MentalHealthCarers
Australia

National Mental Health and Suicide Prevention Agreement Interim Report Submission

7 August 2025

Submitted by: Katrina Armstrong
Position/Role: Chief Executive Officer
Contact Details:
Email: info@mentalhealthcarersaustralia.org.au

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representing Victorian
mental health carers

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Acknowledgement of Country

Mental Health Carers Australia (MHCA) acknowledges the Traditional Custodians of the lands on which we work, live and play. We acknowledge that lands were never ceded, and the First Nations peoples experience of historical and ongoing trauma of dispossession and racism. We pay respects to their spiritual ancestors, elders, and emerging leaders across time. We acknowledge with gratitude their sharing of these lands, their strong connection to Country, community and culture, and their strength and the enduring resilience of their living cultures and ways of knowing, being, and doing. We believe we have a precious opportunity to learn about holistic and community-centred approaches to mental and emotional wellbeing from Aboriginal and Torres Strait Islander people.

About Mental Health Carers Australia

MHCA is the nationally funded mental health family, carer and kin peak body, focused solely on the needs of mental health family, carers and kin. We are led by, and represent, the voices of people with lived experience of supporting someone with mental health challenges. MHCA consists of one national and six state and territory organisations. Our aim is to work constructively with governments to improve policies and programs that directly and indirectly impact mental health families, carers and kin.

About mental health families, carers and kin

Mental health family, carers and kin are everyday Australians providing significant emotional, practical and financial support to their family member or friend living with mental health challenges. They do so because there are gaps in available services, requiring them to undertake unpaid work. There are significant, well-documented impacts of this unpaid work, including but not limited to, emotional distress, depression, financial insecurity, employment insecurity and loss of connections with their own family, friends and community.

In 2015, a report by the University of Queensland, commissioned by Mind Australia, estimated that the total annual replacement cost of informal mental health care was $14.3 billion. After adjusting for a $1.1 billion offset from Centrelink payments, the net cost was $13.2 billion.[1] This figure represents what it would have cost governments at the time to replace the support provided by families and informal carers with formal mental health services such as the then-existing Partners in Recovery (PiR) and Personal Helpers and Mentors (PHaMS) programs or disability support workers.

MHCA estimates, that due to inflation and the discontinuation of PHaMS following the introduction of the NDIS, this figure would now exceed $20 billion — likely by a significant margin. For context, the total expenditure on mental health by the Australian and state/territory governments in 2022–23 was estimated at $13.2 billion.[2]

Note on language

> *MHCA recognises that individuals who support someone with mental health challenges identify in diverse ways based on their personal experiences and relationships. Some prefer the term "carer", while others identify as a family member, specifying their role (e.g., mother, father, partner, son, daughter etc). Others may identify as a friend, support person, or care partner, emphasising the reciprocal nature of care. To maintain clarity and inclusivity in MHCA submissions, we strive to use concise and broadly inclusive language. For this submission, MHCA will use the term "family, carers and kin."*

Executive Summary

The time for transformational change, not repair

Mental Health Carers Australia (MHCA) welcomes the opportunity to provide a further submission to the Productivity Commission's Review of the National Mental Health and Suicide Prevention Agreement ('the PC Review'). We are pleased to see Draft Recommendation 4.7 in the PC Review's interim report ('the Interim Report')[3] acknowledge the role of the national lived experience peak bodies, including the formalisation of our involvement in the governance of a new Agreement. This recognition is long overdue and reflects years of tireless advocacy by families, carers, kin and other lived experience representatives, who have called for more meaningful partnerships in shaping system reform.

Yet recognition alone is not enough. To deliver the change that families and carers have long called for, a fundamental shift is needed in how mental health policy is designed, delivered and held accountable across Australia. We are not seeking to renovate or patch over a fragmented system. The next Agreement and its accompanying National Mental Health Strategy ('the Strategy') must set a clear and coordinated blueprint for transformational reform. This transformation must be grounded in a social, rights-based model of care that centres consumers, families, carers, kin and their communities. It must move beyond a clinically dominant paradigm and instead focus on the social, cultural and relational factors that support recovery and wellbeing.

This submission responds directly to a number of Draft Recommendations ('DR') and Information Requests outlined in the Interim Report. Our response is structured thematically across six reform priorities that reflect the lived experience of mental health carers, families and kin. Each theme is informed by a central principle: that transformational change is only possible when mental health reform is grounded in relational approaches to recovery. These approaches recognise that people recover in relationship, with family, community, culture, and place; and that healing cannot occur in isolation from these relational supports.

MHCA draws on a wide range of evidence, including the practice experience of our members, policy and program evaluations, original research, and consultations. It has been enriched by stories, reflections, and insights shared with us by carers and families across every state and territory, with the support of our member organisations. These contributions have been included with permission and help illustrate both the failures and the possibilities of the current system.

A full list of recommendations can be found in MHCA's previous submission. The few select recommendations mentioned in this paper serve to further emphasise the reality that meaningful reform must begin with the people who experience the system most deeply and who sustain recovery long after clinical services have withdrawn.

Summary of select recommendations:

1. Embed relational approaches as a guiding principle in the next Agreement, Strategy and accompanying bilateral agreements.
2. Support the expansion of the carer peer workforce nationally, with dedicated funding, training pathways, and support infrastructure to address workforce disparity.
3. Include a schedule of distinct family, carer and kin outcomes in the next Strategy, with measurable actions and accountability mechanisms.
4. Fund and sustain a dedicated, independent mental health carer peak body in every jurisdiction.
5. Clearly define government responsibilities for funding mental health carer supports in the next Agreement and require resourced commitments that reflect the essential role families, carers and kin play across the mental health and suicide prevention systems.
6. Urgently review the National Mental Health Service Planning Framework (NMHSPF) in partnership with lived experience peaks to ensure it supports community-based, relational, and non-clinical models of care.
7. Require that all psychosocial commissioning processes include co-production with lived experience governance, regional planning mechanisms, and public release of planning documents to ensure transparency and accountability.
8. Mandate a 'Carer Data Upgrade' led by the National Mental Health Commission (NMHC) and Australian Institute of Health and Wellbeing (AIHW), to refresh and establish disaggregated data collection on mental health families, carers and kin across all national datasets.
9. [If proceeding with the proposed timeline in the Interim Report] Amend the current Agreement to include a time-bound, publicly reportable implementation schedule for the Strategy, with interim milestones led by lived experience co-design.
10. Position the NMHC as an observer on all implementation committees, with responsibility to publish progress and lived experience participation.

Embedding relational recovery

A missed opportunity to anchor reform in relational principles

> *You are culturally and ritually impoverished. You are outside structures of normal relational experiences. You are not invited to the BBQ, you are marginalised, and you cannot put that back together because you don't have shared experiences*

- Victorian carer

While the term "recovery" appears often in the Interim Report, MHCA is disappointed to see that this continues to be framed as an inward process; as something that happens inside a person's mind, placing all onus on the individual to change thoughts, feelings or behaviours. This individualistic framing obscures the reality that recovery is rarely done alone.[4] In truth, recovery is profoundly relational. Most people heal through connection with families, carers, kin, friends, professionals, and community. Hope, identity, and empowerment are not simply private achievements but are built and sustained through the quality of our social relationships.[4]

This insight is not new. Evidence from the AIHW links social isolation and loneliness to poorer mental health and wellbeing outcomes.[5] It is well-established that the social determinants of health are among the most significant predictors of poor mental health outcomes.[6] The PC's own Mental Health Inquiry recognised social connectedness as protective and integral to mental health promotion.[7] However, Australia's legal and social frameworks, funding models, clinical paradigms — including those reflected in the Agreement and the Interim Report — continue to reinforce an individualistic concept of recovery. If we are serious about rebalancing the system towards prevention and recovery, then fostering relational connection must be central.

Relational recovery in practice

The value of relational recovery is already evident in enduring practices across Australia and internationally:

- **Aboriginal and Torres Strait Islander Social and Emotional Wellbeing (SEWB) Framework**: Grounded in culture, family, Country and community, this framework acknowledges the interdependence of individual and collective wellbeing. The Evaluation Framework endorsed in the Interim Report (DR 4.15) cites evidence reviews which confirm that culture, including community and family connection, is positively associated with health and wellbeing and reduces risk behaviours.[8]

- **Te Whare Tapa Whā (Māori Health Model):** A widely adopted model in New Zealand that frames wellbeing through four interconnected dimensions: taha tinana (physical), taha wairua (spiritual), taha whānau (family), and taha hinengaro (mental). The model embeds family and connectedness in all aspects of care.[9] A 2021 literature review examining a range of Māori health models identified the consistent theme of family, connection and relationship as central to one search for wellbeing.[10]

- **Trieste Model**: Developed in Italy and recognised globally, the Trieste model provides a compelling blueprint for person-centred, rights-based, and relational mental health care. It takes a whole-of-life approach grounded in hospitality, trust, and inclusion of family and social networks in all aspects of care.[11] It rejects institutionalisation in favour of 24/7 community-based, clinically integrated supports that prioritise continuity, co-production, and shared responsibility across consumers, families, and professionals. A recent pilot in Birmingham, UK, has adapted this approach to suit a culturally diverse and socioeconomically disadvantaged population, further showing its adaptability and relevance across different settings.[11]

Rebalancing from clinical to community-led responses

> *I'm at breaking point trying to keep everyone afloat. But we [carers] don't have the option to break, otherwise who will support our loved ones?*

- Queensland carer

Feedback from members, submissions to the PC, and recent media coverage[12] all point to a concerning reality: the absence of accessible, community-based supports is driving preventable cycles of hospitalisation, early discharge, and worsening mental health. Emergency departments have become the default entry point for people in crisis, despite being widely recognised as traumatic, unsuitable environments for mental health care.

While the Interim Report acknowledges the positive outcomes of the Medicare Mental Health Centres (MMHCs), MHCA cautions that these centres are fundamentally clinical in nature. Many of our members report that MMHCs have not provided appropriate or effective support for families and carers in their own right. Clinical interventions alone will not deliver transformation.

To break this cycle, the next Agreement must prioritise funding and accountability for non-clinical, relational, rights-based and community-led supports. This includes family-inclusive models such as:

- **Open Dialogue**, which originated in Finland and has been trialled in Australia, centres family and peer networks in all aspects of care. The model embodies the principles of transparency, shared decision-making, and continuity of care.[13] Evaluations suggest improved engagement, reduced hospitalisation, and lower relapse rates.[13]

- **Single Session Family Consultation (SSFC**), informed by Single Session Thinking, provide timely, structured engagement with family and carers during critical points of contact.[14] This framework is being utilised internationally in New Zealand through Whāraurau, a national centre supporting infant, child, and youth mental health and addiction services. It is also being used across Victorian and Tasmanian mental health and alcohol and other drug services. Evaluations of pilots in Australia (including through headspace) have found these sessions reduce service disengagement and improve carer satisfaction.[14]

These models demonstrate that relational approaches are effective, scalable, and ready for system-wide implementation. Their rollout should be supported through training for mental health services in relational and family-centred practice, co-facilitated by carer and consumer peer workers.

To this effect, the Interim Report recognises the disparity in the carer peer workforce, reflecting concerns raised in MHCA's earlier submission.[15] Carer peer workers provide stabilising, relational and navigational support that complements clinical care and directly enhances outcomes for carers and the people they support.[16] Despite a doubling in the number of carer and consumer peer workers between 2017–18 and 2022–23, the recently released National Mental Health Report Card shows that carer peer representation remains disproportionately low.[17] In 2022–23, only 48 full-time equivalent (FTE) paid carer peer workers were employed in specialised mental health facilities, compared to 126 FTE consumer peer workers.[17]

Information Request 4.4

In response to the PC’s request for examples of best practice in integrating peer workers into clinical settings. MHCA highlights the following models:

- **Peacock Centre, Tasmania**: Drawing on the Trieste model, the Centre embeds consumer and carer peer workers in an integrated clinical and community-led, recovery-oriented environment.[18] Mental Health Families and Friends Tasmania (MHFFTas) has previously co-located here with its Call2Connect program, offering carer peer support through informal drop-ins and peer-led meditation groups. However, there are currently no similar integrated drop-in services in Tasmania's Northwest region.

- **The Carer Lived Experience Workforce (CLEW)**, **Victoria**: Family Carer Lived Experience Director roles are embedded in Area Mental Health Services (e.g. Alfred Health) across Victoria. CLEW, supported by Tandem, provides statewide infrastructure to support carer peer workers across clinical and community services, including in rural and regional areas, as well as in Mental Health and Wellbeing Locals.[19]

Embedding relational recovery across the mental health system is not just a philosophical shift; it is a practical imperative. A system that centres relationships, values consumer, family, carer and kin expertise, and moves beyond clinical dominance is essential to long-term recovery and inclusion. By rebalancing investment toward community-led and family-inclusive supports, and strengthening the carer peer workforce, the next Agreement and Strategy can lay the foundations for lasting change. A truly transformed system must embed these principles not as add-ons, but as core pillars across design, delivery and evaluation.

Recommendations:

1. Embed relational approaches as a guiding principle in the next Agreement, Strategy and accompanying bilateral agreements.
2. Support the expansion of the carer peer workforce nationally, with dedicated funding, training pathways, and support infrastructure to address workforce disparity.

Family, carers and kin as equal partners with distinct needs

> *People don't recognise that we are on our own healing journey because we're seen as being the carers, we're the solid rock, and yet we're not. We have to deal with some extremely difficult situations and try to remain undamaged, which, you know, we're all damaged in our own way. So no, it is not acknowledged*

- Tasmanian carer

MHCA acknowledges the inclusion of carers' voices throughout the Interim Report via select quotes. Their stories reinforce the urgency of reform and provide compelling evidence for why lived experience must be central to the next Agreement and Strategy. The more than 900,000 Australians supporting someone living with mental health challenges[20] deserve action and reform that genuinely reflects their experiences and needs. If the next Agreement is to deliver genuine reform, it must reflect these experiences in ways that are visible, specific and systemically embedded. The quotes in the Interim Report only begin to paint the picture of the emotional, practical and systemic impact of caring for someone with mental health challenges.

A case for transformation change

The following story shared with MHCA illustrates how the absence of relational, trauma-informed, and coordinated support can lead to devastating gaps:

A young person experiencing psychosis assaulted their parent and was hospitalised. Due to a lack of appropriate high-needs supports, they faced months in a general paediatric ward where they were not getting the assessments they needed. Despite still working through trauma and without support, the parent agreed to take the child home because the alternative was inconceivable.

The NDIS provider assigned to provide intensive support did not show up until three weeks later, and the only contact was a text message. During that time, the parent was supporting their child through profound guilt and shame, while also managing PTSD triggered by the same incident. Navigating the clinical, legal, and NDIS systems, they described the surreal experience of being the victim of assault while supporting the person who caused it. In their words, what they needed was someone to come into their home, understand how the household was functioning, and support them to rebuild trust and connection. The system left them to carry that alone.

This case is not an anomaly. It reflects a system that fails to see families, carers and kin as equal participants in, and deserving of, recovery and support. Each caring experience is unique, deeply personal, and shaped by the realities of navigating a fragmented system. Families, carers and kin are not simply supporters — they are relational anchors, crisis responders, and advocates who hold the system together when services fall short. Their needs, experiences and expertise must be recognised as distinct from, but equal to, those of the people they support.

Lived experience families, carers and kin are best positioned to share these needs, experiences, and expertise in reform processes. MHCA welcomes the growing recognition of lived experience in the mental health and suicide prevention spaces, which has contributed to the establishment of national peak bodies and is reflected throughout the Interim Report.

Information Request 4.2

In response to the PC's request for examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. MHCA identifies the following challenges for mental health families, carers and kin:

- Tokenistic roles and ad hoc recruitment practices.
- Family, carer and kin dual responsibilities of caregiving and managing their own lives make participation difficult, especially without compensation for time spent in preparation or training.

- Use of NDAs that restrict transparency and public accountability.
- Short consultation windows and insufficient resourcing and infrastructure for preparation and engagement.
- Repeated reliance on a small pool of highly experienced or professionally connected representatives, which can limit diversity of perspective and exclude those with valuable lived experience but fewer structural supports.
- Placement of individuals in governance roles where they are expected to speak on behalf of a broader community, despite only having capacity or support to share personal experience.
- Lack of formal training or structured pathways to prepare carer representatives for governance roles.

We welcome the Interim Report's DR 4.10 call to establish the National Mental Health Commission (NMHC) as an independent, statutory body. This creates an opportunity for the NMHC to monitor participation and track whether governance engagement is meaningful, particularly when NDAs limit public discussion.

To address capability challenges, MHCA is currently in the process of developing a National Capability Framework and Strategic Advocacy Leadership Program that provides structured, transparent, and inclusive development pathways for family, carer and kin representatives. The Capability Framework:

- Establishes four levels of lived experience leadership, from emerging advocates to national policy influencers.
- Clarifies expectations and competencies for participation.
- Supports carer representatives to engage in governance with confidence, skill and systemic insight.

By linking paid participation to demonstrated skill, the framework ensures that diverse carers, not just the most visible or connected, are supported to contribute meaningfully. It also strengthens confidence in the legitimacy of family, carer and kin voices across systems.

We propose the following success metrics for inclusion and engagement of people with lived and living experience (also applicable to Information Request 4.3):

- Percentage of lived experience representatives with voting rights.
- Honoraria paid within 30 days.
- Meeting papers circulated at least 7 days prior.
- Number of LE-initiated agenda items adopted.
- Percentage of LE representatives who report feeling their contribution is valued.

Acknowledging the unique experiences of mental health families, carers and kin, MHCA and our member organisations have long advocated for a standalone Mental Health Carer Strategy. We are aware of the renewed Strategy recommended by the PC and the current work progressing the National Carer Strategy, and we recognise that structural integration of actions across multiple strategies may be complex and require consideration. However, in the absence of a dedicated strategy for mental health families and carers, we must insist that the renewed Strategy include specific, measurable and co-designed actions and outcomes for mental health families, carers and kin. These outcomes must not be buried within generic consumer goals or diluted in broader carer strategies. Whether delivered as a standalone schedule or embedded as a dedicated pillar, the commitment must be concrete, costed, and visible.

To deliver on this, every jurisdiction must also be resourced to support a dedicated mental health carer peak body. We appreciate DR 4.7's endorsement of the national peak body and the call for appropriate resourcing. However, to ensure meaningful implementation, each jurisdiction requires an independent, adequately funded carer peak that can share information freely, and work in partnership across systems to contribute to and provide leadership and oversight in state/territory reform. National reform cannot succeed without a strong, connected network of local lived experience voices.

As one Victorian carer put it:

> *I am not able to live the life of a full citizen*

Transformational reform is a citizenship project. It is about the human rights of the people seeking support and the people that care. It must start by acknowledging this reality and ensuring family, carers and kin are valued and meaningfully included in the mental health and suicide prevention systems we seek to change.

Recommendations:

3. Include a schedule of distinct family, carer and kin outcomes in the next Strategy, with measurable actions and accountability mechanisms.
4. Fund and sustain a dedicated, independent mental health carer peak body in every jurisdiction.

Clarifying funding responsibilities for family, carer and kin supports

> *I would visit my GP and tell them that I was looking after people in my family and that I was feeling really tired and didn't know what to do about it. They told me that it was probably hormonal or that I had an iron deficiency. Even when I did find my own supports, I needed a referral from my GP and they wouldn't give it to me because they didn't understand what I was doing as a carer. Child services didn't understand either. They interpreted my situation as neglect and I was removed from my family*

- Queensland carer

The Interim Report rightly identifies the need to clarify roles and responsibilities for funding family, carer and kin supports under DR 4.5. Clarity in funding is not just a matter of governance; it is the foundational work required to ensure mental health carers can access timely, specialised, and culturally safe support. Too often, carers fall through the cracks of systems that lack accountability and coordination.

We acknowledge that both Commonwealth and state/territory governments have a role to play in funding these supports. As noted in our previous submission, there must be a clear framework specifying which level of government is responsible for the design, commissioning, delivery and monitoring of mental health carer supports. However, clarity is the bare minimum. The PC must insist on resourced commitments to carer supports "commensurate with the significant role they play in Australia's mental health and suicide prevention system,"[21] as acknowledged in the Interim Report DR 4.7 in the context of governance. That recognition should extend beyond governance roles to include funded, cross-jurisdictional supports that enable families and carers to participate meaningfully and sustainably in every part of the system. There are programs already delivering impact that are ready for scale.

Relational recovery in practice

Shovel-ready programs that should be scaled nationally include:

- **Family and Carer Mental Health Program, NSW:** Delivered across multiple Local Health Districts in partnership with NGOs, this program provides one-to-one support, group-based education, advocacy, and linkage to services for families and carers of people with mental illness. [22] An independent evaluation in 2022 found the program to be highly effective in improving carers' understanding, confidence and wellbeing.[22]

As one NSW carer who used the program said:

> *Not only are you given practical information to assist in your caring role but they also stress how important YOU are.*

- **Connect Centres, Victoria:** These provide drop-in, carer-led relational supports that operate outside the clinical model. Connect Centres offer a safe, welcoming environment for carers to access peer support, information, and navigation assistance.[23] They have proven to be a vital community-based access point for carers who often struggle to find support in traditional service systems.

We strongly advise against positioning the Carer Gateway as the primary provider or commissioner of mental health carer supports. Carer Gateway service models are generalist by design, often lacking the trauma-informed, relational, and context-specific approaches needed to support mental health carers.[24] Our members consistently report that carers are referred to the Gateway, only to be redirected back to their local mental health carer service.

Without significant redesign, and without co-leadership from the mental health sector, the Carer Gateway should not be positioned as the default access point for mental health carers. If it is to play any role, this must be contingent on genuine co-design, carer-led governance, and a redesign that centres lived experience.

The Agreement and Strategy must establish funding responsibilities that are not only transparent and enforceable but also reflect a systemic commitment to care that is embedded in relationships, not bureaucracy.

Recommendations:

5. Clearly define government responsibilities for funding mental health carer supports in the next Agreement and require resourced commitments that reflect the essential role families, carers and kin play across the mental health and suicide prevention systems.

Improving how psychosocial supports are commissioned

> *Psychiatrists are experts in the medical domain, but in the psychosocial domain we have a lot to input, not just for the person we love and care about, but for the system, and how the system can improve its understanding of where the psychosocial domain fits into recovery*

- Tasmanian carer

The Interim Report recognises the urgent need to expand psychosocial supports beyond the NDIS.[25] However, it underestimates the risks embedded in current commissioning arrangements and fails to address the inconsistent, inequitable delivery of supports across jurisdictions. For mental health families, carers and kin and the people they support, the impact of fragmented commissioning is deeply felt: services are hard to navigate, poorly integrated, and often skewed toward clinical rather than relational models of care.

Families, carers and kin, along with the organisations representing them, have raised serious concerns about the PC's suggestion in DR 4.4 to rely on Primary Health Networks (PHNs) as interim commissioners while states and territories assume longer-term responsibility.[25] PHNs may have some experience commissioning psychosocial supports, but this experience has been uneven. While a small number have delivered valuable programs, these are exceptions. Many PHNs lack the foundational co-design practices, carer and consumer engagement, and commissioning flexibility needed to deliver effective, relational supports.

PHNs often operate with risk-averse, clinically oriented commissioning models that are not suited to community-based recovery. Further, the National Mental Health Service Planning Framework (NMHSPF) currently used by PHNs has been acknowledged by the PHN Cooperative itself as being geared toward public mental health settings, not the primary or community sector.[26] MHCA strongly urges that the NMHSPF be urgently reviewed in close partnership with lived experience peaks, so that future planning genuinely reflects contemporary relational, community-based and non-clinical models of care. Without these changes, continued reliance on PHNs risks reinforcing the very fragmentation and medicalisation that the next Agreement must move away from.

MHCA maintains that a lived experience-led commissioning body remains the preferred long-term reform. In the short term, however, the next Agreement must set stronger expectations for co-design in all psychosocial commissioning, regardless of whether undertaken by PHNs or State and Territory governments. At a minimum, commissioning must be ‘co-produced’[27] to include mandated governance roles for carers and consumers (extending the principles of DR 4.7), shared regional planning across PHNs and LHNs, transparent funding criteria, and clear lines of accountability.

A case for transformation change

Internationally, Lambeth’s *Living Well Collaborative* in London demonstrates what co-produced commissioning can look like in practice.[27] Commissioners, providers, service users, and families and carers came together in informal settings to reshape local mental health services. This initiative involved co-commissioning across all stages of the commissioning cycle, with meetings taking place in community spaces such as local cafes that also employed people with lived experience.

From these grassroots conversations, the Collaborative developed an outcomes framework and more than 100 stakeholders were involved in designing service experiences that reflected these outcomes. The result was a new portfolio of services including peer support and time banks, targeting both primary care and NHS service users.[27]

Locally, place-based models like Victoria’s Mental Health and Wellbeing Locals demonstrate what is possible when service design is grounded in community, and shaped by the people who use it. Connect Centres and carer-led programs like HelpingMinds’ co-located peer navigation teams are further examples of what commissioning can look like when it begins with relationships rather than outputs.

Where PHNs continue to be used, safeguards must be in place to restore trust. This includes publicly releasing regional mental health profiles to guide service planning, reviewing PHN-LHN boundaries to reduce fragmentation, and ensuring carer and consumer representatives have decision-making roles on all PHN boards and commissioning committees. DR 4.12 should be strengthened to reflect this.

Commissioning is not a neutral task. It either redistributes power or reinforces existing hierarchies. The next Agreement must put its weight behind the former, and ensure that commissioning builds systems of support that begin with people, not bureaucracy.

Recommendations:

6. Urgently review the NMHSPF in partnership with lived experience peaks to ensure it supports community-based, relational, and non-clinical models of care.
7. Require that all psychosocial commissioning processes include co-production with lived experience governance, regional planning mechanisms, and public release of planning documents to ensure transparency and accountability.

Making family, carers and kin count in national data and reporting

> *From the psych ward to the clinic, and from NDIS planners to the providers, I as my son's sole carer have carried most of the responsibility. I have constant carer burn out, and at times I hit rock bottom yet if I do not take care of him I do not think he would survive this system. My career (a law academic) is destroyed, my health is at stake*

- Victorian carer

Despite growing recognition of lived experience in policy, mental health carers remain largely invisible in national data, evaluation, and reporting systems. The Interim Report acknowledges the importance of better monitoring, but unless carers are explicitly named, counted, and included in data design and reporting, their needs will continue to be sidelined.

Current national datasets fail to distinguish mental health families, carers and kin from others, masking the unique and often complex needs of those supporting people with mental health challenges and/or suicidality. We understand that work is currently underway via the National Carer Strategy to capture caring data. However, given the fact that many people providing mental health care fall outside the definition of 'carer' under the *Carer Recognition Act 2010* (Cth), we believe the NMHC is best placed to lead demographic data improvement in this space. We also know that current ABS data does not disaggregate mental health families, carers and kin, and members have reported that the Carer Experience Survey (CES), where used, is outdated and poorly suited to this cohort. It does not account for cultural diversity, intergenerational roles, or the episodic nature of care. Other tools, such as the Carer Star, are described by members as cumbersome and limited in their ability to capture outcomes meaningfully.

Jurisdictions such as Victoria, through co-design with Tandem, have already developed outcome frameworks that reflect relational and family-centred priorities.[28] Members such as MHFFTas and HelpingMinds have also stressed the importance of rural and remote inclusion, culturally responsive metrics, and streamlined systems that allow carer stories and support needs to be retained across transitions. Too often, vital information is lost between services, forcing families, carers and kin to relive traumatic experiences.

Information Request 4.3

In response to the PC's question as to whether a public dashboard tracking progress under the next Agreement is feasible: we believe it is not only feasible, but essential. We recommend AIHW act as the data custodian and the NMHC lead on monitoring, interpretation, and reporting.

Key metrics should include:

- Disaggregated data that clearly identifies mental health carers, including demographic characteristics such as age, gender, cultural background, geography, and caring intensity.
- Regional and local data on access, service use, and outcomes for carers, to identify service gaps and inform targeted investment.
- Revised Carer Experience Survey (CES) results, redesigned in partnership with carer peaks to reflect relational, trauma-informed, and episodic aspects of mental health caring.
- Indicators that account for relational, intergenerational, and intersectional complexity, such as those capturing the impacts of caring on multiple family members or across life stages.
- Wellbeing metrics captured by sources like Carers Australia and PHNs
- Existing metrics and benchmarks from state and territory frameworks, including ACT's Wellbeing Framework (and public dashboard) and Victoria's Mental Health and Wellbeing Outcome and Performance Framework, to avoid duplication and build on co-designed systems.
- Quantitative feedback mechanisms such as carer journaling, story capture, and structured interviews, enabling nuanced insights into carer experience beyond quantitative data.

- Inclusion of metrics on information sharing, carer identification within clinical systems, and transitions in care roles to ensure continuity and reduce re-traumatisation.
- Evaluation of carer involvement in service planning, delivery, and governance, tied to funding and performance measures.

MHCA stands ready to partner with AIHW and NMHC to co-design carer-specific outcomes, metrics, and evaluation mechanisms. Lived experience must not only inform the data collected; it must guide its interpretation, application, and impact. When families are not visible in the data, they are not visible in the solutions. The next Agreement must correct that.

Recommendations:

8. Mandate a ‘Carer Data Upgrade’, led by NMHC and AIHW, to refresh and establish disaggregated data collection on mental health families, carers and kin across all national datasets.

Progressing reform without delays

> *Sometimes the only way to affect any change is to leave the gap, because if we’re constantly filling the gap, we can’t see where the services are needed*

- Tasmanian carer

The development of a new Strategy and actionable Agreement is essential and long overdue. We support the proposed timeline in the Interim Report and agree that the Strategy must lay the foundation for future agreements. However, reform cannot be paused or delayed while the Strategy is developed. People are in crisis now. The current system is not only under strain — it is failing many.

Connect Centres, for example, are a shovel-ready option that could immediately support some of the 500,000+ families missing out on psychosocial supports they need.[29] These centres demonstrate what can be achieved when lived experience is embedded not only in design, but in governance and delivery.

If proceeding with the proposed timeline in the Interim Report, the current Agreement must be extended or amended to include a clear, time-bound schedule for delivery of the Strategy. That schedule should include interim milestones and deliverables that governments can be held accountable to, starting with lived experience-led co-design processes, data reforms, and workforce actions. The Strategy must also be grounded in the non-clinical and relational framing that this submission has repeatedly called for.

Accountability must also be embedded at every level of the Agreement and Strategy. MHCA supports proposals for the NMHC to play a more active role in monitoring implementation. But it must have the authority, access, and resourcing to do so meaningfully. One option is for the NMHC to act as an observer on all implementation committees, with responsibility for publishing a simple, publicly available dashboard tracking milestone delivery across jurisdictions.

We appreciate DR 2.1 calling for the immediate release of delayed papers, including the Stigma and Discrimination Reduction Strategy. We recommend that the national lived experience peaks be given the opportunity to review these papers before publication. Given delays between consultation and release, this is essential to ensure fidelity to the lived experience voices that informed their creation.

The Strategy and Agreement must not just rely on goodwill behind-closed-doors reporting; they must build in structures that make it uncomfortable to delay or deflect the transformational change Australia's mental health and suicide prevention systems require.

Recommendations:

9. [If proceeding with the proposed timeline in the Interim Report] Amend the current Agreement to include a time-bound, publicly reportable implementation schedule for the Strategy, with interim milestones led by lived experience co-design.
10. Position the NMHC as an observer on all implementation committees, with responsibility to publish progress and lived experience participation.

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