Development and implementation of Australian State, territory, and national policy on the health and wellbeing of adolescents and young adults: An exploration of policy actor perspectives using the Consolidated Framework for Implementation Research

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Abstract

Objectives: Government policies that support the health and wellbeing of young people (aged 10 to 25) can have important individual and societal impacts. The aim of this study was to explore policy actor perspectives on the development and implementation of Australian government policies focussed on the health and wellbeing of young people.

Methods: We utilised a qualitative research design consisting of semi-structured interviews with policy actors with experience working with Australian youth health policies. Our interview guide and analyses were informed by the Consolidated Framework for Implementation Research (CFIR). We interviewed 19 participants from various national, state, and territory bodies.

Results: Several specific barriers and facilitators to policy development and implementation were identified using the Consolidated Framework for Implementation Research. Key policy development barriers were limited available resources (e.g. staffing and funding) and low relative priority within health and political systems. Key policy implementation barriers were limited available resources, limited policy compatibility with health services, cosmopolitanism issues related to interagency collaboration, and a lack of policy evaluation. Meaningful engagement of young people could also be improved.

Conclusions: Although Australian youth health policies are perceived as evidence-based and comprehensively developed, the ability to promote implementation remains stalled.

Implications for Public Health: The development of policy implementation plans, monitoring and evaluation mechanisms, funding and resources, and a strong commitment to removing barriers to working across multiple departments and systems is required to improve outcomes for young people.

Key words: youth, public health, policy, implementation science

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Introduction

Health policy has traditionally accorded adolescence a somewhat awkward position betwixt childhood and adulthood. Adolescents' access to health services has reflected this, with transfer from paediatric to adult care occurring at various and inconsistent ages. However, policymaking focussed on youth (10 to 25 years of age) health appears to have increased over the recent years in Australia[1] and, to a varying extent, worldwide.[2,3] This is encouraging as the period between ages 10 and 25 years is recognised as critical for long-term physical, mental and social health,[4,5] with many risk factors, health behaviours and patterns of health service utilisation established during this period.[4,5] Health policy development and implementation has significant implications for public health via health system funding, service provision and initiatives, and the establishment of local guidelines, priorities, and practices.[6–8]

To date, there has been limited academic analysis of Australian national, state, or territory government policy focussed on the health of young people with most work focussed on examining themes stemming from policy document analysis.[1,9] Our recent scoping review found broad consensus on policy goals within current high-level Australian youth health policies[1] but was unable to identify the contexts and mechanisms that influenced policy development and implementation. Document analysis could not offer insights into the barriers or facilitators involved in policy creation or execution. Qualitative exploration of policy actor perspectives offers a sound standpoint to better understand these factors, particularly if supported by a rigorous implementation science approach.[10]

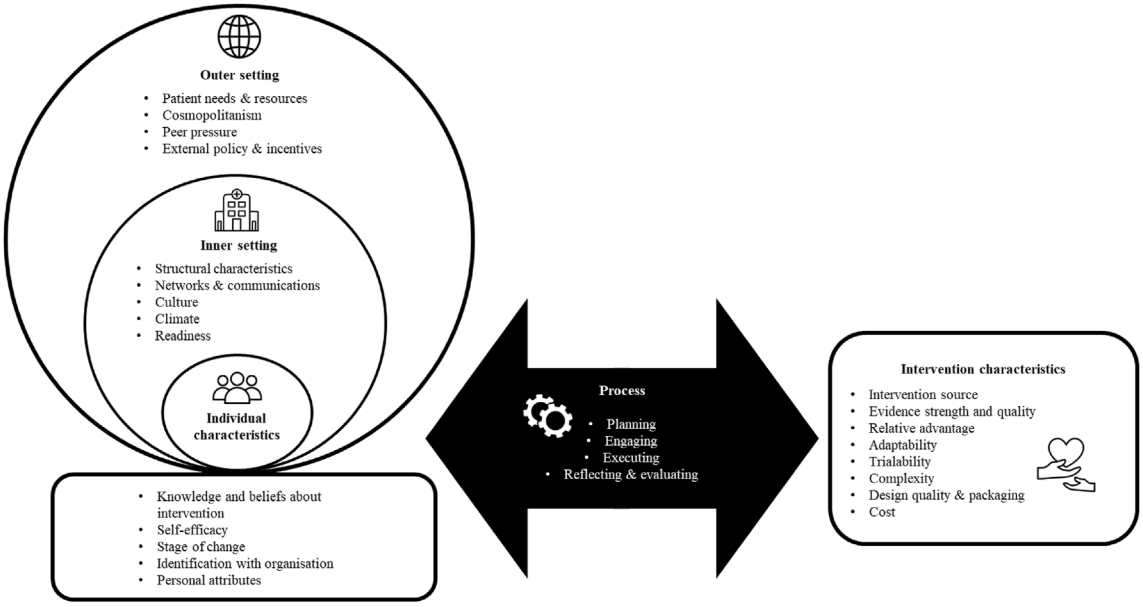
The Consolidated Framework for Implementation Research (CFIR)[10] provides a useful scaffold to explore national, state, and territory policy actor perspectives on policy development and implementation and uncover valuable insights. As a well-established implementation science framework, the CFIR identifies 39 constructs within five domains known to influence the uptake, adaptation, scale-up and sustainability of interventions (including policies). The five domains, relating to intervention characteristics, inner and outer settings, individual characteristics, and processes, provide an organising framework to interrogate data, identify and semantically group barriers and facilitators to implementation, understand the contexts and mechanisms at play and posit potential solutions to implementation issues.[10–12] Using this approach, the context for public health policy development can be understood through the CFIR factors of individual characteristics, the inner and outer settings, whilst mechanisms can be understood through the CFIR factors of intervention characteristics and process (see Figure 1). This helps to identify the barriers and enablers to effective youth health policy development and provides insights into how effective policies can be created, implemented, and evaluated.

The Australian public health setting

Governmental demarcations of public health policy responsibilities in Australia are somewhat idiosyncratic, with funding, policy development, and service provision for a range of multi-disciplinary services overseen by a combination of national, state and territory governments, supplemented by both private (for-profit) and not-for-profit providers.[1] Policy that influences private medical services (including general practice, medical and surgical specialities) is primarily developed by the Australian national government, and free hospital services for public patients are resourced by Australia's nationally funded universal health insurance scheme (Medicare). In contrast, policy that directs service provision in the public sector is primarily the responsibility of state and territory governments (such as hospitals including emergency departments and community/youth/child and adolescent/public mental health services).[13–15]

With this complex landscape, the aim of this study was to use the CFIR[10] to explore policy actor perspectives on the development and

Figure 1: The Consolidated Framework for Implementation Research*. * Adapted from Damschroder *et al.* (2009) [10]. 10. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science* 2009; 4(1): 50.



implementation of Australian government policy focussed on the health and wellbeing of young people. The focus for this work was on the development and implementation of health policies that respond to the needs of young people as a broad population group as opposed to distinct health issues such as mental or sexual health. The purpose of this research was to provide information to guide future policy development and implementation agendas and assist advocacy efforts for promoting the health of young people in Australia and globally.

Methods

Research question

The research question for this study asked this: What implementation barriers and facilitators are reported to impact the development and implementation of Australian youth health policies?

Design and methods

A qualitative descriptive research design, suitable for exploring and describing little-understood topics, was utilised.[16,17] Qualitative processes are described in the COREQ-32 checklist (Supplementary file 1). Semi-structured interviews were chosen as a flexible format to enable interrogation of specific topics and enable exploration of key issues arising from this. An interview guide was developed using an interview template created by the RAMESES II Project team[18] to examine the mechanisms and contexts that may impact policy development and implementation (Supplementary file 2). This interview guide was adapted, discussed and further revised amongst the author team, based on the CFIR.[10]

Recruitment

Convenience sampling and snowball recruitment methods were used.[19] A recruitment list was created by identifying authors of Australian youth health policies, contacting Australian health departments and agencies, searching the LinkedIn website, and utilising the study teams' existing networks. We were interested in identifying policy actors with experience in working with high-level strategic health policies and/or high-level youth policies that featured a health component that was published by Australian national, state, or territory government departments. To be included in the study, participants needed to (A) be an adult over the age of 18 years, (B) be a current employee within an Australian national, state-, or territory government–funded department or agency and (C) have professional experience in the past 10 years in the development or implementation of Australian national, state, or territory government policies that focussed on youth health.

Potential recruits were approached via their publicly available email address and were sent a participant information pack to help them decide if they wanted to participate in the study. Permission to recruit study participants was not sought from government departments as it was considered that this could potentially present risks to an individual's ability and willingness to consent to participation freely and confidentially. Participants provided audio-recorded verbal consent at the time of interview. Participants were invited to provide details for individuals they felt were eligible for the study and who consented to be contacted (snowball recruitment). Sampling continued to data saturation, that is, when no new information appeared forthcoming.[20] A total of 40 invitations to participate were emailed to policy actors. Of these, 27 responded to the email, and 19 consented and participated in interviews. Policy actors who responded to emails but declined participation indicated that they did not have time for an interview or did not feel they were an appropriate participant (e.g. insufficient involvement in youth policy development or implementation).

Table 1: Participants by policy-making body.

Policy body	n
National government funded	1
State government funded	
Australian Capital Territory	2
New South Wales	3
Northern Territory	3
Queensland	3
South Australia	1
Tasmanian	2
Victoria	2
Western Australia	2
Total	**19**

Data collection

Interviews were conducted online in a secure and password-protected Zoom™ meeting room. A PhD-qualified research fellow (DW) with qualitative training led each individual interview using the interview guide. The audio component of the interviews was recorded, transcribed and saved on a secure firewall-protected university data management platform. Participants were given the opportunity to review transcripts for correctness.

Analysis

A thematic analysis of the 19 interview transcripts was conducted by the lead author (DW) using NVivo 12[21]. A co-researcher (SM) provided cross-checks for 2 transcripts to check for fidelity to the coding protocol. Analysis proceeded concurrently with recruitment to allow recognition of data saturation. Coding was managed as an iterative process to ensure comprehensive coding of all interview text. Deductive and inductive coding approaches were utilised.[20,22,23] The deductive coding framework was guided by the CFIR.[10] Inductive codes were utilised to code information deemed important that was not covered by CFIR constructs.

Results

On average, interviews took 42.5 (range = 26 to 61) minutes with a total of 807 minutes of dialogue recorded and analysed. Participants had experience working with high-level strategic health policies and/or youth policies that featured a health component across various national, state, and territory bodies (Table 1).

General and specific themes were identified related to the contexts, mechanisms and outcomes of policy development and implementation, and barriers and facilitators to policy development and implementation under CFIR constructs related to contextual factors and mechanisms.[10] Characteristics of individuals (i.e. those implementing policy) were seldom mentioned and are therefore not discussed. Supplementary file 3 provides definitions and quotation exemplars of key constructs discussed. With all content reported as

participants' perceptions, the most discussed CFIR constructs were as follows.

Context: inner setting

The inner setting encapsulates the structural, political, and cultural contexts through which implementation occurs.[10] Key reported factors within the inner setting were structural characteristics, networks and communications, tension for change, relative priority, compatibility and available resources.

Structural characteristics

Structural characteristics refers to the size, maturity, and social architecture of an organisation.[10] Structural characteristics were consistently cited barriers, often in reference to the size and complexity of health and government systems and Australian health funding arrangements. Participants indicated that these structural factors created inefficiencies and a lack of transparency that impacted policy development and implementation. The challenges raised were of working within conditions of flux and the need for resilience to changes in government and health system structures. The complexity of health and government systems led to silos that could impact capacity for wider collaboration, although this was to some extent expected and was deemed necessary to facilitate policy development and implementation.

> *"We talk about silos all the time really, at all levels really, whether it's a regional silo or if it's to do with infrastructure, organisation, or something between systems. How those systems speak to each other and what crossover happens is forever fluxing again, but I would say there's probably a degree of silo that happens that we're all conscious of".*
>
> *Participant 12, TAS*

Networks and communications

Networks and communications refers to the nature and quality of social networks and communications (both formal and informal) within an organisation.[10] Networks and communications facilitated the development and implementation of youth health policies. Participants reported formal and informal ties to a range of stakeholders (youth advocacy groups, non-government organisations, health and social services, government contacts, health professionals, coalitions of young people, etc.). Networks and communications were often utilised during policy development and implementation processes (see engagement) and were cited as important for achieving progress in budget-constrained conditions (see available resources). Whilst some participants' networks and communications were confined to local contacts, others actively networked with policy actors from other states and territories.

Tension for change

Tension for change is an aspect of the implementation climate that refers to the extent to which stakeholders believe the current situation is untenable or requires change.[10] The participants, who are passionate advocates for youth, often discussed the crucial need to improve approaches towards youth health, contrasting how these issues were viewed within their broader organisations (see relative priority). Participants reported a recent groundswell of attention towards youth health, increasing tension for change and prompting policy development. Attributed to a variety of sources, commonly cited facilitators of tension for change included research publications, champions to drive the policy agenda, and young people advocating for change. Tension for change appeared to be a primary driver of the relative priority of youth health within governments.

> *"The other thing that did help was the WHO launch and the Lancet publications because actually those videos and papers actually did the persuading for us; in that, others had the research and the clout… It seemed like everything was coming together appropriately for us to really put an effort into getting a health policy for young people for the state."*
>
> *Participant 4, WA*

Relative priority

Relative priority is an aspect of the implementation climate that refers to the collective opinion on the topic's perceived importance within an organisation.[10] Whilst participants indicated high tension for change, the relative priority of youth health within government was reportedly low. Multiple challenges were identified in raising the priority of youth health within governments. One cited challenge was how youth health fits within noisy health systems with numerous competing priorities, populations, and health conditions. The perceived low health burden of youth was a detraction, as was the hidden nature of many health conditions affecting youth. Participants indicated that short-term views of governments overlook the long-term impacts of poor youth health, with loss of opportunity for early intervention.

A further barrier came from cannibalisation of attention to other populations. Youth health policies were often packaged with broader policies focussed on wider age ranges or population groups. In this situation, policy attention and resources were typically directed towards other subgroups, especially younger years. A final barrier was governments' and health systems' focus on COVID-19 over the recent years, which reduced prioritisation of youth health policy development and implementation.

> *"I think some of the challenges we face are when people in power, people in the government, don't necessarily consider young people a priority cohort".*
>
> *Participant 15, VIC*

Compatibility

Compatibility is an aspect of the implementation climate that captures how well an intervention fits the context, including workflows and systems.[10] The discussion focussed on the fit of policy directives with work plans in busy health environments. Most youth health policies contained few mandated actions, and implementation was dependent on health services and practitioners being persuaded to adopt recommendations. Youth health policies were often perceived to lack power and authority for implementation within department-funded agencies and services.

> *"You have got your Department of Health and then separate health service providers, and health service providers have their own governing boards and are responsible for implementation, and so you can't mandate certain implementation. But we're still setting the direction. So, it's complex".*
>
> *Participant 17, QLD*

Available resources

Available resources captures an aspect of organisational readiness for implementation and refers to the available resources for implementation and continuing activities including funds, personnel, training, education, physical space, and time.[10] The most highly cited barrier that all interviewees reported was working in low-resource settings with restricted staff, funding, training, and time. Policies for youth mental health were perceived to have received greater attention from funders at the expense of those targeting broader youth health and wellbeing.

"Who will oversee its implementation and check that it got implemented? Those things are always really hard, especially because we don't write our plans with funding. So, they get written and then given to the commissioning body to say, right, this is the plan. They have to look for money".

Participant 6, SA

Context: outer setting

The outer setting refers to the economic, political, and, social contexts impacting an organisation.[10] Key outer settings included consumer needs and resources, and cosmopolitanism.

Consumer needs and resources

Consumer needs and resources refer to the degree to which an organisation effectively understands and prioritises consumer needs, barriers, and facilitators to meeting these needs.[10] Participants' knowledge of patient needs was informed by current research (see evidence strength and quality) and practical experience in the field. The breadth of potential youth health issues was acknowledged as influencing policy scope and, at times, as a challenge for implementation. The health impacts of intersectional social determinants (e.g. poverty, remoteness, racism, etc.) were often cited and were well-understood by participants. Views were mixed on how well organisations understood youth health needs, and participants felt that low awareness detracted from prioritisation of youth health within governments and the health system (see relative priority).

Cosmopolitanism

Cosmopolitanism indicates the degree to which an organisation is connected to other external organisations,[10] which was reported as mixed for participants' organisations. Cosmopolitanism barriers entailed authority and governance concerns related to the external departments and agencies that a policy might influence. Participants pointed to differences in how external entities work, citing different outcomes of interest, reporting frameworks and timelines. Policies developed within one department (i.e. Health) could lack authority to direct other departments on topics outside their specific remit even when intersecting with health issues. Such concerns were notably present where multiple government departments or services aimed to tackle social determinants of poor youth health. Those in support of whole of government approaches stressed that key youth health issues required comprehensive multidepartmental approaches, whilst others flagged the attendant barriers to coordination and collaboration, and occasional issues with 'patch protection' when collaborating with external entities.

"The Ministry of Health and what they have jurisdiction over is service delivery… They did not have authority to influence health education in schools, for example. They didn't have authority to influence Medicare rebates for general practice services. They developed strategic ideas around what they could influence".

Participant 1, NSW

Mechanisms: intervention characteristics

Intervention characteristics refer to specific qualities of interventions that impact implementation success.[10] The key intervention characteristic identified by participants was evidence strength and quality.

Evidence strength and quality

Evidence strength and quality refers to stakeholders' perceptions of the evidence supporting that an intervention is necessary and produces the desired results.[10] Both existing evidence (academic and grey literature) and commissioned new research (e.g. surveys, audits, data linkage, focus groups, etc.) informed policy, although collating and developing this was time-consuming and resource intensive. Participants more often referred to the strength and quality of evidence in relation to policy development *rather than* implementation, and most commonly, to identify patient needs and resources for policy prioritisation. Participants cited difficulties finding evidence for specific interventions that could be implemented to support youth health. Overall, there was limited discussion of formal implementation research to support policy work. Approaches to the publication and dissemination of commissioned research varied across settings. Some retained findings of their commissioned research in-house as organisational knowledge, whereas others favoured dissemination to broader non-policy and academic audiences, including via publication.

"So we had over 200 participants feed into the original concept and design. Through the survey and the focus groups and a thematic analysis, we tested that against the evidence base, which in Australia is, you know, there's great evidence out there and internationally significant evidence out there to support all of this work".

Participant 19, QLD

Mechanisms: process

Process refers to the four key phases of implementation designed to connect an intervention and setting: planning, engaging, executing, and monitoring and evaluation.[10]

Planning

Planning refers to the extent to which tasks are prepared in advance of policy implementation and the calibre of such plans and techniques.[10] Frequently discussed, respondents were typically positive about the planning processes for policy development, commonly focussing on evidence strength and quality, engaging, and compatibility (see discussion above). Planning revolved around understanding the contexts of populations, systems, services, and service gaps and identifying specific interventions or models of care for implementation. Difficulties arose from limited time, staff, budget (see available resources) and authority to direct implementation (see compatibility and cosmopolitanism). Policies often lacked formal implementation plans with participants blaming the aforementioned barriers for this decision.

Engaging

Engaging refers to the approaches and activities used to involve appropriate stakeholders in the development, implementation, and use of an intervention.[10] A broad and comprehensive range of stakeholders (e.g. experts, opinion leaders and implementers) were utilised to develop policies. The engagement of young people was commonly cited as relevant to the planning and development phases of policy making and was seen by some participants as an area of policy improvement in the recent years. When engaging young people, policy actors often relied on pre-existing youth networks and advisory committees and more recently, through commissioned research (see evidence strength and quality). The importance of youth consultation and co-design was highlighted, but participants noted that overuse of the term 'co-design' triggered reservations about the depth of engagement and tokenism. The common lack of compensation for young people's time and the limited feedback provided to young people after they contributed to policy development were concerns, as was the difficulty of engaging marginalised young people, a key policy target group. Few young people were engaged with policy implementation.

> *"Government consults with young people a lot; we wouldn't consider that genuine youth participation. It's not ongoing involvement; they don't always remunerate young people for their time, so then they wonder why they get low rates of turnout and that sort of stuff. Some departments are obviously better than others".*
>
> *Participant 14, VIC*

Executing

Executing refers to the process of accomplishing or completing implementation as planned.[10] Two main approaches emerged for executing policy and translating it into health actions. The first and most common approach involved national, state, or territory funded health services taking responsibility for implementation whilst the second involved commissioning outside agencies for this. Participants noted that the breadth and nature of policy tends to mean that execution is seldom completed but rather exists in a cycle of work competing with other demands in a busy health system.

Reflecting and evaluating

Reflecting and evaluating refers to the collection of quantitative and qualitative feedback on the progress, experiences, and success of implementation.[10] The lack of formal monitoring and evaluation for youth health policy development, implementation or outcomes was commonly noted, with this work inhibited by lack of budget and staffing (see available resources) and limited authority for policy to mandate implementation (see compatibility and cosmopolitanism). This frustrated respondents who argued for the importance of monitoring and evaluation to motivate change within services and to determine the success of youth health policies overall.

> *"There isn't a requirement for the health service providers to actively report on youth health. I think, for example, if our health system required each of the chief executives to actually report on what progress had been made with youth health, it would have more clout. Again, competing priorities, they have other things to report on that they're required to report on, and youth health is not one of them".*
>
> *Participant 4, WA*

Conclusions

Together, our results indicate that Australian youth health and wellbeing policies are typically developed in situations of restricted staff and budgets (available resources), featuring structural barriers to collaboration between services, departments, and governments (structural characteristics, compatibility and cosmopolitanism). Within these contexts, policy development is facilitated where the evidence base is strong (evidence strength and quality); there are collaborative working relationships between individuals and departments (networks and communications); and there is recognition amongst stakeholders, policy actors and funders of the importance of youth health (tension for change). Government bodies have increasingly prioritised engagement for policy development amongst a variety of stakeholders such as public servants, health professionals, academics, and peak bodies. However, whilst young people have been engaged in the development of most youth health policies, concerns remain over tokenism.

Issues for policy development

A perceived barrier to policy development was the limited prioritisation of youth health and wellbeing issues at higher levels of government and the Australian health system (relative priority), not helped by the entrenched two-tier arrangement (adult versus paediatric) of services. Furthermore, whilst participants demonstrated extensive knowledge of the health challenges facing young people, they tended to report that those working in the broader health system often had more limited understanding of the unique health and wellbeing requirements of young people (patient needs and resources). Participants indicated that these issues contributed to restricted provision of dedicated resources for youth health policy development, chiefly by limiting staff and budgets.

Recent research has underlined several factors that can help policy advocates to tackle the aforementioned issues and improve the development of Australian youth health policies.[24] These include partnering with powerful actors who have credibility and communication skills (e.g. Government Ministers, Academics, Clinicians, Managers), consulting with young people with lived experience of health systems, and framing youth issues to attract political attention and garner support.[24] Interestingly, these approaches were also discussed by our study participants and look to be useful tools for continued advocacy and advancement within the Australian youth health and wellbeing space.

Issues for policy implementation

Discussing policy implementation, participants cited barriers related to a lack of funding and resources (available resources) and jurisdictional concerns (compatibility and cosmopolitanism). Working within constrained settings meant that policies were often viewed as recommendations that could be difficult to implement, mandate and sustain. When policies recommended action within their jurisdictional remit (e.g. state health policy guiding local health districts), participants underlined the importance of policy compatibility with the local health settings, population, and context (compatibility and patient needs and resources). When policies worked across broader

remits (e.g. state health departments recommending actions targeting broader social determinants of health), 'patch protection' and collaboration difficulties across departments could deter progress.

There was no consistent view on whether health department or whole of government policies were preferable for acting on social determinants of youth health. These findings add to a growing literature that demonstrates the difficulties of tackling the issues related to youth health through individual government departments (e.g. health) and the complexities of developing broader policies that focus on social determinants of health within the Australian system of governments.[24,25] Further work in this area may look to research from South Australia, where a 'Health in all Policies' approach has been implemented to learn more about approaches that support intersectoral policy efforts.[25]

Monitoring and evaluation of health policies was reportedly rare and was related to resourcing constraints (available resources). This is not unique to youth health policy or Australia.[24,26] For example, recent research has highlighted a lack measurable indicators within Australian policies focussed on the social determinants of health for children.[24] This research cited a case study where indicator measures were removed from a specific policy at the final stages of policy development just prior to publication.[24] This is unfortunate as a prior government-commissioned review has highlighted this as a key area of improvement needed for health policies relevant to children, young people, and families.[27] A factor that may potentially mediate the proposed relationship between available resources and evaluation could be a concern over political embarrassment if policy targets are not met. In such cases, governments may shy away from evaluating policy outcomes if it is perceived that there are limited resources available to achieve policy goals. Importantly, further research is required to either confirm or disprove this hypothesis.

Evidence was less often reported as used to support policy implementation than for policy development. It appears that the current evidence base makes it easier for policymakers to outline and identify risks and key priorities for youth health than to use the evidence base to posit or provide implementable policy solutions. However, given that problem definition necessarily precedes solution generation, perhaps this is a developmental stage issue.[28] Nevertheless, further research focussed on the implementation of Australian youth health policies and the development of evidence-based policy solutions appears warranted.

Finally, limited engagement of young people in both the development but especially the implementation of these policies, also seen in wider youth health research,[29] is a missed opportunity. Meaningful youth engagement is central to improving services for young people, and it is critical that youth voices and perspectives are considered during intervention (e.g. policy) development and implementation. Non-tokenistic engagement can be fostered through the establishment of youth advisory groups, participatory research and through embedding youth-friendly approaches that foster the principles of equity and reciprocity.[29] Whilst the findings of this and other research[1] show that policy actors are increasing their engagement with young people, more can be done to improve how this is approached, embedded, and sustained.

Strengths and limitations

This study has some limitations. First, it is possible that participants were concerned at how their accounts may have been interpreted or misinterpreted as representations of their organisations. This may have resulted in a 'public relations' version of events.[30] To counter this concern, the research team utilised rapport-building techniques, emphasised their position as 'neutral outsiders', and undertook to publish in a manner that assured participant confidentiality. Second, this research utilised a inclusion criterion that may have excluded policy actors who have worked on policies indirectly related to youth health (e.g. policies focussed on specific social determinants of health) and service providers responsible for implementing health policies. Future work should focus on the views of this stakeholders to better understand youth policy development and implementation challenges from their perspectives.

A key strength of this work was the utilisation of the CFIR to analyse, structure, and interrogate interview results. By using this framework, we were able to identify implementation factors influencing both the development and execution of youth health policy. Importantly, identification of these factors can lead to the development of implementation strategies aimed to overcome barriers and promote facilitators.[10,11] Future work should look to develop such strategies to assist ongoing policy development, innovation and implementation.

Implications for public health

This research contributes to a growing body of research that focusses on youth health policy in Australia, with a unique focus on policy development and implementation. This exploration of issues related to policy development and implementation contributes in-depth understanding to support youth health agendas and advocacy in Australia and internationally.

Whilst the production of Australian youth health policies has increased in the recent years,[1] a lack of resources and political power has stalled implementation. Furthermore, the limited ability of health departments to respond comprehensively to the social determinants of health has constrained their capacity to respond to these underpinning issues across state, territory, and national governments. Political will, along with the development of policy implementation plans, monitoring and evaluation mechanisms, and a strong commitment to removing barriers to working across multiple departments and systems will be required to effectively develop and implement future policies that support the health of young people.

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Ethics statement

The study was approved by the University of Technology Sydney Human Research Ethics Committee (Reference: ETH20-4932).

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Conflicts of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.anzjph.2023.100112.