# PHN Business Model Review Submission

January 2025

## Community Mental Health Australia

**Community Mental Health Australia (CMHA)** is the federated peak body representing the community-managed mental health sector across Australia's states and territories. We advocate for the needs of individuals with mental health challenges, ensuring they receive support at home and in their communities.

CMHA provides a unified voice for over 700 community-based, non-government organisations that work with tens of thousands of mental health consumers, families, and carers. The sector is a vital part of civil society, emphasizing accessibility, prevention, early intervention, and holistic approaches to mental well-being. These organisations also address the social determinants of health, offering a wide range of practical supports to enhance recovery and resilience.

Community Managed Organisations (CMOs) are a cornerstone of this sector, with many founded by people with lived experience. CMOs play a critical role in expanding the peer workforce and fostering recovery-oriented services. CMHA provides leadership and advocacy to highlight the importance of community mental health and psychosocial support, ensuring its benefits are recognized and valued nationwide.

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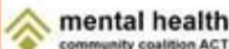

## Acknowledgements

CMHA sincerely thanks our member state and territory community mental health peaks for their expertise and contribution to this submission. These peak representative bodies comprise state community mental health organisations, lived experience advocates from diverse perspectives- LGBTIQA+, First Nation Peoples and culturally and linguistically diverse groups most affected by the withdrawal of community supports at the intersections of cultural identity and disability. We thank and acknowledge the custodians of this land, the Aboriginal and Torres Strait Islander people of the many traditional nations and language groups throughout Australia. We acknowledge the wisdom of their Elders past and present and pay our respect to the Aboriginal and Torres Strait Islander communities whose land was never ceded.

# Introduction

CMHA welcomes the opportunity to provide feedback to the PHN Business Model Review. Since the establishment of the PHN model in 2015 the Community Mental Health sector has partnered with PHN's to deliver psychosocial support programs and has a strong interest in seeing significant and wholesale reform to the current PHN model which is not fit for the purposes of growing a contemporary rights-based, trauma-informed mental health system with locally responsive capabilities for addressing the social determinants of mental health. CMHA notes the ANAO *'Effectiveness of the Department of Health and Aged Care's Performance Management of Primary Health Networks'* report and its eight recommendations and government response, and so will not focus on the performance, compliance, data, accountability and transparency issues that both the ANAO and the community managed mental health sector have raised. The mental health system has specific equity, rights, systemic violence and discrimination, justice and workforce challenges where PHN capability gaps are evident that this submission has focused on instead.

Additionally, four key international Australian and international developments have occurred since 2015 that require significant reforms to an outdated PHN business model that has proved itself to be incapable of delivering its original mandate (integration, coordination, gap-filling) for mental health in the real world:

1. **2017-2022: UN Human Rights Council Special Resolutions**
   Special Resolutions adopted by the UN Human Rights Council following the Special Rapporteur's landmark report on mental health in 2017, including the most recent Human Rights Council resolution on mental health, A/HRC/RES/52/12. These reports explicitly and repeatedly called for a move away from a medical model to a rights-based social model of mental health. PHNs are not resourced for transformation. The existing model is a BAU-template.

2. **2021: World Health Organisation (WHO) *Guidance on Community Mental Health Services*.**

   This document provides international evidence and guidance for the shift away from clinical models to social, rights based and community models of service. Both PHNs and state mental health services have proved to be incapable of shifting to non-clinical services and any review of a business model should interrogate where

these capability gaps are derived from. Members report ongoing clinical capture within PHNs and either ignorance or disinterest in engaging with the community sector.

3. **2023: UN General Assembly Resolution**

Australia co-sponsored the following resolution to the UN General Assembly 'Mental Health and psychosocial support for sustainable development and peace.'

This is the first resolution to address mental health adopted by the UN General Assembly and several of the Explanation of Position statements are worth including in this introduction to highlight the scale of transformation required if future PHNs are to be equipped to deliver needs-adapted services according to the will and preference of people experiencing psychosocial distress and disability.

*"For decades, an insufficient amount of attention has been devoted to mental health and psychosocial support services and systems. Too often, efforts have been centred around a medical model of disability, resulting in the dominance of approaches that favour biomedical intervention, medicalization, and institutionalization."*

**CMHA believes that Australia, as a Member State and as one of the five co-sponsoring countries, should use this review opportunity to ensure alignment in practice with this resolution. We would expect to see demonstrated consideration of our international obligations in any new PHN business model, including justifications if these obligations are not met.**

4. **2024: National Lived Experience Peak Bodies**

Establishment of two national Lived Experience peak bodies, the National Mental Health Consumer Alliance (NMHCA) and Mental Health Carers Australia (MHCA). These peak bodies continue the decades-long lived experience movement call for a move away from a clinically centred system to a social determinants and rights-based system. CMHA supports this call.

Collectively, these four developments provide substantial evidence that a transformation of the PHN business model, entrenched as it is within a broader medical culture and ecosystem is urgently required. The current business model lacks capabilities to enact the structural shift to a social and rights-based model of mental health required to meet the needs of people in the real world.

The current model was not designed by Lived Experience and reflects assumptions of social equity and effectiveness of service models that may be applicable in the broader health ecosystem, but do not reflect the real world experiences of people with lived experience of distress. This is particularly relevant for people with compounded disadvantage, such as First Nations people, LGBTIQ communities, CALD communities and rural and remote communities. Infants and children are also not well accommodated within the current business model given the importance of family/relational approaches. This needs to be urgently addressed.

CMHA's members regularly raise issues regarding inconsistent and rigid commissioning practices, the lack of transparency and accountability issues, and inefficiencies generated by the structure of the 31 PHN's.

Together with the ANAO Report, many other submissions, including from CMHA's member organisations cover these points well. CMHA supports particularly the Queensland Alliance for Mental Health (QAMH) and Western Australian Association for Mental Health (WAAMH) submissions' points in this regard, particularly given the regional and remote issues these states work with.

CMHA also supports the Mental Illness Fellowship Australia (MIFA) submission, particularly in highlighting concerns regarding governance, siloing, data and lack of co-production capability.

Finally, CMHA is delighted to note that for the first time the two national Lived Experience peak bodies (NMHCA and MHCA) have had the opportunity to provide submissions and hopes their recommendations, particularly in relation to building PHN capability to practice co-production with Lived Experience to bridge the gap between policy and practice are adopted. We note the de-commissioning of the PHN Lived Experience network, MHLEEN, and endorse the LE peaks assertion PHNs are not mature enough in their Lived Experience engagement capability to continue without a dedicated Lived Experience network.

Resource constraints mean this brief submission is confined to consultation with member peaks rather than an in-depth and data-supplemented one CMHA would have preferred to be able to provide. We remain committed to working with government in the next stage to ensure PHNs deliver value for money, needs-adapted services.

# Program Objectives and Activities

## Is the role of PHNs clear and understood?

CMHA members consistently report a lack of engagement with local PHN's and therefore a lack of clear understanding between what they experience on the ground and the intended role of PHN's. Because there is such changeability and capability variability between PHNs, together with high staff turnover, short funding cycles and opaque commissioning processes, services do not have a clear understanding of the role of PHNs. Members report a lack of clarity about role and responsibility delineations between DoHAC and PHNs, particularly in relation to flexibility and national-to-local constraints.

## What are the key roles played by PHNs?

Members report widespread variability in these roles, depending on local governance arrangements. There is no shared sense of the role of PHNs because of the difficulties with engagement and variable implementations of perceived roles across the country.

## How have the roles of PHNs evolved?

Despite ten years of maturation and some systemisation, particularly in driving telehealth innovations during COVID, there are no reports from members of evolution of their role. The perception of members is that the rigidity of the model itself as conveyed by PHNs, the clinical culture and opaque commissioning practices mean there is little perceived evolution or maturation of PHNs in the community managed mental health sector.

## What key examples can you share of the benefits delivered by PHNs?

CMHA members report occasional innovative service commissioning. Members are not aware of any performance data demonstrating benefits, particularly those defined by Lived Experience.

## What activities or programs does your PHN excel at delivering?

There are small pockets of better-than bad practice that are worth noting across Australia:

Brisbane North PHN had developed a strong national reputation for its excellence developing peer workforces and lived experience leadership across Australia through its MHLEEN and LEAD activities. This has been de-commissioned.

Northern Territory is known for being more innovative, flexible and responsive to community needs

## What additional roles should PHNs take on?

None. There was no member appetite for role expansion until PHNs develop capability to efficiently deliver within current role definitions.

## Are there roles currently performed by PHNs that might be more effectively managed by other organisations?

The current PHN structure was questioned by members as adding unnecessary layers of rigid administrative burden. One member cited Headspace as an example

> "The funding to run a headspace, within the parameters of the framework that is the headspace model is very difficult, and we struggle to meet all of the expectations of the contract. It is time for the headspace model to be reviewed and the PHN could make some inroads to this happening. We are not across all of the details, however it seems that money spent using the PHN to "manage" the contact could be better spent on the mental health needs of young people. We understand that someone needs to be the contact, but there seems to be an unnecessary layer"
>
> This is consistent feedback received from members; that PHNs often add an inefficient layer of bureaucracy without demonstrated outcomes, and at the expense of a resource-starved mental health system straining under overwhelming demand; a system that does not provide any data on effectiveness for people with lived experience and their families/kin.

# Program governance

Members consulted relayed serious concerns about governance structures, culture and processes across the country. Consistently, feedback provided converged around the following systemic capability failures:

- Opaque and ad-hoc commissioning, data management and performance evaluation practices

- Poor engagement with community managed mental health sector
- Poor engagement with Lived Experience
- Board memberships reflecting clinical rather than social, lived experience and rights-based expertise
- Relationships characterised as being low-trust and high-frustration.

## Regional Planning, Communication and Engagement

Whilst some PHNs participated in joint regional planning practices, the lack of meaningful engagement with the Community Managed Mental Health sector, Lived Experience expertise and the lack of demonstrated contemporary social-determinants and rights-based understandings of the conceptualisation of distress meant much of this is irrelevant if the regional planning lacks capability in meeting real world needs of people with lived experience. PHNs have not demonstrated capability in meeting the needs of people in regional areas, particularly, as highlighted in the WAAMH PHN Review submission (pp8-9)

## Program Funding Arrangements

Short term contracts, inadequate notice for contract renewal, lack of indexation responsiveness, were consistently raised by members as key issues undermining service sustainability. Additionally, inflexibility was noted (despite engagement with PHN staff in the following example being characterised as professional and friendly) One member noted:

*"they are a bit rigid with acquittals making an already difficult contract a bit hard to deliver as perfectly as they expect. Staffing is never rigid, therefore recruitment and staffing gaps aren't taken into consideration which leaves us underspending in salaries in some months, but the funds cannot be moved to an area of need e.g. paying for ASD assessment."*

## Mental Health Flexible Funding Stream

The flexible funding stream, whilst having potential, was also considered problematic in its implementation by PHNs. As CMHA member QAMH put it,

*"The role of PHNs in commissioning services through the mental health flexible funding stream warrants scrutiny. Members report that commissioning approaches are not always evidence-based, with 'new' often prioritised over proven effective approaches. There is also concern that prescribed programs are frequently monopolised by large non-profits who deliver the same program across multiple PHNs, diluting local responsiveness and creating barriers for smaller providers with local knowledge and community integration."*

# Recommendations

CMHA recommends the following reforms based on our consultations.

### 1. Governance Reform

- Government to work with Lived Experience peak bodies to redesign governance arrangements for PHN programs, including evaluation.
- Streamlined, standard rights-based performance measurement of PHNs and programs funded by PHNs to be published regularly.

- Lived Experience embedded at every governance and leadership level, regularly reported against, building on the annual MHLEEN stocktake.
- Commissioning Frameworks transformed to provide transparency and alignment with the Australian Lived Experience Governance Framework (co-produced with MHLEEN), WHO Guidance on Community Mental Health Services and the UN General Assembly Resolution on 'Mental Health and psychosocial support for sustainable development and peace'.
- Consistent (and family-inclusive) rights and outcomes-based data collection and reporting across Australia.
- National Mental Health Commission to monitor, report and evaluate PHNs performance on regular basis.

## 2. Stakeholder Engagement Reform

- Stronger mandated requirements (reported against) to engage meaningfully and regularly with service providers and community members.
- CMHA supports the National Mental Health Consumer Alliance (NMHCA) and Mental Health Carers Australia (MHCA) submissions regarding Lived Experience engagement and leadership, including restoration of MHLEEN.
- Develop capability to strategically support and build capacity for smaller locally responsive and lived experience-led providers.
- Develop capability for cross-portfolio engagement to address social determinants of mental health.

## 3. Funding Model Reform

- Government level funding timeliness in giving PHNs appropriate time to consult with stakeholders.
- Implement the Productivity Commission recommendation for at least five year funding cycles.
- Indexation must be reflected in contracts and not avoided through contract roll-overs.
- Mechanisms built in for engagement with service providers to ensure funding reflects real world costs.
- Alternative commissioning models reflecting need for local and flexible responsiveness that reduce administrative burden on providers.
- Re-orient funding and reporting frameworks to incentivise (non-clinical) outcomes for people with lived experience.

# Conclusion

PHNs are structurally embedded in Australia's mental health system, with over $11.6bn going to PHNs since their establishment. There is no evidence that effectiveness, rights-alignment, experiences and outcomes for people with lived experience have been demonstrated as a consequence. Service providers in the community managed sector remain largely disenfranchised from PHNs and frustrated at their performance, commissioning and engagement practices.

In mental health, like the NDIS over the same period, PHNs have been charged with commissioning billions of dollars for mental health supports but have failed to deliver effective or equitable outcomes for people with lived experience, failed to strategically steward sustainable and robust community sector markets, and remained unresponsive and unaccountable in doing so.

This leaves the community-managed sector, given the well-documented inability of state and territory governments to commission much above 5% of their budgets towards non-clinical psychosocial supports, nowhere to turn and minimal opportunity to point to examples of good practice to build upon.

Whilst it is clear Federal Government mental health funding is necessary and still sits disproportionately well below the burden of 'disease' (noting the UN Special Rapporteur for Mental Health in his UN Reports urged a shift towards a 'burden of obstacles' perspective), the community-managed mental health sector asks government to use the PHN review to more closely align PHNs with a capability to commission towards the *Measurements that Matter* Framework, and to begin implementing Australia's commitment to the UN General Assembly's Resolution 'Mental Health and *Psychosocial Support* for Sustainable Development and Peace' (our italics) that Australia co-sponsored in 2023.

Whilst PHNs remain captured by biomedicalization, mental health reform will remain stuck. Our recommendations acknowledge the scale of transformation required by focusing on engagement, measurement and cultural change.

CMHA is committed to working constructively with government in the required reform work and is encouraged that government agreed with seven of the eight ANAO recommendations (and agreed in principle with the eighth). However it is awaiting a signal from government that it is committed to addressing the mental health-specific significant structural and cultural capability gaps with PHNs identified in our submission.