Submission to the Review of PHN Business Model & Mental Health Flexible Funding Model.

Department of Health and Aged Care.

January 22, 2025.

Acknowledgement of Country

The Mental Health Lived Experience Peak Queensland (MHLEPQ) respectfully acknowledges the Traditional Custodians of the Lands and Waters throughout Queensland. We thank the Elders—past, present, and emerging—for their wisdom and enduring strength.

We recognise that the legacy of colonisation has profoundly impacted First Nations peoples, contributing to unique and significant experiences of societal exclusion and health inequities. Colonisation has enforced systems of racism, stigma, and discrimination, leading to intergenerational social disadvantage and marginalisation. This further impacts the social and emotional wellbeing of First Nations communities.

We acknowledge the enduring resilience and resistance of First Nations peoples in the face of these adversities. We respect their rights and autonomy to lead their own healing journeys, guided by their beliefs and traditional practices and connectedness to Country, family, and spirit.

Who are the MHLEPQ?

The Mental Health Lived Experience Peak Queensland (MHLEPQ) was established in July 2021 to provide advice and advocacy informed by people with lived and living experience (LLE) of the Queensland mental health system. Our work is underpinned by equity, access, cultural safety, recovery, and human rights and we are funded by the Mental Health, Alcohol and Other Drugs Branch, Qld Department of Health. Our peak body advocates for systemic reform of the mental health and suicide prevention systems by partnering and connecting people with lived and living experience for collaborative representation within relevant community, primary, secondary? and tertiary healthcare activities, including joint regional planning. MHLEPQ is a member of the National Mental Health Consumer Alliance, where other state and territory consumer peak bodies meet to coordinate on shared issues, including issues relating to Commonwealth, state and regional government-funded services.

Solidarity with lived and living experience

The MHLEPQ supports people with lived and living experience of mental ill-health, distress and suicidality, some of whom have been harmed by breaches of their human rights within culturally unsafe systems that they sought for support. We work in partnership with and are guided by the lived and living experiences and expertise of the MHLEPQ members, whose valuable recommendations have the power to create lasting change. MHLEPQ is committed to advocating for a human rights-based approach across the mental health and social systems, ensuring reform toward more representative, inclusive and responsive systems that meet the needs of the communities they serve.

Human rights statement

Mental health is integral to the human experience and is related to a person's ability to participate in society and live according to their own sociocultural and political values. The MHLEPQ advocates that the right to mental health is a fundamental human right and a whole-of-society obligation to promote, protect, and uphold.

The right to health and wellbeing should include the system and services working with the whole of person support with the social determinants of mental health such as adequate housing, a clean, healthy and sustainable environment, and health services that are affordable, effective, and culturally appropriate. By acknowledging mental health as a fundamental human right, we affirm our commitment to a just and equitable society where everyone can thrive. Human rights in mental health are both a constitutional and working principle of the peak

and one of the main objectives of its advocacy work. The MHLEPQ work with members to prioritise the human right to mental health for all Queenslanders.

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Recommendations

Program objectives and activities
1. That the Commonwealth government review the PHN funding strategy using equity principles to prioritise timely access and choice based on community health needs, including a program objective for lived experience-led change and embedding lived experience engagement.
2. That the Department requires PHNs to report on demonstrated oversight, evaluation, and quality improvement of co-design with people with lived and living experience, their carers, family, kin and communities, and the lived experience workforce within the projects they commission. Existing LE Governance and Workforce Guidance frameworks should form the basis of the reporting.
3. The MHLEPQ advise that the Commonwealth Government commission lived experience-led research and regular stocktakes of PHN activity in terms of LE engagement and LE Workforce Development including their roles and responsibilities outlined in existing key documents (see Appendix 1).
Program governance and support for improvements
4. That the Government provide budget line items for consumer and carer co-design and resourcing and terms of reference for PHNs to report with data that builds on the Mental Health Lived Experience Engagement Network (MHLEEN) and PHN stocktakes.
5. That the business case for embedding lived experience networks and workforce development is championed by people in identified lived experience roles. at the governance level in key organisations including the Department, National Consumer and Care Peaks, and the PHNs. PHN CEOs should work closely with the Department and a lived experience governance group for accountability of the work.
6. That the Commonwealth government monitors, reports and provides transparency about co-design processes with people with lived and living experience and the lived experience workforce within PHN regional planning and PHN-funded programs, based on national lived experience governance and lived experience workforce frameworks.
Regional planning, communication and engagement
7. That Queensland PHNs advance a human rights-based culture by demonstrating their commitment to the Human Rights Act 2019 (Qld)(HRA). Where PHNs directly or indirectly make decisions relating to state services, they may be a public entity under Section 58(1) of the HRA

and therefore obliged to demonstrate appropriate consideration for human rights in decision-making as required by the HRA.
8. That departments and PHNs are accountable for quality and safety improvement of values-based KPIs including person-centred, recovery-orientated, culturally safe and trauma-aware models and services.
9. All joint regional plans should provide frameworks for consumer engagement and lived experience workforce development that PHNs report to National Government and base recommendations to each jurisdiction on (see recommendation 6).
10. That coordination and independent advice be provided at the national, state/territory and regional local levels to ensure: i. National monitoring and feedback about schemes such as Medicare and Mental Health Hubs; ii. Peak bodies oversee the implementation of psychosocial services and other jurisdictional areas of responsibility according to the bilateral agreements; and iii. Increased provision of local services to priority populations that are not currently supported by PHN-commissioned services.
Program funding arrangements
11. The MHLEPQ recommend standardised reporting on PHN commissioning processes that include KPIs for co-commissioned services with HHSs which demonstrate person-centred, place-based responses to community need.
12. That the Commonwealth government prioritise budget allocation for PHNs to continue the development of lived experience networks, engagement and lived experience (peer) workforce development
13. The MHLEPQ advocates for a strategic governance plan between the Department, PHNs and the National Consumer and Care Peaks to continue MHLEENs work on systemic embedding of the *Lived Experience Governance Framework*[1]/*Toolkit*[2] and *Lived Experience Workforce Development in Mental Health*[3] resource for PHNs.

[1] Hodges, E., Leditschke, A., Solonsch, L., Singh, J & Blazewicz, T. (2023). The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All. Prepared by LELAN for the NMHCCF & MHLEEN. Mental Health Australia, Canberra.

[2] Hodges, E., Leditschke, A., Solonsch, L., Singh, J & Blazewicz, T. (2023). A toolkit to Authentically Embed Lived Experience Governance: Centring People, Identity and Human Rights for the Benefit of All. Prepared by LELAN for the NMHCCF & MHLEEN. Mental Health Australia, Canberra.

[3] National Mental Health Commission (2023). National Lived Experience (Peer) Workforce Development Guidelines. Lived Experience workforce development in mental health. A planning resource for Primary Health Networks

14. The MHLEPQ support PHN co-contribution across each jurisdiction to develop and embed lived and living experience expertise across core business, work that was begun by the MHLEEN in 2018.
Role within the mental health system (MHFFS)
15. That the Department requires the PHNs to report on their commissioning decision-making, including an analysis of the lived experience evidence base and data about where budget underspending has been directed.
16. That the Department require consistent PHN reporting to the National Consumer and Care bodies on evaluation KPIs beyond K5, K10 and the Your Experience of Service (YES) Survey, adopting evidence from the lived experience knowledge base in areas where there are clear outcome improvements for consumers.
17. The MHLEPQ advises that PHNs appoint lived experience framework 'champions' for training lived experience advisory groups throughout the networks.
18. The basis of commissioning decision-making by PHNs should be service user recommendations.
19. That state/territory consumer peak bodies collaborate with and interface between PHN and state/territory-funded streams of the mental healthcare system to support more integrated delivery of services and lived and living experience collaboration.

Our approach to this submission

The MHLEPQ support the intention of this Review to consider whether the PHNs are achieving their objectives and functions to deliver place-based approaches to local population health needs. We have included perspectives and recommendations through the lens of people with lived and living experience who have been consumers of services commissioned by several Queensland PHNs. The MHLEPQ also worked with members who have worked within various PHNs in both identified and non-identified roles and within the lived experience (peer) workforce.

There are two key issues about this review process that MHLEPQ would like to highlight:

i. The timing of the consultation over the Christmas period and short period of consultation has not allowed time for LLE stakeholders to respond.
ii. The stakeholder consultation questions did not reflect pertinent areas most relevant to consumers or carers to review.

We have mitigated this by providing member insights more broadly against the PHN Strategy in the discussion section and making recommendations on the five (5) focus areas of the Department's consultation document *PHN Business Model Review and Mental Health Flexible Funding Stream Review* (the Discussion Paper).

A focus group was held with members before the draft submission was reviewed and approved. This submission contains four (4) major sections that discuss the MHLEPQ position and principles; and the three core functions of the PHNs: coordination, commissioning and capacity-building. Direct member quotes are made in green within the body of the text. Advice was also sought from members individually who were involved with their local PHNs in regional planning and commissioning of services.

The MHLEPQ discussion in the body of the submission was structured around the three core PHN functions under the PHN Strategy:

1. **Coordination** and integration of local health care in collaboration with state Local Hospital Networks or equivalent;
2. **Commissioning** of primary care and mental health services to address population health needs; and
3. **Capacity-building** and support to primary care and mental health providers.

Overview

The MHLEPQ is grateful for the opportunity to submit to the Department of Health and Aged Care's (the Department) consultation on the Review of Primary Health Network Business Model & Mental Health Flexible Funding Model (the Review). There is support amongst our members for the concept of Commonwealth-funded PHNs to increase the efficiency and coordination of primary health providers such as GPs and allied health professionals and work with the state government and the Mental Health Hospital and Health Services in QLD.

The MHLEPQ is committed to working with and representing people with lived and living experience of mental ill-health and suicidality in Queensland. There is the expectation that the seven (7) Queensland PHNs implement place-based, lived experience-led, co-design processes. PHNs are also crucial for integrated mental health and suicide prevention systems for our members by creating seamless pathways between state-funded tertiary and secondary mental health services and primary mental healthcare such as psychosocial services.

The effective and sustainable PHN business model needs to be strategically designed from the national level with at least minimum guidelines, policies and processes for both internal PHN operations and the services they commission to avoid duplication and resources. Minimum standards must also be dynamic and adaptable to people at the state level due to the unique differences, for example in Queensland with large diversities of socio-economic status and geography with large remote, rural and regional population groups. There must be capacity at the local and regional levels to hear directly from PLE about the services they need.

MHLEPQ apply human rights and equity lenses to analyse systems from the viewpoint of people with lived and living experience. Health is a fundamental human right that requires increased resourcing for priority populations to ensure that access is provided for all people, irrespective of ethnicity, identity, sexual orientation or locality. MHLEPQ use working principles that prevention and early intervention of mental distress, ill-health and suicidality begin and end in the community and must be determined by the person and supported appropriately by family, carers

and kin. We consider the upstream social determinants of wellbeing to make systems reform recommendations and advocate for equitable and timely access and choice for support, in line with Queensland's *Better Care Together* strategic plan for mental health system reform (p. 8): MHLEPQ also work and advocate across state government departments such as Community Services, Housing, Justice and Child Protection to try to ensure the whole of person (not just the mental health) is addressed.

New service models and initiatives under the Bilateral Schedule focus on providing services in the community – in a more joined up and integrated way to offer more holistic responses […] [promotion and prevention] includes addressing social determinants of health such as inequity, stigma and discrimination, environmental and sociocultural factors including exposure to trauma and violence, and harm reduction.

Discussion

I don't think there's a real solid understanding within the Community Australia wide about the function and role of the PHN […] it's really confusing some of the programmes or initiatives they deliver and also there's like, astronomical wait times

~MHLEPQ member~

MHLEPQ position and principles

1. **Lived experience leadership** frameworks must be embedded widely in mental health and suicide prevention systems at all levels of seniority within governance, strategic planning, policy and program design, service delivery and community engagement. Both PHN staff and non-staff should comprise the lived experience team.

Lived experience leadership across the system, including by and with people with lived experience, is core to this vision being realised and is itself a key driver of the broader systems change that the mental health and social services sector require[4].

The success of engagement, partnership and co-design with lived and living experience communities, and the effectiveness of lived experience (peer) workforce development depends on lived

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

experience leadership[5]. The PHNs received funding for the National PHN Mental Health Lived Experience Engagement Network (MHLEEN) from 2018, which made some progress concerning LE Leadership. Most notably, the co-production of Lived Experience Leadership work and partnership between MHLEEN and the National Mental Health Consumer and Carer Forum (NMHCCF). Numerous LE-led strategies, guidelines and resources have been developed over recent years, and it is now time to utilise LE expertise that the consumer and carer peak bodies can bring to the table for implementation (Appendix 1). The MHLEPQ would like to see a proactive approach by PHNs to peak bodies for genuine partnership with the peaks and their members that could inform the transformational change required.

2. **A strong evidence base exists** for co-design, co-production and co-governance of lived experience expertise and lived experience (peer) workforce at all system levels (see Appendix 1). The gap between evidence and practice can be narrowed through the implementation, evaluation and monitoring of those frameworks. MHLEPQ supports the Lived Experience Governance Framework and Toolkit which comprehensively provides the tools for PHNs to implement.
3. **Community-led planning and implementation** must be directed according to local need in collaboration with consumers and carers. The Department provided this advice to PHNs in their consumer and carer engagement and participation guidance on primary mental health care flexible funding. This guidance material was produced in 2016 and requires PHNs to embed consumer and carer engagement and participation in regional planning and commissioning.

But if you don't have the general community involved in, I guess saying what they need and how they would like that to happen then it's [PHNs] not going to be fit for purpose

~MHLEPQ member~

4. The MHLEPQ supports the **broader definition of health needs** included in the *Joint Regional Needs Assessment Framework* that considers the "wider social and environmental determinants of health, such as deprivation, housing, diet, education and employment […] beyond the

[5] Byrne, L., Stratford, A., & Davidson., L (2018). The global need for lived experience leadership. Psychiatr Rehabil J. Vol 41(1) pp. 76-79, DOI: https://doi.org/10.1037/prj0000289

confines of the medical model based on health services".[6] This deficit is especially prevalent around physical health and wellbeing, where people who look for encouragement and support to exercise and improve their diet feel this is:

[…] so so important to mental health and wellbeing. I feel that the services are not holistic.

~MHLEPQ member~

In practicality, lived and living experience members continue to describe the lack of visibility of upstream determinants involved in the prevention and early intervention of mental ill-health, distress and suicidality.

[…] one of the biggest topics that comes up in just about every consultation I've had is housing. Oh, I should say, mental health and housing crisis […] and they're setting up the [accommodation] spaces and spending the money and then all of a sudden, it's gone and they're gone.

~MHLEPQ member~

5. **Equity and human rights principles** must underpin all Commonwealth, state/territory and local authority decision-making if a fairer, more integrated and accessible mental health system is to be experienced by all. Evidence of the application of these principles is needed rather than meaningless 'motherhood' statements that are tagged on when referring to stakeholders and become tokenistic.
6. **The MHLEPQ advise prioritising** resourcing and a formal agreement between the National Consumer and Care Peak bodies and all PHNs to continue and build on the learnings and foundational work undertaken by MHLEEN foundational work for establishing the Lived Experience Governance Framework and Toolkit. The MHLEPQ notes that the Queensland Mental Health Commission has adopted and is currently implementing the Framework with the guidance and LE expertise.
7. **State-specific data** must inform equitable healthcare expenditure by sector, population and location. Nationally, hospital budgets continue as the largest component of expenditure and are growing[7], while the primary healthcare spending dropped by 8.2% from the previous year in 2022-2023[8]. In Queensland, large inequities persist across remote,

[6] https://www.health.qld.gov.au/__data/assets/pdf_file/0028/1351549/Joint-Regional-Needs-Assessment-Framework.pdf, p.15

[7] https://www.choreport.health.qld.gov.au/our-investment/expenditure

[8] https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure

rural and regional areas, which points to the need for state peak bodies to work closely with PHNs toward equitable solutions. Queensland PHNs need to be more proactive in co-contributing and investing in integrated services that are required across the state.

8. The MHLEPQ supports the **primacy of cultural safety** as one of the six key priorities for targeted PHN work, following the four fundamental principles outlined in the Joint Statement of Queensland – Commonwealth Partnership[9].
9. **PHNs have a corporatised operational model** (despite being structured as not-for-profits) and service providers are required to win highly competitive commissioning contracts that can drain the resources of small NGOs. A commissioning framework may be less visible than in 2016 and there is a view that PHNs may now function on a more transactional contracting basis. While they exist as a quasi-government entity, where there is underspend and or new funding this should not be used to automatically top up the existing services and 'status quo'. Instead, the surplus should be used for innovation and transformational new models of care such as LE-led and managed programs, and to fulfil its roles and responsibilities to the LE workforce.
10. **Issues with Commonwealth funding of Queenslander's mental healthcare** were identified in the findings from the *Inquiry into the opportunities to improve mental health outcomes for Queenslanders*[10], including limitations to joint planning and co-commissioning activities between PHNs and HHSs. This was evident during the NDIS transition where state government and PHNs did not work together and pool the funding but instead created silos and disjointed service navigation.
11. **Community participation and engagement** should be centred by incorporating community development frameworks in the commissioning cycle. 'Nothing about us without us' can be achieved by:
    i. PHNs having manager/executive level identified roles within the PHN to oversee their engagement strategies and activities
    ii. having LLE expertise and consultants working alongside the PHNs.

[9] https://www.health.qld.gov.au/__data/assets/pdf_file/0028/1351549/Joint-Regional-Needs-Assessment-Framework.pdf

[10] Qld Mental Health Select Committee (2022). Report No. 1, 57th Parliament: Inquiry into the opportunities to improve mental health outcomes for Queenslanders

iii. Ensuring participation and engagement strategies are jointly developed by PHNs and HHSs, and
iv. The Department building in KPIs and public reporting of the level of community involvement in the regional planning and commissioning cycle.

12. **Sustainable service delivery is compromised** by short commissioning cycles, negatively impacting all partners in the supply chain: PHN, PHN-commissioned service workforce, and consumers. Inconsistent and transient service provision may be experienced as systemic trauma by consumers due to disruption in supportive relationships:

We've already got systemic trauma, so…
Like the safe space as when or if the safe space is to close.
You're just going to create even more systemic trauma, and you're going to just do more harm, potentially than even having them in the first place, because soon as people feel safe and secure going and utilising a space like that.

~MHLEPQ member~

PHN Coordination

1. **The lack of cohesion** between HHS/primary and primary/community healthcare streams puts pressure on PHNs, with consumers left in the silos between tertiary/secondary/primary care, as well as primary/community care. Consumers should not be required to understand the different funding pools and eligibility criteria across commonwealth- and state-funded streams. Working in collaboration with consumers and other organisations across the continuum of care is essential to cohesively meet their needs:

It's that warm homely environment and come and go as you please. There's your own room. There's key workers there to talk to. You've got a doctor. You've got a psychiatrist once a week, and all your meds are locked away and they make sure you take the meds every night […] I knew what I needed and located their service to what I needed […] people who have short stays or have had a little bit of time there need a transition back into the community

~MHLEPQ member~

2. **Lived and living experience participation and engagement are inconsistent** across the Queensland PHNs, where some have supported the creation of lived experience networks and others have not (for example, Peer Participation in Mental Health Services (PPIMS) Network in Brisbane North).

3. **PHN CEO and Executive commitment is a critical component** of building the culture and commitment required to make transformational change. We have however seen that with a change of Executive level positions a PHN who had previously built a genuine foundation and partnership with LE such as having Lived Experience Teams within the PHN, providing resources and support to create independent LE networks and advisory structures and solid governance including LE can restructure and discontinue and lose the momentum.
4. **Consistency is lacking across PHNs** for advocacy and lived experience advice despite guidelines such as the 2016 Consumer and Care Engagement and Participation and the planning resource for workforce development for PHNs that have been around since 2019. Work has been undertaken by MHLEEN to address inconsistency across PHNs through regular meetings, sharing of resources and Annual Forums where PLE join PHNs to review and reflect on what has been done, identify what the current priorities are and provide recommendations to the Department and PHN CEO's. While the foundational work has been achieved, the funding of the MHLEEN ceases in June 2025 and there is community uncertainty about the continuation of this work. Statements were made by both the Department and PHNs about working with the new National Peaks, yet no development has occurred apart from an RTF to create a transition plan post-June 2025.
5. **Cohesion and navigation** across the primary health networks and GP and allied healthcare partners is lacking and necessary:

I don't think the PHN would ever not want to be collaborating with GPs, I think it's just realistically they can't. They can't do it in a sustainable manner just based on the number of GP clinics that operate across the region.

6. **Consumers view mandatory partnership between HHSs and PHNs** for joint regional planning as a positive step, given that there is some uncertainty about the extent of collaboration to date. MHLEPQ members note that they have experienced different levels of maturity when it comes to joint co-designing.
7. **There is a lack of clarity about areas of responsibility** between the Commonwealth and state/territories for the integration of psychosocial services, as per the bilateral agreements. The bilateral agreements were put in place to assist in addressing this. MHLEEN had

commenced pilot projects with PHNs working collaboratively on statewide issues, which the MHLEPQ advise should continue.

PHN Commissioning

1. **Commissioned peer-led NGO services** are impacted by short-term and insecure funding, creating difficulties for small teams and organisations writing budget bids and impacting staff retention due to fears about job security.
2. **Concerns about a problematic "underspend" policy** exist, whereby there is little transparency for how underspent funds are allocated or decided. The practice of topping up existing commissioned organisations with budget underspend should be reported, and more discerning practices encouraged. A member who had worked with PHNs described:

topping up of existing as opposed to looking at other uses of underspend to go towards innovative pilots etc… it's the old practice of "quickly spend any underspend in case you lose it" mentality … which in private enterprise is not good practice.

~MHLEPQ member~

3. **The MHLEPQ advocates for a lived experience-specific budget item** provided by the Department to the PHNs to support capacity building of lived experience participation and engagement and lived experience (peer) workforce development in their regional areas. The MHLEPQ advocate for co-contribution towards a National Coordinating Entity to continue the work and build on learnings from MHLEEN.
4. **Clinical evidence bases are prioritised over lived experience-led evidence bases** despite the influx of recent research supporting lived experience-led services and person-centred, culturally safe, and recovery-oriented support models[11].
5. **Access and choice are extremely variable** across the 7 Queensland PHNs and this is of particular significance in Western Queensland. Wait times continue to be an issue and availability is present according to post-code and some amount of luck:

[named PHN] doesn't have a Head to Health centre yet within the region. But they're meant to be delivering services that are accessible to the community […] there shouldn't be wait times for those services. Or if there are wait times, they shouldn't be six months.

[11] See: NMHCCF &MHLEEN Lived Experience Leadership Digital Library: https://livedexperiencedigitallibrary.org.au/

PHN Capacity-building

1. **Inconsistent mental health and other drug service provision** occur throughout the huge geographical and diverse communities of Queensland, particularly for rural and remote communities, many of whom do not understand the role and functioning of the PHNs.
2. **Datasets don't sufficiently** represent lived experience networks or activities at the national or local levels. Quality improvement requires a lived experience-led evaluation with broader qualitative and quantitative KPIs, for example, the evaluation conducted by peer participants and Brisbane North PHN of the Partners in Recovery (PiR) program[12].
3. **Members advocate for the expansion of Community Hub models** (favourably evaluated in metropolitan areas), in addition to peer-led spaces with access to clinicians and other allied health practitioners who provide a range of services that people can select from to direct their recovery.
4. **There is support for the Joint Regional Needs Assessment** framework approach to understanding community needs, but it is unclear whether representative engagement is being achieved to support PHN objectives. Transparency and accountability for equitable engagement of First Nations communities, people with lived and living experience and minority and marginalised communities such as LGBTQIA+, culturally and racially marginalised (CARM) and young people is required.
5. **Despite obligations for PHNs not to duplicate** state-HHS services, there are barriers to receiving timely and appropriate support in the HHSs, and those services could potentially be provided by primary providers, such as in the Head to Health and Safe Space environments:

There's almost like this mismatch between getting a timely adequate response based on your individual needs based on your individual needs at that time and what you can and can't access… "oh, you're not acute enough for the public mental health services". Head to Health is trying to be that bridge, but [PHN} doesn't have a Head to Health yet – if you don't have referral pathways set up, there's no way for people to go to get timely access and support.

~MHLEPQ member~

[12] North Brisbane Partners in Recovery (2016). Peer Participation Project Report. Accessible here.

Contact

MHLEPQ welcomes further discussion about this submission. Please contact:

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Appendix 1: Key reference documents relating to PHNs

Engagement

https://www.health.gov.au/sites/default/files/documents/2021/04/primary-health-networks-phn-mental-health-care-guidance-consumer-and-carer-engagement-and-participation.pdf

Lived experience (peer) workforce

2021: https://www.health.gov.au/sites/default/files/documents/2021/04/primary-health-networks-phn-mental-health-care-guidance-peer-workforce-role-in-mental-health-and-suicide-prevention.pdf

2022: https://www.mentalhealthcommission.gov.au/publications/lived-experience-workforce-development-mental-health

NMHCCF & MHLEEN

https://nmhccf.org.au/news/projects-launched-nmhccf-mhleen-lived-experience-leadership-projects

https://medicine.yale.edu/psychiatry/prch/train-consult/academy/current-cohorts/

Lived experience Leadership Digital Library (2023)

https://livedexperiencedigitallibrary.org.au/