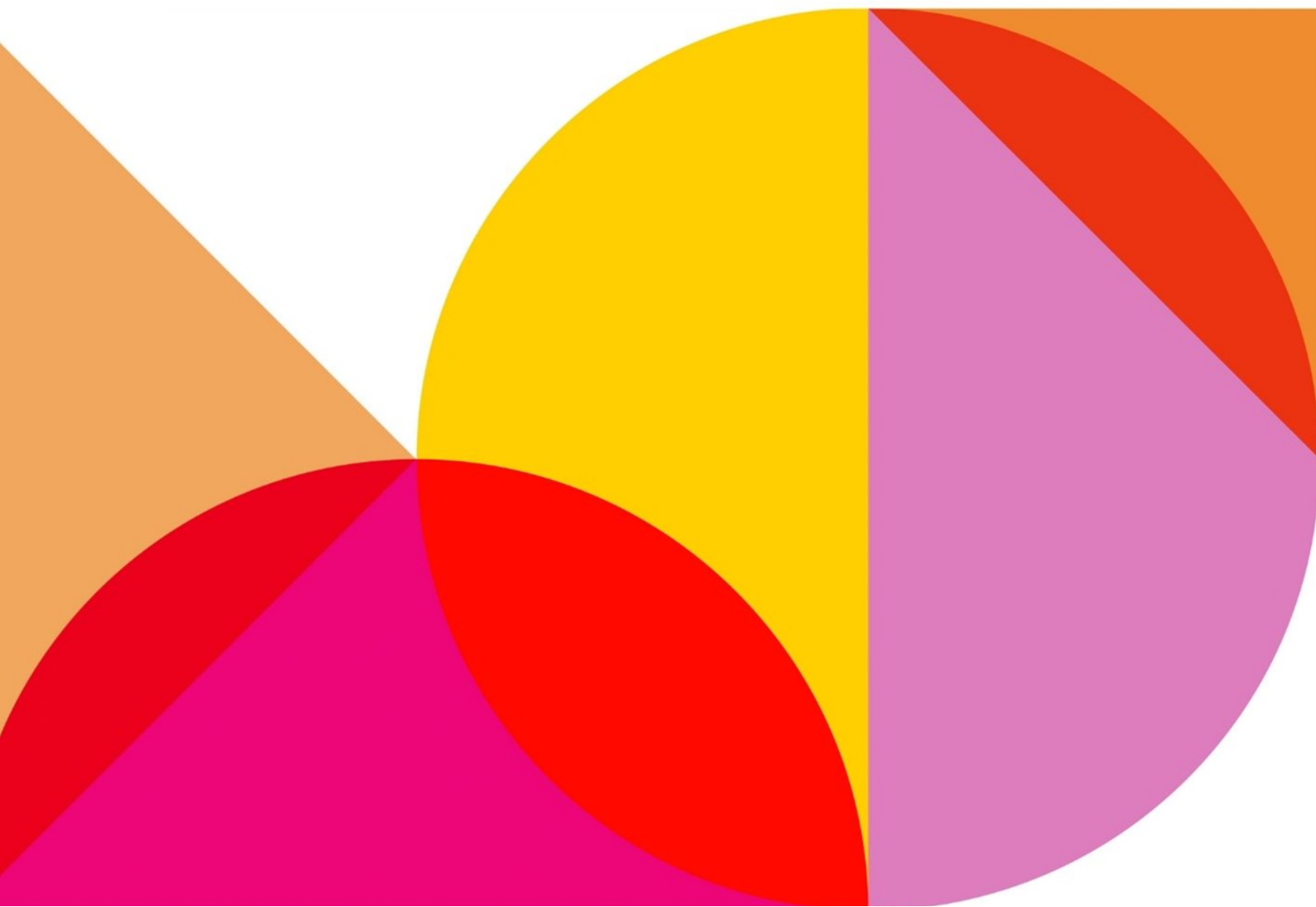


Draft Models of Care for Headspace Plus and Youth Specialist Care Centres

JUNE 2026



Acknowledgement of Country

The National Mental Health Consumer Alliance acknowledges the Traditional Custodians of the lands and waters across Australia where we live, work, and advocate.

We pay our deepest respects to Aboriginal and Torres Strait Islander peoples, and to their Elders past and present. We acknowledge that First Nations lived experience is inseparable from the impacts of colonisation, dispossession, racism, and structural inequity. These ongoing injustices must be named, understood, and addressed.

The National Mental Health Consumer Alliance works in solidarity with the Indigenous Australian Lived Experience Centre, recognising the critical leadership of First Nations peoples in truth-telling, healing, and social and emotional wellbeing.



About Us

The Alliance is the national peak body representing mental health consumers. We work together to represent the voice of all mental health consumers on national issues.

We are the people experiencing mental health challenges, at the table advocating with government and policy makers, and working with a robust network of grassroots communities.

More information is available on the Alliance's website:

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Terminology

All references to 'Consumer' and 'lived experience' in this submission refers to mental health consumers with lived experience of mental health challenges and / or suicidality. We use the term "mental health consumers" as a catchall term due to its connection with our movement's history. We also respectfully acknowledge that different people self-identify with different terms. We do not include family, carers, kin or the bereaved in our definition of lived experience as it appears in this submission.



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Executive Summary

While the National Mental Health Consumer Alliance (the Alliance) acknowledges that the government's \$700 million investment in youth mental health funding reflects a genuine desire to address the youth mental health crisis, we are fundamentally concerned about the structure and effectiveness of these reforms.

The proposed reforms do not adequately address the drivers of the youth mental health crisis. Genuine early intervention and prevention require addressing the structural drivers of psychological distress, not simply expanding the capacity of services to respond reactively. The social conditions driving the youth mental health crisis including housing insecurity, poverty, and discrimination cannot be resolved through clinical intervention alone. The proposed models also risk reinforcing a narrow clinical understanding of psychological distress that overlooks the broader human rights conditions necessary for wellbeing, including autonomy, safety, social inclusion, and freedom from coercion. Without substantial investment in addressing the social determinants of youth mental health, expansion of clinical services alone is unlikely to be sufficient to meet demand. It is both economically and practically unsustainable to rely on continuous expansion of a clinical system to manage a worsening crisis created by social and political conditions. Research reporting poor outcomes across existing youth mental health services – including Headspace – highlights this. Whilst some have attributed these outcomes solely to insufficient service capacity or intensity, we argue that they instead highlight the need to critically examine whether mental health investment is ineffectively targeted.

Furthermore, we contend that establishing new federally funded tiers of intermediate youth mental health services, rather than integrating with and resourcing existing state and territory services, further fractures an

already fractured system and risks worsening workplace shortages, creating navigational barriers for young people, and ultimately failing to serve the very people the models are proposed to support.

We urge the Department of Health, Disability and Ageing to reconsider the proposed tiered service structure and instead explore options that integrate federal investment with existing state and territory services, ensure investment addresses social determinants, and centres mental health consumers within governance and design.

Recommendations

The Alliance makes the following recommendations:

Social Determinants and Human Rights

1. Investment in all models of care should be explicitly linked to, and evaluated against, the social determinants of youth mental health (including housing, income security, education, and freedom from discrimination) through formal connections to the services and portfolios responsible for them.
2. All models of care must include explicit frameworks addressing the social determinants of mental health as core service components.
3. All models of care should be explicitly grounded in a human rights framework, including recognition of the right to adequate housing, bodily autonomy, freedom from coercion, and Australia's obligations under the Convention on the Rights of Persons with Disabilities (CRPD), the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and the Convention on the Rights of the Child (CRC).

4. All models of care must recognise consumer advocacy (supporting young people to navigate and challenge systems that aren't meeting their needs) as a core function.

Service Structure and Integration with Existing Services

5. The Department should investigate alternative models that utilise federal investment to strengthen and connect to existing state and territory public mental health services, rather than creating parallel services.
6. If recommendation 5 is not followed, the proposed models must include explicit integration procedures with state and territory mental health services, including emergency, crisis, and inpatient services.
7. The 'no wrong door' principle should be operationalised so that all services (Headspace, Headspace Plus, or YSCC) provide enhanced support during 'step-up' and 'step-down' transitions, ensuring there are no gaps in care.
8. Formal co-commissioning arrangements must be created to prevent states and territories from reducing their youth mental health investment in response to increased federal funding.
9. Eligibility criteria should allow young people to access the type and intensity of support they need in a timely manner without changing services whenever their presentation, diagnosis, or age shifts. Service model categories based on clinical illness state, diagnostic labels, or

disorder prevalence do not account for the fluctuating and often comorbid reality of youth psychological distress and should be avoided in favour of flexible integrated eligibility arrangements.

Lived Expertise, Co-Design, and Peer Support

10. Consumer-led governance bodies should be established for both Headspace Plus and YSCC models, with genuine decision-making authority. These bodies should be comprised of young people with lived experience of using these services, as well as others with lived expertise.
11. Adequately resourced consumer lived experience peer workforce must be a mandatory component of both models, including specified minimum staffing ratios and explicit investment in pay, supervision, and career development pathways.
12. Annual consumer experience reporting should be mandatory for all services and reported publicly. The evaluation metrics should be designed by consumers.

Digital Care and Safety

13. Digital tools should never be substituted for person-delivered relational care. Both models must guarantee minimum levels of person-delivered care.
14. Models must commit to eliminating coercive practices through genuinely trauma-informed care.

Drivers of the Youth Mental Health Crisis

The draft models of care accurately highlight the rapidly increasing rates of psychological distress among young people. The models frame this crisis primarily as a service supply issue, focusing on the ‘missing middle’ of young people who require a higher level of care than is offered by primary care, but do not meet the thresholds for tertiary public services.

We acknowledge that service gaps do indeed exist and support investment that meaningfully resolves them. Nevertheless, we contend that the youth mental health crisis is to a great degree a social crisis driven by economic, social, and political structures. Accordingly, mental health reform that focuses solely on expanding clinical services without addressing these social determinants of mental health is unlikely to keep up with increasing demand. If the conditions that create psychological distress, such as housing insecurity, poverty, wealth inequality, discrimination, and climate change, continue to persist, they will continue to perpetuate distress faster than services are able to expand.

The following sections further highlight the key role that social determinants of mental health play in driving the youth mental health crisis, and the evidence that service expansion alone has not improved outcomes.

Social Determinants of Youth Mental Health

Evidence clearly demonstrates that many of the most impactful drivers of psychological distress are not individual biological factors but are instead social and structural. Accordingly, analysis of the Household, Income and Labour Dynamics in Australia (HILDA) Survey from 2007 to 2021 by Baker and colleagues, found that increasing youth psychological distress over this period was significantly associated with the following factors: worsening loneliness, lack of social support, family relationships, participation in education and employment, reliance on government income support, and socioeconomic status.¹ Based on these results, the

authors urged all levels of government to invest in holistic, community-based, and socially focused interventions to meaningfully address the youth mental health crisis.

Key social determinants of mental health for young people in Australia include:

- **Housing Insecurity and Homelessness:** Housing insecurity has increased dramatically in recent years,ⁱⁱ with young people disproportionately affected.ⁱⁱⁱ Housing instability is one of the strongest predictors of poor mental health outcomes,^{iv} demonstrating a bi-directional relationship wherein housing instability drives psychological distress, and distress worsens instability.^v Despite this clear relationship, government investment in youth housing supports remains insufficient. For example, despite comprising 11% of Victoria's homeless population, young people receive less than five percent of social housing allocations.^{vi}
- **Poverty and Economic Inequality:** Unemployment, underemployment, insecure work, and financial insecurity create chronic stress, significantly worsening mental health outcomes.^{vii} Young people are yet again disproportionately affected, with the youth unemployment rate (11.1%) more than double the national rate (4.5%),^{viii} and children and young people experiencing poverty at a persistently higher rate than the general population.^{ix} Wealth inequality is also increasing in Australia^x and is associated with worsened mental health outcomes at individual, neighbourhood, and national levels.^{xi}
- **Educational Stress:** Mission Australia's 2025 Youth Survey reported that school or study issues were the most identified source of stress for young people over the past year.^{xii} This is unsurprising, given the Australian education system is built on a system of competition and high stakes assessment known to generate significant psychological distress.^{xiii} Bullying and victimisation has also been found to be a

strong predictor of youth mental health challenges.^{xiv}

- **Discrimination:** Discrimination, including (but not limited to) racism,^{xv} transphobia,^{xvi} homophobia,^{xvii} ableism,^{xviii} and sexism,^{xix} is a key driver of psychological distress for young people.
- **Climate Change:** Climate change has significant impacts on young people's mental health, both directly through the stressful impact of climate anxiety and severe weather events, and indirectly through exacerbating other social determinants.^{xx}

These determinants are shaped by broader policy, economic, and social conditions in which young people live. Housing is one such condition: international human rights law, including Article 11(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR),^{xxi} recognises adequate housing as fundamental to dignity, safety, participation, and wellbeing. Mental health policy that fails to address housing insecurity therefore fails to address one of the key structural conditions necessary for mental wellbeing.

Social determinants also intersect with and compound each other. Any clinical model that assesses severity of 'presentation' in isolation from these social conditions risks misinterpretation of the factors driving the young person's distress and potential appropriate supports.

The failure to address these structural conditions is inconsistent with Australia's obligations under international human rights law, including the United National Declaration on the Rights of Indigenous Peoples (UNDRIP),^{xxii} which recognises that health and wellbeing are inseparable from self-determination, culture, and social and economic conditions.

Given this, we welcome Headspace Plus's focus on providing a holistic model of care, particularly the inclusion of education and employment supports as core services. We propose that this framework should be extended further, with housing support provided as an in-house function. Similarly, the YSCC model should make Individual Placement and Support

(IPS) a mandatory rather than optional component of service delivery.

We also welcome the intention behind Headspace Plus's commitment to extending partnerships with external organisations, including schools, employment services, and housing and homelessness organisations. However, given the chronic under resourcing of these services and their inability to meet current demand, without concurrent investment these partnerships risk becoming warm referrals to closed doors.

What the Evidence Says About the Impact of Clinical Service Expansion

If social determinants are key drivers of youth psychological distress, evidence evaluating decades of service expansion shows the impact of addressing symptoms of a crisis rather than the cause.

Research evaluating the outcomes of the Headspace model raised concerns about the effectiveness of current clinical services despite significant investment. Research by Iorfino and colleagues in 2022 found that only 35% of young people attending Headspace demonstrated good functional outcomes after two years of care.^{xxiii} Similar findings were noted during broader scale research in 2025 that found less than one third of young people showed significant functional improvement.^{xxiv} Headspace's own Government-commissioned external evaluation found that most young people engaged with the service did not experience clinically significant improvements in psychosocial outcomes and noted a significant drop out rate, with 66% of young people attending for only one to three sessions.^{xxv} It is important to note that these poor outcomes were not confined solely to the 'missing middle' cohort that the proposed models aim to serve, indicating that higher intensity of a similar model is unlikely to achieve desired outcomes.

Analysis of youth mental health outcomes before and after the introduction of Medicare Better Access mental health services and Headspace concluded that, despite a very substantial increase in service usage over this period, there was no corresponding improvement in youth mental health outcomes. Instead, outcomes deteriorated from 2015 onwards,^{xxvi} suggesting that increasing demand may be driven by social

conditions not able to be addressed by clinical services alone. Consistent with this interpretation, modelling by Australian researchers Occhipinti and colleagues found that upstream investment in social determinants such as social cohesion and community connectedness could significantly reduce psychological distress and consequently reduce demand upon clinical youth mental health services.^{xxvii} These findings indicate that despite the importance of providing clinical supports, meaningful improvements in youth mental health outcomes are unlikely to be achievable without significant investment in the social conditions that shape wellbeing.

Consistent with the findings of the Productivity Commission, we argue that meaningful mental health reform must extend beyond clinical services provided by the health system and into housing, education, employment, justice, and community life.^{xxviii} Any effective model of early intervention must move beyond reactive clinical intervention and instead invest in addressing these structural social, economic, and political conditions that drive psychological distress.

Structural Concerns Related to Tiered Service Structure

The proposed reforms would create three tiers of federally funded youth mental health services: Headspace for “low to moderate” support needs, Headspace Plus for higher intensity needs, and YSCCs for more “severe” mental health challenges. Whilst the rationale of providing separate services for differing levels of clinical need may initially appear intuitive, it does not reflect young people’s actual lived experience of psychological distress. The models determine eligibility across two criteria, clinical staging of how ‘advanced’ a young person’s presentation is, and disorder prevalence, with low prevalence presentations (psychosis, eating disorders) determining eligibility for YSCCs. Both criteria reflect assumptions from physical medicine that do not translate effectively to a mental health setting. They also continue to perpetuate an outdated, clinical model of wellbeing, when we ought to be focussing on a rights-based approach instead.

A rights-based approach recognises that mental wellbeing is shaped not only by access to treatment, but by access to housing, safety, social connection, autonomy, participation, and freedom from discrimination and coercion. By framing distress primarily through illness severity and diagnostic categorisation, the proposed models risk overlooking these broader determinants and rights protections.

In physical health services, clinical staging is useful as illness progression generally follows a consistent, measurable, and linear pattern. Cancer staged at initial diagnosis generally follows a predictable course, with objective diagnostic testing able to confirm stages of severity. Mental health, however, does not conform to this pattern. No objective medical tests exist to confirm 'stages' of psychological distress. Mental health presentations fluctuate, sometimes rapidly, and are often unable to be confined to discrete diagnostic categories. A young person presenting with apparent 'moderate anxiety' at initial assessment may experience acute crisis soon after and re-present with suicidality or psychotic phenomena. Systems based on discrete illness staging categories do not reflect the lived reality of psychological distress. Separating clinical supports across tiers that require re-assessment and re-referral each time a young person's stage changes risks imposing costly administrative and emotional burdens on already vulnerable young people.

Triage systems based on severity rely on inherently imprecise and subjective clinical assessments that are often experienced by young people and family members/carers as gatekeeping. Consumers regularly report that the experience of being shifted between services due to being 'too unwell' for one service whilst 'not sick enough' for another service is one of the most harmful aspects of engaging with the mental health system. Creating further intermediate tiers of services does not eliminate this gatekeeping or movement between services, it merely increases the number of gates.

Age-based eligibility cutoffs create similar issues. Across most states and territories, youth mental health services cut off eligibility at 18 or 25. In reality, many young people receiving care before these cut-offs require

ongoing support beyond these timeframes. For many young people this results in an abrupt discharge from public mental health services as few meet criteria for adult services. This disruption in care can be profoundly destabilising for young people already experiencing significant distress.

Accordingly, we recommend that models should incorporate flexible eligibility criteria and transition arrangements that allow for care to be transitioned collaboratively with young people.

Lastly, the structure of the proposed models also raises significant workforce concerns. Staffing three separate tiers of federal youth mental health services operating alongside state and territory services and the broader primary care system places significant strain onto an already limited workforce. Dividing this workforce across further tiers risks leaving all tiers severely understaffed.

In summary, these structural concerns demonstrate that a system of severity stratified tiers of service is poorly suited to the fluctuating and complex reality of youth mental health.

An Alternative Model of Care

The structural problems identified above are the result of a model of care that separates public mental health services into additional severity stratified tiers. Instead, the Alliance strongly urges the government to redirect their investment towards strengthening and expanding existing state and territory public mental health infrastructure. The aim of this investment would be to create a single flexible model of care that has the capacity to respond to all young people's needs as they change, rather than separate discrete models all with their own thresholds to entry.

Each state and territory operates their own public youth mental health services across community, crisis, and inpatient settings. These pre-existing services are already embedded in local communities, have established governance and operational frameworks, employ specialist clinical workforces, and in many cases already provide services to the populations that the proposed models aim to target. In many jurisdictions,

specialist youth teams providing care to low-prevalence presentations such as early psychosis and disordered eating already exist but are severely under-resourced.

In practice, the fact there are so many young people missing out on essential mental health supports is a consequence of chronic underinvestment in existing state and territory public mental health infrastructure, not an absence of suitable providers. State and territory mental health services generally respond to their lack of capacity to meet demand by raising eligibility thresholds, excluding young people in genuine need of care, and increasingly restricting care to only the most severe and complex presentations. The solution to this problem is to provide investment to state and territory public mental health services so that they have the resources required to lower their thresholds and support young people so as not to create further federal services that operate in parallel.

An integrated model offers a multitude of inherent advantages over the proposed models:

- **Flexibility and continuity of care:** A single integrated model has more flexibility to respond to the changing needs of young people. Under this model, a young person who experiences deterioration in their mental health and requires additional support would not need to change services; instead, their care team could adjust supports as needed. An integrated model allows the same service to support a young person through changes in severity and diagnosis, reducing the distressing impact of disruptions in care.
- **Workforce:** Instead of recruiting and training separate workforces across multiple tiers, investment into existing state and territory services would build capacity and address current staff shortages, producing system wide gains.
- **Avoids duplication and complexity:** Young people and families already frequently report finding the mental health system complex

and difficult to navigate. Creating further tiers of service with their own eligibility criteria further increases this complexity. In contrast, integrating services would reduce barriers for young people seeking care.

These points are further reinforced by recent research conducted by Skinner and colleagues whose detailed modelling of Australian youth mental health services concluded that better system level outcomes are achieved when specialised high intensity youth mental health services provide care to all young people regardless of the initial 'severity' of their presentation.^{xxix} The modelling found that stepped-care approaches, which restrict access to specialised care until young people fail to respond to lower intensity interventions, can inadvertently delay effective treatment, increase disengagement from care, and contribute to progression to more severe psychological distress. In contrast, the researchers found that outcomes improved when young people were able to access specialised services earlier and more directly, irrespective of clinical stage. Notably, the modelling suggested that providing specialised care earlier in the course of distress was more effective at preventing deterioration than reserving these services solely for the most severe presentations.

The above is particularly relevant to the higher severity cohort targeted by YSCCs. YSCCs are described as serving young people who require more support than can be provided by primary care, but do not require tertiary state and territory-based services. In practice, this boundary is very difficult to maintain as young people presenting with the listed diagnoses of psychosis, eating disorders, personality disorders, and severe mood disorders frequently require periods of inpatient and crisis care delivered by tertiary services. By operating in parallel to these services, YSCC risks creating discontinuities in care that are especially harmful for young people already experiencing severe psychological distress.

There is also a significant risk that creation of additional federally funded youth mental health services will be used by states and territories as justification for reducing their own funding, further exacerbating service gaps. This risk applies to any model that directs new Commonwealth

funding into areas of existing state and territory responsibility, including the integrated approach we propose. It must therefore be managed directly, through co-commissioning arrangements with binding maintenance-of-effort requirements that prevent states and territories from reducing their own investment.

We acknowledge that public youth mental health services differ substantially between states and territories and that state-federal relationships across each of these services are complex. Nevertheless, we urge Government to explore models involving genuine integration, such as co-commissioning services, joint governance arrangements, and shared workforce frameworks.

Regardless of which final model(s) the Department chooses to implement, they must ensure that continuity of care is maintained for young people wherever possible so that young people do not have to engage with new supports whenever their presentation changes. Furthermore, models should ensure a genuine 'no wrong door' approach wherein immediate support is provided to young people regardless of which service they present to. These goals are far more achievable within an integrated model than across separately managed services.

We also recommend that the final model(s) include explicit and enforceable integration protocols with state and territory mental health services that require PHNs to demonstrate genuine engagement with these services in their commissioning plans. This should include joint care planning for shared consumers, coordinated transfers of care, and data arrangements that enable coordinated care without requiring young people to repeatedly reshare personal information.

Genuine Co-design and Consumer Governance

Both models of care highlight the importance of embedding lived experience throughout service design, delivery, and governance. In particular, the YSCC highlights lived experience co-design as a core approach within all aspects of the service. The Alliance welcomes these commitments; however, our concern is the frequent gap between the

aspirational language of co-design and its implementation in practice. Often, mental health services use the language of co-design to describe processes that are merely consultative in practice rather than engaging consumers in genuinely impactful decision making. Genuine co-design will require that youth lived experience, along with lived expertise provided by peak bodies, shapes decisions throughout the design and implementation of these models, rather than merely informing them. The YSCC's stated commitment to co-design provides a strong foundation that the Headspace Plus model would benefit from adopting. This is also consistent with Australia's obligations under the United Nations Convention on the Rights of the Child (UNCRC), which affirms young people's right to have their views heard in decisions affecting them (Article 12)^{xxx}, alongside Article 7 of the Convention on the Rights of Persons with Disabilities, which requires that children with disabilities are enabled to express those views freely and have them given due weight.

That both models highlight peer support as a core service function is also welcome. It is essential, however, to ensure that peer support is substantively integrated within services, rather than a peripheral support. In practice, peer support is often one of the least resourced areas within clinical services, with peer support workers operating within poorly defined roles that have limited authority or capacity for career progression.

Genuinely effective peer support services require minimum ratios of peer support staff, defined career pathways, lived experience supervision for staff, fair remuneration, and peer support integration within leadership and governance structures.

Accordingly, the Alliance recommends:

- Future versions of the models of care include consumer-led working groups with decision-making authority, with co-design commitments commencing whilst parameters of the services are still open and continuing throughout the development and service delivery process. Co-designers must be appropriately resourced and remunerated.

- Governance frameworks for both models should include consumer lived experience representation at all levels, including board composition (including within lead agencies).
- Services should commit to mandatory regular public reporting on consumer experience using consumer developed measures.

Workforce Considerations

Australia's mental health workforce is under severe and worsening strain, with significant staffing shortages across mental health professions, especially in regional, rural, and remote areas. Despite significant increases in the mental health workforce over the past decade,^{xxxix} available supply has continued to be significantly outpaced by growing demand.^{xxxix} A survey of Australian psychiatrists undertaken by RANZCP found that over 90% of psychiatrists believed staffing shortages were harming patient care, and 82% felt that shortages were driving staff burnout.^{xxxix} As acknowledged by the National Mental Health Workforce Strategy 2022–2032,^{xxxix} chronic staff shortages are a predictable consequence of mental health services' frequently excessive caseloads, combined with inadequate supervision, pay, and organisational support. Despite this, neither model meaningfully addresses these issues.

Creating two additional tiers of youth mental health services will either draw staff away from already chronically understaffed state and territory services or will leave Headspace Plus and YSCC positions unfilled. This significantly impacts the feasibility of the YSCC model's stated goal of providing highly specialised workforces across specific diagnostic categories. This is substantially more achievable through investing in and building upon the pre-existing state and territory workforce, rather than creating similar structures that compete for the same staff.

As noted in the prior section, both models commendably highlight the importance of peer support as a core service function. In practice, the challenge in delivering this service is creating the conditions that allow for a well-supported and effective peer workforce. A growing body of research has highlighted the value of peer work in improving engagement and outcomes for young people,^{xxxv} particularly those who find mainstream

clinical services unsafe or unappealing. Implementing effective peer support in practice requires implementing a minimum ratio of lived experience workers to other staff, clearly articulating their distinct contribution to care, and addressing the frequently exploitative conditions of the peer support workforce including inadequate pay, limited job security, and inadequate workplace support.

We recommend that the workforce strategy for both models include:

- Substantial investment in the lived experience workforce, including guaranteed adequate pay and conditions as well as access to peer supervision and career development.
- Tangible and sustained action addressing the systemic drivers of public mental health staff burnout and attrition.

Digital Mental Health Care

Both models of care propose digital mental health interventions as a core component. The Alliance is concerned that despite the models' reported commitment to holistic and relational care, in practice, digital mental health tools may accelerate the replacement of human delivered care with cheaper digital interventions. Evidence clearly demonstrates that high quality therapeutic relationships built over time are a key predictor of positive mental health outcomes, regardless of intervention type.^{xxxvi}

Digital tools are also associated with data security, privacy, and accessibility concerns, particularly for young people already experiencing barriers to accessing care. The Alliance is also concerned about the lack of regulation over digital tools, including those that purport to use clinically valid methods.

Accordingly, the Alliance is concerned that the models of care lack sufficient protection against risks associated with digitally delivered care. We therefore recommend:

- Models should include explicit minimum guarantees of person-delivered care. Digital tools should only be used as an additive, not

substitutive intervention.

- Models must include prohibition on consideration of digital service contacts as equivalent to person-delivered care within reporting and funding frameworks.
- Any digital tools utilised should be co-designed with young people and include explicit data security and privacy provisions and be submitted to the TGA and other relevant regulators for approval as a digital mental health tool regardless of the clinical theories used.

Coercive Practices

Coercive practices are used at alarming rates throughout youth mental health settings,^{xxxvii} especially in under-resourced services that lack viable alternatives. Coercive practices including physical, chemical, mechanical, and psychological restraint, and seclusion cause significant harm, not only to young people subject to them, but also for the staff who engage in or witness these practices.^{xxxviii}

These practices also raise significant human rights concerns. Article 15 of the CRPD recognises the right of people with disability to freedom from torture or cruel, inhuman or degrading treatment or punishment.^{xxxix} Other international human rights frameworks, including the International Covenant on Civil and Political Rights (ICCPR)^{xi} and the Optional Protocol to the Convention Against Torture (OPCAT),^{xii} similarly emphasise the rights to liberty, safety, dignity, and freedom from ill-treatment. The continued use of coercive practices within youth mental health settings is difficult to reconcile with these obligations, particularly where services are inadequately resourced to provide rights-based alternatives. Given the well-documented harms associated with restrictive practices, mental health reform should focus on eliminating coercion through investment in trauma-informed, relational, and rights-based approaches to care.

Despite widespread perception that coercive practices are necessary, research demonstrates that reducing coercive practices is associated with lower levels of violence and distress experienced by both consumers and

staff. Accordingly, we urge Government to ensure that both models explicitly commit to eliminating the use of restrictive practices through embedding trauma-informed de-escalation approaches.

Conclusion

The Alliance welcomes the Government's commitment to improving mental health outcomes for young Australians. We support increased investment in youth mental health services and recognise the urgent need for reform. At the same time, this investment must be designed around continuity of care and connected to the social conditions that drive distress and not delivered in isolation from them. Nevertheless, evidence from both lived expertise and clinical research demonstrates that the effectiveness of investment depends not only on the scale, but on the underlying assumptions underpinning the system it seeks to strengthen. Increased investment can improve capacity; it cannot by itself overcome the limitations of a model that is not designed to address the primary drivers of psychological distress.

A tiered system of separate clinical services, even if well resourced, coordinated, and evidence-based, cannot, on its own, resolve a crisis driven substantially by social and economic conditions. Housing insecurity, poverty, discrimination, climate anxiety cannot be solved by therapeutic intervention alone. The social determinants of youth mental health are structural problems that require structural solutions. These are not merely policy failures, but failures to uphold the social and material conditions necessary for young people's dignity, wellbeing, and human rights. Without substantial investment in these social determinants, demand for clinical services will persistently outpace supply.

The Government's \$700 million commitment represents an exceptional opportunity to fundamentally reconsider the purpose and design of youth mental health investment in Australia. Rather than focusing solely on service expansion that reactively responds to distress, this investment could support a genuinely comprehensive approach that addresses the

social, economic, and political conditions that contribute to psychological distress in the first place. By investing in both prevention and intervention,

Australia could move beyond reactively responding to overwhelming demand for services towards actively creating the conditions that allow young people to thrive.

We call on Government to seize this opportunity by funding services that address social determinants of mental health alongside clinical need; integrating these services with existing state and territory infrastructure to avoid duplication; centring young people's lived expertise in governance, leadership, and service design; and measuring success by considering improvement in young people's *lives*, not just their symptoms.

We thank the Department for the opportunity to contribute to this consultation.

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See nmhca.org.au for more information about the Alliance.

For questions about this submission, please contact us at policy@nmhca.org.au.

Recognition of Lived Experience

As a consumer lived experience-led organisation, the National Mental Health Consumer Alliance values the skill and expertise of consumers with lived experience. We pay tribute to those we have lost for the work that they have done to advocate for our rights. We acknowledge that we stand on the shoulders of giants who have paved the way for the rights we have today, and we will continue their work today and every day until the mental health system recognises and upholds our human rights.

Nothing about us without us.



ENDNOTES

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