

Submission to the Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement, July 2025

Australia is facing a youth mental health crisis. Rates of depression, anxiety, and suicidality among adolescents¹ have risen significantly in recent years. Mental health concerns are the leading cause of death for young people in Australia,² a devastating reality that underscores the urgency of reform. Yet the NSW mental health system, and no doubt that of other states, continues to fall short, particularly in addressing the needs of adolescents. For families like ours, trying to secure appropriate treatment for our child was an exhausting, disheartening, and ultimately devastating process.

The death of our beloved adolescent son in late 2024 was not simply a family tragedy, it was the result of a youth mental health system that is fragmented, under-resourced, and, in many cases, actively harmful. This submission is written to honour our son's life and calls for urgent reform to prevent future loss of life, promote the rights to health, dignity and safety of other young people in distress, and ensure families are empowered to support their adolescent children.

The information provided is based on our family's experience with the mental health system in the months leading to our son's death, the experiences of other parents and families I have been in communication with, and on the extensive available research and reports that demonstrate that the issues raised in this submission are systemic and long-standing.

In our experience, and that of other families, the National Mental Health and Suicide Prevention Agreement has not supported improved mental health and suicide prevention outcomes for all people in NSW. Significant gaps and limitations in the provision of adolescent mental health and suicide prevention systems persist and remain unaddressed by existing funding arrangements for specified services in NSW. Key gaps and limitations are set out below.

Fragmented and unaffordable private services and underfunded public ones

Despite national investment and ongoing political rhetoric, parents struggling to support their adolescent child experiencing mental health concerns find themselves navigating a labyrinth of waitlists and unaffordable services, with private psychiatrists commonly charging up to \$900 per hour and weekly psychology sessions only subsidised by Medicare for ten sessions. Many practitioners working in the private system lack expertise in adolescent mental health conditions, making it difficult for families seeking appropriate care. Given how much relatively well-resourced families in metropolitan areas struggle to find and afford private services, it is difficult to imagine how much worse it is for families with less disposable income and no private health insurance living in regional and remote areas of NSW.

At the same time, public mental health services are chronically underfunded,³ acutely short-staffed, and often lack the specialist practitioners and infrastructure needed to treat adolescents with complex needs or in acute distress. This underfunding is apparent in:

¹ The term adolescent includes young people aged 12 – 19 years of age, though many argue from a developmental perspective, adolescence continues until 24 years of age.

² While not all suicides are due to mental illness, mental illness and distress are primary risk-factors for suicide. Moreover, many young people struggling with mental health issues die due to misadventure or accidental causes and these deaths are commonly not reflected in data on mental health related mortality.

³ See for example the recent NSW Health commissioned Special Commission of Inquiry into Healthcare Funding: <https://www.health.nsw.gov.au/Reports/Pages/special-commission-inquiry-funding.aspx>

- Under-resourced community-based crisis and acute care services;
- Appalling emergency department wait times and environments for distressed and dysregulated adolescents;
- Placement of adolescents in understaffed, untherapeutic and traumatising adult inpatient units which causes significant harm and distress;
- A lack follow-up or aftercare following discharge from hospital to support an adolescent's recovery, health and safety.

It is impossible to reconcile these conditions with government assertions of investment in youth mental health. Without immediate and targeted reform, these systemic failures will continue to inflict harm on young people and those who love and advocate for them. None of the services funded under the National Mental Health and Suicide Prevention Agreement set out in the NSW Bilateral Schedule are targeted to address the needs of adolescents experiencing acute distress or complex mental health needs, or to empower parents to support their adolescent child during crisis. This includes headspace, which is primarily an early intervention service.

The real-life experiences of parents confirm findings in the Productivity Commission's Interim Report that the current Agreement is fragmented, underfunded, and not delivering the systemic change it promised. In our experience, and that of other parents, the National Mental Health and Suicide Prevention Agreement has simply not reduced system fragmentation or addressed gaps in community based mental health and suicide prevention services.

Moving forward, within the National Mental Health and Suicide Prevention Agreement, the Commonwealth should partner with states to co-fund essential acute, crisis and aftercare services for adolescents to promote safety and recovery and reduce risk of harm, advocate for expanded Medicare rebates for adolescent mental health care, including longer-term therapy and multidisciplinary support, set minimum service standards for adolescent care and fund training pipelines for adolescent and youth-specialist psychiatrists and multidisciplinary workers.

Lack of adolescent inpatient facilities

There is an urgent need for dedicated adolescent inpatient mental health units in every local health district, with environments tailored to developmental needs of young people aged 16 to 24, staffed by compassionate clinicians and allied health staff with appropriate training in adolescent and youth mental health care. Placing a distressed adolescent aged between 16 and 19 years old in adult facilities that are not fit for purpose and that traumatised them and cause harm is completely unacceptable. Adult inpatient facilities are geared towards working with autonomous and independent adults and as a result dismiss and exclude parents of adolescents.

Despite evidence-based models of inpatient therapeutic care available in the private sector for young people aged 16 to 24 that are holistic, age appropriate and family-inclusive, these options remain inaccessible to most families due to limited availability and cost. Meanwhile, the public system offers no comparable alternative.

While adolescent inpatient mental health facilities are traditionally the responsibility of state and territory governments, there's a strong argument for Commonwealth co-investment through the National Mental Health and Suicide Prevention Agreement. A Commonwealth funding mechanism could ensure baseline standards across jurisdictions, address geographic and demographic disparities, and support national service planning for adolescent and youth mental health.

The Commonwealth has already committed over \$500 million to Youth Enhanced Services, but these focus on outpatient care. Without inpatient investment, the so-called “missing middle” services will continue to leave adolescents in crisis with nowhere safe to go. There must be national commitment backed by funding and accountability to develop best practice adolescent inpatient units within the public health system. Including inpatient facilities in the National Mental Health and Suicide Prevention Agreement would fill a critical gap in the “missing middle”, align with federal goals for suicide prevention, and support continuity between primary, community, and acute care.

Misuse of confidentiality and privacy provisions

One of the most damaging aspects of current mental health policy in NSW (and reportedly other states too) is the way the Mental Health Act 2007 and privacy legislation are applied to marginalise and exclude parents during their child’s most vulnerable moments. While the law allows for exceptions in cases of diminished capacity or risk of harm, clinical services often adopt a rigid, risk-averse stance excluding parents even when they are desperately trying to help and care for their child.

Turning 18 is a turning point, marking the moment many parents are shut out of their child’s care. From that point on, they are no longer seen as caring parents or partners by the public mental health system. This includes emergency departments, inpatient unit and community acute care teams. Even though an adolescent lives at home, once they turned 18, when admitted to the emergency department in crisis, parents may not even be notified. When they are admitted to hospital, parents seeking information about their treatment may be told that privacy laws prevent disclosure. Even with consent for information sharing, parents may be ignored and not provided appropriate opportunities for engagement or even basic information about their child’s treatment or discharge planning. Community acute care team similarly may not seek to communicate with parents once a child turns 18, even when the child lives at home.

Parents who know their child’s history and circumstances are ignored and dismissed. The clinicians impose their own clinical narratives and dismiss the insight and expertise of those who best know and care about a young person. The system’s interpretation of privacy is not protective, it is harmful and callous. This is not a new issue, nor an uncommon experience. The problematic and callous way in which privacy and confidentiality provisions are used to exclude parents, those who are most invested in an adolescent’s health, safety and well-being, has been raised over many years, yet it is allowed to continue.

NSW (and where needed other states) must reform its legislation and clinical frameworks so that privacy laws serve to protect and support not to exclude and endanger. The Commonwealth Government plays a critical enabling role in ensuring that states like NSW adopt best-practice family-inclusive mental health and privacy laws. Through the National Mental Health and Suicide Prevention Agreement, the Commonwealth can set expectations for family-inclusive practice across jurisdictions, tie funding to measurable reforms, such as mandatory family engagement protocols or improved information-sharing frameworks, encourage harmonisation of privacy and mental health legislation to reduce fragmentation and risk. The Commonwealth has the reach and responsibility to ensure that rights to safety, dignity, and family partnership are embedded in every corner of the mental health system.

Urgent need for person-centred, holistic and integrated approaches to adolescent mental health

Current policy, funding and models of care too often divide young people’s needs into rigid categories of ‘mental health’, ‘suicide prevention’, ‘alcohol and other drug use (AOD)’ as if these

issues exist and can be addressed in isolation. This uncoordinated and siloed approach fails to reflect the reality of adolescents, whose distress is rarely confined to a single diagnosis or service stream. Instead, young people experience complex, overlapping needs compounded by the nature of normative adolescent development.

When services are designed around systems rather than people, adolescents and their families are forced to navigate multiple disconnected pathways between community and inpatient, public and private services, to retell their stories repeatedly, and to adapt themselves to fit into diagnostic boxes. This not only delays access to care, but it can also compound harm. A young person presenting with suicidality may be referred to a suicide prevention service that does not address underlying trauma or substance use. Another may be excluded from mental health care due to their AOD use, rather than their AOD use being understood as a response to unmet mental health needs.

A person-centred approach places the young person, not their labels and diagnoses at the heart of care. It is the opposite of a deficit and diagnosis-based model of care – it recognises an adolescent's strengths as well as their challenges, that recovery is not linear, and that young people and their families need support that is flexible, developmentally appropriate, relational, and responsive to their evolving needs. This support should include:

- Integrated multi-disciplinary care teams that work across mental health, AOD, suicide prevention and family support.
- Therapeutic environments that are developmentally appropriate, trauma-informed, and culturally safe.
- Collaborative decision-making, where young people are empowered and families are engaged as partners in care.

When services are designed around the whole person, outcomes improve, not just in symptom reduction, but in connection, hope, and long-term wellbeing. If we are serious about reform, we must stop asking young people to fit into our broken systems and start building systems that fit around them and those that love and care most about them. The National Mental Health and Suicide Prevention Agreement should mandate system planning and design that does this.

Reform priorities

We urge the Productivity Commission to recommend the following reforms within the National Mental Health and Suicide Prevention Agreement that require states to:

- Adequately fund community and hospital-based acute care and crisis services as an urgent priority. These are life-saving services, yet people are being turned away. It's hard to believe this would be acceptable in any other area of healthcare.
- Establish adolescent and young adult (16 – 24 years) inpatient mental health services in every local health district, with trained multi-disciplinary staff teams, active involvement of families and aftercare services. Placing distressed adolescents into adult facilities is inappropriate, traumatising and harmful and needs to stop.
- Amend privacy laws and legislation such as the NSW Mental Health Act to mandate notification and parental engagement when an adolescent's capacity is impaired or their safety is at risk. Privacy laws and confidentiality should not continue to be barriers to safety or care, particularly when an adolescent lives at home and is not yet independent or autonomous.
- Mandate family-inclusive practice across all adolescent and youth mental health services, with structured protocols for engagement, communication, and care planning. Parents are

the most invested in ensuring their child's health and safety. The National Mental Health and Suicide Prevention Agreement recognises the value of families and carers, but enforcement at the state level is inconsistent. For example, NSW has no binding requirement to embed family inclusive practice in public mental health policy or legislation.

- Publicly fund best-practice treatment models for adolescents currently only accessible through private care, and establish national service standards.
- Introduce system reform to implement person-centred approaches that provide appropriate and coordinated interventions and supports based on an adolescent's needs, not on service priorities and funding models.
- Introduce family advocacy and support resources within mental health teams to empower and enable parents to promote their child's right to access good quality and lifesaving health care through navigating crisis, ongoing care, and raising issues and complaints. It's essential that every family navigating this system is empowered and supported.
- Promote accountability for young people and families harmed by systemic failures. This should include including reparative justice for past harm through a process like Victoria's *Not Before Time* report.

Our son was a gifted, courageous, thoughtful, kind and deeply compassionate young person. He deserved better. Every young person experiencing mental distress deserves better. We and other families deserved better too. Parents should not have to fight, let alone grieve, in the face of exclusion from and inadequate care by public health services. It is hard to imagine that the exhausting, exclusionary and distressing experiences of countless families simply seeking health care and treatment for their adolescent children would be tolerated in other areas of health.

The National Mental Health and Suicide Prevention Agreement offers an opportunity to address these system failings through shared accountability and coordinated reform in key areas to promote adolescent mental health and prevent early death. We ask that this review recognize what we, and so many others, have seen too clearly - that the youth mental health system is not only broken, at times it contributes to the suffering it is supposed to treat. There is no more time for disconnected promises and incrementalism. What we need now is urgent, coordinated, meaningful reform, locally in NSW and nationally through the National Mental Health and Suicide Prevention Agreement, which is meant to drive consistent, life-saving care. We urge the Commission to ensure that the lived experience of parents and adolescents is not only heard, but reflected in mental health policy, legislation, and practice through the National Mental Health and Suicide Prevention Agreement moving forward.

Thank you for considering this submission, which we offer with broken hearts, but also with determination for change. I welcome the opportunity to discuss this submission further with the Commission.