribution of services between metropolitan and regional areas. No single indicator can capture this complexity.^{2,24,25,4}

For this reason, the Index uses a composite scoring approach.

What the Index Measures

The Index measures the relative access environment in each Australian state and territory.

It considers:

- Workforce availability
- Service density
- Regional service access
- Telehealth access
- Mental health expenditure
- Population need
- Socioeconomic disadvantage
- Rurality and remoteness

What the Index Does Not Measure

The Index does not directly measure:

- Individual clinical outcomes
- Quality of care
- Actual appointment availability
- Individual practitioner capacity
- Consumer satisfaction
- Cultural safety at the service level
- Full private-sector service availability
- Real-time wait times
- All NDIS psychosocial or disability-related service access

The Index should therefore be interpreted as a high-level access benchmark rather than a complete service performance measure.

Intended Use

The Index may be useful for:

- Policymakers identifying jurisdictions requiring targeted investment
- Health service planners and Primary Health Networks
- Mental health workforce planning
- Regional service development
- Researchers and policy analysts
- Media reporting and public policy discussion
- Benchmarking future improvements in mental health access over time

Appendix B.2 Index Domains

The Index uses eight weighted domains. Each domain is scored from 0 to 100, where a higher score indicates a stronger access environment.

The Index is strongest when used as a starting point for further inquiry, not as a substitute for local data.

Domain	Weight
Workforce Availability	25%
Service Density	15%
Regional Access	15%
Telehealth Access	10%
Mental Health Expenditure	10%
Population Need	10%
Socioeconomic Disadvantage	10%
Rurality and Remoteness	5%
Total	100%

Domain 1: Workforce Availability (25%)

Definition

Workforce availability refers to the supply of mental health professionals available to provide care within a jurisdiction.^{4,11}

Rationale

Workforce supply is the strongest determinant of service access. Funding programs and referral pathways cannot improve access if there are insufficient practitioners available to deliver services.^{4,11}

Possible Indicators

- Psychologists per 100,000 population
- Clinical psychologists per 100,000 population
- Psychiatrists per 100,000 population
- Mental health nurses per 100,000 population
- Mental health occupational therapists per 100,000 population
- Accredited mental health social workers per 100,000 population
- Workforce growth trends
- Workforce distribution by remoteness

Source Types

- AIHW mental health workforce data
- National Health Workforce Dataset
- AHPRA registration data
- Psychology Board of Australia
- Australian Bureau of Statistics (ABS)
- National Mental Health Workforce Strategy

Intended Applications

- Researchers developing more detailed regional access models
- PHNs comparing regional access environments
- Universities and workforce planners assessing workforce supply risks
- Journalists communicating mental health access inequities
- Mental health organisations advocating for improved service availability

Domain 2: Service Density (15%)

Definition

Service density refers to the availability of mental health services relative to population size.

Rationale

A jurisdiction may have a reasonable workforce but still lack sufficient accessible service points, especially outside metropolitan centres.^{4,11}

Possible Indicators

- Medicare mental health service use per 1,000 population
- Specialised mental health service facilities
- Public community mental health service availability
- Private psychology and psychiatry service availability
- PHN-commissioned service coverage
- headspace and youth mental health service distribution

Source Types

- AIHW Medicare mental health service data
- AIHW specialised mental health facility data
- State and territory health department data
- Department of Health mental health program data
- PHN needs assessments

Scoring Approach

Higher service density and broader service availability receive higher scores.

Limitations

Service utilisation does not always equal access. Low service use can reflect either low need or poor availability. High service use can reflect either strong access or high population demand.

Domain 3: Regional Access (15%)

Definition

Regional access measures the extent to which mental health services are available outside major metropolitan centres.^{5,20}

Rationale

Regional Australians experience substantially greater barriers to accessing mental health care than metropolitan populations. Geographic isolation, workforce maldistribution, travel burden, and limited specialist availability contribute to persistent access inequities.^{4,11,5,20}

Possible Indicators

- Population living outside major cities
- Distribution of psychologists and psychiatrists by remoteness
- Travel distance to specialist services
- Regional service availability
- Outreach and visiting service coverage
- PHN regional service capacity
- Availability of multidisciplinary services

Source Types

- AIHW remoteness and workforce data
- ABS population and remoteness statistics
- PHN needs assessments
- Rural Health Commissioner reports
- State and territory health department data

Scoring Approach

Jurisdictions with stronger service availability across regional and remote areas receive higher scores.

Limitations

State-level averages may conceal substantial regional variation. Local access can differ significantly within the same jurisdiction depending on workforce distribution, transport, and service availability.^{4,11,5,20}

Domain 3: Regional Access (15%)

Rationale

State-level averages can conceal significant regional inequities. A jurisdiction may appear well supplied overall while regional and remote communities experience severe access barriers.^{5,20}

Possible Indicators

- Workforce distribution by remoteness
- Medicare mental health service use by remoteness
- Specialist service availability outside capital cities
- Travel burden
- Proportion of population outside major cities

Source Types

- AIHW workforce by remoteness
- AIHW Medicare service use by remoteness
- ABS remoteness classifications
- PHN needs assessments
- Rural health reporting

Scoring Approach

Jurisdictions with more even metropolitan-regional distribution receive higher scores. Jurisdictions with severe regional maldistribution receive lower scores.^{5,20}

Limitations

Regional access varies substantially within states. A state-level score cannot fully capture differences between, for example, a large regional centre and a remote community.^{5,20}

Domain 4: Telehealth Access (10%)

Definition

Telehealth access refers to the availability and utilisation of mental health services delivered by phone or video.^{2,24,25}

Rationale

Telehealth has become a core access mechanism for Australians who face geographic, mobility, workforce, or privacy barriers.^{2,24,25,4}

Possible Indicators

- Medicare mental health telehealth service utilisation
- Telehealth use by remoteness
- Digital connectivity
- Consumer adoption of telehealth
- Provider availability for telehealth
- Telepsychiatry availability

Source Types

- AIHW Medicare mental health telehealth data
- Medicare Benefits Schedule data
- Department of Health digital health and telehealth materials
- Australian Digital Health Agency materials

Scoring Approach

Jurisdictions with higher telehealth utilisation, stronger digital infrastructure, and broader telehealth availability receive higher scores.

Limitations

Telehealth improves access but cannot fully replace face-to-face care. Effectiveness depends on workforce availability, digital connectivity, consumer preference, and the suitability of telehealth for individual clinical presentations.^{2,24,25,4}

Domain 4: Telehealth Access (10%)**Source Types**

- AIHW Medicare mental health telehealth data
- Medicare Benefits Schedule data
- Department of Health digital health and telehealth materials
- Australian Digital Health Agency materials
- Regional connectivity data where available

Scoring Approach

Higher telehealth utilisation and stronger digital infrastructure receive higher scores.^{2,24,25}

Limitations

Telehealth utilisation data may not fully capture clinical suitability, quality, cultural appropriateness, or whether people have private and reliable spaces to attend appointments.^{2,24,25}

Domain 5: Mental Health Expenditure (10%)**Definition**

Mental health expenditure refers to public and publicly subsidised spending on mental health-related services.^{3,22}

Rationale

Expenditure is a useful but imperfect proxy for investment. Higher expenditure may reflect stronger service investment, but it may also reflect greater population need, higher service costs, or more acute system pressures.^{3,22}

Possible Indicators

- State and territory specialised mental health expenditure per capita
- Medicare mental health expenditure per capita
- PBS mental health-related prescription expenditure
- Community mental health spending
- NGO mental health service expenditure

Source Types

- AIHW mental health expenditure data
- Productivity Commission Report on Government Services
- Department of Health expenditure data
- State and territory budget papers

Scoring Approach

The expenditure score considers both the level of investment and its likely relationship to access. It is not treated as a simple "higher is always better" metric.^{3,22}

Limitations

Expenditure is not equivalent to outcomes. Some jurisdictions spend more because service delivery is more expensive or because underlying need is higher.^{3,22}

Domain 6: Population Need (10%)**Definition**

Population need refers to the level of mental health demand, or likely demand, within the population.

Rationale

Access must be assessed relative to need. A jurisdiction with high need and moderate service availability may have worse access than a jurisdiction with similar service availability but lower need.

Possible Indicators

- 12-month prevalence of mental disorder
- Psychological distress rates
- Suicide burden
- Youth mental health prevalence
- Population growth
- Socioeconomic vulnerability associated with mental health need

Source Types

- ABS National Study of Mental Health and Wellbeing
- AIHW mental health reports
- Australian Bureau of Statistics
- National Suicide Monitoring data
- Population projections and demographic reports

Scoring Approach

Jurisdictions with lower population need relative to available service capacity receive higher scores. Population need is interpreted alongside workforce and service availability rather than in isolation.

Limitations

Population need is dynamic and influenced by demographic change, disasters, economic conditions, and emerging health issues. Available data may not fully capture unmet need or populations who do not seek care.

Domain 6: Population Need (10%)**Possible Indicators**

- 12-month prevalence of mental disorder
- Psychological distress rates
- Youth mental health indicators
- Suicide and self-harm indicators
- Mental health-related prescriptions
- NDIS psychosocial disability participation

Source Types

- ABS National Study of Mental Health and Wellbeing
- AIHW mental health prevalence and impact data
- AIHW suicide and self-harm monitoring
- AIHW mental health prescriptions data
- NDIA participant data
- State and territory social indicator reports

Scoring Approach

Higher need is treated as an access pressure. Therefore, high population need reduces the domain score unless matched by strong service capacity.

Limitations

Prevalence data are not always available at the level required for precise local access comparison. Some underserved populations may be underrepresented in survey-based data.

Domain 7: Socioeconomic Disadvantage (10%)**Definition**

Socioeconomic disadvantage refers to social and economic conditions that may affect a person's ability to access care.²¹

Rationale

Cost, housing stress, unemployment, transport difficulty, and lower educational opportunity can all affect mental health access.

Possible Indicators

- SEIFA Index of Relative Socio-economic Disadvantage
- Income and employment indicators
- Housing stress indicators
- Educational attainment
- Health literacy indicators

Source Types

- ABS SEIFA
- ABS Census
- PHN needs assessments

Scoring Approach

Higher socioeconomic advantage, or lower disadvantage, receives a higher score. Higher disadvantage reduces the access score because it increases the likelihood of cost and navigation barriers.²¹

Limitations

SEIFA measures area-level characteristics, not individual circumstances. It may mask pockets of disadvantage within otherwise advantaged regions.²¹

Domain 8: Rurality and Remoteness (5%)**Definition**

Rurality and remoteness refer to the degree of geographic isolation and the challenges this creates for accessing mental health services.

Rationale

Geographic remoteness remains one of the strongest predictors of reduced mental health service access. Remote communities generally experience fewer providers, longer travel distances, greater workforce shortages, and reduced service continuity.^{5,20}

Possible Indicators

- ABS remoteness classifications
- Population living in regional, remote, and very remote areas
- Geographic isolation
- Travel time to specialist services
- Service distribution across remoteness categories

Source Types

- ABS Australian Statistical Geography Standard (ASGS)
- ABS Remoteness Area classifications
- AIHW remoteness data
- Rural Health Commissioner reports

Scoring Approach

Jurisdictions with lower levels of remoteness and stronger geographic service accessibility receive higher scores. Jurisdictions with large remote populations and greater travel burden receive lower scores.

Limitations

Remoteness does not always equate to poor access. Some remote communities may benefit from strong outreach, telehealth, or Aboriginal Community Controlled Health Organisations, while some metropolitan communities may still experience significant barriers despite geographic proximity to services.^{4,11,5,20}

Domain 8: Rurality and Remoteness (5%)

Definition

Rurality and remoteness measure the geographic complexity of delivering mental health services across a jurisdiction.^{5,20}

Rationale

Remoteness affects workforce recruitment, service continuity, transport burden, telehealth reliance, and specialist availability.^{2,24,25,4}

Possible Indicators

- Proportion of population in major cities
- Proportion of population in inner regional, outer regional, remote, and very remote areas
- Geographic dispersion
- Distance to specialist services
- Transport limitations

Source Types

- ABS Australian Statistical Geography Standard (ASGS) Remoteness Areas
- AIHW rural and remote health reporting
- Rural health workforce materials
- PHN regional needs assessments

Scoring Approach

Jurisdictions with lower geographic delivery complexity score higher. Jurisdictions with large remote and very remote populations score lower.^{5,20}

Limitations

Rurality is not inherently negative. Many regional communities have strong local supports. However, remoteness increases service delivery complexity and is therefore relevant to access scoring.^{5,20}

Appendix B.3 Scoring Formula

Each jurisdiction receives a domain score from 0 to 100 for each of the eight domains.

The final score is calculated as:

Final Access Index Score =

- (Workforce Availability × 0.25)
- (Service Density × 0.15)
- (Regional Access × 0.15)
- (Telehealth Access × 0.10)
- (Mental Health Expenditure × 0.10)
- (Population Need × 0.10)
- (Socioeconomic Disadvantage × 0.10)
- (Rurality and Remoteness × 0.05)

The weighted scores are summed to produce a final Mental Health Access Index score out of 100, with higher scores representing a stronger overall mental health access environment.

Domain Weighting Table

Domain	Weight	Direction
Workforce Availability	25%	Higher workforce = higher score
Service Density	15%	Higher service density = higher score
Regional Access	15%	Better regional access = higher score
Telehealth Access	10%	Better telehealth access = higher score
Mental Health Expenditure	10%	Better access-related investment = higher score
Population Need	10%	Lower unmet demand pressure = higher score
Socioeconomic Disadvantage	10%	Lower disadvantage = higher score
Rurality and Remoteness	5%	Lower delivery complexity = higher score

Normalisation Approach

Indicators are standardised to a 0–100 scale.

For positive indicators, such as workforce per 100,000 population, higher values produce higher scores.^{4,11}

For negative or pressure indicators, such as remoteness, socioeconomic disadvantage, or high population need, the score is inverted so that higher access pressure produces a lower score.^{5,20,21}

Generic Normalisation Formula

For positive indicators:

Normalised Score = [(Jurisdiction Value - Minimum Value) ÷ (Maximum Value - Minimum Value)] × 100

For negative indicators:

Inverted Score = 100 - Normalised Score

Risk Category Table

Risk Category	Score Range
Low access risk	80–100
Moderate access risk	65–79
High access risk	50–64
Very high access risk	0–49

Where exact public values are unavailable, categorical scoring is used.

Example Calculation

A hypothetical jurisdiction receives the following domain scores:

Domain	Score	Weight	Weighted Contribution
Workforce Availability	80	25%	20.0
Service Density	75	15%	11.25
Regional Access	70	15%	10.5
Telehealth Access	80	10%	8.0
Mental Health Expenditure	70	10%	7.0
Population Need	65	10%	6.5
Socioeconomic Disadvantage	70	10%	7.0
Rurality and Remoteness	60	5%	3.0
Final Score			73.25

The jurisdiction's final score would be rounded to 73.

Missing Data Treatment

Where data were incomplete, the Index used one of the following approaches:

- Use the closest available official proxy.
- Use qualitative risk scoring based on multiple public sources.
- Use cautious midpoint scoring where evidence was insufficient.
- Flag the indicator as requiring future improvement.

No single missing indicator was permitted to determine a jurisdiction's final ranking.

Appendix B.4 State and Territory Scoring Table

The following scores are **composite model scores** developed for the Australian Mental Health Access Index 2026. They are not direct official statistics. Scores are scaled from 0 to 100, where a higher score indicates a stronger overall mental health access environment.

The composite score incorporates weighted performance across the eight Index domains:

- Workforce Availability (25%)
- Service Density (15%)
- Regional Access (15%)
- Telehealth Access (10%)
- Mental Health Expenditure (10%)
- Population Need (10%)
- Socioeconomic Disadvantage (10%)
- Rurality and Remoteness (5%)

The scoring framework is intended to support comparative benchmarking between jurisdictions and should be interpreted as an indicative assessment of relative access conditions rather than a precise measure of service performance.

Appendix B.4 State and Territory Scoring Table

The following table presents the composite scores for each Australian jurisdiction across the eight Index domains. Scores are expressed on a 0-100 scale, with higher scores indicating a stronger overall mental health access environment.

Rank	Jurisdiction	Workforce Score	Service Density Score	Regional Access Score	Telehealth Score	Expenditure Score	Population Need Score	Socioeconomic Score	Rurality Score	Final Weighted Score	Rounded Report Score
1	ACT	92	87	92	78	68	68	84	94	84.4	84
2	Victoria	84	84	80	82	80	72	78	84	81.0	81
3	New South Wales	84	83	76	80	76	72	78	78	79.4	79
4	South Australia	74	74	72	80	78	72	72	72	74.2	74
5	Queensland	74	72	68	78	76	68	72	66	72.2	72
6	Tasmania	68	70	65	72	78	74	64	62	69.2	69
7	Western Australia	66	67	55	72	75	68	72	50	66.0	66
8	Northern Territory	52	50	42	65	75	50	45	30	51.8	52

Interpretation

The Australian Capital Territory achieved the highest overall Index score, reflecting strong workforce availability, service density and regional accessibility within a compact geographic area. Victoria and New South Wales also performed strongly, supported by large specialist workforces and extensive metropolitan service networks. South Australia, Queensland and Tasmania formed the middle tier, with workforce distribution and regional access remaining key constraints. Western Australia and the Northern Territory recorded the lowest overall scores due to geographic complexity, workforce shortages and the challenges associated with delivering services across large remote populations. These results highlight the importance of targeted regional workforce investment alongside continued expansion of telehealth and multidisciplinary service models.^{4,11,5,20}

Appendix B.5 Sensitivity Analysis

Composite indexes are affected by weighting choices. For this reason, the Access Index should be interpreted as a structured policy model rather than a mathematically absolute ranking.

Workforce-Heavy Model

If workforce availability were increased from 25% to 40%, the ACT, Victoria and New South Wales would likely retain the top positions. Jurisdictions with smaller specialist workforces, especially the Northern Territory, Tasmania and South Australia, would likely score lower.^{4,11}

Regional-Access-Heavy Model

If regional access and rurality were weighted more heavily, Western Australia, Queensland and the Northern Territory would likely decline further due to service delivery complexity across large remote and regional areas. The ACT would likely remain highly ranked because of its compact geography.^{5,20}

Socioeconomic-Disadvantage-Heavy Model

If socioeconomic disadvantage were weighted more heavily, jurisdictions with greater area-level disadvantage would score lower. Tasmania, the Northern Territory and some regional states would be more affected than the ACT and several metropolitan-dominant jurisdictions.^{5,20,21}

Child-and-Youth-Access-Heavy Model

If child and adolescent access indicators were included as a standalone higher-weight domain, rankings could change. Jurisdictions with long developmental assessment waits, limited child psychiatry access or regional child mental health shortages would score lower. This model would likely reduce scores for Queensland, Western Australia, Tasmania, the Northern Territory and parts of New South Wales.^{13,5,20,9}

Overall Sensitivity Finding

The broad ranking pattern is relatively stable:

- ACT, Victoria and New South Wales remain the strongest access environments.
- Northern Territory remains the highest-risk access environment.
- Queensland, South Australia, Tasmania and Western Australia shift depending on whether workforce, geography or socioeconomic disadvantage receives greater emphasis.^{4,11,21}

Appendix B.6 Limitations

The Index has several limitations.

Public Data Gaps

Not all relevant access indicators are publicly available at state or territory level. Important missing indicators include real-time wait times, provider availability, appointment availability, gap fees and private-sector capacity.

Inconsistent Workforce Definitions

Different workforce categories are measured differently. AHPRA-regulated professions have stronger data than self-regulated professions such as counselling and psychotherapy. Behaviour support, support coordination and psychosocial recovery coaching data are less consistently available.^{4,11,12,15}

Geographic Variation Within Jurisdictions

State-level scores may mask substantial regional variation. Metropolitan centres generally have greater workforce availability than regional and remote communities, meaning local access may differ considerably from statewide averages.^{4,11,5,20}

Composite Model Assumptions

The weighting framework reflects evidence-informed judgement rather than an official government methodology. Alternative weighting approaches may produce modest changes in jurisdiction rankings, particularly among middle-ranked states.

Data Timeliness

The Index draws on the most recent publicly available national datasets. As workforce numbers, service utilisation and expenditure change over time, future updates may produce different scores.

Intended Interpretation

The Australian Mental Health Access Index 2026 is designed as a comparative policy benchmarking tool rather than a definitive measure of mental health system performance. Its purpose is to support policy discussion, workforce planning and future research by highlighting relative strengths, access gaps and investment priorities across jurisdictions.

Data Lag

Many national datasets are published with a delay. The Index therefore reflects the best available public data rather than real-time service conditions.

Expenditure Interpretation

Higher expenditure does not automatically mean better access. Some jurisdictions spend more because they face greater service delivery costs, higher population need or more severe workforce constraints.^{2,10,3,22}

Cultural Safety

The Index includes Aboriginal and Torres Strait Islander access considerations indirectly through regional access, population need and rurality, but it does not directly measure cultural safety, community control or the appropriateness of services.^{5,20,32}

Appendix B.7 Recommended Future Improvements

Future versions of the Index should be strengthened with more granular and real-time data.

PHN-Level Data

PHN-level scoring would provide a more accurate picture than state-level benchmarking. This would better identify regional access gaps and service deserts.^{5,20,27}

Wait Time Data

National reporting should include wait times for:

- Psychology
- Psychiatry
- Child and adolescent mental health
- Autism assessment
- ADHD assessment
- Public community mental health
- Behaviour support

Provider Availability Data

Future models should include whether providers are accepting new clients, average time to first appointment, and availability by funding type.

Cost and Gap-Fee Data

Out-of-pocket costs remain a major access barrier. Future versions of the Index should include:

- Psychology gap fees
- Psychiatry gap fees
- Average out-of-pocket costs by jurisdiction
- Bulk-billing availability
- Regional cost variation

Telehealth Data Limitations

Telehealth utilisation data do not fully capture quality, clinical suitability, consumer preference, digital literacy, private space, cultural safety or internet reliability.^{2,24,25}

Service Use Does Not Equal Service Need

High service use may indicate good access, high demand, or both. Low service use may indicate low need, poor access, cultural barriers, affordability issues or data capture limitations.

Headcount Does Not Equal Clinical Availability

A registered practitioner may not be available for direct clinical work. Practitioners may work part-time, in non-clinical roles, in research, education, management, or specialist areas that do not address general access needs.^{4,11}

State-Level Averages Mask Local Variation

State-level rankings can conceal major local inequities. For example, a state with strong metropolitan service access may still have severe shortages in remote or regional communities.^{5,20}

Additional Data Priorities

Future editions of the Australian Mental Health Access Index would also benefit from the inclusion of:

- Real-time appointment availability
- Provider capacity and closed-book status
- PHN-level workforce mapping
- Regional child and adolescent workforce data
- Aboriginal and Torres Strait Islander mental health workforce data
- Behaviour support practitioner availability by region
- Consumer experience and access satisfaction measures
- Public and private sector workforce distribution

These improvements would support a transition from broad jurisdictional benchmarking toward more precise, region-level mental health access planning and policy development.

Consumer-Reported Access Data

Consumer experience should be incorporated through surveys measuring:

- Difficulty finding a provider
- Appointment delays
- Cost barriers
- Service navigation difficulty
- Cultural safety
- Satisfaction with telehealth

Child Mental Health Access Indicators

Future versions should include a dedicated child and adolescent access domain covering:^{9,18}

- Child psychologist availability
- Child psychiatry availability
- School mental health access
- Developmental assessment wait times
- Youth crisis support availability

NDIS Psychosocial Support Indicators

Future versions should include:

- Behaviour support practitioner availability
- Psychosocial recovery coach availability
- Support coordination access
- Regional NDIS provider availability
- NDIS-related mental health workforce supply

Cultural Safety and Aboriginal-Led Services

A future Index should include specific indicators for:

- Aboriginal Community Controlled Health Organisation availability
- Aboriginal and Torres Strait Islander mental health workforce development
- Culturally safe service access

These additions would strengthen the Index's ability to evaluate equitable access for Aboriginal and Torres Strait Islander communities.^{4, 11, 32}

Cost Measures

Future editions should incorporate additional affordability indicators, including:

- Psychiatry gap fees
- Bulk-billing availability
- Telehealth cost differences
- Assessment costs

Annual Update Process

The Index should be updated annually using the latest available data and methodological improvements. Annual updates would allow policymakers, Primary Health Networks (PHNs), governments and the broader mental health sector to monitor whether access is improving or deteriorating over time.²⁷

Appendix B.8 Methodological Caution

The Australian Mental Health Access Index 2026 is intended to support transparency, discussion and prioritisation. It should not be used as the sole basis for funding decisions, clinical planning or policy conclusions.

The most appropriate use of the Index is as a comparative access benchmarking tool that highlights where further local analysis is required.

Like all composite indexes, the Australian Mental Health Access Index 2026 simplifies a highly complex health system into a structured comparative framework. It is designed to complement—not replace—local workforce data, PHN needs assessments, jurisdictional planning and community consultation.

The Index is strongest when interpreted alongside regional evidence, workforce intelligence and consumer experience data. Future improvements in national reporting, particularly around wait times, provider availability, affordability and child mental health access, will further strengthen the precision and policy value of future editions.

Used appropriately, the Index provides a transparent and evidence-informed framework for understanding variation in mental health access across Australia and for identifying priorities for future workforce investment and service reform.

Appendix C - Top 20 Mental Health Access Hotspots Methodology

Methodology for the Top 20 Mental Health Access Hotspots framework.

Appendix C.1 Purpose of the Hotspot Rankings

The **Top 20 Mental Health Access Hotspots** were developed to identify Australian regions where multiple access barriers overlap and where targeted investment may produce significant improvements in mental health access.

The Hotspot Rankings differ from the **State and Territory Mental Health Access Index**. The Index provides a jurisdiction-level comparison, while the Hotspot Rankings focus on regional and local access pressure. This distinction is important because state-level averages can conceal severe local shortages.^{5,20}

For example, a state may have strong metropolitan mental health infrastructure while remote or outer regional communities in the same state experience limited workforce availability, long travel distances, poor specialist access and high unmet need.^{4,11,5,20}

The Hotspot Framework is intended to assist:

- Primary Health Networks (PHNs) identifying priority service gaps
- Policymakers targeting regional investment
- Universities planning rural placements and workforce pipelines
- Journalists reporting on mental health access inequity
- Community organisations advocating for local resources
- Service planners identifying underserved regions

The rankings are an original composite prioritisation framework. They are not official government rankings and should not be interpreted as definitive statistical measures of local mental health need. Rather, they identify regions where publicly available evidence indicates that multiple barriers to accessing timely and appropriate mental health care occur simultaneously.

Appendix C.2 Definition of a Mental Health Access Hotspot

A Mental Health Access Hotspot is a region where multiple barriers to timely, appropriate mental health care occur together.

Relevant access barriers include:

- Workforce shortages
- Remoteness
- Socioeconomic disadvantage
- High population need
- Disaster exposure
- Psychiatry shortages
- Digital exclusion
- Limited culturally safe care
- Long travel distances
- Limited local provider choice
- Transport barriers
- Service fragmentation
- Aboriginal and Torres Strait Islander access barriers
- Thin NDIS provider markets
- Child and adolescent service shortages

A hotspot is **not necessarily** the region with the highest prevalence of mental illness. Rather, it is a region where people are more likely to experience difficulty accessing care when they need it because multiple structural barriers exist simultaneously.

The Hotspot Rankings are intended to support evidence-informed workforce planning, regional investment and service development by identifying areas where improvements are likely to have the greatest impact on mental health access outcomes.

Appendix C.3 Ranking Domains and Weights

The Hotspot Rankings use eight weighted domains to identify regions where multiple barriers to mental health access overlap.

Domain	Weight
Workforce Availability	25%
Geographic Access and Remoteness	20%
Socioeconomic Vulnerability	15%
Youth Mental Health Pressure	10%
Indigenous Mental Health Access	10%
Future Demand Pressure	10%
Disaster Exposure	5%
Telehealth and Digital Access	5%
Total	100%

Domain 1: Workforce Availability (25%)

Definition

Workforce availability measures the supply of mental health professionals relative to population need.^{4,11}

Rationale

Workforce shortages are the most direct barrier to access. A region may have funding, referral pathways and community demand, but services cannot be delivered without available practitioners.^{4,11}

Indicators

Possible indicators include:

- Psychologist availability
- Psychiatrist availability
- Mental health nurse availability
- Accredited mental health social worker availability
- Child and adolescent workforce availability
- Behaviour support practitioner availability
- Provider recruitment difficulty
- Workforce turnover

Likely Data Sources

- AIHW specialist mental health workforce data
- AHPRA registration data
- RANZCP psychiatry workforce data
- National Mental Health Workforce Strategy
- PHN needs assessments
- State and territory workforce reports

Contribution to Hotspot Risk

Regions with lower workforce availability receive higher hotspot risk scores.

Domain 2: Geographic Access and Remoteness (20%)

Definition

This domain measures the geographic difficulty of accessing mental health services.

Rationale

Distance, travel time and geographic isolation strongly affect mental health access, particularly where specialist services are concentrated in metropolitan centres.

Indicators

Possible indicators include:

- Remoteness classification
- Distance to regional centres
- Distance to psychiatry services
- Distance to child mental health services
- Public transport availability
- Proportion of population in remote or very remote areas
- Travel time to care
- Transport disadvantage

Likely Data Sources

- ABS Australian Statistical Geography Standard (ASGS) Remoteness Areas
- AIHW rural and remote health reporting
- PHN regional needs assessments
- State and territory health service maps

Contribution to Hotspot Risk

Regions with greater remoteness, longer travel burden and lower service proximity receive higher hotspot risk scores.^{5,20}

Domain 3: Socioeconomic Vulnerability (15%)

Definition

Socioeconomic vulnerability measures the social and economic conditions that increase mental health access barriers.²¹

Rationale

Cost, housing stress, unemployment, transport limitations and low service availability can all reduce access to mental health care.

Indicators

Possible indicators include:

- SEIFA disadvantage
- Unemployment
- Low income
- Housing stress
- Educational disadvantage
- Transport disadvantage
- Higher reliance on public services

Likely Data Sources

- ABS SEIFA
- ABS Census
- PHN needs assessments
- State and territory socioeconomic profiles

Contribution to Hotspot Risk

Regions with greater socioeconomic disadvantage receive higher hotspot risk scores because financial and social barriers increase the likelihood of unmet mental health need.²¹

Domain 3: Socioeconomic Vulnerability (15%)**Likely Data Sources**

- ABS Census
- ABS SEIFA
- PHN needs assessments
- State and territory social indicator reports

Contribution to Hotspot Risk

Regions with higher socioeconomic vulnerability receive higher hotspot risk scores.²¹

Domain 4: Youth Mental Health Pressure (10%)**Definition**

Youth mental health pressure measures the degree to which children, adolescents and young adults in a region are likely to experience difficulty accessing support.^{9,18}

Rationale

Child and adolescent mental health services are among the most constrained parts of the system. Regions with limited child psychologists, child psychiatrists, school-based supports and developmental assessment pathways face elevated access risk.^{4,11,13,9}

Indicators

Possible indicators include:

- Child and adolescent mental health demand
- Youth psychological distress
- School refusal concerns
- Child psychiatry availability
- headspace and youth service availability
- Regional school wellbeing service availability
- Autism assessment access
- ADHD assessment access

Likely Data Sources

- AIHW youth mental health data
- ABS mental health data
- headspace reports
- Orygen publications
- PHN needs assessments
- State education and health department data

Contribution to Hotspot Risk

Regions with high youth demand and low child-specific service access receive higher hotspot risk scores.^{9,18}

Domain 5: Indigenous Mental Health Access (10%)**Definition**

This domain measures the degree to which Aboriginal and Torres Strait Islander communities in a region face mental health access barriers.³²

Rationale

Aboriginal and Torres Strait Islander peoples may experience access barriers linked to geography, cultural safety, intergenerational trauma, service availability, workforce shortages and limited availability of Aboriginal-led care.^{4,11,32}

Indicators

Possible indicators include:

- Aboriginal and Torres Strait Islander population proportion
- Availability of Aboriginal Community Controlled Health Organisations (ACCHOs)
- Aboriginal-led mental health services
- Culturally safe mental health services
- Aboriginal mental health workforce availability
- Geographic access to culturally appropriate care

Likely Data Sources

- ABS Census
- AIHW Aboriginal and Torres Strait Islander health reports
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- PHN needs assessments
- State and territory Aboriginal health strategies

Contribution to Hotspot Risk

Regions with large Aboriginal and Torres Strait Islander populations and limited culturally safe service availability receive higher hotspot risk scores.^{4,11,32}

Domain 5: Indigenous Mental Health Access (10%)

Indicators

Possible indicators include:

- Aboriginal and Torres Strait Islander population share
- Availability of Aboriginal Community Controlled Health Organisations (ACCHOs)
- Aboriginal and Torres Strait Islander mental health workforce availability
- Remote community access
- Suicide and self-harm indicators
- Cultural safety considerations
- Availability of local, community-led services

Likely Data Sources

- AIHW Indigenous health data
- AIHW suicide and self-harm monitoring
- ABS Census
- NACCHO and ACCHO sector sources
- PHN needs assessments
- State and territory Aboriginal health strategies

Contribution to Hotspot Risk

Regions with large Aboriginal and Torres Strait Islander populations and limited culturally safe service availability receive higher hotspot risk scores.

Domain 6: Future Demand Pressure (10%)

Definition

Future demand pressure measures whether a region is likely to experience increasing mental health access demand over the coming years.

Rationale

Some regions may already be under pressure and are likely to face further demand growth due to population growth, demographic change, youth mental health demand, NDIS growth or disaster recovery needs.^{15,16,9,18}

Indicators

Possible indicators include:

- Population growth
- Regional migration
- Youth population share
- NDIS participant growth
- Autism support demand
- Older population growth
- Housing growth corridors
- Workforce growth lag

Likely Data Sources

- ABS population data
- PHN needs assessments
- State and territory population projections
- NDIA participant data
- AIHW demographic reports

Contribution to Hotspot Risk

Regions expected to experience rapid growth in mental health demand without corresponding workforce expansion receive higher hotspot risk scores.

Domain 6: Future Demand Pressure (10%)**Likely Data Sources**

- ABS population data
- NDIA participant data
- State planning data
- Regional development reports
- PHN needs assessments

Contribution to Hotspot Risk

Regions with strong projected demand growth and limited existing capacity receive higher hotspot risk scores.^{19,28}

Domain 7: Disaster Exposure (5%)**Definition**

Disaster exposure measures whether a region has been affected by natural disasters or climate-related stressors that increase mental health demand.^{29,30}

Rationale

Floods, bushfires, droughts, cyclones and extreme weather events can create acute and long-term mental health needs. Disaster impacts may persist for years after the event.^{4,11,29,30}

Indicators

Possible indicators include:

- Recent flood exposure
- Bushfire exposure
- Cyclone exposure
- Drought exposure
- Disaster recovery needs
- Housing displacement
- Local economic disruption

Likely Data Sources

- State disaster recovery agencies
- PHN disaster recovery reporting
- Rural health organisations
- National Emergency Management Agency
- Bureau of Meteorology

Contribution to Hotspot Risk

Regions with recent or repeated disaster exposure receive higher hotspot risk scores.^{29,30}

Domain 8: Telehealth and Digital Access (5%)**Definition**

This domain measures whether telehealth can realistically reduce access barriers within a region.^{2,24,25}

Rationale

Telehealth can improve access to psychology, psychiatry and counselling, but its effectiveness depends on internet reliability, digital literacy, access to private spaces and provider availability.^{2,24,25}

Indicators

Possible indicators include:

- Broadband connectivity
- Mobile network coverage
- Digital literacy
- Telehealth service utilisation
- Provider availability for telehealth
- Access to suitable private spaces for telehealth consultations

Likely Data Sources

- AIHW Medicare mental health telehealth data
- Australian Digital Health Agency
- Department of Health digital health reports
- Australian Bureau of Statistics digital inclusion data
- PHN needs assessments

Contribution to Hotspot Risk

Regions with limited digital connectivity, lower telehealth capability and reduced access to technology-supported care receive higher hotspot risk scores.^{2,24,25}

Domain 8: Telehealth and Digital Access (5%)

Indicators

Possible indicators include:

- Telehealth use
- Availability of telehealth-enabled providers
- Private spaces for telehealth access
- Remote service infrastructure
- Regional connectivity
- Broadband connectivity
- Mobile network coverage
- Digital literacy

Likely Data Sources

- Department of Health telehealth data
- AIHW Medicare telehealth data
- ABS Digital Inclusion indicators
- PHN needs assessments
- Regional connectivity reports

Contribution to Hotspot Risk

Regions with poor digital access or limited telehealth feasibility receive higher hotspot risk scores.^{2,24,25}

Appendix C.4 Region Selection Process

Candidate regions were identified using a combination of public data, regional access evidence, PHN needs assessments and known service delivery challenges.^{5,20,27}

The framework considered several types of regional boundaries:

- Primary Health Network (PHN) regions
- Statistical Area Level 4 (SA4) regions
- State health districts
- Remote service catchments
- Disaster-affected regions
- Known underserved rural and remote regions
- Remote Aboriginal community catchments
- Regional growth corridors

Combining Quantitative and Qualitative Evidence

The hotspot methodology uses both quantitative and qualitative evidence.

Quantitative evidence may include:

- Workforce density
- Remoteness
- Medicare mental health service utilisation
- Socioeconomic indicators
- Population growth
- Service utilisation

Qualitative evidence may include:

- PHN-identified service needs
- Rural health reporting
- Workforce recruitment difficulty
- Community service gaps
- Disaster recovery pressures
- Local provider scarcity

Handling Overlapping Regions

Some regions overlap. For example, a PHN catchment may include several remote service areas, and an SA4 region may overlap with state health districts.^{5,20,27}

Where overlap occurred, regions were assessed based on practical service access rather than administrative boundaries. The objective was to identify meaningful access regions that reflect how people access mental health services, rather than forcing every hotspot into a single statistical geography.

Because mental health access does not always align neatly with statistical boundaries, some hotspot regions are presented as broader access regions rather than exact statistical areas. This is particularly relevant for remote service catchments, Aboriginal community regions and areas spanning multiple administrative boundaries.^{5,20,32}

Appendix C.5 Scoring and Ranking Method

Each candidate region is assigned a domain score from 0 to 100 for each hotspot risk domain. Higher scores indicate greater mental health access risk.

Final Hotspot Priority Score

The final score is calculated as:

Hotspot Priority Score =

- (Workforce Availability Risk × 0.25)
- (Geographic Access and Remoteness Risk × 0.20)
- (Socioeconomic Vulnerability Risk × 0.15)
- (Youth Mental Health Pressure × 0.10)
- (Indigenous Mental Health Access Risk × 0.10)
- (Future Demand Pressure × 0.10)
- (Disaster Exposure × 0.05)
- (Telehealth and Digital Access Risk × 0.05)

Example Calculation

A hypothetical region receives the following scores:

Domain	Risk Score	Weight	Weighted Contribution
Workforce Availability	90	25%	22.50
Geographic Access and Remoteness	85	20%	17.00
Socioeconomic Vulnerability	75	15%	11.25
Youth Mental Health Pressure	80	10%	8.00
Indigenous Mental Health Access	70	10%	7.00
Future Demand Pressure	65	10%	6.50
Disaster Exposure	40	5%	2.00
Telehealth and Digital Access	70	5%	3.50
Final Score			77.75

This region would be classified as Very High Access Risk.

Risk Categories

Final Hotspot Priority Score	Risk Category
85-100	Extreme access risk
70-84	Very high access risk
55-69	High access risk
40-54	Moderate access risk
Below 40	Lower relative hotspot risk

Appendix C.6 Top 20 Hotspot Summary Table

Rank	Region	State / Territory	Primary Access Drivers	Workforce Risk	Regional / Remoteness Risk	Youth Mental Health Risk	Indigenous Access Risk	Recommended Investment Priority
1	Remote Northern Territory	NT	Extreme remoteness, workforce shortage, Indigenous access barriers	Extreme	Extreme	High	Extreme	Aboriginal community-controlled mental health expansion
2	Central Australia	NT	Distance, specialist shortage, service continuity	Extreme	Extreme	High	High	Regional multidisciplinary hubs
3	Kimberley	WA	Remoteness, Indigenous access, workforce shortage	Extreme	Extreme	High	Extreme	Aboriginal-led services, telehealth and workforce retention
4	Pilbara	WA	Workforce shortage, FIFO pressures, distance	High	High	Moderate	Moderate	Outreach psychiatry and regional psychology
5	Far West NSW	NSW	Distance, psychiatrist shortage, thin markets	Very High	High	High	Moderate	Telepsychiatry and rural workforce incentives
6	Cape York and Torres Strait	QLD	Remote access, Indigenous mental health, digital barriers	Extreme	Extreme	High	Extreme	Culturally safe regional service models
7	Country South Australia	SA	Regional workforce shortage, child service pressure	High	High	High	Moderate	Child and adolescent workforce expansion
8	North West Queensland	QLD	Large catchments, limited local services	Very High	High	High	Moderate	Telehealth-supported specialist access
9	Far North Queensland	QLD	Population growth, youth demand, workforce shortage	High	High	High	Moderate	Child and youth service expansion
10	Northern Rivers	NSW	Disaster recovery, housing stress, workforce demand	Moderate	Moderate	High	Moderate	Youth and disaster-response mental health services
11	Murrumbidgee	NSW	Rural access, workforce recruitment, service scarcity	High	High	Moderate	Moderate	Rural placements and workforce retention
12	Western NSW	NSW	Large catchments, limited local services	Very High	Very High	Moderate	Moderate	Strengthened regional service networks
13	Gippsland	VIC	Regional workforce shortage, child service pressure	Moderate	Moderate	High	Moderate	Permanent workforce retention and outreach
14	North West Tasmania	TAS	Small provider base, recruitment difficulty	Moderate	High	Moderate	Moderate	Regional service investment
15	Wide Bay	QLD	Population growth, youth demand, workforce shortage	Moderate	High	High	Moderate	Multidisciplinary and child-focused care models
16	Murraylands and Riverland	SA	Rural shortage, travel burden, limited specialists	High	High	Moderate	Moderate	Rural psychology and psychiatry incentives
17	Goldfields	WA	Remote mining region, workforce retention	High	Very High	Moderate	High	Permanent workforce retention and outreach
18	Barkly Region	NT	Extreme remoteness, thin workforce, service continuity	Extreme	Extreme	High	Extreme	Local workforce pathways and Aboriginal-led care
19	Burnie and West Coast Tasmania	TAS	Socioeconomic disadvantage, workforce shortage	High	Moderate	High	Moderate	Long-term disaster recovery mental health funding
20	Darling Downs and South West Queensland	QLD	Rural shortage, travel burden, limited specialists	High	Moderate	High	Moderate	Multidisciplinary regional hubs

Appendix C.7 Limitations

The Hotspot Rankings have several limitations.

Data Gaps

Some regions lack recent, comparable public data on workforce availability, wait times, cost barriers, appointment availability and service quality.^{4,11}

Lagging Public Datasets

Many official datasets are released with a delay. Conditions may change before updated data are published.

Lack of Real-Time Wait Time Data

Australia does not currently have consistent national reporting of mental health wait times by region and service type.

Difficulty Measuring Unmet Need

Low service utilisation may indicate low need, poor access, cultural barriers, cost barriers or limited local services. It cannot be interpreted in isolation.

Inconsistent Regional Boundaries

PHN regions, SA4 regions, local health districts, state health regions and remote service catchments do not always align. This creates challenges when comparing regions.^{5,20,27}

Comparing Different Types of Regions

Remote Aboriginal and Torres Strait Islander communities, regional growth corridors and disaster-affected areas may all be hotspots for different reasons. A composite ranking simplifies complex and distinct access environments.^{5,20,29,30}

Composite Ranking Limitations

Weighting choices affect rankings. A workforce-heavy model, a youth-heavy model or an Indigenous-access-heavy model may produce different results.^{4,11,9,18}

Appendix C.8 Future Improvements

Future versions of the Hotspot Rankings should be strengthened through more granular, timely and region-specific data.

Recommended improvements include:

- PHN-level workforce data
- Real-time wait time reporting
- Provider capacity mapping
- NDIS provider availability data
- Child assessment wait time data
- Gap-fee and affordability data
- Aboriginal-led service availability mapping
- Local crisis service availability
- Consumer access surveys
- Telehealth connectivity data
- Regional school wellbeing access indicators

Annual Update Process

The long-term goal should be the development of an annual Australian Mental Health Access Hotspot Map that enables governments, Primary Health Networks (PHNs), service providers and communities to monitor whether access is improving or deteriorating in priority regions over time.

Annual updates would improve transparency, support evidence-based workforce planning and allow the impact of policy reforms and regional investment to be evaluated using consistent benchmarking methods. As more comprehensive datasets become available, future editions should progressively incorporate real-time service availability, affordability, child and adolescent access, culturally safe care and consumer-reported access measures to strengthen the accuracy and policy value of the Hotspot Rankings.

Appendix D - Data Sources and Technical Notes

Data sources, definitions, limitations and technical interpretation notes.

Appendix D.1 Primary Data Source Categories

Purpose of this Appendix

This appendix explains the principal data sources, definitions, assumptions and limitations used throughout the **Australian Mental Health Access Report 2026**.

The report draws on Australian public data, government publications, professional workforce datasets, Primary Health Network (PHN) needs assessments, disability sector sources, rural health evidence, youth mental health publications and peer-reviewed academic literature.^{4,11,5,20}

Where exact data are unavailable, the report distinguishes between:

- Confirmed public data
- Derived indicators
- Composite index scores
- Interpretive policy analysis
- Sector observations requiring further validation

This appendix is intended to help policymakers, researchers, journalists, Primary Health Networks (PHNs), mental health organisations and external reviewers understand how the report's findings should be interpreted.²⁷

Australian Bureau of Statistics (ABS)

The Australian Bureau of Statistics (ABS) is the primary source for population, demographic, prevalence, socioeconomic and geographic classification data.²¹

Relevant ABS source categories include:

- National Study of Mental Health and Wellbeing
- Census data
- Estimated Resident Population
- Socio-Economic Indexes for Areas (SEIFA)
- Australian Statistical Geography Standard (ASGS) Remoteness Areas

ABS data are central to the report's analysis of mental health prevalence, population need, socioeconomic disadvantage, population distribution and rurality.^{5,20,21}

Australian Institute of Health and Welfare (AIHW)

The Australian Institute of Health and Welfare (AIHW) provides the principal national evidence base for mental health service utilisation, workforce supply, expenditure and system performance.^{2,10,3,22}

Relevant AIHW source categories include:

- Mental Health Services in Australia
- Medicare-subsidised mental health services
- Mental health workforce data
- Mental health expenditure
- Suicide and self-harm monitoring
- Rural and remote health
- Psychosocial disability support reporting

AIHW data underpin much of the report's analysis of mental health service utilisation, workforce availability, expenditure and regional access patterns.^{3,22,4,11}

Department of Health, Disability and Ageing

The Australian Government Department of Health, Disability and Ageing provides policy, program and service data relating to Medicare-funded mental health services, digital mental health initiatives, workforce strategies and national reform priorities.

Relevant departmental publications inform the report's discussion of:

- Medicare Benefits Schedule (MBS) mental health services
- National Mental Health and Suicide Prevention strategies
- Telehealth policy
- Digital mental health initiatives
- Workforce reform
- Primary care and regional service delivery

Departmental publications provide important policy context alongside workforce and service utilisation data used throughout the report.

Department of Health, Disability and Ageing

Departmental sources are used for national mental health policy, workforce strategy, Medicare policy, digital mental health, telehealth and Primary Health Network (PHN) program materials.^{2,10,24,25}

Relevant source categories include:

- National Mental Health Workforce Strategy 2022–2032
- Medicare mental health policy
- Digital mental health policy
- Telehealth policy
- PHN program guidance
- National mental health reform documents

These sources provide policy context for workforce planning, access reform and future service design.^{4,11}

Productivity Commission

Productivity Commission publications are used for cross-jurisdictional reporting, public expenditure, government service performance and national mental health system analysis.^{3,22}

Relevant source categories include:

- Report on Government Services
- Mental health service expenditure
- Productivity and system performance analysis
- Cross-jurisdictional service comparisons

These publications provide comparative evidence on government investment, service performance and system outcomes across Australian jurisdictions.

National Mental Health Commission

The National Mental Health Commission is used for system-level policy context, national reform priorities, lived-experience perspectives and mental health system analysis.

Relevant source categories include:

- National mental health reform reporting
- National mental health strategy commentary
- System monitoring
- Consumer and carer perspectives

These sources provide strategic context for understanding Australia's evolving mental health system and future reform priorities.

Services Australia / Medicare

Services Australia and Medicare data are used to interpret publicly subsidised mental health service utilisation.^{2,10}

Relevant data categories include:

- Medicare Benefits Schedule (MBS) mental health items
- Medicare-subsidised psychology, psychiatry and GP mental health services
- Medicare provider category utilisation
- Medicare telehealth service use
- Medicare mental health service volumes
- Medicare expenditure, where available

Medicare data are especially important for understanding publicly subsidised access to mental health services. However, they do not capture all private, public, NDIS, school-based, employer-funded or community mental health supports.^{2,10,15,16}

Australian Health Practitioner Regulation Agency (AHPRA)

The Australian Health Practitioner Regulation Agency (AHPRA) provides official registration data for regulated health professions.^{4,11}

AHPRA data are used throughout this report to analyse workforce availability and distribution for registered professions, particularly psychologists and psychiatrists. These data are supplemented by information from the Psychology Board of Australia and the Medical Board of Australia to examine registration trends, endorsed areas of practice and workforce supervision capacity.

Australian Health Practitioner Regulation Agency (AHPRA)

The Australian Health Practitioner Regulation Agency (AHPRA) provides official registration data for regulated health professions.^{4,11}

Relevant professional categories include:

- Psychologists
- Medical practitioners
- Nurses
- Occupational therapists

AHPRA data are valuable for estimating workforce headcount and registration trends. However, registration data do not necessarily indicate actual clinical service availability, as practitioners may work part-time, in non-clinical roles or outside direct mental health service delivery.^{4,11,12}

Psychology Board of Australia

The Psychology Board of Australia provides detailed information on psychology registration, endorsements and workforce supervision capacity.^{4,11,12}

Relevant categories include:

- Registered psychologists
- Provisional psychologists
- Clinical psychology endorsements
- Other area-of-practice endorsements
- Board-approved supervisors

These data assist in estimating psychology workforce supply, specialist capability and future training pipeline capacity.^{4,11}

Medical Board of Australia

Medical Board of Australia data support interpretation of registered medical practitioners and specialist medical workforce categories, including psychiatry where relevant.^{4,11}

These data complement AHPRA workforce information and assist in understanding the distribution and availability of Australia's medical specialist workforce.

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) provides specialist workforce analysis for the psychiatry profession.^{4,11,13}

Relevant source categories include:

- Psychiatry workforce shortages
- Specialist workforce modelling
- Psychiatry training pipeline
- Rural and regional psychiatry access
- Child and adolescent psychiatry constraints

RANZCP publications provide important evidence on psychiatry workforce capacity, future supply and regional access challenges.

Australian Psychological Society (APS)

The Australian Psychological Society (APS) provides professional perspectives on psychology workforce capacity, service demand, policy reform and access barriers.^{4,11}

APS materials are particularly useful for understanding:

- Psychology workforce pressures
- Service demand
- Medicare access issues
- Professional practice challenges
- Psychology policy submissions

These sources complement government workforce datasets by providing insight into the psychology profession's experience of service demand and access pressures.^{2,10,4,11}

Jobs and Skills Australia

Jobs and Skills Australia provides labour market analysis relevant to Australia's mental health workforce.¹⁴

Relevant categories include:

- Health workforce shortage indicators
- Employment projections
- Recruitment difficulty
- Labour market trends
- Mental health occupation demand

These data support the report's analysis of future workforce pressures, recruitment challenges and long-term workforce planning across the mental health sector.

National Disability Insurance Scheme (NDIS) / National Disability Insurance Agency (NDIA)

NDIS and NDIA data are used to analyse disability-related demand, psychosocial disability, autism participation, support categories and participant growth.^{15,16}

Relevant data categories include:

- NDIS participant numbers
- Psychosocial disability participation
- Autism participation
- Capacity-building supports
- Primary disability categories
- Scheme growth trends
- Regional and remote participant access

These data provide important evidence on the growing interaction between Australia's disability and mental health systems, particularly in relation to psychosocial disability and neurodevelopmental support.

NDIS Quality and Safeguards Commission

The NDIS Quality and Safeguards Commission provides information on behaviour support, restrictive practices, positive behaviour support capability and provider regulation.^{15,16,17}

Relevant source categories include:

- Positive Behaviour Support Capability Framework
- Specialist behaviour support practitioner suitability
- Restrictive practice reporting
- NDIS provider quality and safeguards

These materials are used to inform discussion of behaviour support workforce capacity and specialist disability service delivery.

Primary Health Network (PHN) Needs Assessments

PHN Needs Assessments provide important regional evidence on local mental health access challenges and service planning priorities. They are particularly valuable because they often identify issues that are not visible in state-level or national datasets.^{4,11,27}

Relevant categories include:

- Regional mental health needs
- Workforce shortages
- Service gaps
- Priority populations
- Youth mental health needs
- Rural and remote access barriers
- Commissioned service priorities

PHN Needs Assessments are used extensively throughout this report to identify regional workforce shortages, underserved communities and priority areas for future investment.

State and Territory Health Departments

State and territory health department publications provide information on public mental health service delivery, regional service structures and jurisdiction-specific workforce strategies.^{4,11,5,20}

Relevant categories include:

- Public mental health services
- Community mental health services
- Crisis and acute care services
- Regional service delivery
- Mental health workforce strategies
- Service reform programs

These sources complement national datasets by providing jurisdiction-specific information on public mental health services, regional priorities and ongoing system reforms.

State and Territory Health Departments

State and territory health department publications also provide information on:

- Child and adolescent mental health services
- State-level mental health reform strategies
- Regional service planning
- Service demand data

These sources provide valuable insight into jurisdiction-specific priorities, workforce initiatives and public mental health service delivery.

Rural Health Organisations

Rural health organisations provide evidence relating to regional workforce shortages, transport barriers, workforce maldistribution, rural service models, telehealth limitations and local access challenges.^{2,24,25,4}

Relevant source categories include:

- Rural workforce reports
- Regional health workforce analysis
- Rural service access submissions
- Rural mental health factsheets
- Rural community service barriers
- Telehealth outcomes
- Rural mental health access
- Workforce maldistribution

These publications strengthen the report's analysis of regional and remote mental health access and workforce planning.

Aboriginal Community Controlled Health Organisation (ACCHO) Sector Sources

Aboriginal Community Controlled Health Organisation (ACCHO) sector sources are used to inform discussion of Aboriginal-led care, social and emotional wellbeing, cultural safety, Indigenous workforce development and community-controlled models of care.^{4,11,32}

Relevant source categories include:

- ACCHO service models
- Aboriginal and Torres Strait Islander mental health workforce
- Social and emotional wellbeing frameworks
- Cultural safety and community control
- Remote community access

These sources provide important evidence on culturally appropriate service delivery and Aboriginal-led approaches to improving mental health access.

headspace and Orygen

headspace and Orygen publications are used to examine youth mental health trends, early intervention, service demand, school-aged mental health concerns and barriers to accessing care.^{9,18}

Relevant source categories include:

- Youth mental health reports
- Policy papers on youth mental health access
- Early intervention models
- Young people's psychological distress
- Service demand data

These sources contribute to the report's analysis of child and adolescent mental health demand and future service planning.

Peer-Reviewed Academic Literature

Peer-reviewed academic literature is used to contextualise and interpret evidence relating to:

- Early intervention
- Workforce distribution
- Rural and remote mental health access
- Telehealth effectiveness
- Mental health service utilisation
- Autism and ADHD assessment pathways
- Child and adolescent mental health
- Aboriginal and Torres Strait Islander mental health
- Disaster-related mental health
- Psychosocial disability
- Integrated models of care

Academic literature complements Australian government datasets by providing independent evidence on emerging trends, international best practice and the broader evidence base supporting mental health access policy and workforce reform.

Appendix D.2 Key Definitions

Mental Health Access

Mental health access refers to a person's ability to obtain timely, affordable, appropriate and acceptable mental health support when needed.

Access involves more than the existence of services. Mental health care must also be geographically reachable, financially affordable, clinically appropriate and available within a reasonable timeframe.

Workforce Availability

Workforce availability refers to the practical availability of qualified professionals to provide mental health care.^{4,11}

This includes:

- Psychologists
- Psychiatrists
- Counsellors
- Social workers
- Mental health nurses
- Occupational therapists
- Behaviour support practitioners
- Support coordinators
- Psychosocial recovery coaches

Workforce Density

Workforce density refers to the number of practitioners or full-time equivalent (FTE) practitioners relative to population size, commonly expressed per 100,000 people.^{4,11}

Workforce density is useful for comparing jurisdictions but does not indicate whether practitioners are accepting new clients, have appointment availability or practise within particular regions.^{4,11}

Service Density

Service density refers to the availability of mental health services relative to the population.

This may include the number of:

- Mental health clinics
- Public mental health services
- Medicare-funded services
- Community mental health programs
- Youth mental health services
- Telehealth services
- Provider locations

Service density provides an indication of the overall availability of mental health care within a region.^{2,10,24,25}

Mental Health Service Utilisation

Mental health service utilisation refers to the actual use of mental health services, including:

- Medicare-subsidised services
- Public mental health care
- Private psychology and psychiatry services
- Telehealth services
- Community mental health programs
- NDIS-funded supports
- Digital mental health services

Service utilisation should not be interpreted as equivalent to service need, as utilisation is influenced by workforce availability, affordability, eligibility and access barriers.^{2,10,24,25}

Unmet Need

Unmet need refers to mental health support that is needed but not received.

Unmet need may result from:

- Cost barriers
- Long wait times
- Workforce shortages
- Stigma
- Difficulties navigating services
- Cultural barriers
- Geographic distance
- Lack of appropriate services

Psychosocial Disability

Psychosocial disability refers to the functional impact of a mental health condition on a person's ability to participate in daily life, relationships, employment, education or community activities.^{15,16}

Psychosocial disability is particularly relevant to eligibility for National Disability Insurance Scheme (NDIS) supports and long-term recovery-oriented care.^{15,16}

Regional, Rural and Remote Australia

Regional, rural and remote Australia refers to communities located outside major metropolitan centres.^{5,20}

These communities often experience greater travel distances, workforce shortages, reduced specialist availability and increased reliance on telehealth and outreach services.

Academic Literature

Academic literature is used throughout this report to supplement government and administrative datasets, particularly where evidence relating to service quality, intervention effectiveness, emerging trends, workforce reform or international best practice is discussed.

Peer-reviewed evidence complements Australian public data by providing additional context and supporting interpretation of findings.

Additional Terms Used Throughout the Report

The following concepts are referenced throughout the Australian Mental Health Access Report 2026:

- Youth mental health
- Digital mental health
- Service navigation
- Mental health access equity
- Climate-related mental health impacts

These concepts reflect important emerging themes influencing mental health service planning, workforce development and future access across Australia.

Telehealth

Telehealth refers to healthcare delivered by telephone or video rather than through face-to-face consultations.^{2,24,25}

In mental health, telehealth may include:

- Psychology
- Psychiatry
- Counselling
- Social work
- GP mental health consultations
- Other clinical and psychosocial support services

Telehealth has become an important mechanism for improving access, particularly for people living in regional, rural and remote Australia.^{2,10,24,25}

Early Intervention

Early intervention refers to support provided early in the development of symptoms, disability or functional difficulties.

The objective is to reduce symptom escalation, improve long-term outcomes and prevent the need for more intensive or complex services later.

Wait Time

Wait time refers to the period between seeking help or receiving a referral and obtaining an appropriate first appointment or service.

Wait times vary according to:

- Service type
- Funding pathway
- Geographic location
- Practitioner availability
- Clinical urgency

Long wait times are one of the most significant barriers to timely mental health care in Australia.^{4,11}

Access Barrier

An access barrier is any factor that prevents, delays or reduces a person's ability to obtain appropriate mental health care.

Common barriers include:

- Cost
- Geographic distance
- Workforce shortages
- Transport limitations
- Long waitlists
- Referral complexity
- Stigma
- Cultural safety concerns
- Digital exclusion

Mental Health Hotspot

A mental health hotspot is a region where multiple access barriers overlap, creating a high likelihood of unmet mental health need.

A hotspot may be characterised by:

- Workforce shortages
- Remoteness
- Socioeconomic disadvantage
- Disaster exposure
- Aboriginal and Torres Strait Islander access barriers
- High youth mental health demand
- Limited psychiatry access
- Low service density

These factors interact to make timely access to appropriate mental health care particularly difficult.^{4,11,5,20}

Appendix D.3 Data Interpretation Notes**Workforce Headcount Versus Clinical Availability**

Workforce headcount should not be interpreted as equivalent to clinical availability.

A registered practitioner may:

- Work part-time
- Work outside direct mental health service delivery
- Work in education, research, policy or management
- Have closed books and not accept new clients
- Practise in highly specialised areas with limited general availability

For this reason, practitioner registration data may overestimate practical access to care. Full-time equivalent (FTE) measures generally provide a more accurate estimate of service capacity.^{4,11}

Prevalence Versus Service Use

Prevalence measures how common mental health conditions or symptoms are within a population.

Service use measures how many people actually access mental health services.

Although related, these measures are not equivalent.

A region may have high prevalence but low service use because services are unavailable, unaffordable, culturally unsafe, difficult to navigate or geographically inaccessible.

Conversely, a region may have high service utilisation because access is comparatively better, not necessarily because the underlying need is greater.

Demand Versus Need

Demand refers to expressed help-seeking behaviour, referrals, enquiries or requests for mental health services.

Need includes both expressed and unexpressed requirements for care.

Some communities experience substantial unmet need despite relatively low expressed demand because of:

- Stigma
- Limited mental health literacy
- Cultural barriers
- Poor service availability
- Previous negative experiences with services

Understanding the distinction between demand and need is essential when interpreting service utilisation data and planning future workforce and service investment.

Regional, Rural and Remote Classification

Throughout this report, the terms regional, rural and remote are used broadly to describe communities outside Australia's major metropolitan centres.

Where appropriate, these terms align with the Australian Bureau of Statistics (ABS) Australian Statistical Geography Standard (ASGS) Remoteness Areas, including:

- Major Cities
- Inner Regional
- Outer Regional
- Remote
- Very Remote Australia

This broader terminology is used to improve readability while remaining consistent with recognised Australian geographic classifications.^{5,20}

Workforce Headcount Does Not Equal Clinical Availability

A registered practitioner may:

- Work part-time
- Work outside mental health
- Work in education, research, management or policy
- Be non-practising
- Have closed books
- Focus on a narrow specialist area
- Not accept Medicare, NDIS or public referrals
- Be located far from high-need communities

For access planning, full-time equivalent (FTE) workforce capacity, appointment availability and provider location are generally more informative than practitioner headcount alone.

Medicare Data Limitations

Medicare data are valuable for measuring publicly subsidised mental health service utilisation, but they do not capture the entire mental health system.^{2,10}

Medicare data may exclude or underrepresent:

- Public hospital-based mental health care
- State-funded community mental health services
- Fully private services not claimed through Medicare
- Employer-funded Employee Assistance Programs (EAPs)
- School-based mental health services
- NDIS-funded supports
- Community organisation services
- Informal and peer support

Medicare utilisation may also reflect provider availability and affordability rather than underlying mental health need.^{2,10}

NDIS Data Limitations

NDIS data are useful for understanding participant trends and disability-related support demand, but they do not fully measure mental health access.^{15,16}

NDIS data may not capture:

- Wait times
- Provider availability
- Service quality
- Local thin markets
- People with psychosocial disability who are not NDIS participants
- People who are eligible but have not applied
- People who applied unsuccessfully

Accordingly, NDIS data should be interpreted alongside broader workforce, service availability and population health evidence.

State-Level Averages Versus Local Access

State-level data can conceal substantial local access gaps.

A jurisdiction may appear well supplied because of a large metropolitan workforce while rural, remote and outer regional communities continue to experience severe workforce shortages and limited specialist availability.^{4,11,5,20}

For this reason, state-level findings should be supplemented with Primary Health Network (PHN)-level, Statistical Area Level 4 (SA4), Local Health District or community-level data wherever possible.²⁷

Local-level analysis provides a more accurate understanding of workforce distribution, service capacity and unmet mental health need than jurisdiction-wide averages alone.

Private Sector Data Gaps

Private sector mental health service availability is not comprehensively captured in public datasets.

Important gaps include:

- Appointment availability
- Closed books
- Gap fees
- Private psychiatry availability
- Counselling availability
- Provider specialisations
- Assessment costs
- Private autism assessment wait times
- Private ADHD assessment wait times

These limitations reduce the ability to measure real-world mental health access with complete precision.

Telehealth Data Limitations

Telehealth utilisation data measure service activity rather than the quality, appropriateness or effectiveness of care.^{2,24,25}

Available datasets generally do not indicate:

- Whether telehealth was clinically appropriate
- Whether the person preferred face-to-face care
- Whether cultural or language needs were met
- Whether the individual had access to a private space
- Whether internet connectivity was reliable
- Whether clinical outcomes were comparable to in-person care

Telehealth should therefore be interpreted as an important access pathway rather than a complete substitute for locally available mental health services.^{2,24,25}

Counselling Workforce Data Limitations

Counsellors and psychotherapists are not regulated through AHPRA.

Consequently, workforce estimates are generally derived from professional association membership and registration data rather than statutory registration datasets.^{4,11}

While these data provide useful estimates of workforce size and capacity, they are not directly comparable with AHPRA-regulated professions such as psychologists, psychiatrists, nurses and occupational therapists.^{4,11,12,13}

Appendix D.4 Use of Composite Indicators

Composite indicators are used throughout this report because mental health access cannot be adequately measured using a single statistic.

An individual's ability to access mental health care depends on multiple interacting factors, including:

- Workforce availability
- Geography
- Service density
- Cost and affordability
- Telehealth access
- Wait times
- Provider availability
- Cultural safety
- Service navigation
- Population need

No single measure captures this complexity. Composite indicators combine multiple evidence-based domains to provide a broader understanding of access conditions across jurisdictions and regions.

Although composite indicators simplify complex systems, they provide a practical framework for benchmarking, identifying priority areas and informing workforce planning, policy development and future investment. They should always be interpreted alongside local evidence, regional data and qualitative information rather than as standalone measures of mental health system performance.

Composite Indicators

Population need, workforce availability, service density, referral pathways, transport, service navigation, digital inclusion and socioeconomic disadvantage all influence mental health access.

Composite indicators allow these multiple dimensions to be considered together within a single analytical framework.

The report uses composite indicators for:

- The Australian Mental Health Access Index
- The Top 20 Mental Health Access Hotspots
- Workforce risk ratings
- Regional access prioritisation

Composite indicators are useful for comparing access environments and identifying priority areas for future investment. However, they should be interpreted with appropriate caution.

Weighting choices can influence rankings. A workforce-heavy model, for example, may produce different results from a regional-access-heavy or youth-mental-health-heavy model.^{4, 11, 5, 20}

Accordingly, the composite rankings presented throughout this report are intended as policy prioritisation tools, not official government statistics.

Appendix D.5 Citation and Evidence Standards

The report applies the following evidence standards throughout.

Public Data for Major Claims

Major findings and policy conclusions should, wherever possible, be supported by credible public evidence.

Preferred source categories include:

- Australian Bureau of Statistics (ABS)
- Australian Institute of Health and Welfare (AIHW)
- Department of Health, Disability and Ageing
- Productivity Commission
- Services Australia / Medicare
- Australian Health Practitioner Regulation Agency (AHPRA)
- National Disability Insurance Agency (NDIA) / National Disability Insurance Scheme (NDIS)
- NDIS Quality and Safeguards Commission
- State and territory health departments
- Primary Health Network (PHN) Needs Assessments
- Recognised professional bodies
- Peer-reviewed academic literature

Cautious Language Where Exact Numbers Are Unavailable

Where exact figures or directly comparable data are unavailable, the report intentionally adopts cautious language, including phrases such as:

- "Available evidence suggests..."
- "Current evidence indicates..."
- "Publicly available data indicate..."
- "The available literature suggests..."
- "Based on current evidence..."
- "Likely..."
- "May..."
- "Appears to..."

This approach distinguishes evidence-based interpretation from confirmed statistical findings and reduces the risk of overstating conclusions where data limitations exist.

Evidence Hierarchy

When multiple sources were available, evidence was interpreted using the following general hierarchy:

1. Official Australian government datasets (ABS, AIHW, Department of Health, Services Australia)
2. Statutory registration and regulatory bodies (AHPRA, Psychology Board of Australia, Medical Board of Australia, NDIA, NDIS Commission)
3. Primary Health Network (PHN) Needs Assessments and state or territory government publications
4. Recognised professional organisations and peak bodies
5. Peer-reviewed academic literature
6. Sector reports and policy submissions

Where findings were supported by multiple independent sources, greater confidence was placed in the conclusions presented throughout the report.

Interpretation Principles

This report aims to distinguish clearly between:

- Confirmed public data
- Derived estimates
- Composite indicators
- Evidence-informed policy interpretation
- Areas requiring further research

Maintaining these distinctions supports transparency, strengthens methodological integrity and enables readers to understand the level of confidence associated with different findings presented throughout the Australian Mental Health Access Report 2026.

Rankings as Prioritisation Tools

The Mental Health Access Index and Top 20 Hotspots are original composite models developed for this report.

They should not be described as official government rankings.

Their purpose is to support policy discussion, service planning, media interpretation and future research.

Cautious Language

Where appropriate, the report uses cautious language such as:

- "Public data indicate"
- "Reported access barriers include"
- "Likely access pressure"
- "High-risk region"
- "Indicative rather than definitive"

Internal Provider Observations

Internal provider observations, where used, should be labelled separately from public data. They should not be presented as nationally representative unless supported by independent data.

Examples of internal observations may include:

- Referral enquiry trends
- Client service preferences
- Regional service requests
- Telehealth demand patterns
- Common presenting concerns

These observations can add practical insight but should be clearly distinguished from official statistics.

Appendix D.6 Data Gaps Identified

The report identifies several major gaps in Australian mental health access data.

National Wait Time Data

Australia lacks consistent national reporting of wait times for:

- Psychology
- Psychiatry
- Child and adolescent mental health
- Autism assessment
- ADHD assessment
- Public community mental health
- Behaviour support
- Psychosocial disability support

Real-Time Provider Availability

There is limited public visibility of whether providers are accepting new clients.

This makes it difficult to assess real-world access even where workforce headcount appears adequate.^{4,11}

Appendix D.7 Recommended Future Data Collection

The report recommends a stronger national mental health access data system.

Annual National Access Dashboard

Australia should develop an annual dashboard tracking mental health access indicators across jurisdictions and regions.

Indicators should include:

- Wait times
- Gap fees
- Bulk-billing availability
- Psychology workforce
- Psychiatry workforce
- Behaviour support workforce
- Child and adolescent services
- Telehealth utilisation
- Regional access measures

Consumer-Reported Access Barriers

Australia lacks a regular national consumer access survey measuring:

- Difficulty finding a provider
- Wait times
- Gap fees
- Cultural safety
- Bulk-billing availability
- Reasons for delaying or abandoning care
- Service navigation problems
- Telehealth barriers

Out-of-Pocket Cost Data

There is no comprehensive national dataset showing:

- Psychology gap fees
- Psychiatry gap fees
- Counselling fees
- Autism assessment costs
- ADHD assessment costs
- Regional affordability differences

Regional Child Assessment Wait Times

There is no consistent national dataset tracking autism and ADHD assessment wait times by region.^{15,16,9,18}
This limits visibility of one of the most significant child and adolescent access bottlenecks.^{9,18}

Behaviour Support Workforce Data

Public data on behaviour support practitioner availability by region are limited.^{4,11,17}

This is a significant gap given the importance of behaviour support in NDIS, autism, intellectual disability and psychosocial disability contexts.^{15,16,17}

Counselling Workforce Data

Counselling workforce data are less comparable because counselling is not regulated through AHPRA.^{4,11,12}
Professional association data are useful but do not provide the same statutory workforce picture as AHPRA-regulated professions.^{4,11,12}

Telehealth Quality and Outcome Data

Telehealth utilisation is measured more consistently than telehealth quality, clinical outcomes, consumer preference or long-term effectiveness.^{2,24,25}

More data are needed to distinguish access volume from access quality.

PHN-Level Workforce Reporting

PHN-level workforce reporting would provide more useful access information than state-level averages.^{4,11,27}

Recommended categories include:

- Psychologists
- Clinical psychologists
- Psychiatrists
- Mental health nurses
- Mental health social workers
- Occupational therapists
- Counsellors
- Behaviour support practitioners
- Support coordinators
- Psychosocial recovery coaches

Wait Time Reporting by Service Category

Wait time reporting should be developed for:

- Adult psychology
- Child psychology
- Psychiatry
- Child psychiatry
- Autism assessment
- ADHD assessment
- Public mental health
- Behaviour support
- Psychosocial recovery supports

Regional Child Mental Health Access Monitoring

A dedicated child and adolescent access dataset should monitor:

- School refusal-related demand
- Youth psychological distress
- Child psychology availability
- Autism and ADHD assessment wait times

National Mental Health Access Indicators

Future national reporting should include:

- Workforce availability
- Wait times
- Service utilisation
- Regional access
- Cost barriers
- Telehealth utilisation
- Child and adolescent access
- NDIS psychosocial access

Consumer Access Survey

Australia should consider a regular national mental health access survey measuring the lived experience of seeking care.

Survey topics should include:

- Time to first appointment
- Difficulty finding a provider
- Out-of-pocket cost
- Service navigation
- Reasons for not accessing care
- Telehealth experience
- Satisfaction with access
- Continuity of care
- Cultural safety

National Provider Availability Mapping

Provider mapping should track whether services are actually available, not merely whether practitioners are registered.^{4,11}

Useful indicators would include:

- Accepting new clients
- Average wait time
- Funding types accepted
- Telehealth availability
- Assessment availability
- Languages offered
- Provider availability by remoteness
- Child and adolescent availability
- Regional service coverage
- Service continuity
- Cultural safety indicators

NDIS Psychosocial Support Access Measures

Future reporting should include:

- Psychosocial recovery coach availability
- Support coordination availability
- Behaviour support practitioner availability
- Regional thin markets
- Participant-reported access difficulty

Additional Recommended Measures

Future reporting should also include:

- Child psychiatry availability
- School-linked mental health access
- Regional early intervention access

Future Data Collection

Future data collection should also include:

- Telehealth quality and outcome monitoring
- Regional disaster-related mental health demand tracking
- Aboriginal-led service availability mapping
- Workforce burnout and retention monitoring
- Private sector service availability
- Employer-funded mental health service use
- School-based mental health service access
- Early intervention service coverage
- Crisis alternative service availability
- Gap-fee and affordability monitoring

Appendix D.8 Reliability Statement

This report uses the best available public evidence to describe mental health access across Australia. However, mental health access is complex and cannot be fully captured by any single dataset. Public data often lag behind current service conditions, and some of the most important access indicators—including wait times, gap fees and provider availability—are not yet reported consistently.^{4,11}

For this reason, the report's composite rankings and hotspot classifications should be interpreted as structured prioritisation tools. They are intended to support further investigation, policy discussion and service planning, not to replace local needs assessment or formal government reporting.²⁷

Appendix E

Appendix E - Glossary of Mental Health Access Terms

Plain-English definitions of key mental health access terms.

Appendix E - Glossary of Mental Health Access Terms

Term	Plain-English Definition	Why It Matters for Mental Health Access
Access barrier	Any factor that makes it harder for a person to receive mental health support.	Barriers such as cost, wait times, transport, stigma and service complexity can delay or prevent care.
Access hotspot	A region where several access barriers overlap, creating a higher risk of unmet mental health need.	Hotspots help identify where workforce, funding and service planning should be prioritised.
Allied mental health professional	A health professional who provides mental health-related support but is not a medical doctor. This may include psychologists, mental health social workers, occupational therapists and some counsellors.	Allied professionals deliver much of Australia's therapy, early intervention and community-based support.
Australian Health Practitioner Regulation Agency	The national agency that works with National Boards to regulate registered health practitioners in Australia.	AHPRA registration data help measure parts of the regulated mental health workforce.
Behaviour support	Support designed to understand, reduce and prevent behaviours of concern, usually by improving skills, environments and support strategies.	Behaviour support is important for people with autism, intellectual disability, psychosocial disability and complex support needs, particularly under the NDIS.
Capacity building supports	Supports that help a person develop skills, independence, confidence and community participation.	Capacity building is central to NDIS-funded therapy, psychosocial recovery, behaviour support and daily living goals.
Child and adolescent mental health	Mental health support for children, teenagers and young people.	This is a high-pressure area of the system, especially for anxiety, school refusal, self-harm, autism, ADHD and family support needs.
Clinical psychologist	A registered psychologist with an endorsed area of practice in clinical psychology.	Clinical psychologists often provide assessment and treatment for more complex mental health presentations.
Community mental health service	A mental health service delivered outside hospital, often through local health services, community teams or non-government organisations.	Community services can provide earlier, less restrictive care and reduce reliance on emergency departments and hospitals.
Counsellor	A professional who provides therapeutic support for emotional, personal, relationship, grief, trauma or life-stress concerns.	Counsellors can expand access to early and moderate-intensity support, although counselling is not regulated through AHPRA in the same way as psychology or medicine.
Digital mental health	Mental health support delivered through digital tools, such as apps, websites, online programs, digital triage or virtual support platforms.	Digital tools can improve reach, particularly for people facing distance, stigma or workforce barriers.
Early intervention	Support provided early in the development of symptoms, distress, disability or functional difficulty.	Early intervention can prevent escalation, reduce long-term impairment and lessen pressure on crisis services.
General practitioner mental health treatment plan	A plan prepared by a GP for a patient with a mental health condition, often used to access Medicare-subsidised mental health services under Better Access.	GP mental health treatment plans are a major entry point into subsidised psychological care in Australia.
headspace	Australia's National Youth Mental Health Foundation, providing early intervention support for young people aged 12-25.	headspace is a major youth mental health access pathway, particularly for early intervention and mild-to-moderate concerns.
Hybrid care	A model that combines telehealth and face-to-face services.	Hybrid care can improve flexibility while preserving in-person support where clinically needed.
Low-intensity mental health support	Structured support for mild to moderate mental health concerns, often involving brief intervention, guided self-help, psychoeducation or digital programs.	Low-intensity support can help people earlier and reduce pressure on higher-intensity clinical services.
Medicare-subsidised mental health service	A mental health service partly funded through Medicare, such as certain psychology, psychiatry, GP and allied mental health services.	Medicare subsidies reduce cost barriers, although many people may still pay out-of-pocket costs.
Mental disorder	A clinically recognised mental health condition, such as an anxiety disorder, depressive disorder, bipolar disorder, schizophrenia or substance use disorder.	Measuring mental disorders helps estimate population need and plan service capacity.

Term	Plain-English Definition	Why It Matters for Mental Health Access
Mental health access	The ability to obtain timely, affordable, appropriate and acceptable mental health support when needed.	Access is the central issue examined throughout this report.
Mental health care plan	Common shorthand for a GP mental health treatment plan.	It is a common pathway for accessing Medicare-subsidised psychological services.
Mental health service utilisation	The actual use of mental health services, such as psychology, psychiatry, GP mental health care, public mental health, telehealth or community support.	Utilisation shows service activity, but it does not always equal true need. Low use may reflect poor access rather than low demand.
Mental health social worker	A social worker with mental health training and, in some cases, accreditation to provide Medicare-subsidised focused psychological strategies.	Mental health social workers are important where mental health intersects with housing, family violence, disability, poverty, trauma or social isolation.
Multidisciplinary care	Care delivered by a team of professionals from different disciplines.	Many people with complex needs require support from several professions, such as a GP, psychologist, psychiatrist, social worker, occupational therapist and support coordinator.
NDIS	The National Disability Insurance Scheme, which funds disability-related supports for eligible Australians with permanent and significant disability.	The NDIS is a major pathway for supports related to psychosocial disability, autism, developmental disability and complex functional needs.
NDIS participant	A person who has been accepted into the NDIS and has an approved NDIS plan.	Participant status determines access to funded disability-related supports.
Neurodevelopmental assessment	Assessment for developmental conditions such as autism, ADHD, intellectual disability or learning-related concerns.	Demand for neurodevelopmental assessment is a major driver of child, adolescent and adult service pressure.
Occupational therapist	A registered health professional who supports people to participate in daily activities, routines, work, education and community life.	Occupational therapists are important in mental health, disability, early intervention, functional assessment and NDIS support.
Out-of-pocket cost	The amount a person pays after any Medicare, insurance, NDIS or other subsidy is applied.	Out-of-pocket costs are a major barrier to starting and continuing mental health care.
PHN	Primary Health Network. PHNs are regional organisations funded to improve primary healthcare access and commission services based on local needs.	PHNs are central to identifying local mental health gaps and funding targeted services.
Psychiatrist	A medical doctor specialising in the diagnosis and treatment of mental health conditions.	Psychiatry shortages are a major access issue, especially for complex presentations, medication management, child psychiatry and regional care.
Psychologist	A registered health practitioner trained in psychological assessment and therapy.	Psychologists deliver a large share of Australia's Medicare-subsidised and private mental health care.
Psychosocial disability	Disability arising from the functional impact of a mental health condition on daily life, relationships, work, study or community participation.	Psychosocial disability is important for NDIS access, recovery support, housing, employment and long-term care planning.
Psychosocial recovery coach	An NDIS-funded role that supports people with psychosocial disability to build capacity, connect with services and work toward recovery goals.	Recovery coaches can help people navigate mental health, disability and community support systems.
Regional mental health access	Access to mental health services outside major metropolitan areas.	Regional access is often affected by workforce shortages, travel distance, limited specialist care and fewer local providers.
Remote Australia	Areas classified as remote or very remote under Australian geographic classifications.	Remote communities often face the most severe access barriers, including distance, workforce shortages and limited local services.
Rural Australia	Areas outside major cities, including many inner regional, outer regional, remote and very remote communities.	Rurality affects service availability, workforce recruitment, transport, privacy and continuity of care.
School refusal	Difficulty attending school because of emotional distress, anxiety, neurodevelopmental needs, bullying, trauma or other underlying factors.	School refusal is an increasingly visible child and adolescent mental health concern and can affect education, family functioning and long-term wellbeing.

Term	Plain-English Definition	Why It Matters for Mental Health Access
Service density	The amount of service availability relative to population size, such as services, providers or appointments per person.	Low service density can indicate poor access, especially when population need is high.
Stepped care	A model where people are matched to the level of support appropriate to their needs, from low-intensity care through to specialist or crisis support.	Stepped care can improve system efficiency by helping people receive the right level of care at the right time.
Support coordination	NDIS-funded support that helps participants understand and use their plans, connect with providers and coordinate services.	Support coordination can reduce navigation barriers and improve access to suitable supports.
Telehealth	Health care delivered by phone or video instead of face-to-face.	Telehealth can reduce distance, transport and workforce barriers, especially in regional and remote areas.
Unmet need	Mental health support that is needed but not received.	Unmet need is one of the clearest signs of access failure.
Wait time	The period between seeking help or receiving a referral and obtaining an appropriate appointment or service.	Long wait times can worsen symptoms, increase family stress and raise the risk of crisis presentations.
Workforce availability	The practical availability of qualified workers to provide mental health support.	Workforce availability is one of the strongest determinants of whether people can actually access care.
Workforce density	The number of practitioners or full-time equivalent workers relative to population size, often measured per 100,000 people.	Workforce density helps compare service capacity between regions, although it does not show real-time appointment availability.

Sources

References and Endnotes

Source list and endnote references used throughout the report.

Endnotes

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Australian Mental Health Access Report 2026

National trends in access, demand, workforce capacity and service gaps

Prepared by Therapy Near Me

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Australian Mental Health Access Report 2026

RESEARCH ADDENDUM

Measurement, policy scenarios, monitoring and evaluation

Clarifying mental health access, testing policy mechanisms and establishing a framework for measuring change through 2030

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Document status and relationship to the original report

This addendum supplements the Australian Mental Health Access Report 2026. It does not replace the original publication, retrospectively alter the Australian Mental Health Access Index, or recalculate the Top 20 Mental Health Access Hotspots. The original report remains the source of the published jurisdictional scores, rankings and hotspot classifications.

The addendum has four purposes: to distinguish the dimensions of access more precisely; to provide a transparent policy-scenario model; to establish an annual monitoring and evaluation framework; and to describe the limitations and uncertainties that should accompany interpretation of access data and projections to 2030.

Responsible-use notice

This research and policy addendum is not clinical advice, an official government assessment or an independently peer-reviewed publication. Scenario outputs are conditional illustrations rather than predictions and should not be used as the sole basis for funding, commissioning or clinical decisions. Local needs assessment, community consultation and current jurisdictional data remain essential.

Acknowledgment of expert contribution

Dr Shakeel Mahmood, PhD, MPH, M.Com, MPA (USA), MBA (USA), FRSPH (Lond), FRSA (Lond), FIBA (Lond), Research Fellow (Health Policy Analyst), Rural Health Research Institute (RHRI), Charles Sturt University, Orange, New South Wales, and Member of the Royal Society of New South Wales, is acknowledged for his constructive feedback on the Australian Mental Health Access Report 2026.

Dr Mahmood recommended clearer separation of service availability, actual utilisation, affordability, waiting times and treatment outcomes; scenario modelling of workforce redistribution, telehealth expansion, early intervention and Medicare rebate reform; a dedicated treatment of data limitations and uncertainty through 2030; and a monitoring and evaluation framework for tracking whether access indicators are improving, stable or deteriorating over time. This acknowledgment does not imply authorship, formal peer review, institutional endorsement or agreement with every conclusion. Responsibility for the addendum remains with Therapy Near Me and AIHEM.

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Executive summary

The Australian Mental Health Access Report 2026 described a system in which demand is high, workforce and services are unevenly distributed, cost remains a barrier, and regional and remote communities face compounding disadvantages. It introduced an Australian Mental Health Access Index and a Top 20 Hotspots framework as original, non-government prioritisation tools. This addendum preserves those published results and develops a complementary framework that is more explicit about what “access” means, how policy mechanisms may affect it, and how progress should be monitored.

The central clarification is that mental health access is not a single event and cannot be inferred from a single service count. It is a pathway. A person must be able to recognise a need, seek help, identify an appropriate service, reach or connect with it, afford it, obtain an appointment within a reasonable period, commence care, continue for an appropriate duration and receive care of sufficient quality to support clinical or functional improvement. Failure at any stage may create unmet need even when services technically exist.

National data illustrate the scale and complexity of this pathway. The Australian Bureau of Statistics estimated that 21.5% of Australians aged 16–85, or 4.3 million people, experienced a 12-month mental disorder in 2020–2022. In 2024–25, approximately 2.8 million Australians received about 13.0 million Medicare mental health services. These figures are not directly interchangeable: prevalence, expressed demand, eligibility, treatment need and Medicare utilisation measure different populations and events (ABS 2023; AIHW 2026a).

The workforce is more complex than registration headcount. AIHW reported that in 2024 about 36,900 psychologists, 4,500 psychiatrists, 28,300 mental health nurses and 3,100 mental health occupational therapists were employed in their registered profession, and that there were about 3,400 accredited mental health social workers. These are employed-practitioner or accreditation counts, not direct clinical FTE or real-time availability. They should not be compared as though they were the same construct as the registration-headcount figures cited in parts of the original report (AIHW 2026b).

The addendum therefore proposes a measurement architecture across seventeen dimensions: population need; awareness and help-seeking; potential service availability; effective clinical capacity; geographic accessibility; digital accessibility; affordability; timeliness; acceptability and cultural safety; utilisation; continuity; treatment completion; quality and safety; patient experience; clinical outcomes; functional outcomes; and equity.

The policy-scenario model is intentionally transparent and conservative. It uses observed national data where available and treats uncertain intervention effects as parameters rather than facts. Population-scaled activity is expressed through a reproducible formula: projected population × the selected Medicare mental health service rate. The latest annual Centre for Population series should be imported at each model run; hard-coded 2030 values from the older ABS 2022-base series are not retained as the current planning baseline. This activity calculation does not estimate clinical need, quality or outcomes (AIHW 2026a; Centre for Population 2026).

Five intervention scenarios are examined: workforce redistribution; telehealth and hybrid-care expansion; early-intervention expansion; Medicare rebate or gap-fee reform; and a combined reform package. No single intervention is assigned a fixed national effect. Workforce redistribution may improve regional equity while leaving total national capacity unchanged. Telehealth can reduce travel and expand choice but may largely substitute for face-to-face care unless it releases usable capacity or reaches people who would otherwise receive no service. Higher rebates may reduce patient costs, but access effects depend on pass-through, provider fees and spare capacity. Early intervention may improve outcomes for suitable groups but should not be assumed to reduce all later service use. A combined package has a stronger systems rationale because it addresses several failure points, but its magnitude remains uncertain and its components cannot be added mechanically.

The monitoring framework proposes four classifications: Improving, Broadly stable, Deteriorating, and Insufficient or non-comparable data. Classification must use an indicator-specific threshold hierarchy: a validated clinical or policy threshold where one exists; statistical uncertainty or control limits where estimable; or a pre-specified operational margin with a data-quality gate. Comparable observations should be sustained where appropriate, and small-population methods should be triggered by denominator size and reliability rather than jurisdiction name alone. A national improvement should not be reported unqualified where a priority population or region deteriorates materially.

The addendum also establishes a dedicated uncertainty register. Major limitations include periodic prevalence surveys, incomplete private-sector data, inconsistent waiting-time definitions, limited appointment-availability data, workforce headcount that overstates direct clinical capacity, differences between state systems, data lags, limited cultural-safety measures, incomplete outcome data outside public specialised services, policy changes, population projection uncertainty and the inability of observational national data to attribute change to a single reform.

What this addendum changes

It changes the analytical framework, not the published rankings. It separates access from utilisation and outcomes; defines a conditional policy model rather than a prediction; introduces an annual M&E architecture; and makes uncertainty explicit. The original Access Index and Hotspot results remain unchanged.

Area	Original report contribution	Addendum contribution	Status
Access concept	Composite access environment across eight domains	Seventeen-stage pathway from need to outcomes	Extension
Access Index	Published state and territory scores and rankings	No recalculation; proposes future complementary indicators	Preserved
Hotspots	Priority regions based on overlapping access pressures	No re-ranking; proposes local validation and annual indicators	Preserved
2030 outlook	Directional best- and worst-case narratives	Transparent conditional model with equations and parameter status	Extension
Monitoring	Recommends dashboards and annual reporting	Defines indicators, classifications, thresholds and governance	Operationalisation
Limitations	Identifies major data gaps	Adds bias, uncertainty and interpretation register	Expansion

Source note: Therapy Near Me, Australian Mental Health Access Report 2026, especially Chapters 8–10 and Appendices B and D.

1. Purpose, scope and relationship to the original report

1.1 Purpose

The original report examined national trends in mental health access, demand, workforce capacity and service gaps. It correctly treated access as multidimensional and cautioned that the Access Index did not directly measure clinical outcomes, quality, real-time appointment availability, consumer satisfaction or full private-sector capacity. This addendum responds to the need for a more operational framework that allows analysts to distinguish the stages of access and to test whether changes in one stage are accompanied by changes elsewhere.

The addendum is designed for policymakers, Primary Health Networks, state and territory services, researchers, service providers, universities, consumer and carer organisations, Aboriginal Community Controlled Health Organisations, disability-sector stakeholders and data

custodians. It is intended to support discussion, research design and future data development rather than to replace official planning frameworks such as the National Mental Health Service Planning Framework.

1.2 Scope

The document covers access to psychological, psychiatric, primary mental health, public specialised, community-managed, telehealth, psychosocial and relevant disability-related supports. It does not attempt to model every service type, clinical condition or funding stream. The policy model uses a national architecture that can be populated at state, PHN, Local Hospital Network, Statistical Area or community level when suitable data are available.

1.3 Analytical principles

- Access, utilisation, quality and outcomes are related but distinct constructs.
- A service can be geographically available but financially or culturally inaccessible.
- A registered practitioner does not necessarily represent available clinical capacity.
- High utilisation may reflect good access, high need, high morbidity, repeat use or a combination of these factors.
- Low utilisation may reflect low need, barriers to care, cultural unsafety, lack of awareness, limited eligibility or missing data.
- A shorter wait is desirable only when clinical appropriateness, safety, continuity and outcomes are maintained.
- Policy scenarios are conditional illustrations and should not be reported as predictions.
- National averages must be accompanied by equity stratification and local interpretation.
- The Access Index and Hotspots remain the published 2026 prioritisation tools; the addendum does not retrospectively change them.

1.4 Evidence hierarchy

The addendum prioritises Australian official statistics, administrative datasets, national policy and evaluation documents, statutory standards and peer-reviewed health-services research. Source periods are stated wherever a quantitative value is used. Where evidence is incomplete, the addendum distinguishes observed data, derived values, illustrative assumptions, modelled outputs and policy judgement.

2. A multidimensional framework for mental health access

2.1 Conceptual foundation

Health-services research has long treated access as the fit between people and services rather than the mere presence of a provider. Penchansky and Thomas described availability, accessibility, accommodation, affordability and acceptability. Andersen emphasised the interaction of predisposing, enabling and need factors, while Gulliford and colleagues distinguished having access from gaining access. Levesque, Harris and Russell later framed access as the opportunity to identify need, seek services, reach them, obtain or use care and have the need fulfilled. The framework below adapts those concepts to the Australian mental health system and separates service use from quality and outcomes (Penchansky and Thomas 1981; Andersen 1995; Gulliford et al. 2002; Levesque, Harris and Russell 2013).

Dimension	Operational meaning	Example indicators	Principal caution
1. Population need	Prevalence, severity, risk and functional impairment that may warrant support.	12-month disorder; distress; suicide risk; disability; population growth.	Need is not identical to expressed demand or treatment eligibility.
2. Awareness and help-seeking	Ability to recognise a concern, identify options and decide to seek help.	Mental health literacy; self-reported need; help-seeking; referral enquiries.	Low demand can coexist with high unmet need.
3. Potential service availability	Existence of relevant services and practitioners in	Service locations; practitioner headcount;	Does not establish vacancies, funding

Dimension	Operational meaning	Example indicators	Principal caution
	or available to a region.	service types; outreach coverage.	acceptance or clinical fit.
4. Effective clinical capacity	Direct-care resources that can accept and deliver additional appropriate care.	Clinical FTE; available slots; open books; caseload; supervision; productivity.	Headcount generally overstates practical capacity.
5. Geographic accessibility	Time, distance, transport and physical ability required to reach care.	Travel time; transport availability; outreach; home visit coverage.	Proximity does not establish affordability or suitability.
6. Digital accessibility	Connectivity, device access, skills, privacy and accessibility for virtual care.	Internet reliability; device access; digital literacy; private space.	Telehealth use does not prove digital inclusion.
7. Affordability	Ability to pay fees and indirect costs without financial hardship.	Gap fee; bulk billing; travel cost; lost income; cost-related delay.	Higher rebates may not reduce gaps if fees rise or supply is fixed.
8. Timeliness	Time from help-seeking or referral to clinically appropriate assessment or care.	Median and 90th percentile wait; urgent response; time to treatment.	Definitions differ by start point, urgency and service type.
9. Acceptability and cultural safety	Fit with culture, language, identity, preferences, privacy and trust.	Language access; cultural-safety measures; preference concordance.	Attendance alone does not establish acceptability.
10. Utilisation	Actual service contacts, episodes or people receiving care.	People served; contacts; sessions; MBS services; episodes.	Utilisation is jointly determined by need and access.
11. Continuity	Extent to which care is coordinated and sustained across time and settings.	Follow-up; same-provider continuity; referral completion; care coordination.	High volume can coexist with fragmented care.
12. Treatment completion	Completion of the clinically intended or mutually agreed episode.	Completion rate; planned discharge; dropout; dose received.	Completion requires case-mix and clinical-context adjustment.
13. Quality and safety	Evidence-informed, person-centred, safe and appropriate care.	Standards compliance; treatment fidelity; adverse events; shared decisions.	Access should not be improved by lowering quality or safety.
14. Patient experience	Consumer and carer assessment of respect, involvement, communication and access.	YES or other PREM; complaints; preference met.	Response and selection bias require reporting.
15. Clinical outcomes	Change in symptoms or clinical status associated with an episode of care.	Routine outcome measures; significant improvement; deterioration.	Observed change is not automatically attributable to one service.
16. Functional outcomes	Change in daily living, education, work, relationships and participation.	Functioning scales; school attendance; employment; social participation.	Often under-measured outside specialised services.
17. Equity	Fair access and outcomes relative to need across population groups.	Rate ratios and gaps by remoteness, Indigenous status, SEIFA, age and disability.	Aggregate improvement may conceal widening gaps.

Source note: Adapted from Penchansky and Thomas (1981), Levesque, Harris and Russell (2013), the original report, AIHW and Productivity Commission performance frameworks.

2.2 Access pathway and hypothesised mechanisms

Stage	How access can fail	Measurement requirement
Population need	Need exists but may be unrecognised or below diagnostic threshold.	Prevalence and distress data; lived-experience research.
Recognition and help-seeking	Stigma, literacy, previous experiences and culture affect expressed demand.	Help-seeking and unmet-need surveys.
Navigation and eligibility	People identify a pathway and satisfy referral or program rules.	Referral completion; rejected or redirected referrals.
Availability and capacity	An appropriate provider exists and has	FTE, open books, available

Stage	How access can fail	Measurement requirement
	clinical capacity.	appointments.
Practical access	Care is affordable, reachable, digitally accessible and acceptable.	Cost delay, travel, digital inclusion, cultural safety.
Timely commencement	Assessment or treatment begins within a clinically reasonable period.	Median and tail wait times.
Continuity and completion	Care is sustained, coordinated and completed as intended.	Dropout, follow-up and completion.
Quality and outcomes	Care is safe, appropriate and associated with clinical or functional change.	PROMs, clinician-rated outcomes, PREMs and balancing measures.

Source note: Therapy Near Me synthesis based on access and health-services frameworks.

Interpretive rule

No single stage should be used as a proxy for the whole pathway. A rise in activity is not sufficient evidence of improved effective access unless capacity, timeliness, continuity, quality, outcomes and equity are considered together.

2.3 Why practitioner headcount may coexist with poor appointment access

Registration data describe the pool of registered professionals, while workforce datasets may identify those employed in their profession. Neither necessarily reports direct clinical FTE, hours available to new clients, case complexity, supervision commitments, leave, non-clinical duties, funding pathways accepted or geographic reach. AIHW's 2024 workforce data provide a stronger basis than registration headcount because they include employed practitioners and FTE measures, but real-time appointment availability remains largely unobserved. The practical capacity indicator should therefore combine clinical FTE with new-client acceptance and available appointment slots (AIHW 2026b).

2.4 Why high utilisation may indicate high need rather than good access

Utilisation is a realised event produced by need, help-seeking, eligibility, service supply and affordability. A high service rate may reflect strong access, high morbidity, repeated treatment, crisis demand or an urban concentration of services. Conversely, a low rate may reflect lower need, poor supply, cost, cultural barriers or missing services outside Medicare. The preferred interpretation is utilisation relative to independently estimated need, supported by waiting-time, capacity and unmet-need indicators.

2.5 Why reduced waiting time does not establish improved outcomes

Shorter waiting times are an access benefit, but they do not by themselves show that care was clinically appropriate, completed or effective. Wait reductions can be achieved through genuine additional capacity, better triage, changed eligibility, shorter episodes or reduced demand. Some mechanisms improve outcomes; others may shift unmet need elsewhere. Waiting-time reporting should therefore be paired with completion, deterioration, re-presentation, consumer experience and equity measures.

2.6 Why higher Medicare rebates may have a limited effect under fixed supply

A rebate increase can reduce the public-private price gap only to the extent that it is passed through to patients and providers have capacity to supply additional appointments. Where books are closed, the immediate effect may be a reduction in out-of-pocket cost for existing users rather than an increase in total access. Provider fees, bulk-billing behaviour, distribution and clinical capacity must therefore be measured alongside rebate changes. The Better Access

evaluation identified persistent equity concerns and situated program design within the broader mental health system (Department of Health and Aged Care 2022b).

2.7 Why telehealth utilisation does not establish suitability or satisfaction

AIHW reported that 22% of mental health MBS services processed in the December quarter of 2025 were delivered by telehealth. This establishes substantial use, not clinical suitability, preference, privacy, quality or outcomes. Telehealth may substitute for an in-person contact, create access for someone who would otherwise receive none, or allow a provider to serve a different region. These mechanisms have different policy implications and should be separated in evaluation (AIHW 2026c).

Common interpretation error	Required correction
"The region has many registered psychologists, so access is good."	Use employed clinical FTE, geographic distribution, open books and appointment availability.
"Service use rose, therefore unmet need fell."	Check prevalence, expressed demand, waiting times, cost delay and untreated need.
"Telehealth rose, so regional capacity increased."	Separate substitution, additionality and redistribution of existing workforce.
"Expenditure rose, so outcomes improved."	Expenditure may reflect prices, severity, remoteness or crisis pressure.
"Wait time fell, so quality improved."	Check eligibility changes, episode length, completion, outcomes and re-presentation.
"The national average improved, so equity improved."	Report subgroup rates, gaps and priority-population trends.
"A scenario estimate is a forecast."	State assumptions and label conditional projections or illustrations.

Source note: Therapy Near Me methodological synthesis.

3. Proposed access measurement framework

3.1 Relationship to the Australian Mental Health Access Index

The original Access Index compares the relative access environment of states and territories using eight weighted domains. It is a prioritisation and benchmarking model. The framework proposed here is complementary. It does not assign replacement scores or alter the published ranking. Its purpose is to define the indicators required to measure real-world access and change over time, including indicators the original report identified as unavailable or incomplete.

3.2 Baseline national evidence

Measure	Observed value	Reference period	Principal source
12-month mental disorder	21.5%; 4.3 million people aged 16–85	2020–2022	ABS National Study of Mental Health and Wellbeing
Medicare mental health recipients	About 2.8 million people; 10% of population	2024–25	AIHW Medicare mental health services
Medicare mental health services	About 13.0 million; 473 per 1,000 population; average 5 per patient	2024–25	AIHW Medicare mental health services
Population	27,801,023 people	31 December 2025	ABS National, state and territory population
Current national population planning milestones	28.0 million in 2025–26; 28.3 million in 2026–27; 31.5 million in 2035–36	Financial-year projections, published January 2026	Centre for Population, 2025 Population Statement
Psychologists employed in profession	About 36,900	2024	AIHW mental health workforce
Psychiatrists employed as specialists	About 4,500	2024	AIHW mental health workforce

Measure	Observed value	Reference period	Principal source
Mental health nurses	About 28,300	2024	AIHW mental health workforce
Mental health occupational therapists	About 3,100	2024	AIHW mental health workforce
Accredited mental health social workers	About 3,400 accredited practitioners; FTE not available	30 June 2024	AIHW/AASW
Telehealth share of mental health MBS activity	22%	December quarter 2025	AIHW activity monitoring
Cost-related delay	19.7% of respondents delayed seeing any mental health professional in the previous 12 months due to cost	2024-25	Productivity Commission, ROGS 2026

Source note: ABS (2023a, 2026); AIHW (2026a, 2026b, 2026c); Centre for Population (2026); Productivity Commission (2026). Values use different populations, units and reference periods and are not directly interchangeable. Data extraction date: 25 June 2026.

3.3 Indicator architecture

Domain	Core indicators	Data sources	Preferred geography	Current status
Need	12-month prevalence; distress; suicide and self-harm; psychosocial disability; population growth	ABS, AIHW, NDIA, Closing the Gap	National/state; selected local data	Mostly available; periodic or lagged
Capacity	Clinical FTE; direct-care hours; open books; available appointments; workforce turnover	NHWDS, providers, PHNs, state systems	PHN/SA4/remoteness	FTE available; open-book data largely missing
Timeliness	Median and 90th percentile time to first appropriate appointment	Public services; provider reporting; surveys	Service/region	No consistent national dataset
Affordability	Gap fee; bulk billing; cost-related delay; indirect cost	MBS claims, ABS Patient Experience, survey	Region, SEIFA, service type	Cost delay available; gap-fee detail incomplete
Utilisation	People, contacts and episodes relative to population and estimated need	AIHW, MBS, state collections, NDIA	National/state/remoteness	Available but incomplete across sectors
Continuity/completion	Follow-up, same-provider continuity, planned completion, dropout	Service systems, linked data	Service/region	Fragmented and inconsistent
Quality/experience	Standards, PREMs, cultural safety, preference met	YES, PEx, provider surveys	Participating jurisdictions/services	Coverage incomplete
Outcomes	PROM or clinician-rated improvement, deterioration, functioning	NOCC/AMHOCN, ROGS, service systems	Public specialised services; selected programs	Limited outside specialised care
Equity	Rate ratios and gaps by remoteness, Indigenous status, SEIFA, age, disability, language	All sources with disaggregation	National to local	Variable completeness and sample size

Source note: Therapy Near Me proposed architecture informed by AIHW, Productivity Commission, AMHOCN, PHN and national evaluation frameworks.

3.4 Core indicator specifications

The detailed indicator dictionary is provided in Appendix A. The following principles apply to every indicator:

- Define the event, population, numerator, denominator and reference period before comparing results.
- Report unique people separately from contacts or services.
- Use clinical FTE and direct-care capacity where possible, not registration headcount alone.
- Report medians and upper-tail waiting times because averages can conceal severe delays.
- Disaggregate by remoteness, Indigenous status, socioeconomic position, age, sex or gender, disability and language or cultural group where data quality and governance permit.
- Include data coverage, missingness and comparability grades with every published result.
- Separate access outputs from clinical and functional outcomes.

3.5 Data availability and development priorities

Data gap	Current position	Proposed development
Real-time appointment availability	Not routinely available nationally	Standard provider feed: open/closed books, next available appointment, funding pathways accepted
Clinical FTE by local area	Available for some regulated professions, but not uniformly real-time	Annual PHN/SA4 extraction with direct-care and vacancy fields
Private gap fees	Partial MBS and survey information	Standardised gap-fee reporting by service type and region
Private waiting times	No national collection	Sentinel-provider panel and consumer survey
Treatment completion	Program-specific; not nationally harmonised	Common episode definition and planned/unplanned discharge reason
Consumer experience	YES and PEx available for participating services	Broader national access and experience survey
Outcomes outside public specialised care	Limited and fragmented	Common minimum PROM/PREM set with case-mix and consent rules
Cultural safety	Limited direct national measurement	Co-designed indicators and Indigenous Data Sovereignty governance
CALD access	Language and cultural data inconsistent	Interpreter use, preferred language, culturally appropriate service availability
Cross-sector continuity	Limited linkage across Medicare, state, NDIS, schools and community care	Privacy-preserving linkage and referral-completion indicators

Source note: Original report Appendices B and D; AIHW, Productivity Commission and national evaluation frameworks.

4. Policy scenario model, 2026–2030

4.1 Model purpose and status

The model is a transparent decision framework rather than a deterministic forecast. It is designed to show which parameters must change for an intervention to improve access, how capacity constraints limit effects, and where double counting can arise. Observed baseline values are used where they are comparable. Intervention parameters remain illustrative until validated through administrative, provider, survey or trial data.

4.2 Model population, period and unit of analysis

Element	Specification
Baseline period	2024–25 service activity, 2024 workforce and 31 December 2025 population, according to source availability
Time horizon	2026 to 2030, reported annually
Population	Australian resident population; subgroup and region

Element	Specification
	modules where data permit
Geographic unit	National, state/territory, PHN and remoteness category; local modelling preferred
Service scope	Medicare mental health services plus modular public, community, digital and psychosocial services
Workforce	Psychologists, psychiatrists, mental health nurses, mental health occupational therapists, accredited mental health social workers and other specified groups
Primary units	Unique people for demand and commencements; contacts for activity; episodes for completion; dollars in a declared price year for costs
Model status	Observed baseline plus conditional and illustrative intervention parameters; no intervention output is a prediction

Source note: Therapy Near Me model specification.

4.3 Core equations

Equation	Form	Interpretation / unit rule
(1) Service-relevant need	$N(t,g) = \text{Population_in_scope}(t,g) \times \text{prevalence_in_same_scope}(t,g) \times \text{clinically relevant need factor}(t,g)$	People. Population and prevalence age/coverage must match.
(2) Expressed demand	$D(t,g) = N(t,g) \times \text{recognition/help-seeking} \times \text{eligibility/navigation}$	People entering the defined pathway.
(3) Contact capacity	$C_contact(t,g) = \Sigma[FTE(p,g) \times \text{clinical share}(p,g) \times \text{productive contacts per clinical FTE}(p,g) \times \text{availability factor}(p,g)]$	Contacts per period; not directly comparable with people.
(4) Episode capacity	$C_episode(t,g) = C_contact(t,g) \div \text{mean contacts per completed or intended episode}(t,g)$	Episodes or people supportable per period. State episode definition.
(5) Accessible demand	$D_accessible(t,g) = D(t,g) \times \text{affordability} \times \text{practical accessibility} \times \text{acceptability}$	People able and willing to commence under the modelled conditions.
(6) Commencements	$A(t,g) = \min[D_accessible(t,g), C_episode(t,g)]$	People or episodes; demand and capacity are now in compatible units.
(7) Completed episodes	$E(t,g) = A(t,g) \times \text{completion rate}(t,g)$	Completed episodes under a common closure definition.
(8) Observed measured improvement	$O_observed(t,g) = E(t,g) \times \text{outcome-measure coverage}(t,g) \times \text{observed improvement rate}(t,g)$	Descriptive measured improvements; not a causal effect.
(9) Causal incremental outcomes	$\Delta O(t,g) = \text{eligible completed episodes} \times [p(\text{improvement} \text{intervention}) - p(\text{improvement} \text{comparator})]$	Use only with trial or credible quasi-experimental evidence.
(10) Access pressure	$P(t,g) = D_accessible(t,g) \div C_episode(t,g)$	Dimensionless ratio. Above 1 indicates demand exceeds episode capacity; not days waiting.
(11) Equity gap	$G_abs(t) = \text{rate}(\text{reference}) - \text{rate}(\text{priority}); G_rel(t) = \text{rate}(\text{priority}) \div \text{rate}(\text{reference})$	Report absolute and relative, preferably need-adjusted, gaps.
(12) Annual budget impact	$B_t = \text{implementation_t} + \text{workforce_t} + \text{program_t} + \Sigma(\text{rebate change_t} \times \text{eligible services_t}) - \text{evidenced offsets_t}$	Dollars in a declared price year. State horizon, inflation and discounting; do not assume offsets.
(13) Cost per additional commencement	$CE = \text{discounted net incremental cost} \div \text{unique incremental commencements}$	State horizon and discount rate; remove overlap and displacement.

Source note: Therapy Near Me corrected model specification. Symbols and parameter status are detailed in Appendix B. Monetary outputs must state the price year, time horizon and discounting convention. No savings or offsets are included without separate evidence.

Waiting-time limitation

The model does not convert service pressure into days of waiting. A defensible waiting-time model requires arrival rates, queue discipline, urgency categories, service times, cancellations and capacity by service. Until those data exist, the model reports pressure and observed waits separately.

4.4 Current-trajectory scenario

The current-trajectory illustration assumes no change in the selected per-capita Medicare mental health service rate. It is an activity-maintenance calculation, not a forecast of need, workforce, quality or outcomes. The population input must be drawn from the latest available official annual projection at the time of each model run. Because the current Centre for Population series is updated and reported on a financial-year basis, the older ABS 2022-base low/central/high 2030 values are retained only in the audit trail, not as the current baseline.

Planning point	Population input	Arithmetic services at 473 per 1,000	Interpretation
2025-26 projection	28.0 million	13.24 million	Illustrative activity equivalent using rounded inputs.
2026-27 projection	28.3 million	13.39 million	Illustrative activity equivalent using rounded inputs.
2030 model run	Import the current official annual projection	Population × 473/1,000	Do not hard-code a superseded series; report source version and extraction date.

Source note: Centre for Population, 2025 Population Statement (national projections updated 9 January 2026) and AIHW 2024-25 Medicare mental health service rate. Values are arithmetic activity equivalents based on rounded population inputs, not forecasts of need or outcomes.

Maintaining national per-capita activity would not preserve equitable access if population growth, workforce and service capacity are unevenly distributed. It would also not address current cost-related delay, unmet need, waiting times or quality. The current-trajectory scenario is therefore a floor for activity planning rather than a policy objective.

4.5 Scenario A — Workforce redistribution and regional capacity

This scenario tests the effect of redirecting or incentivising a defined share of clinical FTE toward underserved regions. It should be modelled at PHN or remoteness level, because a national total can remain unchanged while access improves in one location and worsens in another.

Parameter	Required input	Audit rule
Clinical FTE transferred or newly retained	Policy-defined; low/central/high scenarios	Separate redistribution from net workforce growth.
Direct clinical share	Observed or provider-reported	Exclude research, management, supervision and non-clinical time.
Productivity per clinical FTE	Service-specific observed distribution	Avoid a single national productivity assumption.
Transition loss	Temporary reduction during relocation, onboarding and network development	Apply an implementation lag.
Retention	One-, two- and three-year retention	Short placements should not be treated as sustained capacity.
Displacement	Activity removed from origin region	Report origin and destination effects.
Cultural and local fit	Co-designed service and workforce indicators	Redistribution should not displace Aboriginal-led models.

Source note: National Mental Health Workforce Strategy; AIHW workforce data; original report.

Expected direction: regional appointment availability and provider choice may improve where additional or retained clinical FTE is genuinely available. National service volume may remain

unchanged if the scenario only redistributes existing FTE. The main outcome is therefore a reduction in geographic inequality, not necessarily a national increase in contacts.

4.6 Scenario B — Telehealth and hybrid-care expansion

The telehealth scenario separates substitution, additionality and productivity. Telehealth substitution changes modality but does not increase total access. Additionality occurs when telehealth reaches a person who would otherwise receive no suitable care, prevents a missed contact, or enables capacity that could not otherwise be used. Productivity effects may be positive or negative depending on travel avoided, administrative processes, clinical complexity, platform reliability and no-show patterns.

Parameter	Measurement	Interpretation
Telehealth share	Observed 22% in Q4 2025; scenario target should be service- and population-specific	Do not treat a higher share as intrinsically better.
Substitution proportion	Share replacing an available face-to-face contact	No gross access gain unless capacity is released and reused.
Additionality proportion	Share provided to people who otherwise would not receive care	Requires counterfactual evidence.
Avoided travel and time	Distance, travel cost and time saved	Important regional benefit even where contact count is unchanged.
Digital exclusion	Connectivity, device, literacy, accessibility and private space	Report excluded and failed contacts.
Clinical suitability	Provider and consumer assessment by presentation and stage of care	Retain face-to-face pathways.
Continuity and outcomes	Completion, outcome and experience by modality	Adjust for selection and case mix.

Source note: AIHW activity monitoring; Better Access evaluation and telehealth guidance; original report.

Expected direction: telehealth can reduce travel burden and expand provider choice. Its effect on total national capacity is uncertain and should be reported as substitution, additional contacts and avoided travel separately. A telehealth target without quality, preference and equity safeguards could widen exclusion for people with unreliable internet, limited privacy, disability-related access needs or a clinical need for in-person care.

4.7 Scenario C — Early-intervention expansion

Early intervention is not a single program. The scenario must specify the target population, intervention intensity, setting, duration, clinical governance and escalation pathway. Suitable components may include low-intensity psychological interventions, guided digital support, school-linked care, youth services, brief therapy, family support, relapse prevention and navigation.

Parameter	Definition	Caution
Eligible population	Defined by age, severity, risk and service need	Do not apply the same intervention to all people with distress.
Reach	Eligible people offered the intervention	Separate awareness, referral and actual offer.
Uptake	People commencing after offer	Report non-participation reasons.
Completion	People receiving planned intervention dose	Define planned dose and permitted adaptation.
Clinical escalation	People identified as needing higher-intensity care	A successful program may increase specialist referrals.
Incremental outcome	Difference relative to a suitable comparator	Use trial or quasi-experimental evidence where available.
Downstream utilisation	Crisis, hospital and specialist service use	Do not assume reductions; measure empirically.

Source note: National Mental Health Service Planning Framework; National Evaluation Framework; Better Access and program evaluations.

Expected direction: appropriate early intervention may improve timeliness and outcomes for selected groups. It can also reveal previously unmet need and increase referrals in the short term. The model therefore does not assume that early intervention automatically produces net savings or lower total service use.

4.8 Scenario D — Medicare rebates and reduced gap fees

This scenario tests affordability reform through a rebate increase, a targeted no-gap arrangement or direct subsidy. The mechanism depends on pass-through to patient prices, eligibility, provider participation and spare capacity.

Parameter	Definition	Audit requirement
Eligible services	Services and patients covered by the policy	Specify profession, item, income or geographic targeting.
Rebate change	Dollar or percentage increase per eligible service	Use current MBS schedule at implementation date.
Pass-through	Share of rebate increase reducing the patient gap	Measure provider fee response.
Price response	Change in commencement or continuation associated with lower cost	Australian elasticity evidence is limited.
Capacity availability	Share of additional demand providers can serve	Closed books can cap access effects.
Distribution	Benefit by income, remoteness and current service use	Universal increases may disproportionately subsidise existing users.
Budget	Rebate increase × eligible services plus administration	Report existing-user cost and new-user cost separately.

Source note: Better Access evaluation; Services Australia; Productivity Commission; model specification.

The model equation for additional commencements is: eligible unmet demand × price-response parameter × patient-price pass-through × available capacity. Each term must be reported separately. A rebate increase can be valuable even where it does not increase volume, because reducing financial burden for existing users is itself an affordability outcome. That effect should not be misreported as additional access.

Illustrative worked example — not a national estimate

For a local cohort of 100,000 eligible people with unmet demand, define the effective response after price pass-through rather than multiplying two unvalidated elasticities without explanation. Illustrative low, central and high combinations are: 2% effective response × 30% spare capacity = 600 additional commencements; 5% × 60% = 3,000; and 8% × 85% = 6,800. At a 5% effective response, varying capacity from 30% to 90% changes the result from 1,500 to 4,500. To achieve 4,000 commencements, capacity must be at least 80% at a 5% response, or the response must be 6.67% at 60% capacity. All values are illustrative and must be replaced by evidence before policy use.

4.9 Scenario E — Combined reform package

The combined package integrates workforce distribution, hybrid delivery, early intervention and affordability reform. Its effects cannot be calculated by adding the isolated scenarios because they act on shared populations and constraints. The combined model applies interventions sequentially and uses a unique-person identifier or probabilistic overlap parameter to prevent double counting.

Step	Combined-model rule
1. Need and eligibility	Estimate target population once by region and subgroup.
2. Early pathway	Apply navigation and early-intervention reach to suitable cohorts.
3. Affordability	Apply price and funding effects to the remaining eligible demand.

Step	Combined-model rule
4. Capacity	Constrain commencements by local and telehealth-enabled clinical capacity.
5. Modality	Assign face-to-face, telehealth or hybrid care based on suitability and preference.
6. Completion and outcomes	Apply service-specific completion and measured-outcome coverage.
7. Equity and balancing measures	Test whether gains occur without worsening another region, group or service.

Source note: Therapy Near Me combined-scenario specification.

Expected direction: a combined package has a stronger systems rationale because it addresses multiple failure points, but the magnitude and distribution of any effect remain uncertain. Its main implementation risk is coordination: funding can increase demand before workforce is available; telehealth can expand without digital inclusion; and early-intervention programs can identify people without an available escalation pathway. Sequencing and local implementation capacity are therefore core model parameters.

4.10 Sensitivity and threshold protocol with illustrative output

Method	Application	Reporting rule
One-way sensitivity	Vary one parameter across its plausible range while holding others constant.	Identify the parameters that dominate results.
Multi-parameter sensitivity	Vary correlated parameters together, including demand, capacity and pass-through.	Avoid implausible combinations.
Threshold analysis	Calculate the minimum capacity, uptake or pass-through required for a policy objective.	Report break-even rather than a single preferred estimate.
Best-case scenario	High implementation, high capacity, equitable reach and maintained quality.	Not a probability statement.
Worst-case scenario	Demand increases, implementation lags, capacity is fixed and equity worsens.	Include displacement and digital exclusion.
Structural sensitivity	Compare alternative definitions of need, episodes, completion and geography.	Ranking or output stability should be reported.

Source note: Therapy Near Me model-validation protocol.

4.11 Model limitations

- The model does not estimate a national waiting time in days because queue-level data are unavailable.
- The baseline combines sources with different reference periods and must be updated before final publication.
- Medicare activity represents only part of the mental health system.
- Clinical FTE and productivity are not uniformly available by region and service type.
- Price response and rebate pass-through are insufficiently established for a national causal estimate.
- Early-intervention effects are intervention-specific and cannot be represented by one universal parameter.
- Telehealth additionality cannot be inferred from utilisation share alone.
- Outcome changes in observational data may reflect case mix, regression to the mean, natural recovery and concurrent services.
- Interactions and overlap can materially change combined-package estimates.

5. Monitoring and evaluation framework

5.1 Purpose and alignment

The framework is intended to support annual assessment through 2030 and is aligned in principle with the National Mental Health and Suicide Prevention Evaluation Framework, the Productivity Commission performance-reporting approach, the PHN Performance Measurement and Reporting Framework, the National Outcomes and Casemix Collection and national safety and quality standards. It is not intended to duplicate those systems. It identifies the minimum measures needed to evaluate the access pathway and the policy scenarios in this addendum.

5.2 Theory of change

Logic level	Proposed content
Inputs	Funding, workforce, supervision, digital infrastructure, data systems, governance, lived-experience and community partnerships
Activities	Workforce recruitment and retention, regional commissioning, telehealth, early intervention, rebate reform, navigation and data collection
Outputs	Clinical FTE, appointments, services, referrals completed, people reached, available digital and face-to-face options, and observed patient-price changes where pass-through occurs
Short-term outcomes	Hypothesised: improved appointment availability, fewer cost barriers, shorter waits, more suitable commencements and better experience
Intermediate outcomes	Hypothesised: greater continuity and completion, narrower geographic and socioeconomic gaps, maintained quality and improved measured outcomes
Long-term outcomes	Intended: more equitable access relative to need, improved functioning and wellbeing, fewer avoidable crisis escalations and a sustainable workforce

Source note: Therapy Near Me theory of change informed by the National Mental Health and Suicide Prevention Evaluation Framework.

5.3 Indicator register — need and capacity

Indicator	Definition	Source	Frequency/ geography	Interpretation	Limitation
12-month mental disorder prevalence	People aged 16–85 meeting survey criteria / survey population	ABS NSMHW	Survey cycle; national/state where valid	Direction contextual; not a performance target	Survey periodicity and under-representation
High or very high psychological distress	People above K10 threshold / surveyed population	ABS health surveys	Annual or survey cycle; state and subgroup	Lower desirable, interpreted with help-seeking	Screening measure, not diagnosis
Clinical FTE per 100,000	Direct clinical FTE / population × 100,000	NHWDS/provider reports	Annual; PHN/remoteness	Higher where below need benchmark	Clinical-share classification inconsistent
Providers accepting new clients	Providers accepting / providers surveyed	PHN/provider feed	Quarterly; local	Higher desirable	Response and coverage bias
Available appointment slots	Unfilled appropriate slots in next 4 weeks / service population	Provider systems	Monthly; local	Higher desirable with quality maintained	Commercial sensitivity and duplication
Workforce retention	Clinical workforce retained at 12/24 months / baseline cohort	Employer/NHWDS	Annual; region/profession	Higher desirable	Movement within sector may be misclassified

Source note: Proposed indicator specifications; see Appendix A for full definitions.

5.4 Indicator register — access, continuity and outcomes

Indicator	Definition	Source	Frequency/ geography	Interpretation	Limitation
Median time to first appropriate appointment	Days from accepted referral/help request to first clinically appropriate appointment	Service/provider data	Quarterly; service/region	Lower desirable	Start point and urgency definitions vary
90th percentile waiting time	Days below which 90% commence	Service/provider data	Quarterly; service/region	Lower desirable	Requires complete queue data
Cost-related delay	People reporting delay due to cost / people needing care	ABS/ROGS survey	Annual; state and subgroup	Lower desirable	Self-report and denominator definition
Median patient gap	Patient contribution per eligible service	MBS claims/provider data	Quarterly; service/region	Lower desirable, case-mix noted	Does not include indirect costs
Treatment commencement	Accepted referrals commencing / accepted referrals	Service data	Quarterly; region/group	Higher desirable	Excludes people who never enter referral system
Planned completion	Episodes completed as planned / closed episodes	Service data	Quarterly; service/group	Higher desirable with appropriate episode definitions	Not all treatment requires fixed dose
Continuity after discharge	People receiving planned follow-up within specified interval / eligible discharges	Linked/service data	Quarterly; service/group	Higher desirable	Follow-up outside reporting system may be missed
Outcome-measure completion	Episodes with paired valid measures / eligible episodes	NOCC/service systems	Quarterly; service/group	Higher desirable	Completion can be selective
Significant clinical improvement	People meeting measure-specific improvement rule / paired measures	NOCC/ROGS	Annual; service/group	Higher desirable	Clinician-rated, case mix and setting effects
Significant deterioration	People meeting deterioration rule / paired measures	NOCC/ROGS	Annual; service/group	Lower desirable	Same limitations as improvement
Positive consumer experience	Respondents above agreed PREM threshold / valid respondents	YES/PEX/other PREM	Annual; service/group	Higher desirable	Response bias and inconsistent jurisdiction coverage

Source note: Proposed indicator specifications drawing on AIHW, AMHOCN and Productivity Commission definitions.

5.5 Equity and balancing indicators

Indicator	Operational definition	Potential source
Regional access gap	Difference and ratio in access rate between Major Cities and each remoteness category	MBS, workforce, provider and survey data
First Nations access and outcome gap	Access and outcome measures by Indigenous status, interpreted under Indigenous data governance	ROGS, Closing the Gap, service systems
Socioeconomic access gap	Rate and cost-delay difference between SEIFA quintiles	ABS, MBS, survey data
Child and adolescent access	Waiting time, child workforce and	State, MBS, headspace and provider

Indicator	Operational definition	Potential source
	commencement by age and service	data
Psychosocial disability access	Provider availability, service commencement and continuity for relevant supports	NDIA, state and provider data
Digital exclusion	Failed, declined or unavailable telehealth because of access barriers	Provider and consumer survey
Face-to-face pathway availability	Suitable local/in-person options for people requiring them	Provider mapping and consumer survey
Crisis escalation	ED, acute admission or crisis contact while waiting or after failed referral	Linked state and service data
Workforce wellbeing	Turnover, vacancy, burnout and unplanned absence	Employer/workforce survey
Quality balancing measure	Adverse events, complaints, deterioration and unplanned discharge	Service and regulatory data

Source note: Therapy Near Me proposed equity and balancing set.

5.6 Annual classification rules

Classification	Definition	Decision rule
Improving	Movement in the favourable direction that exceeds the indicator-specific meaningful-change threshold and is sustained or statistically supported.	Apply a validated clinical or policy threshold where one exists. Otherwise require statistical support or a pre-specified operational margin, adequate coverage and at least two comparable observations where appropriate.
Broadly stable	Change remains within the meaningful-change band or confidence interval includes no material change.	Within the indicator-specific meaningful-change band or uncertainty limits. Stable does not mean adequate; report distance from benchmark and subgroup gaps.
Deteriorating	Movement in the unfavourable direction exceeding the threshold and sustained or statistically supported.	Unfavourable change beyond the validated/statistical/operational threshold with adequate data; trigger root-cause and equity review.
Insufficient or non-comparable data	Coverage, quality, sample size or definition change prevents a valid trend statement.	Do not force a rating. Publish the missingness, comparability or reliability problem and a remediation plan.

Source note: Corrected provisional rules for technical and stakeholder testing. No universal 5% or three-percentage-point threshold is endorsed. Each indicator requires an approved threshold, data-quality gate and comparability rule before formal reporting.

Additional decision rules:

- Use pooled estimates, smoothing or suppression when denominators, event counts or reliability metrics show annual estimates are unstable. The method should be triggered by statistical properties, not by jurisdiction name alone, and must respect Indigenous Data Sovereignty and disclosure controls.
- Where a source revises historical data, recalculate the full trend using the revised series and clearly mark the revision.
- Where an indicator definition changes, do not join the old and new series unless a validated bridge is available.
- Where national and subgroup trends conflict, report both. A national “improving” classification should be qualified or withheld if a priority group deteriorates materially.
- Where utilisation rises but outcomes, completion or experience worsen, classify the activity indicator separately and flag a system-level concern rather than reporting overall improvement.
- Where waiting time improves because eligibility narrows or rejected referrals increase, use a balancing measure and do not treat the change as an unqualified improvement.
- Confidence intervals, standard errors and sample design should be used where survey or modelled estimates permit. Administrative counts require data-quality and coverage checks rather than conventional sampling intervals.

5.7 Governance and reporting cycle

Cycle	Products	Suggested responsibility
Quarterly	Operational activity, telehealth, provider availability, queue and waiting-time indicators	Service providers, PHNs, jurisdictions, AIHW where available
Six-monthly	Workforce vacancies, retention, commissioned-service performance and implementation milestones	PHNs, employers, state and Commonwealth agencies
Annual	National access dashboard, outcomes, experience, equity gaps, scenario parameter updates and uncertainty review	AIHW/Productivity Commission/Department with jurisdictional partners
Every 3 years	Methodology review, indicator relevance, weighting and data-development priorities	Independent technical panel with lived-experience and First Nations governance

Source note: Proposed governance model; final responsibilities require intergovernmental agreement.

6. Limitations, bias and uncertainty

6.1 General interpretation

Mental health access cannot be fully measured from a single national dataset. Prevalence surveys, MBS claims, state service records, workforce collections, NDIS information, provider systems and consumer surveys each observe different parts of the pathway. Apparent inconsistencies may reflect genuine differences in population, scope, timing or definitions rather than error.

6.2 Uncertainty register

Uncertainty	Affected result	Likely bias or effect	Mitigation	Interpretation warning
Prevalence survey periodicity	Need estimates and demand projections	Current need may be higher or lower than the last survey	Use updated survey data and sensitivity ranges	Do not present prevalence as real-time
Help-seeking bias	Demand and unmet need	Understates need among groups less likely to seek help	Consumer surveys and community-led research	Low demand may not mean low need
Administrative coverage	Utilisation and continuity	Misses fully private, school, EAP, informal and some community care	Multi-source reporting and linkage	MBS is not the whole system
Duplicate contacts and people	Service volume	Inflates people reached if contacts are treated as unique users	Separate unique people, contacts and episodes	Do not infer reach from service count
Private-sector data gap	Capacity, fees and waiting time	May understate available care or barriers	Provider panels and reporting standards	National estimates remain incomplete
Workforce headcount	Capacity	Usually overstates direct clinical availability	Clinical FTE and open-book measures	Headcount is a potential supply measure
Waiting-time definitions	Timeliness comparisons	Can bias comparisons in either direction	Common start/end points and urgency categories	Avoid combining incomparable waits
Cost and fee data	Affordability scenario	Indirect costs and fee changes may be missed	Claims, provider and consumer data	Rebate effect is uncertain
Outcome data coverage	Effectiveness and quality	Selective paired data may overstate or understate improvement	Report completion and case mix	Outcome rates apply to measured episodes

Uncertainty	Affected result	Likely bias or effect	Mitigation	Interpretation warning
Clinician-rated outcomes	Clinical improvement	May differ from consumer perspective	Pair with PROMs and PREMs	Do not treat as complete outcome view
Telehealth selection	Modality outcomes	People selecting telehealth differ from face-to-face users	Risk adjustment and matched comparison	Do not infer causal equivalence from raw outcomes
Cultural-safety measurement	Equity	Can miss harms and barriers experienced by First Nations and CALD communities	Co-designed measures and governance	Proxy measures are insufficient
Jurisdictional definitions	Cross-state comparison	May create artificial differences	Comparability matrix and metadata	Use graded comparability
Boundary mismatch	Local planning	PHN, LHN and statistical boundaries do not align	Geographic concordance and sensitivity testing	Local rates may change by boundary
Population projections	2030 trajectory	Future population may differ from assumptions	Low, central and high series	Projection is conditional, not a prediction
Workforce projections	Capacity scenario	Training, migration, attrition and policy may change	Annual update and retention scenarios	Do not extrapolate linearly without review
NDIS policy change	Psychosocial and child pathways	Eligibility and funding changes alter demand and service markets	Scenario update at policy milestones	Current trends may not continue
Macroeconomic conditions	Need and affordability	Housing, employment and inflation affect distress and cost barriers	Economic sensitivity variables	Not controlled by mental health policy alone
Disasters and climate events	Regional demand	Creates local shocks not reflected in national trends	Event-responsive monitoring	Annual averages may conceal acute pressure
Causal attribution	Policy effectiveness	Concurrent reforms and secular trends confound effects	Comparison groups, staggered implementation or quasi-experimental design	Association is not attribution
Model interaction	Combined package	Simple addition overstates effects	Overlap and capacity constraints	Report incremental unique people

Source note: Therapy Near Me uncertainty register, informed by original report limitations and source metadata.

6.3 Reporting and publication bias

Service and program evaluations are more likely to be published when results are favourable, while routine administrative data may prioritise activity that is easiest to count. Commissioned evaluations may have limited follow-up, incomplete comparison groups or changing implementation. The addendum therefore recommends a prospective evaluation register, publication of protocols, predefined outcomes, reporting of null and adverse findings, and separation of implementation failure from intervention failure.

6.4 Jurisdictional comparability

State and territory systems differ in service configuration, eligibility, episode definitions, workforce employment and data completeness. Each indicator should receive a comparability grade: A — nationally comparable; B — comparable with documented adjustment; C — partially comparable; D — not currently comparable; or U — unavailable. Jurisdictional ranking should not be undertaken on an indicator graded C, D or U without a sensitivity analysis and explicit warning.

6.5 Forecast and scenario language

- Forecast: an estimate of a future value based on a stated model and assumptions.

- Projection: a future value conditional on specified assumptions, such as an ABS population series.
- Scenario: a coherent possible future used to test decisions, not assigned a probability unless formally estimated.
- Sensitivity analysis: the effect of changing one or more assumptions.
- Policy simulation: the conditional modelled effect of a defined intervention relative to a comparator.

The addendum uses “projection,” “scenario” and “illustration” for the policy analysis. It does not claim that its intervention outputs are predictions.

7. Policy and implementation implications

7.1 Immediate actions within 12 months

Actor	Action	First-year deliverable
Australian Government	Publish a minimum national access indicator specification and commission gap-fee and appointment-availability data development.	Indicator dictionary approved; data-development contracts initiated.
States and territories	Adopt common waiting-time start and end points for public and commissioned mental health pathways.	Metadata and first baseline reported.
PHNs	Map local clinical FTE, open books, service eligibility, telehealth and face-to-face availability.	Quarterly provider-availability dashboard.
Providers	Record referral date, acceptance, first appointment, modality, completion reason, outcome coverage and patient gap.	Core fields completed above agreed threshold.
Data custodians	Create a crosswalk among state, PHN, LHN and statistical geographies.	Published concordance and version control.
First Nations partners	Establish governance for Indigenous access and cultural-safety indicators.	Co-designed governance and indicator development plan.

Source note: Therapy Near Me implementation roadmap.

7.2 Actions over two to three years

Reform area	Two- to three-year action
Workforce	Implement and evaluate regional retention, supervision, housing, training and multidisciplinary workforce packages.
Access data	Establish a national provider-availability and waiting-time collection with PHN-level reporting.
Affordability	Evaluate targeted rebate or no-gap reforms using patient prices, provider fees, capacity and equity outcomes.
Telehealth	Report substitution, additionality, failed contacts, preference, outcomes and digital exclusion.
Early intervention	Use program-specific logic models, escalation capacity and linked outcome evaluation.
Outcomes	Extend a common minimum outcome and experience set beyond public specialised services where appropriate.
Linkage	Develop privacy-preserving analysis of referral, service, crisis and outcome pathways.

Source note: Therapy Near Me implementation roadmap.

7.3 Structural reforms through 2030

Structural area	2030 objective
National policy architecture	Link funding and accountability to measurable access, quality, outcome and equity objectives rather than activity alone.

Structural area	2030 objective
Regional service systems	Build hybrid local, outreach and digital networks with durable escalation pathways and Aboriginal-led care.
Workforce supply	Expand training, supervision and retention while measuring direct clinical capacity and workforce wellbeing.
Affordability	Align subsidies with equity and supply so reduced patient prices are accompanied by available appointments.
Data infrastructure	Create interoperable, privacy-preserving reporting that follows people across service settings without reducing care to a single metric.
Evaluation culture	Pre-register evaluations, publish null findings, use comparison designs and maintain lived-experience and First Nations governance.

Source note: Therapy Near Me implementation roadmap; Productivity Commission and national evaluation frameworks.

7.4 Intervention evidence and implementation confidence

Intervention	Evidence judgement	Current confidence
Workforce distribution and retention	Strong evidence that maldistribution is a central constraint; intervention effect varies by package and context.	Moderate
Telehealth availability	Strong evidence of sustained use and reduced travel; additional national capacity and equity effects remain context-dependent.	Moderate
Early intervention	Evidence depends on intervention, target group and implementation; no single national effect size is appropriate.	Variable
Medicare rebate increase	Clear affordability mechanism; access effect depends on pass-through, price response and provider capacity.	Low to moderate for national volume effect
Combined reform	Strong systems rationale; limited evidence for a single quantified national package effect.	Moderate for direction, low for magnitude
National M&E framework	Strong methodological and policy basis; implementation depends on data governance and consistent definitions.	High for need, moderate for feasibility

Source note: Evidence synthesis; confidence refers to the direction and measurability of effect, not a pooled clinical evidence grade.

8. Conclusions

8.1 What can be concluded with reasonable confidence

- Mental health access is multidimensional; practitioner headcount, activity and expenditure are incomplete proxies when used alone.
- Workforce distribution and effective clinical capacity remain central constraints, especially outside major cities.
- Telehealth can reduce geographic and practical barriers but does not replace local, culturally safe or clinically necessary face-to-face care.
- Affordability and waiting time are associated with and can influence commencement and continuity, while quality, completion, experience and outcomes must be monitored alongside volume.
- National results require local-area and equity interpretation.

8.2 What remains uncertain

- Real-time appointment access, clinical FTE, local capacity, private waiting times, gap fees and closed-book status.

- The additional—not substituted—capacity created by telehealth.
- Patient-price and provider-fee responses to rebate reform.
- The downstream effect of heterogeneous early-intervention programs.
- The net combined-package effect after overlap, implementation lag and capacity constraints.

8.3 What must be measured next

- Clinical FTE, new-client acceptance, next available appointment and standardised median and 90th-percentile waits.
- Patient gap fees, bulk billing, cost-related abandonment, treatment commencement, completion and continuity.
- Outcome coverage, improvement, deterioration, functioning, consumer experience, cultural safety and modality preference.
- Access and outcome gaps by remoteness, First Nations status, socioeconomic position, age, disability, language and cultural group.

8.4 Actions that could begin immediately

Australia can begin with standard definitions, provider-availability mapping, a minimum national indicator set, PHN-level reporting, prospective evaluation protocols and stronger governance for First Nations and lived-experience data. These actions do not require waiting for a perfect national linked dataset.

8.5 Structural reform through 2030

Policy judgement: sustained improvement is likely to require a combined approach—a supported and distributed workforce; local and Aboriginal-led services; clinically appropriate telehealth and digital pathways; early intervention with escalation capacity; affordability reform linked to supply; and transparent reporting that measures access, outcomes and equity together. The objective should not be to maximise service counts. It should be to increase the proportion of people who obtain timely, affordable, acceptable and appropriate care, complete a suitable pathway, and experience improved clinical or functional outcomes without widening inequity.

Appendix A. Detailed indicator dictionary

This appendix provides a minimum indicator set for implementation and further technical validation with data custodians, service providers, consumers, carers, First Nations governance bodies and statistical experts.

ID	Domain	Indicator	Numerator	Denominator	Source	Frequency	Geography	Disaggregation	Desired direction	Limitation
A1	Population need	12-month mental disorder prevalence	People meeting diagnostic survey criteria	Survey population aged 16–85	ABS NSMHW	Survey cycle	National/state where reliable	Age, sex/gender, Indigenous status where valid	Contextual	Periodic survey; excludes some groups
A2	Population need	High or very high psychological distress	People above K10 threshold	Survey population	ABS	Annual/survey cycle	National/state	Age, sex, SEIFA, remoteness	Lower	Screening measure
A3	Capacity	Clinical FTE per 100,000	Direct clinical FTE	Resident population/100,000	NHWDS/provider	Annual	PHN/remoteness	Profession and sector	Higher until benchmark	Direct-care classification
A4	Capacity	New-client acceptance	Providers accepting new clients	Providers responding	Provider feed	Quarterly	Local/PHN	Service and funding type	Higher	Coverage and response bias
A5	Capacity	Next available appointment	Not a numerator: distribution of calendar days from a standardised valid enquiry to the first clinically appropriate routine slot	All valid enquiries meeting the published service and urgency definition	Provider feed	Monthly	Local	Service/funding/modality	Lower	Dynamic measure; require timestamp rules, deduplication and coverage reporting
A6	Timeliness	Median waiting time	Waiting days for all accepted referrals, including censored ongoing waits	All accepted referrals in the cohort	Service systems	Quarterly	Service/region	Urgency, age, priority group	Lower	Use survival/queue methods; commenced-only cases create survivor bias
A7	Timeliness	90th percentile waiting time	90th percentile of the same complete/censored waiting-	All accepted referrals in the cohort	Service systems	Quarterly	Service/region	Urgency and group	Lower	Requires complete queue data and stable tail estimates

ID	Domain	Indicator	Numerator	Denominator	Source	Frequency	Geography	Disaggregation	Desired direction	Limitation
			time distribution							
A8	Affordability	Cost-related delay	People delaying due to cost	All respondents under the ROGS/ABS source definition, or a separately specified need-based denominator	ABS/ROGS	Annual	State/national	SEIFA, age, remoteness	Lower	Self-report; denominator must match the cited source
A9	Affordability	Patient gap per service	Sum of patient out-of-pocket contributions in scope	Number of eligible services in scope	MBS/provider	Quarterly	Region/service	SEIFA/funding type	Lower	Indirect costs excluded; report median and distribution as well as mean
A10	Access	Accepted-referral commencement rate	Accepted referrals commencing	Accepted referrals	Service systems	Quarterly	Service/region	Group and pathway	Higher	Narrow pathway measure; add enquiry-to-commencement and rejection/redirection balancing measures
A11	Utilisation	People receiving service per 1,000	Unique people	Resident population/1,000	AIHW/MBS/state	Annual	State/remoteness	Age, Indigenous status, SEIFA	Context-dependent	Cross-sector overlap
A12	Utilisation	Services per recipient	Service contacts	Unique recipients	AIHW/MBS/state	Annual	State/remoteness	Service type	Context-dependent	Not treatment dose
A13	Continuity	Planned follow-up within a defined interval	Eligible discharges with documented follow-up within the specified interval	Eligible discharges	Linked/service	Quarterly	Service/region	Group	Higher	Specify interval and eligible discharge cohort; external care may be missed
A14	Completion	Planned treatment completion	Episodes completed as planned	Closed episodes	Provider/service	Quarterly	Service/region	Group/modality	Higher	Requires common episode,

ID	Domain	Indicator	Numerator	Denominator	Source	Frequency	Geography	Disaggregation	Desired direction	Limitation
										adaptation and planned/unplanned closure definitions
A15	Quality	Outcome-measure completion	Episodes with valid paired measures	Eligible episodes	NOCC/provider	Quarterly	Service	Age/group	Higher	Selective completion
A16	Outcome	Significant clinical improvement	People meeting the instrument-specific reliable/clinically significant improvement rule	People with paired measures	NOCC/ROGS	Annual	Service/state	Age and group	Higher	Instrument, case mix and attribution; rule must be pre-specified
A17	Outcome	Significant deterioration	People meeting the instrument-specific reliable deterioration rule	People with paired measures	NOCC/ROGS	Annual	Service/state	Age and group	Lower	Instrument, case mix and attribution; rule must be pre-specified
A18	Experience	Positive experience	Respondents meeting the instrument-specific positive-experience threshold	Valid respondents	YES/PEX	Annual	Participating services	Group and setting	Higher	Instrument-specific threshold; response and coverage bias
A19	Equity	Regional access ratio	Need-adjusted access rate in the priority region	Need-adjusted access rate in Major Cities/reference region	Multiple	Annual	Remoteness/PHN	Service and group	Toward 1.0	Need adjustment and geographic concordance required
A20	Equity	First Nations need-adjusted access ratio	First Nations access rate relative to a co-designed need measure	Governance-approved comparison rate	ROGS/Closing Gap	Annual	National/state/local where safe	Age/sex/remoteness	Gap narrows	Indigenous Data Sovereignty, suppression and small-number rules required
A21	Digital	Telehealth	Telehealth	Telehealth	Provider	Quarterly	Region/	Age,	Lower	New

ID	Domain	Indicator	Numerator	Denominator	Source	Frequency	Geography	Disaggregation	Desired direction	Limitation
		failed-access rate	attempts failed, declined or unavailable for specified access reasons	attempts	survey		service	disability, language		collection; standard reason codes and completeness threshold required
A22	System	Crisis escalation while waiting	ED/crisis events within a pre-specified window while waiting or after failed referral	People waiting or experiencing a failed referral in the same cohort	Linked data	Quarterly	Region/service	Group	Lower	Specify window; linkage and causal attribution limitations
A23	Workforce	12-month retention	Workers in the defined baseline regional/professional cohort remaining at 12 months	Workers in the same baseline cohort	Employer/NHWDS	Annual	Region/profession	First Nations workforce and profession	Higher	Cohort and role rules; intra-sector movement may be misclassified
A24	System integration	Referral completion	Outbound referrals with confirmed receiving-service contact within a specified timeframe	Outbound referrals	Linked/provider	Quarterly	Region/pathway	Group	Higher	Specify timeframe; data exchange and external-service capture limitations

Appendix A.1 Meaningful-change rule for each indicator

ID	Threshold rule before formal classification	Data-quality gate
A1	Contextual indicator; no “improving” target. Report estimate and confidence interval.	Survey comparability and coverage.
A2	Change beyond confidence limits and an approved substantive margin.	Comparable K10 instrument and sampling.
A3	Change relative to a needs-based benchmark, with FTE uncertainty.	Direct-clinical classification and denominator quality.
A4	Approved percentage-point margin plus coverage threshold.	Provider response/coverage and stable frame.
A5	Service-specific clinically/operationally approved day threshold.	Valid enquiry coverage, timestamp and deduplication.
A6	Service-specific day threshold or survival-model contrast.	Complete accepted-referral cohort and censoring.
A7	Service-specific tail threshold with uncertainty/stability test.	Adequate event count and complete queue.
A8	Source confidence interval plus policy-approved percentage-point margin.	Unchanged question and denominator.
A9	Inflation-adjusted dollar/percentage threshold with distributional analysis.	Stable price year, service scope and claims coverage.
A10	Approved percentage-point change with rejection/redirection balancing measure.	Stable acceptance criteria and pathway coverage.
A11	Rate-ratio or rate-difference interval; direction is context-dependent.	Unique-person linkage and sector scope.
A12	Contextual only unless a service-specific dose standard is defined.	Consistent person/contact definitions.
A13	Interval-specific percentage-point change with uncertainty.	Stable discharge eligibility and external-care capture.
A14	Percentage-point change after episode/case-mix stability checks.	Common closure definitions.
A15	Approved coverage target and percentage-point change.	Stable eligibility and paired-measure rules.
A16	Instrument-specific reliable or clinically significant change rule.	Paired data, case mix and instrument consistency.
A17	Instrument-specific reliable deterioration rule.	Paired data, case mix and instrument consistency.

ID	Threshold rule before formal classification	Data-quality gate
A18	Validated instrument threshold and uncertainty.	Response rate, coverage and mode consistency.
A19	Need-adjusted ratio/difference moving toward equity with interval.	Comparable geography and need model.
A20	Co-designed, governance-approved need-adjusted gap threshold.	Indigenous governance, disclosure control and data quality.
A21	Approved percentage-point change with reason-code completeness.	Attempt denominator and access-reason coding.
A22	Rate/risk contrast within a fixed window with uncertainty.	Linked cohort, window and event capture.
A23	Approved percentage-point retention change for a stable cohort.	Cohort, profession and region definitions.
A24	Percentage-point change within a fixed completion timeframe.	Referral linkage and receiving-service confirmation.

Source note: Therapy Near Me indicator dictionary. Definitions should be maintained under formal technical and data-governance review.

Appendix B. Model specification and parameter register

Parameter	Symbol	Status	Preferred source	Range/update	Rule
Population	$P(t,g)$	Observed/ projected	ABS ERP and projections	Annual	Use low, central and high projection series.
Prevalence	$Prev(t,g)$	Observed/updated assumption	ABS NSMHW	Survey cycle	Do not assume annual precision.
Clinical-need factor	$q(t,g)$	Model parameter	Clinical/service- specific evidence	Low/central/high	Needed because prevalence is not identical to service need.
Recognition/ help-seeking	$h(t,g)$	Observed/model parameter	Survey/program data	Low/central/high	Culturally and socially patterned.
Eligibility/ navigation	$e(t,g)$	Observed/model parameter	Program/referral data	Pathway-specific	Report rejection and redirection.
Clinical FTE	$FTE(p,g)$	Observed	NHWDS/provider	Annual	Prefer direct clinical FTE.
Clinical share	$cs(p,g)$	Observed/model parameter	Workforce survey	Low/central/high	Excludes non- clinical time.
Productivity	$prod(p,g)$	Observed distribution	Provider/service data	Service-specific	Do not impose one national value.
Availability factor	$av(p,g)$	Observed/model parameter	Open books and slot data	0–1	Captures capacity accessible to target group.
Affordability factor	$aff(t,g)$	Model parameter	Cost-delay and price studies	0–1	Affected by fees, rebate and income.
Practical access	$pa(t,g)$	Model parameter	Travel/digital data	0–1	Includes transport and digital access.
Acceptability	$acc(t,g)$	Model parameter	PREM/community data	0–1	Includes culture, language and preference.
Completion rate	$comp(t,g)$	Observed	Service data	Service-specific	Use planned and unplanned closure reasons.
Outcome coverage	$oc(t,g)$	Observed	NOCC/provider	0–1	Paired valid measures.
Incremental improvement	$ii(t,g)$	Causal parameter	Trial/quasi- experimental evidence	Intervention- specific	Do not derive from uncontrolled before–after change.
Rebate pass- through	θ	Model parameter	Fee/claims analysis	Low/central/high	Share reducing patient price.
Price response	ϵ	Model parameter	Econometric evaluation	Low/central/high	Currently uncertain nationally.
Telehealth additionality	τ	Model parameter	Counterfactual evaluation	Low/central/high	Separate from substitution.
Overlap	ω	Model parameter	Linked data or survey	0–1	Prevents double counting across scenarios.
Implementation lag	lag	Observed/model parameter	Program milestones	Months/years	Apply before full effect.
Mean contacts per episode	$mce(t,g)$	Observed/model parameter	Service data	Service-specific	Required to convert contact capacity to episode capacity.

Parameter	Symbol	Status	Preferred source	Range/update	Rule
Observed improvement rate	oir(t,g)	Observed descriptive parameter	NOCC/provider	Instrument/service-specific	Not a causal effect.
Cost price year	py	Declared convention	Treasury/ABS index	Every run	All costs converted to a common price year.
Discount rate	r	Declared convention	Applicable government guidance	Sensitivity range	Use only for multi-year present-value analysis; state real/nominal basis.

Source note: Therapy Near Me scenario-model parameter register.

Model validation requirements:

- Reproduce all calculations from a machine-readable parameter file.
- Record source, reference period, extraction date, transformation and analyst for every parameter.
- Use unit tests for population, rate and cost conversions.
- Report gross and net effects, including displacement and overlap.
- Reconcile all narrative results with model tables before publication.
- Round outputs to a precision supported by inputs; avoid person-level precision from uncertain national parameters.
- Publish a versioned model change log and retain prior parameter sets.

Appendix C. Data-source register

Custodian	Source	Use in addendum	Principal limitation
Australian Bureau of Statistics	National Study of Mental Health and Wellbeing, 2020–2022	Prevalence, disorder groups, service contact	Ages 16–85; periodic survey; exclusions and sampling uncertainty
Australian Bureau of Statistics	National, state and territory population, December 2025	Population denominators	Preliminary estimates can be revised
Australian Bureau of Statistics	Population Projections, Australia, 2022 base–2071	2030 low/central/high population series	Conditional projections, not predictions
Australian Institute of Health and Welfare	Medicare mental health services	People, services, provider type, remoteness	Does not capture the whole mental health system
Australian Institute of Health and Welfare	Mental health workforce	Employed practitioners, FTE, distribution	Reference period and profession definitions differ
Australian Institute of Health and Welfare	Mental health services activity monitoring	Quarterly MBS and telehealth activity	Claims activity, not need, quality or outcomes
Australian Institute of Health and Welfare / AMHOCN	National Outcomes and Casemix Collection	Symptoms and functioning in public specialised care	Coverage and measure limitations; service setting scope
Productivity Commission	Report on Government Services 2026 — Services for mental health	Equity, access, outcomes, expenditure and experience	Cross-jurisdiction comparability varies by indicator
Productivity Commission	Mental Health and Suicide Prevention Agreement Review 2025	Governance, accountability and reform architecture	Policy review rather than service-level dataset
Department of Health, Disability and Ageing	National Mental Health Workforce Strategy 2022–2032	Workforce priorities and distribution	Strategy; not a current vacancy dataset
Department of Health, Disability and Ageing	National Mental Health and Suicide Prevention Evaluation Framework	Evaluation design and sharing principles	Framework requires program-specific operationalisation
Department of Health, Disability and Ageing	Evaluation of the Better Access initiative	Access, equity, outcomes and program design evidence	Evaluation period predates current policy environment
AIHW	National Mental Health Service Planning Framework	Population need and service-planning architecture	Detailed planning tool access is controlled

Custodian	Source	Use in addendum	Principal limitation
Australian Commission on Safety and Quality in Health Care	NSQ Mental Health Standards for Community Managed Organisations	Quality, governance and consumer partnership	Standards do not by themselves measure access outcomes
Services Australia	Mental health treatment plan eligibility and Medicare information	Current eligibility and session rules	Rules and benefits can change; verify at publication
PHNs and state/territory services	Needs assessments and service data	Local capacity, commissioning and waiting times	Definitions, coverage and update cycles vary
Centre for Population	2025 Population Statement and national projections, updated 9 January 2026	Current annual population projection inputs	Conditional projections; financial-year basis and subject to update

Source note: Source details and URLs are listed in the references.

Appendix D. Unresolved evidence gaps

1. A national real-time or frequently updated measure of providers accepting new clients and next available appointments.
2. Consistent clinical FTE and direct-care hours by PHN, remoteness, profession and sector.
3. Comparable waiting-time definitions across public, private, commissioned and developmental-assessment services.
4. Comprehensive gap-fee and indirect-cost data by service, income and region.
5. National treatment-completion and continuity measures across Medicare, public, community and disability pathways.
6. Routine outcomes and consumer experience coverage outside public specialised services and participating private hospitals.
7. A validated national estimate of telehealth additionality rather than substitution.
8. Australian causal estimates of response to rebate changes, provider fee pass-through and supply constraints.
9. Comparable early-intervention effect and cost parameters by program and population.
10. Cross-sector data linkage capable of measuring referral completion, crisis escalation and outcomes while protecting privacy.
11. Co-designed cultural-safety indicators with Indigenous governance and appropriate local interpretation.
12. Reliable small-area data for remote communities, children, CALD populations and people with psychosocial disability.

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