[PRODUCTIVITY COMMISSION SUBMISSION]:

From Systems Thinking to Embedded Lived Experience Leadership, A Blueprint for Transforming Australia's Mental Health and Suicide Prevention System

Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network)

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Acknowledgement

LELAN acknowledges the Traditional Custodians of the lands we live, work and play on. We pay our respects to elders – past, present and emerging, and the long and ongoing connection and relationship they have with Country. We acknowledge that this land was never ceded.

We are grateful for the privilege of sharing this land and recognise and are sorry for the historic and continued cost of that sharing to First Nations People.

ABOUT LELAN

LELAN is the independent peak body in South Australia *by*, *for* and *with* people with lived experience of mental distress, social issues or injustice.

Our systemic advocacy targets the mental health and social sectors in South Australia, whilst our thought leadership and expertise on lived experience, leadership and governance is borderless.

By centring the experiences, collective insights and solution ideas of people with lived experience in all of our work, as well as being immersed in the lived experience community from grassroots to strategic and governance levels, we demonstrate the principles, practices and change dynamics that the social sector is calling for and desperately needs.

We have extensive experience and a proven methodology for leading lived experience-led and/or co-creation initiatives, frequently with a focus on sensitive issues and including groups that bring divergent perspectives to the conversation.

LELAN's vision of a world where people experiencing distress retain their dignity, autonomy and human rights – no matter what, will be achieved when:

- The capability, influence and expertise of people with lived experience and lived experience communities have grown.
- People with lived experience and lived experience communities have authentic partnerships within the mental health and social sectors.
- Lived experience led systems reforms that directly benefit people with lived experience and the community are common practice.
- LELAN's thought leadership and innovation are recognised as industry leading and are recognised as industry leading and influence best practice standards.
- LELAN is a strong, sustainable and impactful organisation.

LELAN was founded in 2017, pivotal pieces of work completed in partnership and/or led by us with the lived experience community include the groundbreaking *Model of Lived Experience Leadership* that launched in 2021, as well as *The Lived Experience Governance Framework* and *A Toolkit to Authentically Embed Lived Experience Governance* that were released in July 2023 (all available at www.lelan.org.au/shared-resources).

LELAN'S APPROACH

This submission responds to the Productivity Commission's Interim Review of the National Mental Health and Suicide Prevention Agreement and reflects the views of LELAN, the South Australian consumer peak body for people with lived experience of mental distress, social issues, and injustice. It draws upon our localised systemic advocacy, collective lived expertise and thought leadership on embedding lived experience within organisations and systems across Australia.

The current National Mental Health and Suicide Prevention Agreement ('the Agreement') has failed to deliver the transformational change that people with lived experience and allies have long called for. Despite pockets of progress, there has been little to no structural shift toward community-led, culturally responsive, peer-informed models of care. Instead, we continue to see fragmented services, underinvestment in prevention, and governance processes that exclude or tokenise lived experience autonomy, contributions and leadership. As the Commission has rightly found, *there has been little systemic change* and the Agreement is *not fit for purpose*.

Through this submission LELAN outlines a blueprint for creating a mental health and suicide prevention system that works for the people it serves.

Our approach recognises that transformational reform must begin with the **right system thinking**. We cannot achieve change where a common vision or agenda across levels of government and jurisdictions is missing, within the confines of an entrenched and narrow biomedical paradigm and a fragmented policy architecture. Reform must be grounded in a systems change approach that embeds human rights, addresses social determinants, dismantles structural inequities and is informed by the insights, solution ideas and decision-making authority of those most impacted by the system.

From this foundation, we need the **right mechanisms**. Bilateral agreements are the structural 'bridge' that connects national priorities with state and regional level delivery; they are critical to aligning reform efforts across jurisdictions. They must include clear, integrated frameworks, articulate Commonwealth and state responsibilities, and set nationally consistent standards that sit outside of political cycles and party rooms to ensure coherence across a federated system.

For this to operate as a functioning ecosystem, it must be underpinned by **a robust accountability structure**—both top-down and bottom-up. Independent oversight, agreed measurement approaches, transparent performance reporting, and community-led monitoring are essential to track progress, enforce standards, and ensure reform efforts are coherent, consistent, equitable and remain anchored in what matters to the people they are meant to serve.

Only when this scaffolding is in place can we meaningfully address **unmet needs** by ensuring a spectrum of responses from community-based to clinical options are available that are tailored to need and promote choice. This includes investing in psychosocial supports for people excluded from the NDIS, expanding access to relational and community-led models of care, and fully recognising and resourcing the **Lived Experience (Peer) Workforces** as an immediate, practical solution to ongoing service gaps and as a core pillar of the system with its potential yet to be realised.

Finally, the submission closes the loop where it begins: with **lived experience leadership and Lived Experience Governance**. Embedding lived experience at all levels is not only key to disrupting entrenched paradigms and influencing system thinking because of the embodied knowing that lived expertise brings to life, but also to designing mechanisms, services and governance structures that reflect community realities. If we fully invest in lived experience—as core infrastructure and as a driver of reform—we create a **virtuous cycle**, where the rights, insights and contributions of people with lived experience continuously strengthen the system, its mechanisms, and its ability to meet their needs and priorities.

To deliver not just incremental improvements but a transformed, equitable and person-driven and -led mental health and suicide prevention system LELAN puts forward the following:

- **Start with system-level foundations** to shift thinking and build structural coherence.
- **Strengthen mechanisms and accountability** to create an integrated, functioning ecosystem.
- **Address unmet needs through immediate solutions**, particularly psychosocial supports and the lived experience (peer) workforces.
- **Meaningfully embed lived experience everywhere**, enabling it to permeate everything and closing the loop to drive sustainable reform. The result will be a system that learns, adapts, and improves from the ground up.

Each section includes a clear statement of the issues, alignment with relevant draft findings and recommendations from the interim report, supporting evidence and practical recommendations.

LELAN welcomes the opportunity to contribute to this critical national conversation and stands ready to partner in building a more just, inclusive, and effective mental health system.

CROSS-REFERENCING TABLE

The table below maps LELAN's recommendations and information against the Productivity Commission's draft findings, recommendations and information requests to assist with cross-referencing.

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[SECTION 1]: SYSTEM TRANSFORMATION REQUIRES THINKING SYSTEMICALLY. WE HAVE THE RIGHT AMBITION BUT WRONG THINKING

The National Mental Health and Suicide Prevention Agreement ('the Agreement') aspires to create a more effective, equitable, and person-centred system. This ambition is undermined by outdated, narrow thinking. Rather than adopting a systems change approach that reflects the complexity of mental health and its social determinants, the Agreement remains confined within a narrow biomedical paradigm.

This mismatch of right ambition and wrong thinking has stalled progress, reinforced fragmentation, and failed to deliver meaningful transformation for consumers and the broader community. As the Productivity Commission notes in **Draft Finding 2.1**, there has been ***little systemic change*****,** and despite reform efforts, the system remains ***not fit for purpose*****.**

To understand why, we must examine the fundamental flaws in the Agreement approach.

Lack of Strategic Vision

The Agreement misses a key opportunity to align with significant recent reforms – most notably the *Royal Commission's Inquiry into Victoria's Mental Health System*. The inquiry outlined a nationally significant blueprint for change grounded in lived experience leadership, human rights, and community-based responses. Yet the interim report makes little reference to this work, weakening national coherence and momentum.

LELAN supports the Productivity Commission interim report's call for ***a renewed National Mental Health Strategy*** **(p2)** to provide a clear, unifying vision for the future. Without such a strategy, reform efforts risk remaining fragmented and reactive, driven more by political imperatives than by agreed, system-wide planning.

Reform cannot succeed within three-to-four year political cycles. Yet the Agreement continues to be constrained by electoral cycles and a lack of political will for enduring change. True reform must be staged, resourced, and guided by shared goals and long-term accountability across jurisdictions. Without structural and political shifts, systems will continue to default to quick fixes that that they can see and touch yet fail those most in need of care and support.

A Biomedical Paradigm Not in Sync with What Consumers Want More Of

The current Agreement reflects a narrow and dominant biomedical paradigm – one that frames distress as a disorder to be treated in clinical and acute settings, rather than a human experience shaped by trauma, social context, and systemic injustice that calls for healing through connection and community.

This paradigm extends beyond clinical or acute settings only, deeply influencing non-clinical services, governance arrangements where clinical governance trumps everything, and funding contracts. Many community-based and psychosocial programs remain saturated by biomedical frameworks, where medical gatekeeping, compliance-focused outcomes, and risk-averse practices overshadow holistic, relational, or rights-based approaches. Without deliberate structural change, mental health and suicide prevention systems will continue to reproduce models of care that fail to reflect the diverse ways in which people

understand and seek support for their mental health, constrain people's autonomy, choice and control and silence lived experience.

As a result, reform efforts have focused on expanding access to clinical services rather than transforming the conditions that create or compound distress. Structural inequities, cultural disconnection, coercive practices, and disempowerment remain unaddressed. While biomedical approaches currently dominate the system, this leaves little room for people to access other forms of support that may better reflect and address their needs, values, experiences and preferences. On their own, biomedical models cannot create the conditions for inclusion, recovery and healing.

Fragmented Implementation as A Symptom of Wrong Thinking

As the Productivity Commission highlights in **Draft Findings 2.1 and 2.2**, fragmented and short-term implementation reflects the absence of a systems thinking and transformational change approach. Government have relied on disconnected initiatives, short-term pilots, and siloed funding, with weak governance and unclear roles. The limited integration of co-design, let alone awareness of or commitment to the higher standard of co-production, and embracing lived experience leadership have only deepened divisions.

This incremental approach prioritises outputs over outcomes and fails to establish the structural scaffolding necessary for meaningful change. Without a systems approach, reform becomes transactional and reactive, rather than strategic, power shifting and transformative.

These challenges are magnified within Australia's federated system, where reform must operate across both federal and state/territory levels. The absence of shared vision and investment across jurisdictions and levels of government creates duplication, competing priorities, and additional points of tension that stall progress. As a result, reform becomes fragmented not only nationally but also within individual states and territories, undermining efforts to deliver cohesive, equitable change.

The systems reform required rests on a fundamental shift in power, narrative, and accountability. It requires privileging consumer experience, embedding human rights, investing in community-based and peer-led responses, and creating flexible structures capable of responding to the complexity and diversity of mental distress. Without this shift, the system will continue to reproduce exclusion, coercion, and disempowerment.

RECOMMENDATIONS:

- Aligned with **Draft Recommendation 4.1**, extend the next iteration of the Agreement beyond election cycles to allow for long-term transformation, with a minimum of five-year rolling commitments to ensure continuity and impact.
- Shift the overarching paradigm of the Agreement from a biomedical, service-centric model to a rights-based, whole-of-community approach grounded in equity, prevention, and social determinants of health.
- Adopt and integrate the reform blueprint outlined by the Royal Commission into Victoria's Mental Health System, including lived experience leadership, non-clinical models, and human rights protections.

- Embed Lived Experience Governance at all levels of the system, including national and state/territory peaks, to ensure accountability and legitimacy in reform (more about this recommendation in Section 6 of this submission).

[SECTION 2]: REFORM NEEDS STRONG FOUNDATIONS. WE HAVE GOALS BUT WRONG MECHANISMS TO ACHIEVE THEM

The current Agreement aspires to deliver reform but is constrained by mechanisms that are not fit for purpose. Despite clear goals, at least around activity and outputs, the tools and structures used to implement the Agreement—its policy architecture, bilateral agreements, funding mechanisms, and supporting schedules—are misaligned with the complexity of mental health and suicide prevention reform.

Instead of building the scaffolding needed for integrated, long-term change, these mechanisms entrench fragmentation, short-termism, and inequity. Consequently, little progress has been made.

Policy Architecture Is Not Fit for Purpose

LELAN echoes the Productivity Commission's assessment that the current policy architecture underpinning the Agreement is fragmented, opaque, and lacks a coherent logic model. There is no clear or measurable connection between the Agreement's goals, the initiatives being funded, the outcomes being pursued, and the people and communities they are intended to support.

Without clear mechanisms to align federal and state/territory priorities, gaps emerge in implementation responsibility, oversight, funding accountability, and performance monitoring. National strategies often fail to translate into effective state-level delivery, while state-led initiatives frequently lack the national policy frameworks or investment needed to sustain them.

LELAN therefore welcomes the Commission's call to co-design a new policy architecture. We particularly support **Draft Recommendation 4.3,** which highlights the importance of connecting mental health and suicide prevention policy with surrounding systems such as housing, justice, disability, and social services. The reform agenda must reflect the impacts of trauma and complexity of people's lives and address the interdependent social determinants that shape mental health and wellbeing.

A reimagined policy architecture must be purpose-built to drive system-wide reform. It should be informed, influenced, and led by lived experience, grounded in human rights, and centred on dignity, autonomy, choice, and control. Lived experience must not be treated as an afterthought or token inclusion, but as a powerful lever for redesigning policy and shifting toward person-centred, community-driven care.

It is essential that people with lived experience, including representatives from the National Mental Health Consumer Alliance, Mental Health Carers Australia and state/territory lived experience peak bodies, are embedded in the design and governance of this architecture to ensure its relevance, legitimacy, and impact at each level of government.

Bilateral Agreements Are Critical but Fragile

Bilateral agreements are central to implementing the Agreement, yet these agreements remain politically fragile, inconsistently structured, and disconnected from community-led priorities and self-determined preferences for care and support by consumers. They are often tied to or influenced by electoral cycles, particularly in the South Australian experience from 2022, leading to fragmented delivery, variable commitments, and level of investment not matched to population or burden across states and territories. The absence of legislated, co-designed national minimum standards exacerbates these inequities.

In the Interim Report, the Productivity Commission underscores this challenge, noting that 'quality care' remains undefined and that no shared mechanisms exist to measure or guarantee it. Without a co-designed, nationally agreed definition of quality, grounded in consumer experiences and expertise, it is impossible to meaningfully evaluate outcomes or ensure accountability.

Further compounding this issue is the lack of transparency between bilateral schedules and national strategic objectives. This weakens system coherence, limits joint planning, and undermines evaluation. For bilateral agreements to achieve their intended purpose, they must be reimagined as instruments of reform—anchored in shared standards, clear accountability, and community-defined measures of quality care that are publicly reported.

Co-Funding Commitments Keep Falling Short

In principle, bilateral agreements should be the bridge between federal ambition and state/territory delivery. While shared federal-state funding is a structural feature of the Agreement, it has not translated into investment at the scale or depth required to meet community needs. The Agreement itself ***contains only limited funding commitments*** **(p. 5)**, and many of its key actions remain unfunded, leaving reform efforts underpowered from the outset.

Current arrangements continue to reflect a maintenance model – funding the status quo and less than the known level of 'burden of disease'– rather than enabling the shift to a system that supports true prevention, early intervention, and genuine choice in care. This is particularly evident in areas where states and territories underinvest relative to population need, or where state-level oversight fails to uphold agreed national standards. Without joint accountability and strategic coordination, bilateral agreements risk reinforcing gaps rather than closing them.

Hospital and crisis responses continue to absorb most of the investment, while community-led, culturally responsive, and peer-informed and peer-led services remain underdeveloped and under-resourced. This imbalance reinforces a reactive system, one that intervenes too late, in the wrong place, and often in ways that do not align with consumers rights, needs and preferences.

Further compounding this, there ***is no funding allocated to enable collaboration between the different parts of government working to improve mental health and suicide prevention outcomes***. Without resourced mechanisms for cross sector, cross levels of government and cross portfolio planning—spanning health, housing, justice, education, and social services—efforts to address the impacts of trauma and the social determinants of mental health remain siloed.

Lived Experience Peak Bodies Are Essential but Currently Underutilised

Lived experience peak bodies are essential structures for system reform. Consumer peaks exist formally nationally and in every jurisdiction with the exception of the Northern Territory where a pilot is currently in place. The consumer peaks hold critical roles in ensuring the collective experiences of consumers are heard and responded to, as well as translating national policy into locally responsive opportunities and action for consumers.

The role of consumer peak bodies is inconsistently recognised and funded across jurisdictions by state/territory governments. Wide variations in per capita funding for consumer peaks and/or certainty of funding are in place that undermine national equity and the peaks' capacity to contribute fully or lead in the reform work required. Additionally, peer-led and lived experience peaks in most jurisdictaions have to

date been excluded from bilateral agreement negotiations and implementation despite the Agreement's stated commitment to the recognition of people with lived experience.

Federated reform cannot succeed without lived experience leadership. These consumer peaks, at both national and state/territory level, must be formally embedded in the planning, delivery, monitoring and governance of bilateral agreements. Their involvement is not symbolic; it is fundamental to creating a system that includes and reflects the people it is intended to serve.

This being said, the inclusion of peak bodies must complement, not replace, the direct involvement of people with lived experience most impacted or excluded by the policy and service environment, particularly those from underserved and marginalised communities or with intersectional experiences and identities. Peaks bring a high-level, continuous, collective input that is strategic and systemic, shaping reform agendas over time rather than representing individual experiences in isolation.

To be effective, reform must leverage both: the systemic vantage point of peaks, which can hold governments accountable and align reform within and across state/territory jurisdictions, and the lived experiences of those currently using, or sometimes actively avoiding, services and those most impacted by policy and political decisions.

Dedicated Schedules Are Important but Incomplete

The inclusion of dedicated schedules within the Agreement, particularly for Suicide Prevention and Aboriginal and Torres Strait Islander Social and Emotional Wellbeing, is a positive development. These areas deserve focused attention, tailored actions, and targeted investment.

As noted in **Draft Recommendation 5.1**, the Productivity Commission supports a dedicated Aboriginal and Torres Strait Islander schedule. However, this schedule must not simply be co-designed—it must be led by Aboriginal Community Controlled Health Organisations (ACCHOs) and those with cultural authority. This leadership is essential to ensure the schedule is grounded in self-determination, cultural legitimacy, and the priorities of Aboriginal and Torres Strait Islander peoples. **Draft Recommendation 6.1** similarly calls for Suicide Prevention to remain a distinct schedule in the next Agreement.

Despite these positive commitments, the schedules have the potential to remain underdeveloped disconnected from a unifying framework. It is imperative that they align with the broader reform agenda, Without this, there is a risk of entrenching silos and fragmentation.

As the Productivity Commission notes, the current Agreement lacks a cohesive policy architecture capable of driving whole-of-system reform. The absence of an overarching, integrated framework across schedules will limit their effectiveness and reduce their ability to address the interconnected social determinants that shape mental health outcomes. Schedules must be designed as levers for transformation, not as symbolic standalone documents - a point underlined by **Draft Finding 6.1**, which notes that while policy intent in Suicide Prevention has improved, outcomes remain largely unchanged.

To be effective, schedules must be operationalised through coherent overarching bilateral agreements and supported by appropriate funding, co-produced implementation plans, and lived experience leadership. Without these elements, even well-intentioned schedules risk becoming symbolic rather than transformative.

A Dedicated Non-Clinical Supports Schedule is Missing, It is Necessary

A major gap in the current Agreement is the limited recognition of and scope for the role of non-clinical and community-based or peer-led approaches to mental health and suicide prevention despite growing national and international evidence speaking to their effectiveness. Supports such as safe spaces, community hubs, lived experience navigation services, and peer-led alternatives to emergency departments have been consistently shown to reduce crisis escalation, prevent unnecessary hospitalisation, and offer meaningful support outside of clinical settings. Beyond these benefits, they also align with what LELAN overwhelming hears from consumers about their experiences with current services and what they would prefer to choose.[1]

The importance of this type of reform is reflected in **Information Request 4.1**, which invites feedback on the inclusion of additional schedules in the next Agreement. LELAN's recommendation to establish a standalone Non-Clinical Supports Schedule directly responds to this request and reflects an urgent need to rebalance the system.

Crucially, such a schedule would also address the barriers to systems change identified throughout this submission. The dominance of the biomedical paradigm continues to crowd out non-clinical, relational, and rights-based approaches. Establishing a Non-Clinical Schedule would provide a structural mechanism to counter this imbalance and embed system reform principles into the Agreement itself.

These supports are not peripheral; they are essential components of a responsive, compassionate, and effective mental health and suicide prevention system. They provide trauma-informed, rights-based, and culturally responsive care that meets people where they are, fosters trust, and supports recovery on people's own terms. For many, they are the only accessible or acceptable form of support. Yet without formal recognition or structural investment, these services remain underfunded, unmeasured, and at constant risk of being sidelined or decommissioned.

A dedicated Non-Clinical Schedule would signal a much-needed shift away from a system that defaults to acute and hospital-centric responses, and toward one that values prevention, peer support, and relational care. It would provide a platform for embedding lived experience leadership and enabling genuine choice in how people access mental health support.

RECOMMENDATIONS:

- Co-design a new national mental health policy architecture with a clear logic model: long-term goals, intermediate outcomes, and funded deliverables, led by lived experience and connected to social systems (**Draft Recommendation 4.3**).
- Decouple bilateral agreements from political cycles and introduce legislated, co-designed national minimum standards for service delivery and outcomes.
- Define 'quality care' through a co-design process led by people with lived experience, ensuring metrics reflect what matters to consumers.
- Mandate inclusion of aftercare and continuity of care as standard components in all bilateral agreements, with funding tied to evidence-based and culturally responsive models.

[1] As evidenced in LELAN's *One Radical or Innovative Idea Report* that spotlights the experiences of over 500 people with lived experience. Available here.

- Introduce legislated, per capita funding benchmarks that reflect community needs and ensure equitable investment across jurisdictions, indexed to population trends and service demand.
- Shift investment away from hospital-centric responses towards prevention, early intervention, and peer-led community-based care.
- Formally recognise and fund the role of lived experience peak bodies at both state/territory and national levels, in bilateral agreement governance and reform implementation.
- Have schedules for Suicide Prevention and Aboriginal and Torres Strait Islander Social and Emotional Wellbeing, but embed them within a coherent, integrated system reform framework to prevent siloed implementation.
- Introduce a new schedule focused on non-clinical supports as proposed in response to **Information Request 4.1**.
- Ensure all schedules are co-designed with people with lived experience, and include culturally responsive, and trauma-informed outcome measures, embedded accountability and lived experience oversight, in line with **Draft Recommendation 4.2**.

[SECTION 3]: ROBUST ACCOUNTABILITY STRUCTURES ARE ESSENTIAL. WE HAVE A SYSTEM WITHOUT CONSEQUENCES FOR ITS INACTION AND HARMS

Australia's mental health and suicide prevention system lacks the robust accountability and performance structures required to drive enduring reform. While ambition is high, there are few ***consequences for stalled progress*** **(p. 9)**, and mechanisms for independent oversight remain weak. Performance measures rely too heavily on self-assessment by jurisdictions, with no standardised, transparent system for tracking outcomes or compelling action where reform falters.

This lack of authority and accountability is compounded by the system's federated structure. National, state/territory, and regional actors operate in silos, with insufficient alignment between national oversight, state-based planning and governance, and local commissioning.

Without a clear performance framework spanning all levels of government, reform risks remaining fragmented, reactive, and disconnected from the lived realities of the people it is meant to serve.

National Accountability Held by an Inadequate National Mental Health Commission

The current iteration of the National Mental Health Commission lacks authority, ambition, and courage. LELAN supports **Draft Recommendation 4.6** regarding the establishment of the National Mental Health Commission (National Mental Health Commission) as an independent statutory authority, and agrees with **Draft Finding 4.1** that a new, more effective National Agreement is urgently required that is best monitored and reported on by the National Mental Health Commission.

However, independence alone will not guarantee success. LELAN supports **Draft Recommendation 4.10**, which highlights the need for proper resourcing and strong legislative authority for the National Mental Health Commission.

To fulfil its role effectively, the National Mental Health Commission must be empowered to compel the provision of information across jurisdictions, impose consequences for stalled progress, report independently and transparently, and provide a consistent and accurate national picture of progress. Equally important is the embedding of a learning and adaptive culture within the National Mental Health Commission —one that is improvement-focused and committed to ongoing reflection, innovation, and system transformation.

Independent reporting is not merely a technical exercise—it is a critical mechanism for building trust, particularly with people who have been historically harmed, excluded, or silenced by mental health and suicide prevention systems. It fosters transparency, cross-jurisdictional learning, and genuine accountability.

While **Draft Recommendation 4.6** calls for improved transparency and collaboration, it is the formal inclusion of people with and the expertise of lived experience in governance and decision-making roles that will determine success. Without lived experience at the heart of its work, the National Mental Health Commission risks replicating the power imbalances it is meant to challenge.

The National Mental Health Commission must work in genuine partnership with the national lived experience peak body and recognise their leadership, expertise, and connection to communities. This body holds a significant role in holding systems to account based on consumer perspectives. Its strength lies in its federated model, where governance and decision-making power are shared equally between national and

state-level bodies, ensuring local context, lived experience, and community priorities shape national direction.

Seizing this moment requires more than rhetoric. It demands the courage to reform the system beyond the narrow interests of those who have long dominated it—government departments resistant to power-sharing, organisations and professions that marginalise lived experience voices, and legacy institutions prioritising self-preservation over transformation.

True reform means centring the leadership of those most affected by the system—not as a symbolic gesture, but as a structural commitment embedded in policy, service design, decision-making and accountability mechanisms at every level.

Local Accountability Through Inflexible and Highly Variable Primary Health Networks (PHNs)

LELAN calls for careful reconsideration of the role that Primary Health Networks (PHNs) play in the mental health and suicide prevention system. While the current Agreement delegates significant commissioning responsibilities to PHNs, there is a lack of structural oversight or consistency to ensure these responsibilities are exercised equitably, are aligned with community needs, and are responsive to lived experience advocacy and involvement in decision-making.

There is significant variability across PHNs in how they fund, evaluate, and incorporate lived experience insights and preferences into service design, delivery, and commissioning. Some PHNs have been open to peer-informed, influenced, and led and governed models, while others continue to prioritise biomedical approaches that do not reflect community preferences or contemporary practice.

LELAN stresses that lived experience-led and community-led models are not peripheral—they are essential to a rebalanced and effective system. Innovation in commissioning must include resourcing, valuing and creating space for these approaches on equal footing with traditional service models. If this is to be realised an evolution of current governance arrangements and approach to risk will need to emerge. If this does not occur full fidelity to peer values, principles and practices will be constrained and proof of concept will be tainted.

The Productivity Commission's suggestion to explore procurement standardisation (p.15) is welcome. LELAN supports the development of minimum national procurement standards to ensure fairness, transparency, and the inclusion of lived experience in commissioning processes. Importantly, these standards must be a baseline, allowing PHNs the scope to go further and embed community co-design/production, processes and practices aligned with Lived Experience Governance, and innovative local approaches in decision-making.

Evaluation Must Reflect What Matters

The Productivity Commission highlights difficulties in evaluating the impact of commissioned services, citing inconsistent monitoring and incomplete data. Information Request 4.3 seeks feedback on the feasibility of tracking and reporting progress against the objectives of the next Agreement.

LELAN supports the creation of a public-facing performance dashboard as a critical accountability mechanism. Such a tool would improve transparency and allow communities to see whether services are aligned with local needs and are delivering meaningful outcomes.

However, the measures used must be co-designed with consumers. Progress tracking must move beyond narrow, clinically driven indicators such as hospital avoidance and symptom reduction. Where non-clinical programs are delivered, their evaluation must be grounded in non-clinical measures that reflect their purpose and approach, rather than being assessed through a clinical lens that build in biases and overlay a model of thinking at odds with their intent. This means prioritising holistic, person-centred outcomes such as access, connection, safety, cultural relevance, and sense of agency—outcomes that genuinely reflect what matters most to people using services.

Joint Planning and Commissioning to Date Has Been Minimal or Non-Existent, States and Territories Have Not Been Adequately Structured into the Reform Agenda

Between the National Mental Health Commission's national oversight and PHN's local commissioning sits a critical missing link: state-level regional planning and commissioning.

While the Agreement commits jurisdictions to joint regional planning (**Draft Recommendation 2.1**), progress has been slow, piecemeal, and uneven across state and territories.

The Productivity Commission has highlighted that the effectiveness of the Agreement is compromised because ***roles and responsibilities at the national and regional level are still unclear*** **(p. 20)**. More broadly, the state component of reform remains largely invisible, with only occasional references to state governments and Local Health Networks (LHNs) or their equivalents across jurisdictions.

This absence of clarity and accountability at the state level, as well as the role and current invisibility of the state/territory consumer peaks to the Productivity Commission, creates a serious barrier to system integration. The lack of publicly available national guidelines for regional planning means there are no consistent expectations or performance standards, leaving gaps in oversight, duplication of services, and persistent fragmentation—particularly for psychosocial supports and services that fall outside PHN responsibility.

Building on this, there is a clear opportunity for reform lies in embedding people with lived experience—including representatives from state and territory-based peak bodies and national lived experience organisations—as equal partners in commissioning processes. This ensures that commissioned services are grounded in lived experience, reflect community priorities, and align with national objectives.

RECOMMENDATIONS:

- Establish the National Mental Health Commission as an independent statutory authority **(Draft Recommendation 4.6)**, with legislative powers to compel data sharing, report publicly, and enforce accountability across jurisdictions.
- Embed lived experience leadership structurally in National Mental Health Commission governance, monitoring, and evaluation, partnering with national peak bodies and the state/territory consumer peak bodies where relevant (**Draft Recommendation 4.7**).
- Develop a national performance dashboard, co-designed with people with lived experience, to track outcomes that matter to consumers, using non-clinical measures for non-clinical services.
- Develop comprehensive national guidelines on regional planning (**Draft Recommendation 2.1)**, mandating lived experience leadership and integration of state-level and regional priorities into the national reform agenda.

- Mandate the inclusion of lived experience leadership in PHN commissioning, governance and evaluation processes, using the established Lived Experience Governance framework as a guide.

[SECTION 4]: PSYCHOSOCIAL SUPPORTS AND UNMET NEEDS, THE GAPING PILLAR OF REFORM

Despite successive national inquiries and reform agendas, access to psychosocial supports remains deeply inadequate for people who are ineligible for the National Disability Insurance Scheme (NDIS). This includes people living with complex mental and emotional distress, often alongside compounding social and economic disadvantage, who remain excluded from both clinical and disability systems.

The split in responsibilities between federal and state governments has created a double layer of complexity and inertia. This fragmented funding landscape fosters gaps, duplication, and service silos—making it harder to develop coordinated, community-based responses that meet people where they are. As a result, people experiencing psychosocial distress too frequently fall through the cracks, with no system taking full responsibility for their support needs.

The Productivity Commission's interim report rightly identifies this gap as an urgent priority (**Draft Recommendation 4.4**). However, proposed solutions do not go far enough in recognising the critical role of authentic, community-based and peer-led models. These supports—delivered outside clinical systems and rooted in community and lived experience, trust, and cultural responsiveness—are often the only accessible and appropriate options for people who cannot or do not engage with traditional services.

One Size Does Not Fit All, We Are at Risk of Repeating Old Patterns

People experiencing psychosocial distress require different forms of support at different times. Some need clinical interventions and others may find community and peer-led relational models more accessible and appropriate—particularly those that offer connection, trust, mutuality, and cultural responsiveness. People deserve choices, however; the current system does not provide this. Instead, it reinforces program silos, narrow eligibility criteria, and rigid service pathways that fail to reflect the diversity of people's needs, preferences, and lived realities.

This failure is compounded by systemic barriers inherent in Australia's federated model of governance. Responsibility for psychosocial supports is frequently shifted between levels of government, further delaying reform and entrenching service gaps for those already most marginalised. Short-term, pilot-based funding further compounds the instability of these services, undermining their sustainability and impact.

Without a deliberate shift in approach at state and national levels, new investments risk replicating old structures. Simply expanding existing programs without embedding Lived Experience Governance or upholding the principles and values of peer work, will fail to address/close these gaps.

Peer-led models must be offered as a solution in their own right**.** Designed and governed by people with lived experience, they remain grounded in community priorities and provide trauma-informed, culturally responsive support. Unlike traditional services, they operate relationally rather than clinically, embedding mutuality, choice, and non-hierarchical relationships without the threat of coercion or force.

What is Needed: A Modern, Integrated System with Real Choice

A reimagined psychosocial support system must provide a spectrum of care that meets people where they are. It should ensure:

- Clinical services that are accessible, evidence-informed, and appropriate for those with high or complex needs that maintain the dignity of people and are non-coercive or restrictive.
- Peer-led and community-based supports that are embedded with integrity, governed by people with lived experience, and delivered in ways that prioritise safety, agency, and connection.
- Integrated service pathways that enable people to move fluidly across clinical and non-clinical supports depending on their evolving needs and preferences.
- Governance and funding arrangements that embed lived experience leadership, culturally responsive practice, and trauma-informed approaches across all service types.

Ultimately, psychosocial support must be understood as a core pillar of the national mental health and suicide prevention system—not an optional add-on. It must be available to everyone who needs it when they want it, regardless of diagnosis or NDIS eligibility, and it must reflect the diversity of ways people experience distress and recovery.

RECOMMENDATIONS:

- Design a nationally consistent psychological support system that reflects the full spectrum of responses – from clinical to peer-led – based on rights, needs, preferences and lived experiences.
- Fully fund peer-led psychosocial supports as essential infrastructure within the national mental health system, particularly for people ineligible for the NDIS, ensuring they are recognised as core components of the national mental health system, not peripheral or discretionary services.
- Invest in models that are designed, delivered and governed by people with lived experience, with structural integrity to peer work principles, including mutuality, choice, and non-hierarchical support.
- Ensure all services delivering psychosocial supports—whether fully peer-led or not—adopt governance structures that uphold the integrity of rights-based care and peer values, embedding lived experience leadership, culturally responsive and trauma-informed practice, and values such as mutuality, choice, and relational support.
- Establish sustainable, long-term funding models that enable service continuity, system integration, and equitable access within and across all jurisdictions.

[SECTION 5]: LIVED EXPERIENCE (PEER) WORKFORCES ARE INCREASINGLY RECOGNISED YET REMAIN UNDER RESOURCED AND ON THE FRINGE

Lived Experience (Peer) Workforces are increasingly being recognised as the workforce of the future in mental health, suicide prevention, and related sectors. Grounded in the insight, empathy and recovery perspectives that come from lived experience, these roles offer unique and transformative support that other workforces cannot.

LELAN recommends that Lived Experience (Peer) Workforces are recognised as a collective priority in the renewed National Mental Health Strategy, as outlined in **Draft Recommendation 4.1**. We also welcome the opportunity to address **Draft Recommendation 4.12** through Lived Experience (Peer) Workforces, firmly agreeing with the Productivity Commission's focus on strengthening such workforces through **Draft Recommendation 4.14**.

Embedding both Lived Experience (Peer) Workforces and Aboriginal and Torres Strait Islander peer workforce with robust infrastructure and enabling conditions is critical for more responsive, person-centred mental health and suicide prevention systems. Despite policy commitments, implementation gaps remain. Systems must move beyond rhetoric to practice, ensuring that these workforces are genuinely resourced, supported, respected, empowered and protected to lead change.

Distinction and Integration of Lived Experience (Peer) Models/Workforces is Needed

LELAN advocates for the following core positions:

1. Lived Experience is a distinct discipline, technical skillset and standalone profession, with its own values, principles and ways of working.
2. Lived Experience (Peer) Workforces must be equal and valued contributors to care alongside clinical and non-clinical workforces.
3. When effectively integrated, Lived Experience (Peer) Workforces strengthen service delivery by enhancing service engagement, update, and recovery outcomes.
4. There is also a need for the consumer Lived Experience (Peer) Workforces to exist in their own right and have full responsibility for designing, delivering, leading and governing services and organisations.

LELAN also strongly supports the Productivity Commission's call to *expand the Aboriginal and Torres Strait Islander peer workforce* through identified and designated positions. We note that this is already underway in South Australia. We urge government to work in genuine partnership with Aboriginal and Torres Strait Islander people, Aboriginal Community Controlled Organisations, and Aboriginal Community Controlled Health Services who are best placed to lead this work.

LELAN supports the integration of lived experience (peer) roles into multidisciplinary teams and the funding of independent, peer-led models as critical reforms. These approaches expand support options, promote system diversity, and ensures care is inclusive, responsive, and grounded in choice, autonomy and control.

It is also imperative and non-negotiable that peer practice, whether in integrated teams and settings or in peer only spaces, that fidelity to the values and principles of peer work and the consumer movement are upheld without compromise.

Implementation Gaps Are Holding Back Lived Experience (Peer) Workforces

Despite strong policy recognition, major implementation gaps continue to undermine Lived Experience (Peer) Workforces. Roles are inconsistently applied, poorly understood and unevenly supported across jurisdictions, threatening the integrity, sustainability, and fidelity of the workforce and limiting its transformative potential. Critically, there is no formal governance structure to ensure lived experience (peer) roles and peer-led models are embedded, resourced, and evaluated as core components of the system.

Responsibility for embedding and legitimising this discipline and workforce cannot rest solely with lived experience (peer) roles. LELAN welcomes the Productivity Commission's recommendations to improve clinical awareness but emphasises that this is only a starting point. Cultural changes within organisations and systems and structural support are required across all levels to ensure lived experience (peer) roles are properly supported, understood and integrated into mental health and suicide prevention systems. Clinical and non-clinical workforces must recognise the unique value of lived experience (peer) work and make space for its distinct contributions. At the same time, organisations and systems integrating Lived Experience (Peer) Workforces must ensure consistency in role clarity, scope of practice, enabling conditions and supporting infrastructure, while protecting against the dilution of these roles, workforces, and models to fit in existing framings that conflict with lived experience (peer) values and principles. Particular attention must be given to the latter.

LELAN acknowledges the future National Peer Workforce Association as a critical mechanism to deliver on **Draft Recommendation 4.14**. Ideally, the Association will strengthen the growth, integrity and sustainability of Australia's Lived Experience (Peer) Workforce, and ensure nationwide consistency. However, if delays in establishing and operationalising the Association continue, alternative mechanisms must be put in place. In the interim, significant work is underway nationally. LELAN highlights two national resources to guide this work.[2]

Earlier in 2025 the Victorian Department of Health released state-based discipline frameworks that articulate the knowledge, skills and scope of practice for each lived experience discipline in their state.[3] These frameworks guide workforce development and training, providing greater clarity for Lived Experience (Peer) Workers and their managers. They also help non-lived experience workers and managers in mental health and alcohol and other drug (AOD) services to better understand, support, and work alongside Lived Experience (Peer) Workforces.

RECOMMENDATIONS:

- Recognise Lived Experience as a technical skillset and distinct profession with defined values, principles, practices and standards to ensure its unique contributions are respected, expanded and sustained.
- Establish a nationally consistent scope of practice, safe co-reflection/supervision structures, and clear leadership development pathways to support career progression and sustainable workforce contributions.

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[2] The National Lived Experience (Peer) Workforce Development Guidelines and the Pathways for Supporting the 'Not Negotiable' Lived Experience (Peer) Workforces to Thrive report.

[3] The AOD Lived Experience Workforce Discipline Framework, The AOD Family Lived and Living Experience Workforce Discipline Framework, The Harm Reduction Lived and Living Experience Peer Workforce Discipline Framework, The Mental Health Consumer Lived Experience Workforce Discipline Framework, and The Mental Health Family Carer Lived and Living Experience Workforce Discipline Framework.

- Fund education, training, and career pathways specific to lived experience (peer) roles to build a skilled, supported, and sustainable workforce beyond direct care and support roles.
- Develop national frameworks and resources to support successful integration of Lived Experience (Peer) Workforces in clinical and non-clinical mental health and suicide prevention settings, leveraging what already exists.
- Create opportunities for peer-led models that are designed, delivered and governed by consumers.
- Allocate dedicated and sustainable long-term funding for peer-led and peer-governed approaches and organisations to exist separate to clinically governed arrangements and enable them to contribute to developing the evidence base in this area.

[SECTION 6]: WE'VE MADE IT A STANDARD BUT EMBEDDING CONSUMERS REMAINS TOKENISTIC, NOT TRANSFORMATIVE

For too long, mental health and suicide prevention systems have been shaped in the absence of those most affected by or excluded from them. Despite growing recognition of the value of lived experience, people with lived experience were often consulted but rarely heard. They were invited to the table but not given a vote. They were asked to share their perspectives but not empowered to influence, lead, or decide. This approach has contributed to systems that remain unresponsive to the realities and rights of people they are meant to support and serve, and sometimes cause harm to.

The transformation of Australia's mental health and suicide prevention systems cannot be achieved without the expertise, influence, and leadership of people with lived experience. Embedding lived experience at all levels and across systems – in service design and delivery, workforce, policy, commissioning, governance and evaluation – can no longer be mere rhetoric. It is necessity for systems change and transformation that sticks.

Consumer and Carers Remain Underrepresented but Equality Isn't Enough

The framing of lived experience representation in the Interim Report reflects persistent structural barriers to equity and influence within Australia's mental health and suicide prevention systems. Much of the framing within the report speaks to the experience and contribution of consumers and carers being equal which LELAN and the broader consumer movement refutes.

Reducing inclusion to *people with lived experience* without recognising the distinct positionalities of consumers and carers, family, kin and other supporters of choice undermines the complexity required for genuine lived experience involvement. It collapses fundamentally different perspectives into a single category, masking the disparities in power, proximity to systemic harm, and decision-making influence. It is also important to clarify to distinguish between lived experience of mental health, suicide, bereavement by suicide and supporting someone who is suicidal. These experiences may overlap but are not the same and must be representatively appropriately and where relevant.

Additionally, the Productivity Commission notes the importance of recognising carers in care. They emphasise that: *Carers emphasised the need for more dedicated supports as well as greater recognition of their role in the treatment of the people they care for.*

Draft Recommendation 4.5 calls for greater clarity in the roles and responsibilities of carers, family, kin and other supports of choices.

Carer perspectives must not overshadow those of consumers. The role of carers is to love, guide, support and walk alongside consumers, not to '*treat'* or provide care that should be provided by service providers and addressed through good policy and service/system design. They are not a part of the treatment team and should never be considered as such.

Carer representation is important, particularly in relation to issues that directly impact their own needs and experiences. Consumers must have full autonomy in deciding whether to involve carers, family, kin and other supporters of choice in their care, and this decision must be respected without question. While carer perspectives can offer context, they must not override or dilute the voice, rights, and leadership of consumers in spaces that affect their lives. Therefore, in matters of service use, care decisions, and systems reform, consumers must be preferenced, prioritised and amplified.

The prevailing 'one consumer, one carer' model is fundamentally flawed. It enshrines structural tokenism by presenting equal representation as equity, while ignoring the different power dynamics and systemic exposures between the two roles. Consumers—those with direct experience of mental health issues and suicidality– often face disempowerment, coercion, and loss of agency within these systems. Carers, family, kin and other supporters of choice, while deeply affected, are witnesses to these experiences rather than direct recipients of systemic harm and often hold greater access to systemic or institutional power. These dynamics are rarely acknowledged in governance structures. The 'one-for-one' approach often results in the dilution, overshadowing, or silencing of consumer voices—especially when carers, family, kin and other supporters of choice hold greater social, economic, or systemic power, or are more closely aligned with established service and policy perspectives.

LELAN affirms that meaningful representation requires acknowledging and responding to these dynamics. This is not to diminish the carer perspective, but to ensure each role is recognised in its own right and included in ways that reflect its relevance, impact, and relationship to power. To advance genuine equity in consumer and carer representation, LELAN recommends that representation must move beyond simplistic ratios and toward nuanced, context-driven representation and that centres those most directly affected by the issues at hand.

Lived Experience Involvement and Valued Recognition Continues to Fall Short

The Productivity Commission highlights that current arrangements prioritise government and health system perspectives while remaining opaque and unclear about how lived experience should be embedded. Quoting the Productivity Commission (p. 5):

The Agreement emphasises the need to incorporate the voices of people with lived and living experience in all aspects of the system but says little on how this should be achieved.

Through its work as South Australia's peak body, LELAN observes that lived experience involvement is often absent, tokenistic, isolated, under-resourced and inconsistently or naively implemented. Too often, actions do not match words, resulting in systems where consumers are present but unheard, consulted but disempowered, and employed but undervalued. This undermines the potential for meaningful reforms and leads to systems that fail.

To address this, governments must follow through on commitments to embed lived experience across and at all levels of the system, supported by long-term investment and structural reform. LELAN supports the Productivity Commission's call for government to *clarify the distinct roles and responsibilities of each level of government in progressing reform* and further emphasises the need to define roles and responsibilities and opportunities for consumer peak bodies at Commonwealth, and state and territory levels, including their collaboration with PHNs.

Equally important is the direct involvement of people with lived experience, beyond formal roles or organisational representation: current and future service users, community members, grassroots groups and collectives with intersecting lived experiences. This must also include people at different stages of their journey, contributing in various ways: through their lived experience, Lived Expertise, and Lived Experience

Leadership.[4] Embedding lived experience must also go beyond consultation to co-leadership, where people with lived experience are empowered to lead, contribute their lived expertise, share decision-making power and shape policy and practice from the outset.

LELAN welcomes **Draft Recommendation 4.7**, which calls for limiting confidentiality agreements and ensuring equitable remuneration for people with lived experience. These are not symbolic shifts—they are structural changes that acknowledge the capacity of people with lived experience to hold complex information, manage relationships, and address conflicts when provided with full and transparent access to the necessary information.

This reflects a move toward valuing lived expertise on par with clinical, non-clinical, and bureaucratic knowledge, and begins to redress longstanding power imbalances

Tokenistic recognition remains common. Too often, lived experience workers are treated as the sole or default voice on all matters relating to lived experience, including being asked to provide input on issues well outside their personal expertise. This places undue pressure on people and reflects a deeper abdication of responsibility by organisations to engage more broadly and meaningfully with the lived experience community—particularly in high-level system design, policy development, and governance.

Meaningful Co-production is Compromised From the Start

LELAN supports **Draft Recommendation 4.2**, which calls for dedicated funding to enable collaboration and shared decision-making. The interim report identifies co-design as the preferred approach to embedding lived experience. However, the Productivity Commission comments that:

There is no funding allocated to enable collaboration between different parts of government working to improve mental health and suicide prevention outcomes. (p. 5).

Successful co-design requires government agencies to be genuinely willing to share decision-making power. This is likely to require a substantial shift in organisational cultures within government (p. 14).

The reality is, many government agencies lack resources, as well as the cultural readiness, structural capacity and willingness to involve consumers meaningfully. Creating the conditions for genuine co-design is itself a significant part of the work and must be explicitly resourced in policy for practice.

To support organisations with co-design/production, LELAN and TACSI co-developed a reflective resource for organisations to assess their preparedness for authentic co-design processes. The 'Ready, Willing, Able' (RWA) Reflective Resource offers a set of questions for organisations to evaluate their readiness, willingness, and ability to involve people with lived experience in co-design processes. While there is growing readiness and willingness across the sector co-design and co-produce with people with lived experience, alongside increasing system expectations to do so, most organisations lack the practical knowledge and capability to meaningfully implement these approaches. LELAN thus supports these organisations through this process by scaffolding learning, holding space for reflection and guiding

[4] Based on Bryne & Wykes (2020)'s definition, *lived experience* refers to the process of reimagining and redefining ourselves, our place in the world, and our future. *Lived Expertise* builds on this by using lived experience in ways that are purposeful and beneficial to others. *Lived Experience Leadership*, as defined by Loughhead et al. (2021), goes further – describing how people draw on their Lived Expertise to influence communities, raise awareness, shape organisational culture, inform policy and politics, and create inclusive spaces and pathways for others, and drive meaningful change.

progress. Yet, LELAN urges for a broader systemic respond to embed and sustain best practice co-design across mental health and suicide prevention systems.

The True Impact of Lived Experience Involvement Isn't Being Measured

Information Request 4.2 asks for measures and indicators to determine the success of lived experience involvement in systems reform and change, given a lack of available evidence and data. The following measures have been devised from LELAN's deep work with organisations grappling and trying to improve in this areas. Measures and indicators are broadly categorised into three levels: at the lived experience, organisation, and system level.

To support with the development of measures and indicators in this context, examples are summarised below in the following table. The Table describes each area with relevant reflective questions from the RWA Reflective Tool, discussed in the previous section, which can be used to guide data collection.

Measures of Success and Indicators at the Lived Experience Level		Relevant RWA Reflective Questions or adaptation of sentiment
Involvement and Connectedness	For example, measure the involvement of people with lived experience across metropolitan, regional, and rural areas, including partnerships with hard-to-reach groups and communities.	What specific mixes of lived experiences, knowledges and skills, community connections are present when your organisation works with and partners with people with lived experience?
Experiences of People with Lived Experience	For example, assess whether people with lived experience felt safe, valued, and able to meaningfully contribute to spaces they are involved in. Process-based examples include assessing whether people with lived experience felt there were (1) clear, standard, and consistent processes in place and (2) communication loop-back showing how the impact of their contributions and related output, and determining whether people with lived experience were (1) offered opportunities for visibility and acknowledge and (2) received fair and timely remunerations for their contributions.	Do people with lived experience share feedback about their involvement? If so, what do they say about their experiences working with and partnering with your organisation?
Diversity, Inclusion and Representation	For example, capture whether representation reflects diversity across gender, culture, ability, age and identity.	Does your organisation actively seek out people who are part of, or connected to, specific cultural or identity groups? If so, which groups?

Power to People with Lived Experience	For example, track lived experience representation through quotas, with a benchmark of 50% lived experience representation on committees or advisory groups as an indicator of power sharing and structural shift.	Power imbalances often exist between health and social sector professionals and people with lived experience when they come together. Has your organisation identified and implemented practices to ensure power is more distributed?

Measures of Success and Indicators at the Organisation Level		Relevant RWA Reflective Questions or adaptation of sentiment
Enabling Organisational Culture	For example, identify whether organisational conditions such as psychological safety and workforce attitudes towards lived experience integration.	Is there explicit permission and ongoing support within your organisation to try new approaches? Is there a blame-free environment that empowers staff to design and test innovative – where no one is expected to have all the answers? Is there support for testing ideas on a small scale before piloting or implementing them more broadly? Does your organisation foster a culture of learning through prototyping, testing, and refining? Are people comfortable working in uncertainty, where solutions may not be clear-cut?
Co-design/Production and Innovation	For example, measure organisational readiness, willingness, and ability to employ co-design and co-production methodologies.	Do those facilitating or convening co-design processes have dedicated time and resources to do so, or is co-design treated as an add-on to an already full workload? Is there funding to run co-design processes, including fair financial compensation for people with lived experience, covering their contributions, time and travel? Is there access to funding to support next steps and outputs that emerge from a co-design process?
Leadership and Stewardship	For example, lived experience leadership roles exist at senior levels, with clear authority and decision-making power.	Is your organisation open to making lived experience perspectives – and the people who hold them – a meaningful part of its decision-making processes?

		Does your organisation have the tools, systems, and capabilities to ensure lived experience is integrated into decision-making? Does your organisation invest into building the skills of people with lived experience, so they can be active co-designers, delivery partners, co-evaluators and co-leaders?

Measures of Success and Indicators at the System Level		Relevant RWA Reflective Questions or adaptation of sentiment
Systems Transformation	For example, assess whether lived experience is positioned at the forefront of system improvement and transformation agendas.	Is authentic lived experience involvement at the forefront of your organisation's scope of operations and related change work?
Peer-Led Approaches	For example, capture the number and quality of alternative supports, services and models available as a direct result of lived experience involvement.	Are lived experience informed, influenced, and led solutions being implemented in your organisation as a result of co-design efforts with people with lived experience?

Lived Experience in Governance is Not Lived Experience Governance

Draft Recommendation 4.7 calls for lived experience involvement in governance, which LELAN clarifies means more than mere presence within existing structures. Without genuine decision-making power, influence, and legitimacy, lived experience roles risk being tokenistic: symbolic and valued for visibility rather than for real systems reform and transformation. People with lived experience must be able to influence, lead, and make decisions through formal mechanisms such as voting rights, leadership roles, and co-chairing arrangements.

Quoting the Productivity Commission on Page 23, **Draft Recommendation 4.6**:

The effectiveness of the next Agreements' governance arrangements should be improved by including a governance framework that emphasises transparency and collaboration, and outlines accountability, reporting and evaluation functions, and embedding and formalising the participation of people with lived and living experience of mental ill health and suicide in the design and implementation of governance arrangements.

LELAN firmly believes that **Draft Recommendation 4.6** is best addressed through the adoption of the Lived Experience Governance Framework. Lived Experience Governance moves beyond individual representation to embed lived experience values and principles into the core of organisational culture, decision-making and accountability. Lived Experience Governance is not solely for or the responsibility of people with lived experience. It is a shared responsibility for all, ensuring that the rights, needs, and preferences of people that use services or are at the centre of services and policy are reflected in every aspect of governance.

Lived Experience Governance compliments existing governance systems and strengthens the broader landscape of 'good governance'. It redefines how decisions are made, and how lived experience actively shapes outcomes. In response to calls on how to operationalise Lived Experience Governance, LELAN directs government to the national *Lived Experience Governance Framework* ('the Framework')[5] developed in 2023, which is supported by a practical toolkit[6] to help organisations embed lived experience authentically and effectively in governance processes. Both the Framework and toolkit provide governments and the sector with accountability, reporting and evaluation mechanisms to assess progress.

The Lived Experience Governance Framework has been benchmarked against established National Safety and Quality and NDIS standards, accreditation and quality frameworks, reinforcing its rigour, applicability and relevance across sectors and settings – including, but not limited to health systems, structures, policies, processes, practices, programs and peer-led initiatives.

Moreover, the Framework responds to calls for reform from major inquiries such as the *Royal Commission into Victoria's Mental Health System* and the *Productivity Commission's Mental Health Inquiry*. Its adoption is currently underway in various ways across across Australia.

RECOMMENDATIONS:

- Establish separate, equitable funding and governance mechanisms for consumers and carers, family, kin and other supporters of choice, with clear distinctions of role maintained to avoid reductive definitions of lived experience and opportunities for involvement.
- Apply an equity not equality lens to all structures, funding, and lived experience involvement strategies – prioritising the involvement of historically underrepresented and marginalised lived experience people and groups, including grassroots and community-led groups.
- Establish formal, well-resourced roles for people with lived experience in governance at all levels, ensuring they have clear mandates, decision-making authority, and adequate resources to influence policy, planning, commissioning, and evaluation.
- Include consumer national and state/territory peak bodies in commissioning processes, alongside all levels of government agencies, to ensure services are informed by lived experience insights and leadership.
- Mandate and fund authentic co-production and co-leadership opportunities by people with lived experience as equal partners from the outset.
- Resource the full spectrum of lived experience roles across all sectors.
- Monitor and evaluate lived experience involvement through co-designed frameworks that measure impact, not just presence or involvement experience.

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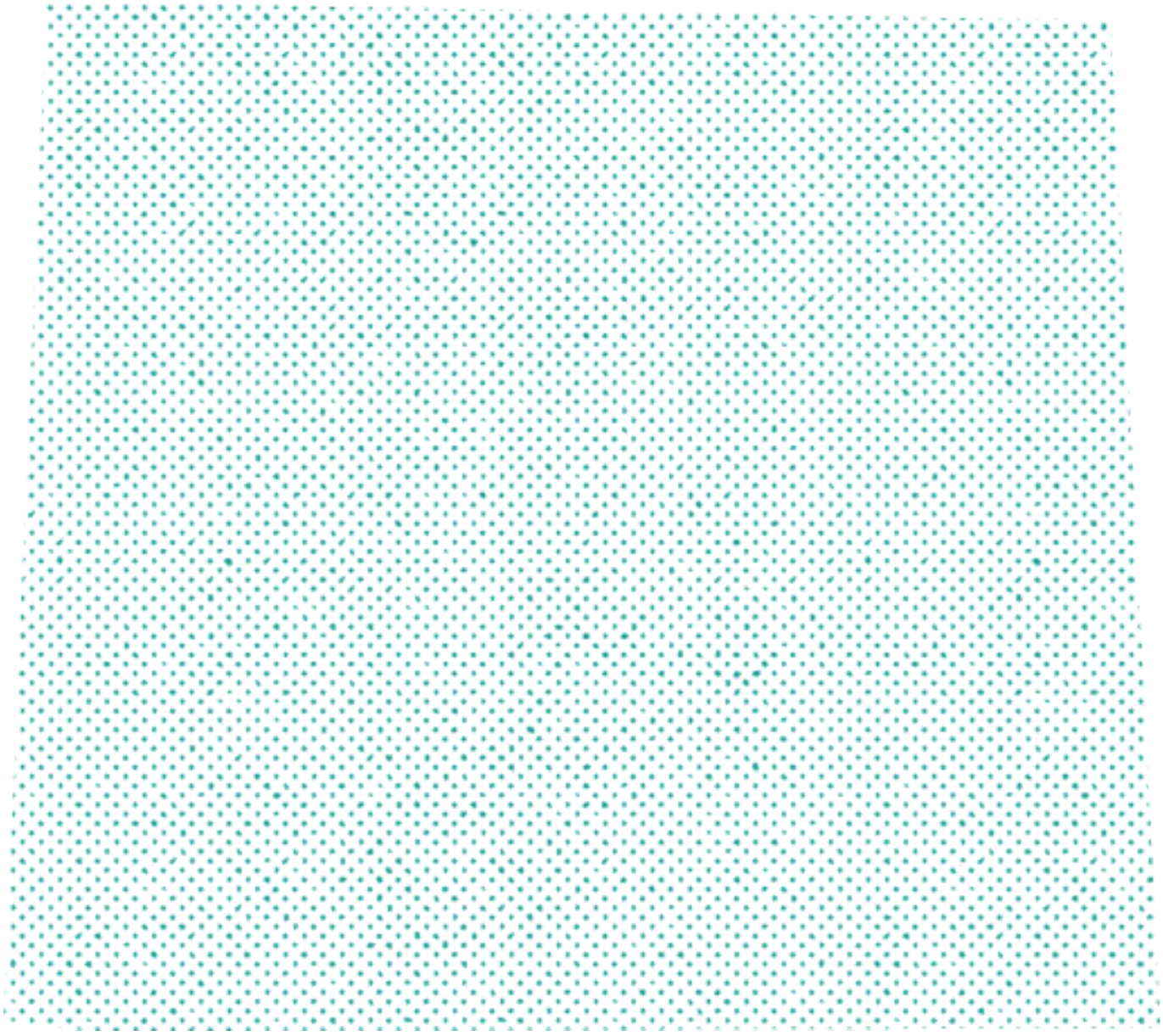
[5] Hodges, E., Leditschke, A., & Solonsch, L. (2023). The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All. Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia, Canberra.

[6] Hodges, E., Leditschke, A., Solonsch, L., Singh, J., & Blazewicz, T. (2023). A Toolkit to Authentically Embed Lived Experience Governance: Centring People, Identity and Human Rights for the Benefit of All. Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia, Canberra.

- Endorse and embed the Lived Experience Governance Framework as a national standard in the next Agreement and/or through the National Safety and Quality Standards, ensuring consistency of minimum standards across jurisdictions and sectors.



As a lived experience-led organisation LELAN values the lives and work of people with lived experience of mental distress, social issues and injustice. Particularly those that intentionally, passionately and skilfully use their lived experience for change.

We thank those that came before, remember those that we have lost, and stand in solidarity and allyship with our communities now and into the future.

We are stronger together.