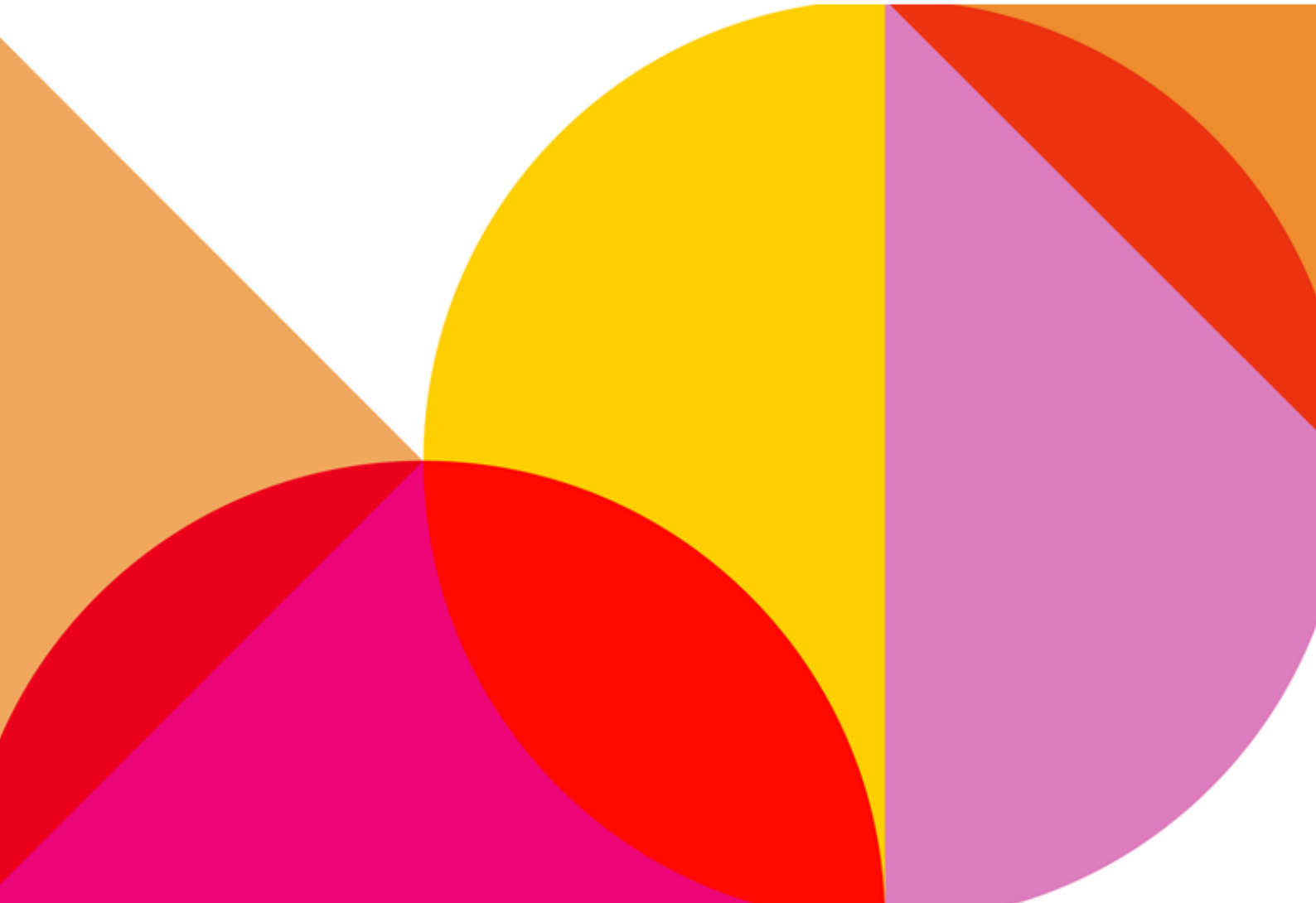
NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

POLICY POSITION

National Psychosocial Supports Scheme

Version 2

SEPTEMBER 2026



NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Acknowledgement of Country

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

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

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



About Us

We thank Indigenous Australian Lived Experience Centre, Mental Health Carers Australia, Gayaa Dhuwi, and Community Mental Health Australia for their substantial input and collaboration on this paper.

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

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

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Contents

Acknowledgement of Country 2

About Us 3

Executive Summary 5

Current State of Play 6

Nationally Consistent System 12

Key Principles 13

The Proposed Model 14

Joint Peak Government Commissioning *16*

Consumer Embedded Delivery Model *18*

Interface with Medicare Mental Health Centres *20*

Interface with state and territory clinical and hospital services *28*

Governance *29*

Data collection and analysis *31*

Co-designed Services *32*

Funding *34*

Challenges with modelling costs *34*

Recognition of Lived Experience 38

Appendix One 39

Appendix Two 42

Endnotes 44

Executive Summary

This paper outlines the position of the National Mental Health Consumer Alliance (the Alliance) on provision of psychosocial supports in addition to the National Disability Insurance Scheme (NDIS) to address current unmet needs for people in all areas of Australia with psychosocial disability and life altering mental health challenges.

At a high level, we propose the introduction of a *National Psychosocial Support Scheme* (NPSS), which would be an integrated and consistent national system of psychosocial supports to address unmet need, improve mental health outcomes, and enable every mental health consumer to live their best life.

Commissioning for services will include mental health consumer peak bodies in governance roles to ensure that consumer lived experience principles and values are incorporated and services are held accountable.

The NPSS would recognise the reciprocal and relational nature of inter-personal relationships and provide tailored support based on a person-led understanding of functional needs, individual circumstances, life stage, cultural contexts, and living arrangements, rather than diagnosis, clinical symptom severity, or proof of permanent impairment. This could include support for families or carers of a person or young person living together, or living separately while maintaining an ongoing caring or supportive relationship; support for partners to maintain their relationship; as well as support for partners in their own right; and support to children and young people with a parent living with a mental health challenge.

More broadly, psychosocial supports can recognise and strengthen safe, mutually nurturing relationships. It might also include support for people to disconnect from those causing harm and establish healthy alternative relationships. Relational approaches support connection, purpose, and participation in community life. Healthy relationships and well communities are the building blocks of a good life and should be facilitated and promoted through the program. As should approaches that support collective, community-led wellbeing.

The NPSS will work with, and for, culturally and racially marginalised and other consumers at the intersections by design rather than by later accommodation. A scheme that is built for a 'default' consumer and then adjusted for everyone else reproduces the access barriers it is intended to remove. We recognise the onus for change sits with the system, not with communities.

Psychosocial support programs have been shown to be effective and provide economic value across quality of life and increase employment engagement[i]. In addition, our modelling indicates that psychosocial disability supports for nearly half a million are less expensive than the supports provided by National Disability Insurance Scheme (on a per person basis)[i]. If psychosocial supports are provided, it is expected that the need for high-cost clinical supports, such as inpatient services, outpatient services and rehabilitation, will decrease[ii] which would in turn reduce national health budgets, including public hospital funding, significantly.

Current State of Play

The Alliance defines psychosocial supports as "*the full range of social, relational, cultural, material, and structural conditions that enable a person to live with dignity, agency, connection, and self-determination. High-quality psychosocial supports strengthen a person's capacity to have full and equal participation; experience belonging; determine identity; feel safe; participate in community; sustain relationships; access housing, employment and income; and navigate systems that affect their wellbeing*".

Rather than associating with language around "citizenship rights", the purpose of psychosocial supports are to strengthen people and communities' capacity and right to the enjoyment of the highest attainable standard of mental health and Social and Emotional Wellbeing, as articulated by the Gayaa Dhuwi Declaration and United Nations Declaration for the Rights of Indigenous Peoples (UNDRIP).

The Australian Government defines psychosocial supports as *"non-clinical and recovery-oriented services, delivered in the community and tailored*

to individual needs, which support people experiencing mental illness to live independently and safely in the community"[iii] *(Psychosocial Project Group, 2023).*

Psychosocial supports are effective across the public health spectrum of prevention, early intervention, response, and recovery, with direct evidence-based benefits for individuals, their families/friends/kin, and broader communities. Psychosocial supports could involve and support family, chosen family, and community relationships with the consent and agreement of all parties. Psychosocial supports should be flexible to needs across the lifespan, and consider family, community and relational approaches specific to people of different ages, needs and preferences.

The NPSS will identify need through structures and drivers alongside other categories, such as the experience of racism in service settings, inability to access support in a preferred language, and experience of cultural unsafety in particular contexts.

Critically, psychosocial supports enable people with psychosocial disability, their families, carers and kin to improve the social and economic determinants of their health, and more effectively exercise their human and consumer rights (including the rights encompassed under the United Nations Declaration on the Rights of Indigenous Peoples, for Aboriginal and Torres Strait Islander people).

A significant, proven benefit to governments of psychosocial supports is they reduce the use of expensive clinical services[iv].

Psychosocial services may include, but are not limited to:

1. **Life-skills, daily living and housing support**
    - building/maintaining routines for daily activities (self-care, household tasks, transport assistance, caring for Country obligations)
    - financial management/budgeting supports (help with money, bills)

- assistance finding, securing and maintaining housing (or adjusting to a new living arrangement); including support to remain on/return to Country/traditional lands
- provision of specialist housing options
- help with managing health and wellbeing (physical activity, nutrition, sleep)
- managing substance use
- practical support for children and young people in distressed households such as support to attend school and extra-curricular activities (as a family option when needed)
- support for children and young people living in distressed households to have access to activities/opportunities with peers experiencing similar challenges e.g. group supports
- tailored supports for your carers

2. **Social, community and relationship support**

- peer engagement (people with lived experience supporting each other)
- social skills development (making and keeping friendships, cultural connections, communication)
- support to join, participate and lead in community groups, spiritual hubs, clubs, sports, recreation as well as cultural and community ethno-specific groups (reducing isolation)
- support to improve the wellbeing of the relational unit. People thrive when their closest personal relationships are healthy and supportive. Personal relationships take many forms and are diverse by nature. This includes with immediate family, family of choice, grandparents, extended family, kinship networks, peer communities, partnerships, and friendships. This includes Aboriginal and Torres Strait Islander concepts of Social and

Emotional Wellbeing within family, kinship networks, community, and Country

3. **Vocational, educational and economic participation supports**
    - assistance in planning for work or study, developing vocational skills, finding and maintaining employment or volunteering, upholding community obligations
    - education/training supports (to build skills, transitions to new roles)
    - support to maintain or regain economic independence/capacity
4. **Support coordination, navigation and brokerage**
    - services to help individuals, their families, carers and kin navigate various supports (health, mental health, Social and Emotional Wellbeing supports, social services) and connect with them
    - brokerage funds or discretionary funding to access particular supports (e.g., short-term assistance beyond standard services)
    - support for people to transition from challenging environments and circumstances (e.g. from prison; from involuntary treatment circumstances)
    - complaint and grievance process navigation for when health, mental health and/or social services are unsafe or inadequate
5. **Psychosocial recovery coaching / capacity building**
    - short-term, strength-based interventions focused on recovery of citizenship and/or rights as articulated by UNDRIP for Aboriginal and Torres Strait Islander people (rather than focussing only on symptoms)
    - coaching to build resilience, self-management skills, decision-making, coping strategies
6. **Group-based and community-based programs**

- programs that bring consumers, families and other communities together to design and implement solutions (such as Open Dialogue)
- educational groups (for rights education, wellbeing, recovery, mental health education)
- specialist outreach, assertive community support (for those with hardly reached, intersecting, unmet or (historically) underserved needs

7. **Development of a dedicated national psychosocial stream for multicultural communities**

   Australia has a growing multicultural population: In the 2021 census, 51.5% of the Australian population was born overseas or had at least one parent who was born overseas. Migration to Australia is predicted to grow. As such psychosocial supports for culturally or racially marginalised communities are often considered in the context of 'refugee health' as a proxy for 'multicultural mental health' needs. They do not consider the broader multicultural populations alongside the needs of refugees and newly arrived humanitarian program communities. Whilst the focus on mental health support for refugee survivors of torture and trauma continues to be crucial, the broader mental health needs experienced in the wider multicultural population requires intentional exploration.

   It is critical that there is a significant shift in policy considerations to be more inclusive and considered for culturally diverse communities. From the limited data that is available, the 'healthy migrant effect' diminishes after ten years of settlement, with some migrants experiencing higher prevalence of chronic disease (including mental health challenges). In addition, current data collection mechanisms are not keeping pace with overseas jurisdictions that have greater capacity to track and address disparities in mental health concerns related to racial and ethnic inequities arising due to stigma, discrimination and barriers to access. This is alongside a lack of positive experiences or ability to access culturally-responsive and led psychosocial supports.

To address these gaps in multicultural mental health, investing in national, multicultural consumer and carer-led shared governance initiatives will drive improvement in culturally-responsive mental health focused psychosocial-supports through the inclusion of culturally-oriented lived expertise. This should build on existing mechanisms such as the Alliance's Multicultural Affinity Group and MHCA's Multicultural Expert Panel, both of which currently support policy reform in this space nationally.

The Australian Government has proposed the introduction of several funding "buckets" for support for individuals who are not NDIS participants. These include the Early Intervention Scheme, Targeted Foundational supports, and General Foundational supports, alongside the existing Commonwealth Psychosocial Support Program (CPSP).

The CPSP is delivered through Primary Health Networks (PHNs) to provide short-term support to 25,000 people with "severe mental health challenges". This program will be evaluated between 2025-2027 and builds on the previous National Psychosocial Support Measure and Continuity of Support Program.

We know from the Analysis of Unmet Need for psychosocial supports outside of the National Disability Insurance Scheme[v] published in 2024 that there were 230,500 people with what the government calls "moderate support needs" and a further 263,100 people with "high support needs" that are currently not receiving the psychosocial supports they require. In total, the report estimated there were 493,600 people across Australia, between the ages of 12 - 64 who may benefit from additional psychosocial supports.

The report also stated that in 2022-23, there were 54,992 people over the age of 65 years with "severe mental illness" and 78,266 with "moderate mental illness" who did not receive any psychosocial supports. This cohort of people are also ineligible to apply for the NDIS but may be covered by the NDIS if they are accepted prior to turning 65 years.

Population-level categories such as "moderate" and "high" need are useful for estimating unmet need, service demand, and required investment, but they should not become individual eligibility thresholds.

These categories do not identify what assistance a particular person requires, how frequently it is needed, or for how long. Diagnosis and clinical symptom severity are also poor proxies for functional support need. People with the same diagnosis may have very different support needs, while people without a formal diagnosis may still need substantial assistance with daily living, housing, relationships, community participation, or navigating services.

The Analysis of Unmet Needs report also found that overall, 1.9 million hours of carer psychosocial support was required over a 12-month period in 2022–23, of which 0.4 million relates to support provided by peer workers (individual and group peer support), 0.8 million for day and flexible respite support and 0.7 million for other individual, group and family support services[vi].

In early 2026, a report commissioned by NSW Health estimated that 95,000 carers in NSW did not receive required psychosocial support. Extrapolated nationally, over 300,000 families, carers and kin across Australia require psychosocial supports in their own right.[vii]

Nationally Consistent System

We know that psychosocial services are not provided, or funded, in a consistent or equitable manner across the country.

One of the reasons for this inconsistency is that in the lead-up to the NDIS being introduced in 2013, some states continued funding some psychosocial support services, while others allocated all or most of their funds to the Commonwealth Government for the NDIS. At the same time, the Commonwealth Government closed some psychosocial programs, including Partners in Recovery (PiR) and Personal Helpers and Mentors (PHaMS). However, not everyone who used PiR or PHaMS was accepted under the NDIS and so they were left without psychosocial support. Further, the NDIS did not replace all state funded community mental health services.

While place-based services should be a key feature of psychosocial supports, a system that funds only specific and discrete projects in particular locations is inherently limited and unfair and will not

meaningfully address unmet need. An inconsistent national program also makes data collection and evaluation across different projects and jurisdictions complex and limits the accountability services have to the people who use them or seek access to them.

As such, **the Alliance recommends a jointly funded State/Commonwealth psychosocial support system, secured through the Mental Health and Suicide Prevention National Agreement, that requires all governments to follow consistent key national principles for implementing psychosocial supports.**

We know that this type of commissioning process already exists to some extent, with some states, including Tasmania, Victoria and South Australia, directly commissioning mental health services that are funded through the Commonwealth.

Key Principles

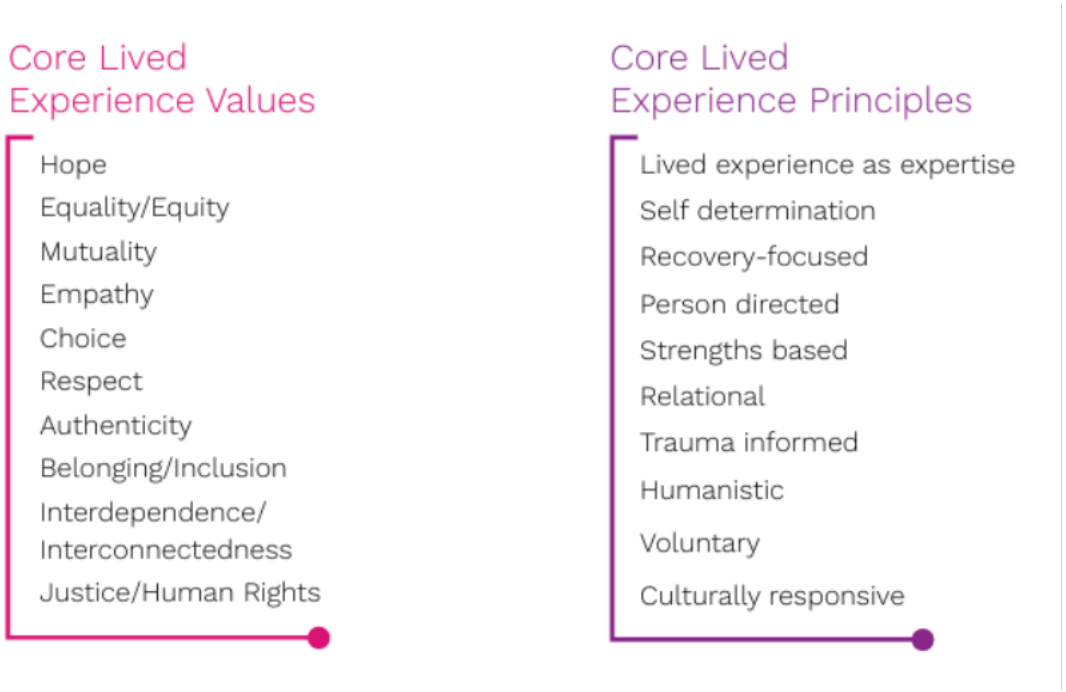
On the following pages, we explain that we would like to see services which:

- incorporate peer values
- embed diverse consumer and carer leadership at all levels of the organisation including governance
- are produced by or co-produced with diverse consumers, carers and community
- are flexible to respond to/support individual, family and/or community wellbeing
- are accountable to consumers, carers and community through qualitative and quantitative analysis
- are free for individuals to access and affordable for the Australian economy
- are free from stigma and discrimination, providing safety, dignity and recognition of intersectional identities including the rights of

Aboriginal and Torres Strait Islander peoples articulated under UNDRIP and the Gayaa Dhuwi Declaration

- name racism as a mental health issue, rather than only as a barrier to access, given racism experienced by consumers is frequently covert and systemic, difficult to evidence individually and cumulative in effect. Psychosocial supports that do not account for racism as a driver of distress will misread its effects as symptoms

A list of peer values and principles are explained in the Lived Experience Governance Framework[viii], with specific examples of how these might be incorporated in a workforce and in a governance setting. These values and principles are:



To ensure that the mental health system is realigned to peer values and principles, consumers, carers and communities want to see a minimum standard set for service providers that ensures they are incorporating these values and principles.

The Proposed Model

The Alliance proposes the introduction of a *National Psychosocial Support Scheme* (NPSS), which would be an integrated and consistent national system of psychosocial supports to address unmet need, improve mental

health outcomes, and enable diverse mental health consumers, carers and community to live our best life.

The NPSS should be co-produced with people with lived experience, including their family, carers and kin. As part of the upcoming Agreement, responsibility, funding, and planning for psychosocial supports should be clarified.

Access to the NPSS should not require a diagnosis, evidence of clinical severity, or proof of permanent impairment. Instead, a person-led functional needs assessment should identify the assistance required, taking account of the person's circumstances, goals, preferences, existing supports, and relevant social, cultural, material, and environmental barriers. The assessment should consider the nature, extent and sustainability of informal support provided by families, carers and kin, including their own account of the support they provide. It should guide flexible, proportionate support that can increase, decrease, or pause as needs change, without requiring reassessment of eligibility – stepped supports. People should be able to return quickly when support is needed again without having to go through additional functional needs assessments.

A functional needs assessment should guide support planning, not operate as a deficit-based eligibility test or gatekeeping mechanism. Assessment must also account for the limits of translation, given interpreting alone does not resolve access where a concept has no equivalent term or shared context. Assessment should also accommodate collective and family-based understandings of wellbeing, consistent with the relational approach set out above.

The consumer-led functional and environmental needs assessment should take a holistic approach, considering the person's environmental, housing, family and caring circumstances, relationships, community connections, financial security and employment, cultural needs and other social determinants of health. It should identify both unmet needs and the informal, family, kinship and community supports the person wishes to sustain, without assuming that families or carers can sustain unpaid support across the lifespan.

People should be able to access the NPSS through self-referral or referral from family, carers, kin or community, and multiple trusted pathways, including Community Managed Organisations (CMOs), Aboriginal Community Controlled Organisations (CCOs), Social and Emotional Wellbeing services, peer-led organisations, specialist and tailored multicultural mental health community based psychosocial support pathways, housing and homelessness services, primary care, Medicare Mental Health Centres (MMHCs), hospitals, and state or territory mental health services.

Clinical referrals should not carry a greater weight than the person's own account of their functional needs. People should not need to enter through the clinical system or experience a crisis before their support needs are recognised.

Access to the NPSS should not be determined by visa status or residency. People seeking asylum, people on temporary visas, and international students experience significant unmet psychosocial need and are excluded from most existing programs. Fear that service contact will affect a visa application is itself a barrier to help seeking. Where eligibility is constrained by Commonwealth settings outside the scheme, this should be stated explicitly rather than discovered at the point of refusal.

Nationally consistent reporting on lived experience-led outcome measures should be phased in, proportionate to its purpose, and matched by funding and practical support for providers, without reducing their capacity to deliver direct support.

Joint Peak Government Commissioning

The Alliance proposes to play a key formal governance role in commissioning psychosocial supports. Commissioning bodies should not undertake regional planning in isolation but should work in partnership with consumer, carer, family, kin, Aboriginal and Torres Strait Islander, CMO, and ACCO peak bodies. Regional arrangements should enable joint service mapping and gap analysis, shared investment planning, and clear accountability for service coverage and system interfaces. They should preserve consumer co-governance by including dedicated resourcing for community-stewardship, collaboration and relationship-building, rather

than relying on informal cooperation between individual services. Where a service is designed for people facing barriers of cost, language, visa precarity or geography, the people designing it must include people who have faced those barriers. Cultural background alone does not constitute lived expertise.

Any pooled or aligned regional funding arrangements should preserve the identity and purpose of NPSS funding. Psychosocial support funding should be protected from diversion to clinical or hospital budget pressures. Commissioning should maintain diverse community-managed, community-controlled, culturally responsive, and peer-led provision, direct access to support, and consumer choice, rather than rationalising psychosocial services around clinical system priorities.

To ensure the commissioning process for psychosocial supports is a robust and evidence-based process, we propose establishing a National Psychosocial Supports Committee (NPSC). The NPSC should include commissioning bodies, lived experience peak bodies (the Alliance, MHCA, IALEC), CMHA, Gayaa Dhuwi and dedicated multicultural consumer/carer lived experience representation.

The NPSC would develop:

- national service scope (aligned with a reformed definition of psychosocial supports)
- national service coverage (including in rural, regional and remote areas, and for discrete service populations)
- service requirements and KPIs included in funding agreements and provider plans, including application of the Lived Experience Governance Framework[ix]
- merits based selection criteria for providers
- selection criteria for lived experience and community representatives on commissioning panels, based on relevant experience of the access barriers a service is intended to address

- data collection methods for input into a national outcome framework
- quarterly performance evaluation and continuous, collaborative improvement.

Existing CMOs and ACCOs that already provide some psychosocial supports will be commissioned to deliver psychosocial services under five-year block-funding grants. CMOs and ACCOs already have a good knowledge of psychosocial supports, infrastructure in place, a peer workforce to implement psychosocial services, and a foundational understanding of peer values and principles. We support the existing mandates and propose a comparable and distinct mechanism for multicultural consumers, recognising these as different histories requiring different frameworks.

Funding would be re-routed from psychosocial support funding that is currently earmarked for separate buckets such as Foundational Supports (Targeted and General), state-funded psychosocial supports, PHN-commissioned psychosocial supports, and the CPSP. This would ensure that the best supports are consistently available for people right across the country, while less effective support services are closed and people who use those services are redirected to other services.

The Alliance does not want to see NDIS participants with psychosocial disability be removed from the NDIS, nor for people with psychosocial disability to be prevented from becoming a participant under the current criteria. The NPSS would be a new service which complements the NDIS to ensure all people with psychosocial disability are able to access appropriate supports.

Consumer Embedded Delivery Model

Successful providers will need to meet minimum requirements. A portion of their funding will be quarantined for:

- employment of a peer workforce, with all lived experience workers holding appropriate qualifications and registration with the new Peer Workforce Association and access to peer supervision paid for by their employer

- governance arrangements that include consumers and carers– as per the Lived Experience Governance Framework[x]– with appointment based on governance capability and lived experience alongside those accredited by the Australian Association of Peer Workers and with the induction of ongoing support and supervision funded by the provider
- where accreditation is a condition of funding, funded pathways to accreditation must be provided. Bilingual and bicultural capability should be recognised and remunerated as skilled practice
- all consumers in identified roles to be accredited by the Australian Association of Peer Workers and have membership of their local state/territory consumer peak body if desired
- all family, carers or kin in identified roles be accredited by the Australian Association of Peer Workers and have membership of their local state/territory mental health carer peak body if desired
- independent evaluation by accredited consumers, carers and community
- cultural governance from local Aboriginal and Torres Strait Islander leaders, including those with lived experience (as defined by IALEC)
- employment of a bilingual lived experience workforce when a providers catchment includes communities using languages other than English, classified and paid for both the peer function and any language or cultural bridging function performed, with interpreting provided by accredited interpreters rather than being absorbed into peer roles

The consumer-led functional needs assessment should be facilitated by a trained peer worker, Social and Emotional Wellbeing worker or psychosocial support practitioner wherever possible, including through a bicultural lens, rather than being owned exclusively by clinical professionals. A person should be able to involve chosen supporters, advocates, family members, carers, and/or kin, while their own account, preferences, and decisions remain central. Assessment processes should be culturally safe and accessible, including through Aboriginal and Torres

Strait Islander-led approaches and appropriate language, communication, cultural, and identity-specific support.

Relevant peak advocacy bodies in states and territories will be funded to provide capacity-building, quality assurance, and network support for each state/territory peak to be able to fulfil its role:

- to provide a co-governance role in the commissioning process
- to train and support diverse lived experts to sit on commissioning panels
- to oversee and maintain the consumer co-management and co-governance accreditation requirements for approved providers
- to allow the Alliance and MHCA to utilise internal affinity group/expert panel advice and connection with multicultural peaks to ensure functional assessments are suitable for diverse communities

IALEC and Gayaa Dhuwi will be funded to undertake the above for their representatives along with any other training their representatives will require.

We understand other parties have undertaken research on models for psychosocial supports. These models have focused on economic or clinical models which do not consider the experiences of those of us using the system, and have not adequately engaged with the lived experience community in the development or analysis of their models.

Interface with Medicare Mental Health Centres

MMHCs could provide a visible, no-cost pathway into psychosocial support, but their role within the NPSS requires careful definition. MMHCs currently vary considerably in the level and range of services they provide. Any formal NPSS role would therefore require a nationally defined minimum service standard, while allowing flexibility across different state, territory, regional, and local contexts. Appendix One summarises current jurisdictional variation in MMHC implementation.

MMHCs should not become the sole gateway to support, impose clinical eligibility requirements, or absorb community-managed psychosocial services into clinical governance. Safe spaces, safe havens, urgent mental health care centres, Aboriginal and Torres Strait Islander and other cultural community spaces, and other alternatives to emergency departments should operate alongside MMHCs and the NPSS as complementary parts of the service system

Peer-led safe spaces can provide immediate, low-threshold, relational support for people seeking connection or experiencing distress, including before, during, and after periods of acute distress, while clinically led urgent-care services provide urgent assessment, short-term treatment, and stabilisation. MMHCs and NPSS providers should continue to provide navigation and ongoing psychosocial support, including assistance with the functional and practical consequences of distress. People should be able to move between these services through voluntary, supported pathways without losing existing support or having to begin again once the immediate need has passed. Peer-led safe spaces should remain independently and directly accessible, rather than being absorbed into clinical governance or treated solely as referral pathways into acute care.

The following three models outline different approaches to the MMHC–NPSS interface, with increasing levels of MMHC responsibility for navigation, continuity, coordination and provision of psychosocial support services. Each model carries different funding, workforce, governance, information-sharing, cultural-safety, and implementation requirements. Diagrams of each model can be found in Appendix Two.

Option 1: The Front Door

Access and warm navigation

Under this model, MMHCs would provide a visible, no-cost access point to the NPSS, while psychosocial supports would continue to be delivered primarily by CMOs and ACCOs. MMHC staff could:

- provide a warm entry to mental health supports/services
- identify functional support needs

- explain available psychosocial and community support options
- warm entry navigation to actively connect people with domestic and family violence, housing and homelessness, tenancy, employment, and other relevant services
- where there are immediate safety or housing risks, facilitate direct contact with an appropriate specialist service
- provide families, carers and kin with information about relevant support options

We know that the most defining moment in any service experience is the very first one — the way people with lived experience of mental health challenges and their loved ones are welcomed through the door. Warm Entry is the idea that how a consumer and their chosen support people are received by a service isn't a courtesy or a nice-to-have. It is the first human rights intervention. It sets the conditions for whether trust, safety, and genuine support are even possible.

A Warm Entry means moving from a culture of processing — where a consumer's arrival triggers paperwork, assessment, and categorisation — toward a culture of relational anchoring, where the first priority is simply to ensure the consumer feels seen, safe, and valued as a human being. Warm Entry also means a person does not have to arrive pre-translated. The work of contextual interpretation, cultural explanation and self advocacy sits with the service.

Warm entry navigation would involve facilitating contact and confirming that an appropriate service has accepted responsibility, rather than simply providing information or referral details. The specialist service would then retain responsibility for assessment and ongoing support[xi].

This model would preserve a relatively clear division between the MMHC's access and navigation role and the delivery role of CMOs and ACCOs. Its effectiveness would depend heavily on local service systems. Key limitations include:

- inconsistent navigation support across MMHC locations

- limited capacity to help where appropriate services are unavailable, full, unsuitable, or culturally unsafe
- repeated connection to services that are available but not suitable or culturally safe with the outcome recorded as disengagement
- people losing support during waiting periods or unsuccessful referrals
- MMHC responsibility ending once a handover has been completed
- privacy and consent risks arising from repeated assessment or information transfer

Changes required to implement this model

Implementation would require a national minimum standard for warm navigation, supported by:

- staff training in functional needs, supported decision-making, cultural responsiveness, family-inclusive and relational practise, intersectional equity and local service systems
- current service information and formal handover arrangements with NPSS and specialist providers
- clear consent and information-sharing protocols
- sufficient workforce capacity to provide practical assistance
- monitoring of unsuccessful connections and local service gaps

Option 2: The Anchor Point

Ongoing navigation and coordination

Under this model, MMHCs would retain responsibility for navigation beyond the initial referral or connection. Wherever possible, the same named worker or peer navigator could:

- provide follow-up and practical assistance during waiting periods, unsuccessful referrals, service withdrawal, or changes in eligibility

- coordinate between psychosocial, clinical, disability, alcohol and other drugs, domestic and family violence, housing, employment, culturally specific and other services
- assist with applications, eligibility requirements, and appointments
- remain involved until a stable connection or handover has been achieved
- provide a clear point of return and rapid re-entry where support arrangements break down, or when support needs change, without requiring the person to start again
- focus on consumer and carer rights within a human rights-based framework designed from a lived experience lens to support complaints or grievance processes for services that are unsafe or unsuitable

This model could provide greater continuity and reduce the risk of people being left to navigate fragmented systems alone. **However, navigation cannot compensate for services that are unavailable, full, unsuitable, or culturally unsafe.** Key limitations include:

- variation in service availability and navigation capacity between locations
- confusion or duplication between MMHC navigators, NPSS providers, NDIS support coordinators, and state and territory services
- navigation becoming superficial without dedicated roles and manageable caseloads
- increased privacy and consent risks arising from information exchange across services
- limited access to services that meet people's cultural, communication, language and accessibility needs

Clear responsibility, dedicated workforce funding, and national minimum standards would be required. Information sharing should occur only with informed consent, for an agreed purpose, and remain limited and person-

controlled. Navigators would also need strong knowledge of local communities and formal relationships with CMOs, ACCOs, multicultural organisations, religious organisations and other culturally specific providers.

Changes required to implement this model

Implementation would require dedicated, recurrent funding for named navigation roles, supported by:

- national minimum standards for follow-up, continued involvement, and rapid re-entry
- clear caseloads, responsibilities, and boundaries
- protocols defining the respective roles of MMHCs, NPSS providers, ACCOs, NDIS support coordinators, specialist services, culturally-specific organisations and state and territory services
- systems for recording agreed needs and actions without repeated assessment
- person-controlled information-sharing arrangements
- local service mapping, strong knowledge of, and connection with, local communities, and formal relationships with ACCOs, multicultural organisations, religious/faith organisations, and other community-managed, community-controlled, and culturally specific providers and spaces
- practice guidance for recognising and understanding the role of families, carers, kin and other informal supports in navigation and coordination

Option 3: The Partnership Hub

Formal partnership and shared planning

Under this model, MMHCs and CMOs would work through formal, locally designed partnerships. These arrangements could include:

- co-located peer and psychosocial support workers

- coordinated intake and person-led support planning
- shared referral, transition, and follow-up protocols
- immediate peer support and limited practical or interim assistance
- space for CMOs to provide appointments, groups, or community and cultural connection activities
- outreach for people unable to attend the Centre
- formal partnerships with domestic and family violence, housing and homelessness, tenancy, employment, culturally-specific and other community services
- visiting or co-located specialist workers and coordinated planning where appropriate

This model could improve access and coordination while reducing repeated referrals and handovers. However, it would be the most complex and resource-intensive option. Key limitations include:

- variation between locations depending on the availability and capacity of local partner organisations
- CMOs and ACCOs become subordinate delivery partners rather than equal participants
- blurred responsibility between clinical and psychosocial services
- psychosocial support being absorbed into clinical governance or narrowed towards clinical outcomes
- increased privacy and consent risks arising from joint planning and information sharing
- culturally specific organisations participating without adequate authority, resourcing, or control over culturally responsive practice
- MMHCs becoming the main gateway to psychosocial support, creating barriers for people who prefer a non-clinical or community-based pathway

The model should not require MMHCs to become comprehensive community wellbeing hubs or directly deliver the full range of psychosocial supports. Services should be run by CMOs and ACCOs and independently accessible, with equal partnership governance, dedicated funding, person-controlled information sharing, and formal roles for culturally specific providers.

Changes required to implement this model

Implementation would require substantial changes to commissioning, governance, workforce, infrastructure, and service design, including:

- dedicated funding for CMOs and ACCOs to participate as equal partners, including funding for ongoing evaluation of partnership effectiveness and development
- formal agreements defining authority, accountability, respective responsibilities, and dispute-resolution processes
- infrastructure and funding for co-location, outreach, groups, and limited interim support
- coordinated intake, planning, transition, and follow-up arrangements
- shared governance involving diverse and intersectional consumers and carers, peer workers, and community partners
- safeguards protecting psychosocial support from clinical control
- interoperable but person-controlled information and consent arrangements
- preservation of direct access to NPSS providers outside the MMHC pathway

Together, the three options represent increasing levels of MMHC responsibility: from facilitating connections, to maintaining continuity across services, to formal partnership and shared planning.

Interface with state and territory clinical and hospital services

State and territory governments should retain primary responsibility for public specialist community mental health services, acute and crisis responses, hospital and inpatient care, and statutory mental health functions, within the broader shared responsibilities established under the National Health Agreement and the National Mental Health and Suicide Prevention Agreement. The NPSS would operate alongside these services, providing voluntary, community-managed support addressing the functional, practical, social, cultural and material consequences of mental distress.

This division should reflect the distinct functions of clinical and psychosocial services—not a hierarchy that redirects people to services funded by states/territories or Commonwealth depending on 'severity'. People may require intensive psychiatric treatment and substantial psychosocial support concurrently, or have significant functional support needs without requiring specialist clinical care, including cultural needs. Clinical severity, diagnosis, hospital admission, or compulsory treatment should therefore neither determine nor end access to the NPSS. We note the pattern of diagnostic overshadowing, where physical symptoms are attributed to distress and treated accordingly. Two-way pathways should not assume a clinical account of need is more accurate than the person's own.

State and territory clinical services and the NPSS should hold distinct but concurrent responsibilities, with the mix of support changing as a person's circumstances change. The NPSS should not be expected to provide specialist clinical treatment, nor should state and territory services substitute for ongoing psychosocial support.

Clear, two-way pathways would be required between the NPSS and state and territory services. NPSS providers should facilitate voluntary and supported access to clinical assessment, treatment, or urgent care where the person wants this, while maintaining clear arrangements for immediate safety concerns. Clinical services should identify functional and relational support needs and offer supported connections to the NPSS. Responsibilities should be clear during waiting periods, unsuccessful referrals, hospital admission and discharge, changes in need, and other

transitions. People should not simply be redirected without agreement about who will respond and how continuity will be maintained.

Existing peer and psychosocial support should continue wherever possible before, during, and after engagement with specialist, acute, or hospital services. With the person's consent, NPSS providers could maintain contact during admission, contribute to person-led discharge planning, and provide practical and relational support following discharge, including with housing, income, relationships, daily living, cultural and community participation. Clinical or NPSS involvement should not automatically displace established community and carer, cultural, peer or psychosocial relationships.

The Agreement should establish national minimum standards for these interfaces, with bilateral and local arrangements adapting them to different jurisdictional and regional systems. Implementation would require dedicated resourcing for relationship-building, joint planning, supported transitions, resolving disputes about responsibility, and evaluating effectiveness of those activities. Information sharing should remain limited, purposeful, and person-controlled, with additional safeguards where compulsory assessment or treatment is involved.

Governance

Recommendation 4.1: Governments should endorse a Mental Health Declaration that outlines long-term reform goals [through a co-design process with people with lived experience]

Recommendation 4.3: Building the foundations for a successful agreement [including people with lived experience identifying relevant and measurable mental health and suicide prevention objectives and outcomes for the next agreement]

Recommendation 5.3: The next agreement should support a greater role for people with lived and living experience in governance

The Productivity Commission's *Mental Health and Suicide Prevention Agreement Review Inquiry Report*[xii], published in October 2025, makes several recommendations that involve people with lived experience having a central role in governance of the next National Agreement. The Alliance strongly supports these recommendations, which call for formal

roles for the two national lived experience bodies, with the caveat that the Indigenous Australian Lived Experience Centre should also be included.

We recommend that the Framework be implemented by the NPSC providing oversight of the state/territory PSSCs through a broad and specifically multicultural/intersectional lens to help ensure consistency, accountability, and share best practice.

Ultimately, the NPSC and the relevant jurisdictional peak body/s would hold service providers accountable if they underperform. This may include remedies such as performance management, redirecting funding and withdrawing funding. In such cases, care and measures should be taken to ensure consumers and their families, carers and kin continue to receive support.

The measures against which underperformance is assessed should also be specified in advance and drawn from the data set described below, so that the accountability mechanism has an observable mechanism rather than relying on judgement.

We recommend that the Lived Experience Governance Framework[xiii] , the Co-created Philosophy of Care[xiv] and a cultural responsiveness framework are incorporated into service provider requirements.

Work is underway with multicultural consumer and family, carer and kin leaders to develop shared foundation principles in this area, and we recommend the resulting framework be incorporated once available.

Implementation of the NPSS should be subject to regular public reporting and an independent mid-term review, enabling problems to be identified and addressed before the end of the Agreement. Consumer, Carer and Aboriginal and Torres Strait Islander lived experience bodies (including those who sit at the intersections such as multicultural communities) should help determine the review questions, interpret the findings, and recommend changes where implementation is not meeting agreed principles, access expectations, or outcomes. Review findings and government responses should be made public.

Data collection and analysis

The Alliance suggests that the Australian Institute of Health and Welfare (AIHW) and National Mental Health Commission play independent roles in collecting, monitoring, and assisting the three lived experience peak bodies in holding service providers accountable to their consumer, carer and community outcomes and social impact commitments.

The Alliance would also like a role in determining which data are collected. As of recently, data collected about PHN services (whether directly provided or commissioned) is managed by AIHW. However, much of this data is clinical in nature. We would like to see a review of this dataset to ensure that the information collected is meaningful to consumers, carers and communities, and reflects their support needs, experiences, and outcomes alongside structural drivers and mechanisms.

Data collection should capture functional support needs, unmet need, waiting periods, service gaps, cultural safety, effectiveness of partnership approaches, language justice mechanisms (language/s spoken at home, whether an interpreter was offered and whether the interpreter was used/useful) and where responsibility is lost between systems. Data should also be disaggregated in ways that are analytically useful. Migration pathway, time in Australia, and reported experience of discrimination in service settings are informative and actionable. Where a jurisdictional outcomes framework cannot disaggregate to multicultural consumers, this should be reported as a design failure.

Evaluation should combine quantitative data with consumer and carer-led, structural and qualitative evidence and examine system-level outcomes, including continuity, navigation, repeated assessment, unnecessary service duplication, and access to appropriate psychosocial support.

Aggregated data should inform planning, investment, and accountability without relying primarily on diagnosis, clinical severity, or standardised impairment measures. Regional planning and service-modelling tools should incorporate data on functional and psychosocial support needs alongside lived-experience knowledge, as frameworks based primarily on clinical activity, diagnosis, or bed-based care may significantly

understate the need for community-based psychosocial support. Individual information should remain proportionate, person-controlled, reviewable, and protected by strong consent, privacy, and governance safeguards.

Nationally consistent reporting requirements should be introduced progressively, with providers adequately funded and supported to develop their data capability. Reporting should remain proportionate and should not divert excessive resources from provision of direct support.

Further work with diverse communities could explore whether a person-controlled support profile, health or disability passport, or service-record flag would help record and communicate functional support needs across services. Any mechanism would require safeguards against gatekeeping or inappropriate use and should prompt a person-led conversation and support response, not replace that conversation or determine eligibility, priority, funding, or support intensity. Data governance and data privacy are important issues that will be considered in this process.

Co-designed Services

The Alliance endorsed the Productivity Commission's Recommendation 4.3 to "extend the current National Agreement to enable genuine co-production"[xv] by 12 months to ensure that there was enough time to co-design, co-produce, and co-create psychosocial support services which would be incorporated within the next National Agreement under the NPSS.

The Alliance proposes that an analysis of past and present psychosocial support services is carried out prior to co-designing new services.

Ideally, this assessment would involve evaluation against the Lived Experience Governance Framework[xvi] and cost effectiveness analysis (for example, measuring all services consistently such as by Quality-Adjusted Life Years (QALYs) or by the Strathclyde/Yale citizenship model[xvii], and how NPSS would reduce use of hospital emergency departments and hospital admissions).

Unfortunately, there is not yet a standardised measure of psychosocial supports that would help us evaluate and compare services, so initially we will need to draw upon qualitative evidence from mental health consumers and families, carers and kin who have used these services. The analysis should also include community led design not captured by existing frameworks.

Based on limited qualitative and secondary evaluative evidence that that the Alliance has already analysed, it is anticipated that services such as Clubhouses, Recovery Colleges, PHaMS, and Community Living Supports may be supported by this assessment.

Clubhouses

Clubhouses provide "non-clinical social support for adults living with a diagnosed mental illness or self-reported mental ill-health (referred to as 'members')". In 2024, there were six Clubhouses in Australia (only two accredited) and of those, Stepping Stone in Queensland was the largest and longest running. An independent evaluation published in 2025 stated that "New members had significantly higher rates of mental health-related hospitalization (41%, 31 out of 76 members) than existing members (16%, 26 out of 161 members) and this difference was statistically significant" [xviii]. This demonstrates the powerful difference membership of Clubhouses can have on long-term mental health.

Community Living Supports (CLS)

CLS is a program funded by the NSW Government which "provides psychosocial supports that help people build independence in daily life … the types of support people receive depends on their individual needs and own unique goals for what they want to achieve". An independent evaluation in 2022[xix] found that the estimated cost per QALY was negative over 5 years. The average time consumers stayed in CLS was 10.7 months, and in 2018-2019, the average program cost per consumer was $35,622. Consumers' hospital admissions due to mental health challenges dropped in the year after entering the programs by 44.8%. Year 2 showed a further 29.2% decrease. This adds to a total decrease of 74.0% following program entry.

Funding

To ensure that effective place-based services continue to thrive, funding for psychosocial supports should be provided according to expressed need, and not on a per capita basis. Where expressed need is under recorded for communities with low service use, this may reflect the accessibility and safety of available services as much as it reflects need. Allocation should thus also account for known under identification, drawing on data from adjacent sectors where mental health data is absent.

Funding arrangements should provide the certainty required to sustain services, retain skilled workers, and build trusted community relationships. Five-year grants should provide appropriate indexation and dedicated resourcing for the partnership-building, supported transitions, data capability, and system-development work required to establish and sustain the NPSS.

CMOs and ACCOs would be funded by the Commonwealth Government and state/territory Governments. Supports would be provided to:

- people currently receiving psychosocial support
- people identified in the Unmet Needs report as lacking access

Challenges with modelling costs

There is limited economic evaluation analysis available on psychosocial supports. CMHA's commissioned report by the Centre for Social Impact at the University of Western Australia concluded that psychosocial supports generate significant economic and social value, improving quality of life while reducing pressure on expensive parts of the health and social service system. However, the evidence base remains underdeveloped because relatively few Australian psychosocial programs have been subjected to rigorous economic evaluation.[xx]

In 2025, the Mental Health Council of Tasmania (MHCT) undertook comprehensive cost analysis of community-managed psychosocial support programs[xxi]. This analysis calculated estimated annual per-individual costs for CMOs to support people living with psychosocial

disability with "moderate and severe support needs". MHCT included staffing, infrastructure, supervision, and overheads in the cost analysis, making the costs appropriate for modelling a fully integrated and scalable service.

Using the MHCT costing data, the average annual cost of funding CMOs to support people living with psychosocial disability with "moderate needs" is $8,408 per person and for a person with "severe needs" is $23,573. This excludes housing support.

The current reporting of data does not inform what psychosocial supports and services a person identified to have "moderate needs" requires versus the requirement of someone with "severe needs", or how long they may need to receive supports for. The HPA analysis noted that not all people with "severe or moderate" mental health challenges require mental health services during a 12-month period. It estimated that 40% of people aged 25-64 years with "severe non-complex" mental health challenges and 20% of people with "moderate" mental health challenges need "some" psychosocial support in a year.

According to the latest data from the AIHW[xxii], of all people requiring residential care, most required it for 1 month or less with half requiring care for up to 2 weeks. 3% of episodes of care lasted greater than 1 year. The Alliance has not been able to identify granular data on:

- specific services required per individual
- duration of support needed
- differentiation between supports required for moderate and severe needs

There are additional cost discrepancies when it comes to costing residential mental health services – a possible requirement for people with "moderate or severe" needs. The *Unmet Needs* analysis did not include non-acute and sub-acute residential support services many of which have significant psychosocial components of service delivery.

Interpreting and translation, translated materials, bilingual and bicultural workforce, cultural supervision, childcare and transport assistance are

consistently identified as necessary and consistently unfunded. Where these are absent from cost models, the modelled cost is the cost of delivering to the people easiest to reach. Any national costing should identify these components separately rather than treating them as overhead.

The AIHW reports that some state and territory governments fund residential mental health services at a total cost of $522 million[xxiii] nationally, supporting 7,400 people[xxiv]. This is an average cost of $70,540 per person.

Likewise, modelling is constrained by a general lack of current and sufficiently granular data about families, carers and kin, including the number of people providing informal care, the type, intensity and duration of that care, how it fluctuates with episodic need, and the supports carers themselves require. In 2015, a University of Queensland report commissioned by Mind Australia estimated that the total annual replacement cost of informal mental health care was $14.3 billion, or $13.2 billion after adjusting for a $1.1 billion offset from Centrelink payments.[xxv]

This represented what it would have cost governments at the time to replace support provided by families and carers with formal mental health services, such as the then-existing PiR and PHaMs programs, or disability support workers. MHCA estimates that, after accounting for inflation and the discontinuation of PHaMS following the introduction of the NDIS, this replacement cost would now exceed $20 billion, likely by a significant margin. For context, total expenditure on mental health by the Australian and state and territory governments in 2022–23 was estimated at $13.2 billion.[xxvi] Without better family and carer data, national modelling risks assuming that unpaid care will remain available and understating both demand for formal services and the support required by families, carers and kin.

These difficulties compound when comparing costs of supports included in the proposed policy models Foundational Supports – General Supports and Foundational Supports – Targeted Supports (Psychosocial Supports). Some General Supports, such as evidence-based information supports that help build skills, improve confidence and independence, and supports that will develop connections between peers and within the

community and supports to find other services and resources are very similar to some psychosocial supports provided. The lack of service-level cost data prevents accurate separation of these categories.

Additionally, while the NDIS is not intended to support people aged 65 years and over, the provision of psychosocial supports outside of the NDIS continues as people do not suddenly 'get well' upon turning 65. The *Unmet Needs* analysis reported 88.1% of 62,420 people (65+) with "severe mental illness" who required some psychosocial support in 2022–23, did not receive any. Of 82,040 people with "moderate mental illness" who required support, 95.4% did not get services[xxvii]. This cohort needs to be included in any modelling carried out for CMO delivery of psychosocial supports.

The limitations in the current data available mean that it is not yet possible to provide a cost estimate for a universal *National Psychosocial Support Scheme* with reasonable confidence. The Alliance looks forward to working with relevant agencies on developing a robust estimate.

It is noted that as of December 2025, there were 65,827 NDIS participants with a primary psychosocial disability, receiving an average payment of $88,700, at a projected annual cost of $6.07 billion[xxviii].

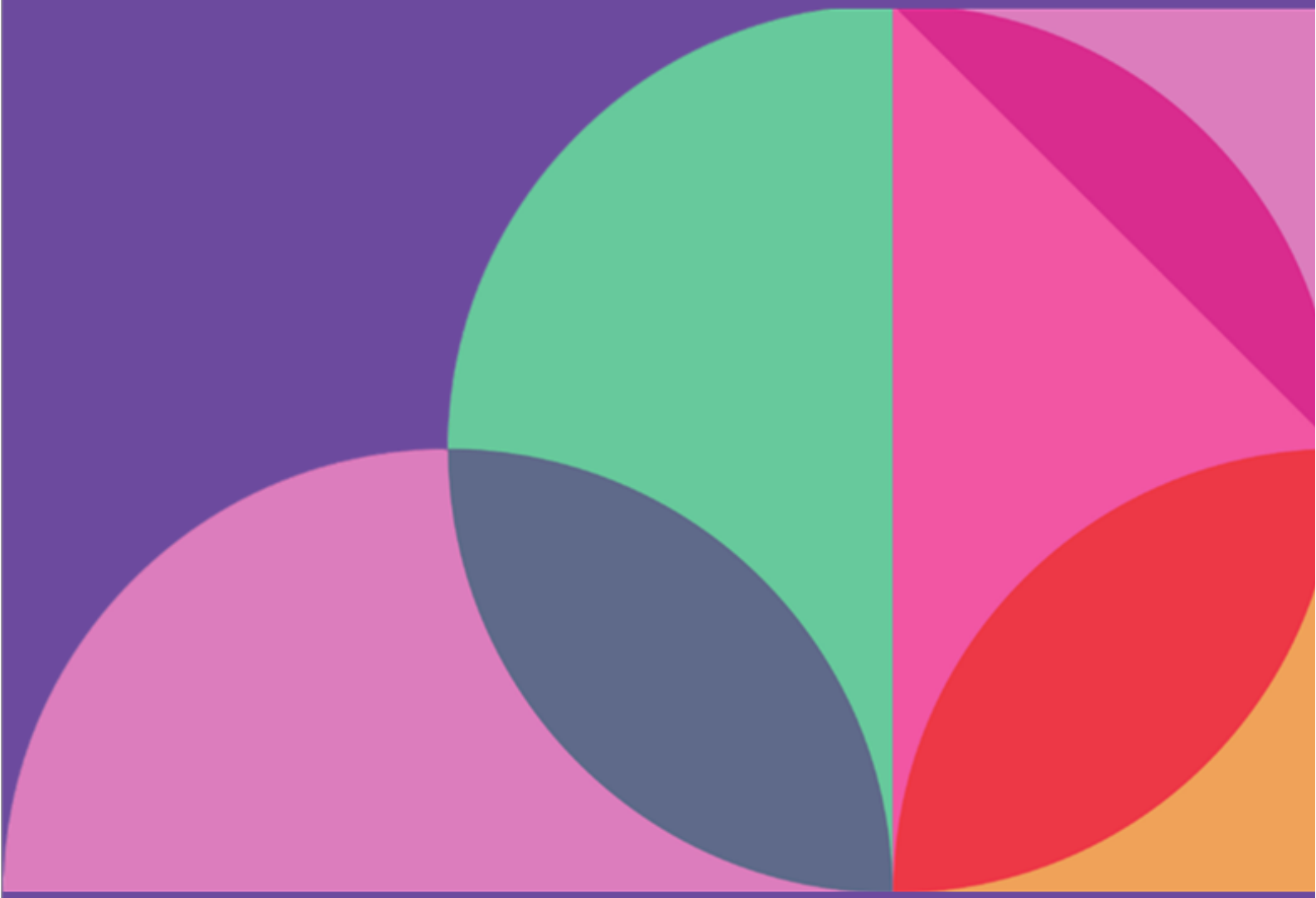
The above modelling indicates that a *National Psychosocial Support Scheme* would be significantly less expensive per person than the NDIS, and the Alliance believes can be delivered in a highly efficient and targeted manner, including via the use of well-trained and supported peer workers. It should be noted that some people using psychosocial services may also be NDIS participants.

NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Recognition of Lived Experience

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

Nothing about us without us.



Appendix One

Jurisdictional variation in Medicare Mental Health Centre service models

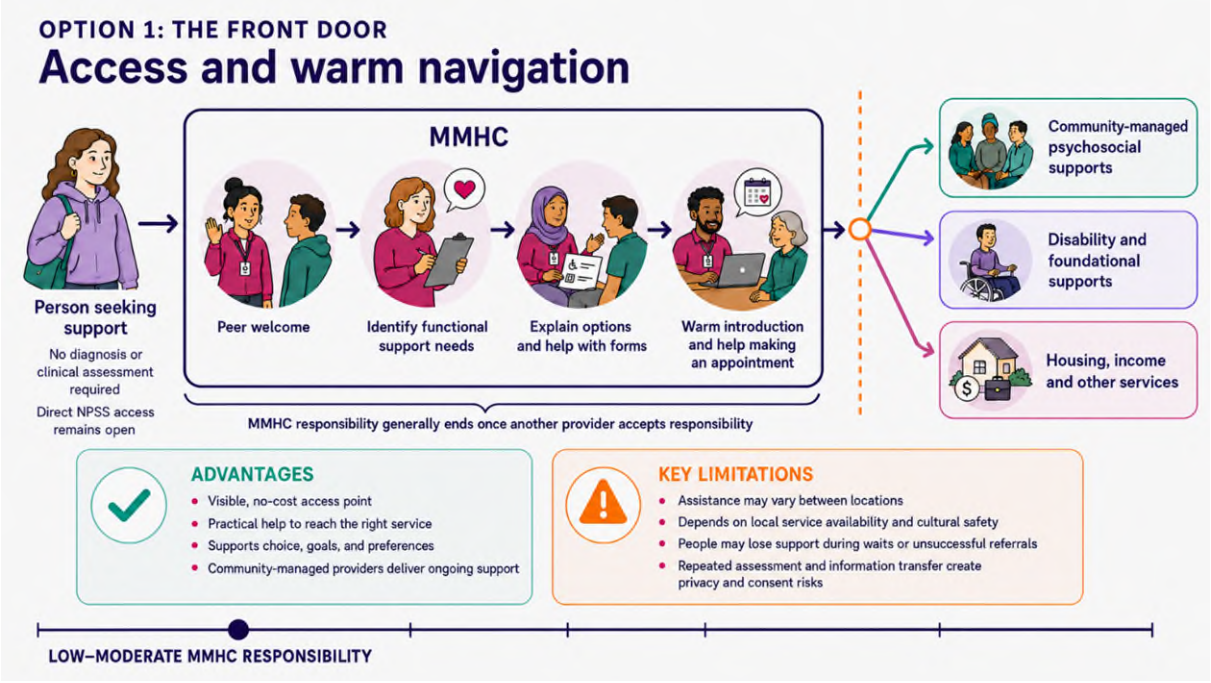
Jurisdiction	Broad arrangement	Relevant distinction
NSW	A mixed network supported through Commonwealth funding and Commonwealth–NSW bilateral investment, with services generally commissioned through PHNs.	MMHCs operate alongside NSW Local Health District services and state-funded crisis and community mental health services. Arrangements and integration vary locally.
Victoria	Commonwealth funding contributes to Victoria's Mental Health and Wellbeing Locals, rather than funding a conventional parallel network of MMHCs. The Commonwealth separately funds the Geelong MMHC.	Victoria is the clearest departure from the standard model: Locals are delivered under Victorian service specifications aligned with the national MMHC model. The bilateral provides for Commonwealth funding to transfer from former HeadtoHelp clinics as Locals are established.
Queensland	MMHCs are principally Commonwealth funded and commissioned through Queensland PHNs, with joint planning and interfaces with Queensland Health services.	Queensland has a large, geographically dispersed network. Centres operate alongside Hospital and Health Services, 1300 MH CALL, and other crisis and community services, but the

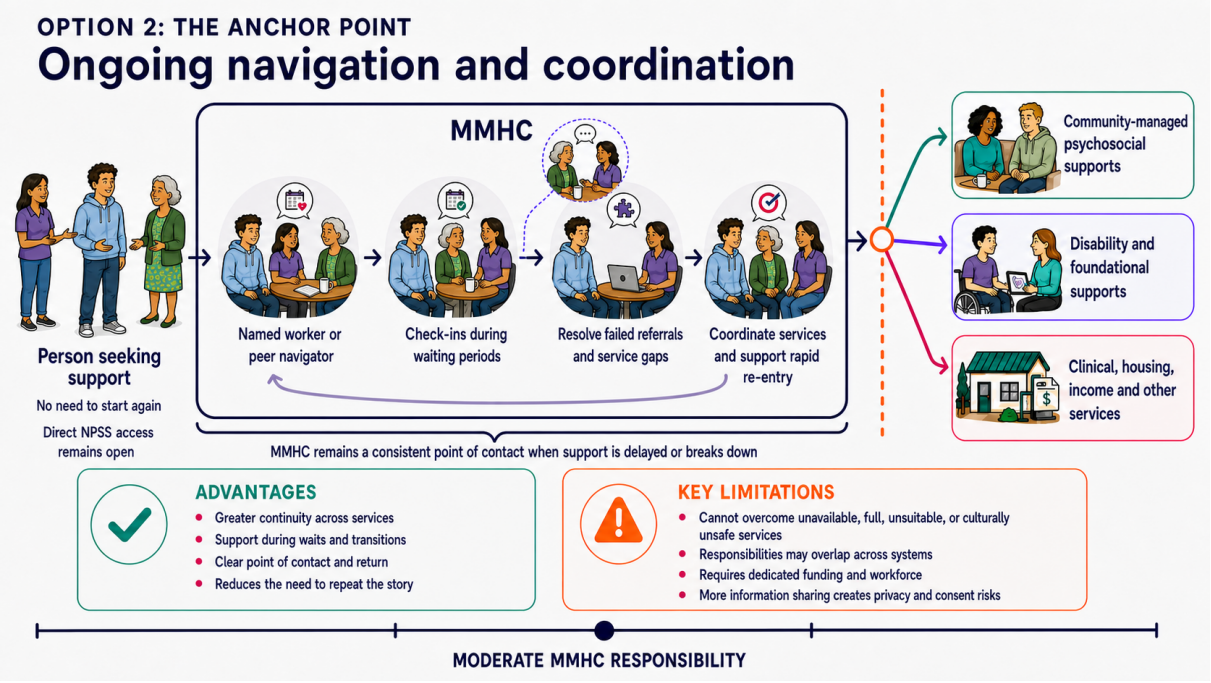
		strength of integration varies locally.
South Australia	Commonwealth-funded MMHC services have been formally planned alongside state-funded crisis and urgent mental health services. Commonwealth funding is provided through PHNs, with joint planning and co-commissioning involving SA Health.	The bilateral provides for an MMHC to be co-located with a state-funded Crisis Stabilisation Centre in northern Adelaide and another with a state-funded Urgent Mental Health Care Centre at Mount Barker. This is a particularly explicit example of complementary Commonwealth and state functions.
Western Australia	MMHCs are Commonwealth funded and commissioned through WA Primary Health Alliance, the state's PHN organisation.	Integration with WA specialist, hospital, and community services is principally shaped through local pathways and partnerships.
Tasmania	MMHCs are Commonwealth funded and commissioned through Primary Health Tasmania.	The model is being adapted to Tasmania's regional geography. Devonport is an example of multidisciplinary clinical and peer support, but "wraparound support for more ongoing needs" is not a confirmed jurisdiction-wide feature.
ACT	MMHCs are Commonwealth funded and commissioned	The ACT's compact service system may facilitate close interfaces with territory services, but the quality or

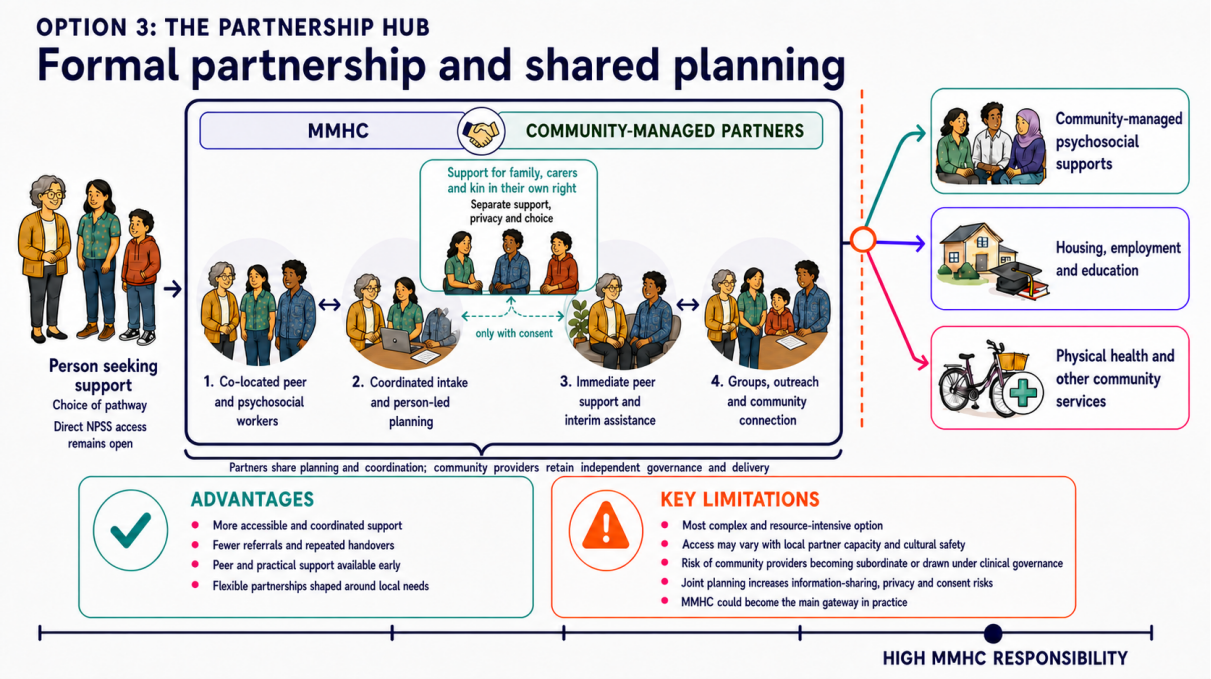
	through Capital Health Network, the ACT PHN.	extent of integration should not be assumed without site-level evidence.
Northern Territory	MMHCs are Commonwealth funded and commissioned through the Northern Territory PHN.	Darwin is established and Alice Springs has been announced. Geography, workforce availability, and the limited number of alternative services make pathways to territory-funded services especially important, although this describes the service context rather than a distinct formal funding model.

Appendix Two

Diagrams of three Medicare Mental Health Centre options.







*Images generated with use of AI.

Endnotes

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