Translational research for driving reform in the mental health sector

Roadmap and strategy for action

Provide feedback on our draft strategy!

DRAFT

SUPPORTED BY

Queensland Mental Health Commission

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The organising committee involved Justin Chapman, Tony Stevenson, Rob Ramjan, James Maskey and Ilyse Elphick. Keynote speakers were Ivan Frkovic, Mike Bosel, Helena Roennfeldt, and Tony Stevenson, and panel members were Simon Katterl, Irene Clelland, Peggy Brown, Kieran Kinsella, Zoe Rutherford, James Maskey and Libby Dunstan. Table discussants were Nicola Warren, Rob Ramjan, Zoe Black, Kris Sargeant, Dan Siskind, Peggy Brown, Tony Stevenson, Rob Ramjan, Greg Pratt, Amanda Wheeler, Donna Humphreys, Jordan van Rosmalen, Nicola Akeroyd, Zephanie Tyack, Sonja March, Ingrid Hickman and Di Krome. Notetakers for table discussions were Meg Doohan, James Challender, Cherie Lamb, Deb Pratt, Peter Davison, Donni Johnston, Hayley Abell and Ilyse Elphick. Attendees who agreed to be named on this output are listed at the end of the document.

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Executive summary

Mental health system reform remains a national priority. However, a persistent gap between evidence generation and its application in policy, commissioning, and service delivery continues to limit impact. Misalignment between community need, research priorities, and decision-making has contributed to fragmentation, inefficiencies, and suboptimal outcomes.

The 2020 Productivity Commission Inquiry highlighted the need to improve the evidence base for policy and programs, and strengthen accountability for outcomes, integration, and commissioning. Central to this is a learning mental health system, where evaluation, continuous improvement, and innovation are embedded in practice.

Aligned with Queensland's Shifting Minds 2023–2028 strategy, the *Co-design and Research Translation Alliance in Mental Health* (CoRTA) was convened on 3 March 2026, sponsored by the Queensland Mental Health Commission and hosted by Psychosis Australia and the Mental Illness Fellowship of Australia. The workshop brought together over 60 leaders and people with lived experience to identify priorities for reform.

Views from diverse keynote presenters, a panel discussion, and facilitated table discussions with dedicated notetakers has been incorporated into this Roadmap and strategy for action. Key themes included redistributing decision-making power, strengthening lived experience leadership, building workforce capability, and linking evidence to outcomes.

Based on over a decade of collaboration, CoRTA is a place-based, cross-sector consortium that embeds research aligned with community priorities into policy and practice. This approach positions translational research as a system-level lever for change, enabling a learning mental health system that is more responsive for improving the wellbeing of individuals and communities.

The challenge

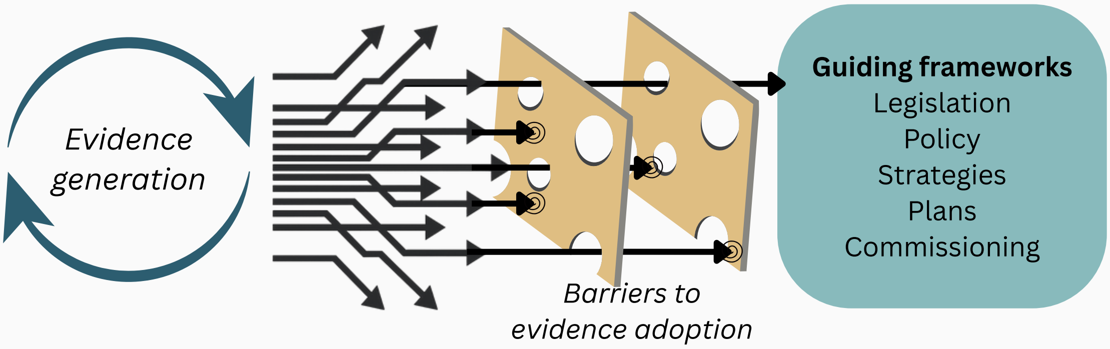
‘Guiding frameworks’ in the mental health sector are intended to support mental health services to improve outcomes for people who access these services and the community more broadly.

To meet the needs of our community, these frameworks should be informed by the experiences of the intended beneficiaries and the challenges facing service providers.

Reform is an ongoing process that broadly aims to better support the wellbeing of communities. Evidence should drive the reform process; however, this is often sub-optimal because of:

- misalignment between research funding priorities, policy directions, and community needs
- limited systematic synthesis of evidence to inform place-based solutions
- barriers between evidence and its utilisation in reform efforts

...leading to a disconnect between community needs and decision-making processes.

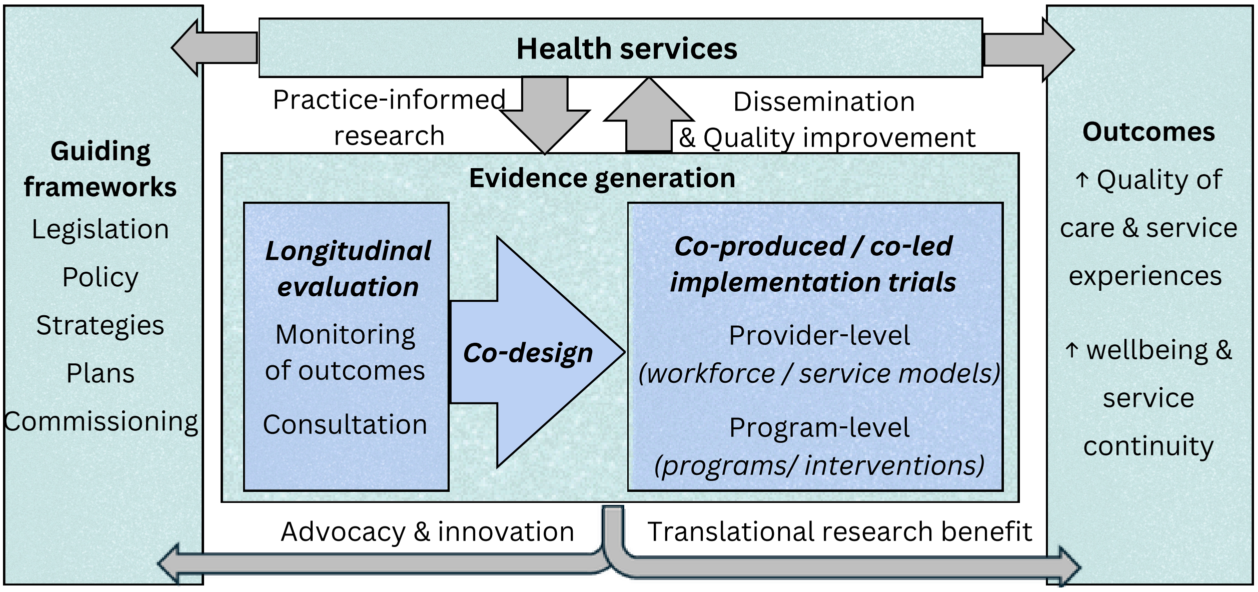


The challenge is inefficient generation of evidence, and ineffective translation of evidence for public health impact, which is also termed ‘research waste’.

The opportunity

‘Translational research’ broadly aims to generate meaningful evidence that can be implemented to improve health outcomes. When applied in health services, it can become an integral driver of system reform.

For this to happen, translational research in health services must coherently align with a clear reform agenda founded on community needs, and evidence must be periodically synthesised to guide innovation over time.



- Longitudinal evaluation incorporates existing evidence, data systems, and ongoing consultation with staff and people with lived experience.
- Co-design ensures that research is aligned with community priorities and policy directions.
- Co-produced and co-led implementation trials generate fit-for-purpose evidence that builds capacity, and drives reform to improve outcomes.

Improving the effectiveness of translational research for driving reform is possible with the right partnerships and principles, commitment to a common vision, transparent and equitable governance, and collective impact values.

The opportunity is to embed this ‘relational infrastructure’ into a cross-sectoral consortium for this purpose, which can be leveraged by partners to achieve the objectives of their own institutions while contributing to the momentum of broader sector reform.

Insights from sector leaders

Keynotes & panel discussion

Reform requires re-distributing power

Lived experience involvement must shift to genuine authority

- Lived experience leadership to conceptualise the problem, methods and solutions
- Co-designed outcomes and performance framework to ensure we’re measuring what matters to people
- Lived experience authority in governance to centre around outcomes and impact rather than activity and outputs.

“Lived experience leadership, including first nations, at the highest levels in the organisation so when we come to design the capability is there.”

“It needs to be a fight between ‘the system we have’ and ‘the system we want,’ and we need to be on the same side of that fight.”

“We need to start where power formally sits with people with lived experience, so it’s not something that can be taken away from us when we say something that you don’t like.”

“We need an outcomes and performance framework – people with lived experience, families, carers and supporters should be at the forefront of developing to articulate what the system is for.”

“We need to align incentives so that change, not placation, is the thing that advances your goals.”

Workforce is critical

Reform fails without a capable, sustainable, and engaged workforce.

- The determinants of organisational culture need to be identified and supported long-term
- Staff should be enabled to collect meaningful data and experiential evidence by embedded into workflows and closing the loop to improve practice
- Leadership commitment to empower staff and accept risks associated with quality improvement and change management.

“Change might mean that something goes wrong, but a lot might go right, and we need to convey that message to the people making decisions”

“From a staff perspective, everybody is responsible for collecting data – we need to collect the right data at the right time in the right way, and use it to drive decision making. They need to feel empowered”

“Not all consumers and families want to engage in research, but they’ll tell their support workers what’s not working every day of the week – there’s other ways of gathering information that doesn’t sit in formal research avenues.”

“The need for courage - part of resisting change is fear when something goes wrong and who’s going to get blamed”

“We can have all the evidence and funding, but if we haven't got the staff in place who are motivated to make that change, we'll struggle to improve the services that we provide to the community.”

There is a persistent gap between evidence and decision-making

Place-based commissioning exists, but it is not effectively using local evidence to drive reform.

- Research and evaluation are generally not funded in commissioning.
- Existing data systems are fragmented, and experiential evidence is inconsistently collected, providing an incomplete picture.
- Evidence generated is often not aligned with policy priorities or community needs.

“There's a disconnect between the data systems at a state and national level, and there is a gap around what the evidence tells us and what government will fund now.”

“There needs to be a fundamental commitment to research in governance and structures – it should be clear that this is not to be seen as extras – they should be a requirement in every contract.”

“Researchers should be in the room at conception and be able to affect decisions around what gets measured when, and bring the evidence to the table for those early decisions.”

“We've got an infrastructure of place-based commissioning, but there's so much disconnect between the reform we're looking for, and the evidence that we're generating on the ground.”

“We need research that's translatable to support decision making, and that actually considers the needs of those that are impacted.”

Research should be an active driver of reform

Accountability mechanisms connecting evidence and action are needed to challenge systems.

- Political drivers of structural inequities need to be understood and leveraged
- Human rights and dignity should be fundamental legislative and conceptual framing
- Effective programs should be sustained and scaled, not decommissioned

“We’re interested in structural determinants of mental health, but we need to take that one step further and ask what are the political determinants that mean these aren’t getting acted on.”

“We know the future we want - research should be challenging power structures to help us get there.”

It should be part of the accountability process - if the system isn’t performing effectively, research has a role of putting an evidence base around that.”

“What would happen if didn’t accept the status quo that we’ve inherited, or the timelines we’re given around reform?”

“The QLD Human rights act is to inform governance, design and operation of mental health services…

…embedding this from the beginning puts people at the centre of the decision-making process and in the context of legal obligations.”

Table discussions

What does the sector need?

How can evidence be used to achieve your mission and purpose?

- Research agendas established through co-design with people with lived experience, policymakers, staff and researchers from the outset.
- Research questions with human rights framings and explicitly linked to service planning and system-level decision needs.
- Dissemination and adoption of evidence enhanced through narrative-driven outputs tailored to different audiences (policymakers, service providers, community members) to close the feedback loop.
- System re-orientation away from narrow activity-driven metrics toward impact metrics designed by lived experience and considering service efficiency.

What mechanisms are needed to leverage translational research for impact?

- Enable advocacy/planning/commissioning partners (‘system connectors’) to link researchers with service providers and lived experience to generate the right evidence for decision making.
- Accountability mechanisms for these ‘system connectors’ to ensure the adoption of evidence into policy, regional planning and commissioning frameworks.
- Embed meaningful data capture into staff workflows, enhance its availability to improve quality of care and service efficiency, and improve data sharing across settings.
- Establish end-to-end research pipelines involving co-production across the spectrum of development, implementation, scale and sustainment.

What is needed to enhance capacity of the sector for reform?

- Support collective governance and ‘backbone capacity’ to align inter-organisational and cross-sectoral efforts.
- Workforce development for translational capacity through place-based research hubs linking communities, universities and research institutes, and services.
- Systems leadership to address cultural barriers and service silos, reinforced by collective impact governance models focused on a reform agenda.
- Commissioning and service contracts with funded quality improvement and change management deliverables.

How do we get there?

Equitable, transparent, community-led, and collaborative

Clear direction

- Shared purpose aligned with community and system needs.
- Strong interorganisational relationships resilient to change.
- Common consortium vision, outcomes framework, and success indicators.

Authentic lived experience leadership

- Ongoing leadership from lived experience organisations and diverse representatives.
- First Nations governance integrated with lived experience governance.
- Clear benchmarks for co-design, co-production, and community-led research.

Equitable participation

- Inclusive membership across all organisation sizes and regions.
- Early and meaningful inclusion of underrepresented voices.
- Clear value proposition and onboarding for new partners.
- Mechanisms to address power imbalances, conflict, and ensure safe dialogue

Transparent governance and decision-making

- Defined roles, expectations, and scope across partners.
- Clear governance aligned with our functions and collective purpose.
- Coordinated working groups driving measurable milestones.
- Regular, structured engagement touchpoints (meetings, forums, symposia).

Relational infrastructure for long-term impact

- Grassroots community engagement via lived experience networks.
- Opportunities for research embedded in care pathways and staff workflows.
- Consortium participation evidenced in partner strategies and plans.
- Proactive communications via partners for awareness and knowledge sharing.
- Ongoing monitoring, evaluation and reporting of the consortium impact.

What are the risks and how can we avoid them?

Challenges and risks	Mitigation strategies
Lack of clarity or shared direction	
Fragmented efforts Loss of engagement	Invest in development of shared vision Regular alignment and review Master protocol underpins research efforts
Power imbalance and inequity	
Larger organisations dominating decision-making Smaller organisations unable to contribute equally	Explicit equity principles and participation rules Shared resource models Transparent contribution expectations Governance processes to call out inequity
Competition and conflict	
Competition for funding Conflicting or hidden agendas Reduced trust and withholding information	Formal CoI disclosure and management Safe spaces for open discussion Shared goals that emphasise collective benefit
Tokenistic or disingenuous engagement	
Harm to community trust Undermines legitimacy of consortium	Clear protocols for meaningful involvement Risk registers openly managed with balancing actions prioritised
Bureaucracy and inefficiency	
Slow decision-making Overly complex governance	Lean governance structure Clear delegation when appropriate Action-oriented participation
Disillusionment and disengagement	
Lack of value for partners Unequal contributions Inequitable benefits	Demonstrate organisational benefit Clear expectations of commitments Equal opportunities and equitable benefits embedded in governance
Resourcing constraints	
Reliance on short-term funding Competing organisational priorities	Demonstrate inherent value to funders Require minimal resource commitments from partners Embed commitments into organisational plans Accommodate organisational restructures and sector disruptions

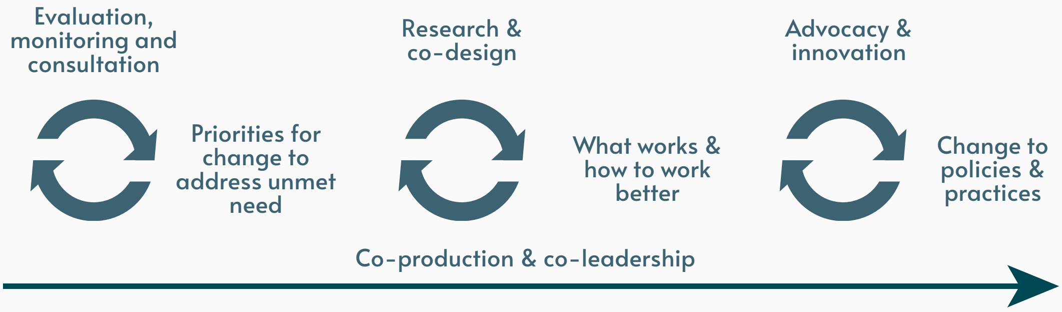
The way forward

The Co-design and Research Translation Alliance in Mental Health (CoRTA) is a 'grassroots' place-based consortium based on over a decade of collaboration with service providers, Primary Health Networks, peak advocacy bodies, and researchers in the Brisbane South and North regions.

CoRTA is being mobilised to enable translational research for driving reform in the mental health sector, with the current scope of improving psychosocial outcomes for people with severe mental health challenges.

This will be achieved by embedding:

- co-production and co-leadership of research with people with lived experience (consumers, carers and families) and people who provide services (staff)
- evidence generation that addresses real-world implementation challenges and opportunities
- advocacy and innovation to translate evidence into policy and practice impact.



Evaluation, monitoring and consultation

Priorities for change to address unmet need

Research & co-design

What works & how to work better

Advocacy & innovation

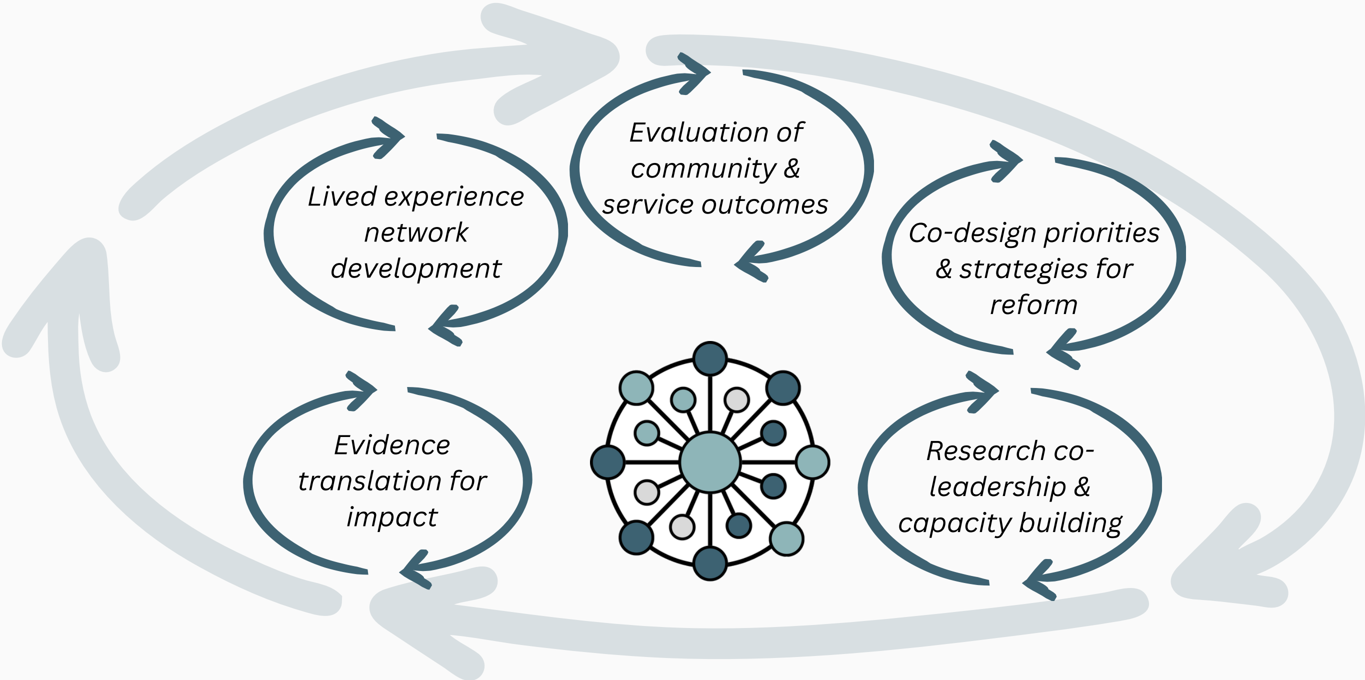
Change to policies & practices

Co-production & co-leadership

How will it work?

Each partner connects via the Steering Committee and decides their scope of involvement aligned with their role in the mental health sector.

- Researchers and service providers may be more directly involved with co-design and co-production of research because of their role in engaging the community for service provision and research.
- Peak advocacy bodies and strategic governance organisations may be more directly involved with guiding priority setting and disseminating evidence because of their role in policy and planning.

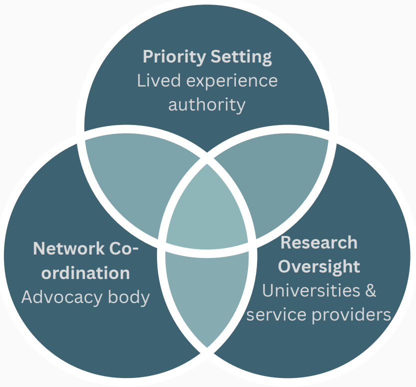


- Lived experience networks enable foundational engagement for community-led research and collectively driven reform.
- Evaluation against outcomes that matter most to people with lived experience highlight the system’s strengths and weaknesses.
- Priorities and strategies for reform are co-designed, and guide co-leadership of research, capacity building, regional planning, commissioning and reform.
- Research proposals aligned with the co-designed priorities and strategies will be co-produced with consortium partners.
- Evidence translation via adoption in policy, planning, commissioning, and organisational quality improvement with consortium partners will progressively shift the system toward what communities want.

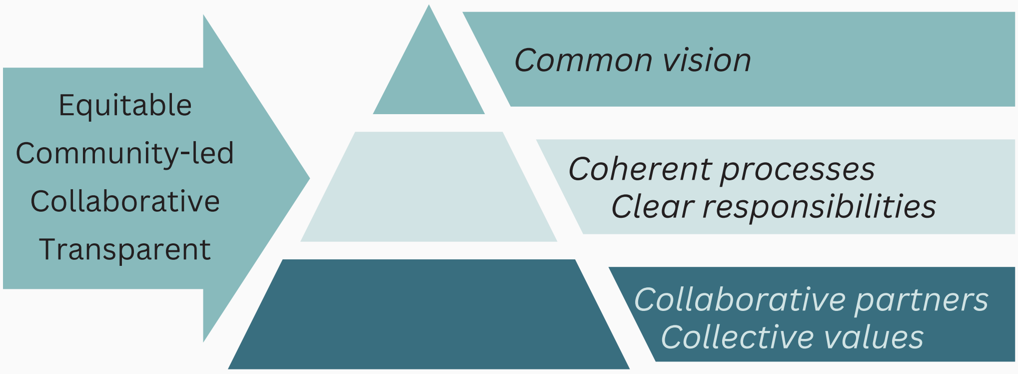
How are we different?

Key to the consortium is ‘distributed governance’ which challenges conventional power structures. Conventional structures involve a single institution as the administrator of network coordination, priority setting, and research oversight.

By separating these core responsibilities, community leadership, equitability, and transparency are embedded in the way we operate, enhancing collaboration toward a common goal.



Distributed governance



Motto: *Individual activity with collective values for systemic benefit*

- *Priority setting*: A lived experience authority will be established with lived experience peak advocacy organisations to oversee research co-design and co-leadership.
- *Research oversight:* Mental health research teams and service providers collaborate for implementation research that addresses the co-designed priorities.
- *Network coordination:* A not-for-profit advocacy body for research in the mental health sector will act as the hub of coordination of the network.

CoRTA consolidates existing collaborations while accommodating competition toward a common vision, thereby *enabling* translational research that addresses community priorities rather than becoming a gatekeeper.

CoRTA’s strength is in diversity of partnership underpinned by a research master protocol that guides evidence generation with the consortium in the same direction, and enables pooling of research data over time to coherently answer an overarching research question[1].

Roadmap & strategy for action

Phase 1: Formation

Move from *collective vision* to *verifiable commitment*

Partnership agreement fully executed with all partners:

- Core functions of the consortium articulated
- Commitments within scope of partners clarified
- Working group structure formalised

Distributed governance model function and scope clearly defined:

- Lived experience authority
- Research development group
- Network coordination hub

Operational guidelines collectively developed and endorsed:

- Processes for equity, decision-making, and conflict resolution
- Procedures for research development and support
- Principles for transparent funds management

Resourcing strategy identified and mapped:

- Value proposition for funders
- Seed funding opportunities
- Long-term sustainability strategy

Milestone achievements	**Success indicators**
• Partnership agreement signed. • Core documentation endorsed. • Initial funding pipeline identified.	• Communications from all partners via internal and public channels (newsletters, social media, etc). • Funding applications submitted.

Phase 2: Stand-up

Build a shared direction for community-led translational research

Resourcing secured for:

- Lived experience and community-led governance
- Co-design of lived experience outcomes framework aligned with policy priorities
- Development of lived experience networks with service providers
- Co-production of implementation trials aligned with co-designed outcomes

Members and contributors mobilised for:

- Lived experience and First Nations authority
- Working groups for lived experience network formation
- Research co-production teams
- Consortium coordination hub

Core activities begun:

- Co-designed lived experience outcomes framework
- Lived experience networks initiated across partners
- ‘Master protocol’ to enable implementation trials
- Dynamic risk register reviewed quarterly by governance groups

Milestone achievements	Success indicators
• Funds secured specifically for consortium establishment. • ‘Backbone capacity’ established through authority, groups, teams and hub. • Publication of guiding documents for the consortium. • Collaborative research agreement finalised with partners.	• Funds disbursed to partners to support consortium functions. • Individuals recruited to fulfil membership and contributor functions. • Consortium activity monitored and progress toward milestones documented. • Communications from all partners (newsletters, social media, etc) and membership structure described on the consortium website. • Citation of consortium outputs in regional plans and partner organisation strategies.

Phase 3: Deliver

Connect relational infrastructure to enhance capacity

Lived experience network harmonisation

- Consistent processes lived experience networks for extensive engagement.
- Embedded capacity building for lived experience led research.
- Community forums used for consultation and evidence generation.

Workforce capacity building networks

- Opportunities for co-design and co-production across staff and researchers.
- Capability development in implementation science and quality improvement.
- Strong feedback loops linking evidence to care processes and organisational culture.

Research network integration

- Longitudinal data aligned with lived experience outcomes and system needs.
- Establish data sharing arrangements across research teams.
- Enable use of data systems across settings for evaluation.
- Embed research recruitment pathways into routine care.

End-to-end translational research pipeline

- PHN-supported co-design and local evidence synthesis to inform commissioning.
- Government funding for workforce and service innovation aligned with lived experience outcomes framework.
- Nationally competitive grants (NHMRC, MRFF, ARC) secured for implementation trials aligned with community needs and policy priorities.

Milestone achievements	**Success indicators**
• Establishment of lived experience networks within each service provider partner. • Development of capacity building activities with lived experience and workforce. • Master protocol enacted with data sharing arrangements across research teams. • Funding secured from a diverse range of competitive, commissioned, government, industry, and philanthropic sources.	• The number, size, demographic and engagement processes with lived experience networks and forums across partners. • Citation of outputs and utilisation of evidence in planning, policy and partner organisation strategy. • Funding proposals submitted and the sources and amount successfully secured for core functions and implementation trials.

Phase 4: Scale

Hold the consortium accountable to the reform mission and vision

Position the consortium as a system-level influencer:

- Embed the consortium into monitoring and reporting performance indicators for policy, commissioning and advocacy organisations and service contracts to solidify engagement.
- Ensure that evidence is disseminated via tailored strategies for policymakers, commissioners, services and communities, and used to guide regional planning and policy.
- Evidence-to-action accountability loops established through policy/commissioning “challenge reports”, public-facing reporting on system performance gaps, and formal response requirements from ‘system connectors’ (advocacy/planning/commissioning partners).
- Replicate the consortium development process across regions, being led by local community needs and relationships, but maintaining fundamental principles of transparency, equitability, community leadership and collective impact.

Milestone achievements	Success indicators
• Reporting on consortium achievements evident in strategic planning ad review documents. • Evidence generated adopted in planning and commissioning. • Consortium approach to reform developed with other communities.	• The number and types of reports and plans that adopt evidence generated with the consortium. • Citation of outputs and utilisation of evidence in regional planning, policy and partner organisation strategy. • Engagement and interest in replicating the consortium approach in other regions.

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