VACCHO | The Balit Durn Durn Centre

Review of the Mental Health and Suicide Prevention Agreement

VACCHO and the Balit Durn Durn Centre submission to the Productivity Commissions Interim Report of the Review of Mental Health and Suicide Prevention Agreement

Content Warning:

Aboriginal and Torres Strait Islander people are respectfully warned that the following report includes information associated with deceased persons from events that have occurred on Aboriginal land in Victoria and Australia. We encourage readers to prioritise their wellbeing and seek support if needed.

For help or information please contact:

13 YARN: 13 92 76

Brother-to-Brother: 1800 435 799

Yarning safe n strong: 1800 959 563

Lifeline: 13 11 11

Language Note

The term 'Aboriginal' in VACCHO documents is inclusive of Torres Strait Islander peoples and includes all Aboriginal people living in Victoria. The terms 'Community' or 'Communities' in this document refers to all Aboriginal and/or Torres Strait Islander communities across Australia, representing a wide diversity of cultures, traditions, and experiences.

Acknowledging Aboriginal and/or Torres Strait Islander peoples living experience

We acknowledge all Traditional Owner's ongoing connection to these lands, waterways, and skies. We pay our respects to all Aboriginal and/or Torres Strait Islander peoples past and present. To the giants whose shoulders we stand on today and every day. And we acknowledge that sovereignty has never been ceded.

It is important that we hold space to acknowledge the living experiences of our Aboriginal and/or Torres Strait Islander Elders, brothers and brotherboys, sisters and sistergirls, and cousins from all Nations and language groups. Peoples who have breathed life into these lands, waterways, and skies, immersed with vibrant yet diverse cultures from the very beginning of time itself.

The ongoing impacts stemming from colonisation on the social and political determinants of Aboriginal peoples have been profound. Its impacts continue to reverberate across several generations. In Victoria, colonialism has been especially brutal. Colonial violence has been enduring and takes many forms. From various government policies intent of genocide, and those that led to the Stolen Generations – a form of cultural genocide in itself - to police brutality and the continuing torment of Black deaths in custody, to the trauma that is a product from unchecked, unchallenged racism and discrimination – whether structural, systemic, overt, casual, or "unconscious bias". Inert, culturally unsafe service systems and models of care designed to cater to the majority are incapable of understanding our needs and ways of being. It needn't matter the form of violence, its impacts are felt deeply, the trauma compounding.

Despite all that colonisation has wrought in the last 235 years, our connection to Country, culture and kin remains enduring. It remains strong. Despite dislocation borne from colonial violence, we are healing. We are finding our voice, a voice that was so ruthlessly taken from and denied to our Ancestors. We are telling our stories, sharing our experiences with the belief that society, systems, and structures can learn from us and those who went before us – whose footsteps we follow. The belief that with our advocacy, systems and structures can evolve to place the social and emotional wellbeing model at the core of service design and delivery. A holistic model that recognises our mob's health and wellbeing as being influenced by cultural, historical, political, and social determinants.

VACCHO

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) is the peak body for Aboriginal health and wellbeing in Victoria – the only organisation of its kind in the state - with 34 Aboriginal Community Controlled Organisations (ACCOs) as Members.

Founded in 1996, VACCHO has a simple aim: to ensure Aboriginal and Torres Strait Islander people have access to high-quality, culturally safe health, wellbeing, and social services – wherever they are in Victoria.

VACCHO trains, supports, and advocates with and on the behalf of our Members and their Communities across Victoria. ACCOs deliver a suite of culturally safe and responsive frontline health and community care services for Aboriginal Communities. ACCOs have a proud, long history as sustainable, grassroot organisations that assist in building Aboriginal self-determination. They deliver culturally safe, high quality, holistic health and wellbeing services through a unique and effective ACCO model of care.[1]

ACCO's hold Aboriginal health in Aboriginal hands.

Balit Durn Durn Centre of Excellence for Aboriginal Social Emotional Wellbeing

In 2022, VACCHO established the Balit Durn Durn Centre of Excellence for Aboriginal Social and Emotional Wellbeing (BDDC) as part of the recommendations from the Royal Commission into Victoria's Mental Health System. The BDDC fosters innovation and improvement in social and emotional wellbeing practice, policy, and research, working to improve the awareness and culturally safe delivery of Social Emotional Wellbeing (SEWB) services across Victoria.

The BDDC supports and leads sector-wide change in Aboriginal SEWB by connecting communities, using evidence-based practice, and incorporating Aboriginal ways of Knowing, Being and Doing in our everyday practice.

Balit Durn Durn comes from the Wurundjeri/Woiwurrung language and means 'Strong Brain, Mind, Intellect and Sense of Self'. Permission to use Balit Durn Durn as the name for this Centre of Excellence was provided by Wurunjderi Traditional Owners.

[1] The+VACCHO+Model+Brochure+Sept+2024

Executive Summary

VACCHO and the BDDC support the Productivity Commissions (Commission) findings and recommendations of the Interim Report. We support the establishment of a new National Mental Health and Suicide Prevent Agreement (National Agreement) that is responsive to local community needs and an accompanying National Strategy for mental health and suicide prevention.

We urge that a new National Agreement and Strategy should be accompanied with adequate investment and driven by sustained bipartisanship across government. It should enable consistency across jurisdictions but allow flexibility for self-determined local responses to addressing mental illness and suicide.

The Commission has noted the multitude of policy documents, frameworks, and strategies that sit alongside the National Agreement, including at the state level, resulting in a severe lack of jurisdictional integration. The Jumbunna Institute recently undertook an independent review[2] of progress made towards Closing the Gap (CtG) targets for the Coalition of Peaks and their findings are aligned with the Interim Report. Jumbunna's review noted that the CtG Agreement was not an effective mechanism to facilitate collaboration between governments to build better person-centred mental health services and was doing little to address targets and meet local community needs. The repercussions of poorly planned policy documents and under-resourced initiatives reverberate locally across our Communities, exacerbating the unmet mental health and social emotional wellbeing need of our people.

This submission is organised across two parts. In Part A, we provide evidence and suggestions for the Commission to consider in drafting the Final Report. In Part B, we provide responses on the Commissions requests for further information to the four key areas.

VACCHO and the BDDC also provide our endorsement and support on the submission provided by the Victorian Aboriginal Legal Service (VALS) that provides tangible insights and recommendations on the intersection of mental health, AOD and justice contact.

We look forward to further discussions and working together to ensure the diverse perspectives of Aboriginal and Torres Strait Islander people are included in the new iteration of the National Agreement.

Dr Jill Gallagher AO

[2] Jumbunna Institute for Indigenous Education & Research. (2025). Closing the Gap – Independent Aboriginal and Torres Strait Islander Review, Closing+The+Gap+Review.pdf

Summary of Recommendations

Aboriginal SEWB / PHN's

1. Aboriginal Social Emotional Wellbeing (SEWB) needs to be made explicit in the next iteration of a National Agreement and a National Strategy.
2. The role of PHNs as commissioning agents for First Nations mental health needs to be reconsidered.
    a. The Commission should consider alternative Aboriginal-led models for the commissioning of mental health and suicide prevention programs for First Nations communities.
    b. Data measures and reporting requirements for Aboriginal health and Wellbeing should be self-determined

Mental health, suicide and AOD

3. The next Agreement needs to address mental health, alcohol and other drug (AOD) use, and suicide interconnectedly to realise change
4. For meaningful change and outcomes, funding distribution and resourcing for mental health, suicide and AOD needs to be reconsidered.

Lived and living experience representation

5. Lived and living experience representation should be embedded for the successful development, implementation and monitoring of programs, policies and services.
6. Successful inclusion of people with lived and living experience in governance forums that also establish equal decision-making authority to all members.
7. Measuring lived and living experience participation should consider the impact and effectiveness of representation.

Public Data Dashboard

8. Indigenous Data Governance and Sovereignty should be embedded for all data pertaining to Aboriginal and Torres Strait Islander people.
9. Outcomes and data metrics relating to Aboriginal health and wellbeing should be self-determined by Aboriginal communities.
10. Capturing data that is self-determined by Aboriginal communities will shift the deficit narrative.
11. A public data dashboard should consider alignment with other outcomes frameworks.

Best practice in integrating peer workers

12. Peer workers are an essential part of multidisciplinary teams and should be adequately supported to excel in their roles.

A. For the Productivity Commission's consideration

Aboriginal Social Emotional Wellbeing (SEWB) needs to be made explicit in the next iteration of a National Agreement and a National Strategy.

The Interim Report notes the importance of Aboriginal SEWB and recommends the incorporation of a separate schedule in the next Agreement to outline actions to improve Aboriginal SEWB. We welcome this and uphold that inclusion of SEWB within a new iteration of the Agreement would not only benefit Aboriginal communities but Australians more broadly. The SEWB framework[3] provides for a robust and holistic approach to health and wellbeing, with programs created around the SEWB framework addressing the social determinants of health, which are often 'risk' factors for poor mental health and suicide when they remain unaddressed.

Aboriginal SEWB is a complex, multi-dimensional concept encompassing connections to land, culture, spirituality, ancestry, family, and community, representing a holistic and interconnected approach to health and wellbeing, that includes physical, mental, emotional, and spiritual wellbeing.[4]

Figure 1 Aboriginal social and emotional wellbeing model ('SEWB wheel') adapted by the Balit Durn Durn Centre from Gee, Dudgeon, Shultz, Hart & Kelly (2014)

[3] Gee, H., Dudgeon, P., Schultz, C., Hart, A. & Kelly, K. (2014). Aboriginal and Torres Strait Islander Social Emotional Wellbeing, in, Eds. Dudgeon, P., Milroy, H. & Walker, R. (2014) Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, ISSN 978-0-9775975-3-6

[4] Gee, H., Dudgeon, P., Schultz, C., Hart, A. & Kelly, K. (2014). Aboriginal and Torres Strait Islander Social Emotional Wellbeing, in, Eds. Dudgeon, P., Milroy, H. & Walker, R. (2014) Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, ISSN 978-0-9775975-3-6

The SEWB wheel (figure 1) includes protective factors that support good health and wellbeing (connections to Culture, Community, Country etc.) while the outer wheel speaks to how these factors interact with social, historical, and political determinants of health and wellbeing, and the importance of each element in keeping well.[5]

Gayaa Dhuwi (proud spirit) has established an implementation plan[6] for improving mental health, social emotional wellbeing, and addressing suicide amongst Aboriginal and Torres Strait Islander communities, which aligns with the CtG framework. VACCHO and BDDC support Gayaa Dhuwi's plan, which has been created through Aboriginal-led community consultation, but this plan is not currently resourced.

The role of PHNs as commissioning agents for First Nations mental health needs to be reconsidered.

The Commission's draft recommendation *4.12, Funding should support Primary Health Networks (PHN) to meet local needs,* recommends two amendments for reform; a) more flexibility for PHN's to commission local services; and b) national consistency in standardising reporting requirements. While VACCHO agrees with these recommendations we urge the Commission to consider the role of PHN's as commissioners more broadly, particularly when commissioning funds to Aboriginal health and wellbeing services. Further clarification to this is provided below.

The Commission should consider alternative Aboriginal-led models for the commissioning of mental health and suicide prevention programs for First Nations communities. VACCHO's 34 Member organisations across Victoria have varied experiences with PHN's. In some regions PHN's have demonstrated capacity to support Aboriginal self-determination, allowing flexibility and responsiveness to challenges. PHN's in other regions, however, have failed to make meaningful adjustments to their engagement and commissioning processes, which has fractured relationships and impacted local service delivery. In an independent review[7] of sector funding for First Nations programs nationally, the role of PHN's as commissioning agents was evaluated, and the recommendation was to establish an alternative approach. The review proposes several alternative funding models for consideration, but to date, there is no consensus on a definitive model of commissioning that should be implemented amongst the ACCO sector, albeit an overarching consensus in the idea of an Aboriginal-led commissioning agent.

[5] ibid
[6] Gayaa Dhuwi (Proud Spirit) Implementation Framework and Plan
[7] Ninti One and First Nations Co. (2024). Review of First Nations mental health and suicide prevention services and the Integrated Team Care program – Final report, Australian Government Department of Health, Disability and Ageing, accessed from link

Data measures and reporting requirements for Aboriginal health and Wellbeing should be self-determined. VACCHO supports the notion of national consistency in standardising reporting requirements and data collection processes across PHN's. The current performance management requirements set out by the Commonwealth are paternalistic, overly burdensome and disempowering; not representative of self-determining Aboriginal community control. VACCHO urges any changes to reporting requirements (and determining data measures) specific to Aboriginal people's health and wellbeing be caucused through appropriate Aboriginal sector leadership throughout development.

B. Responses to the Commission's request for further information

Co-occurrence of Alcohol and other drug dependence, mental illness and suicide

The next Agreement needs to address mental health, alcohol and other drug (AOD) use, and suicide interconnectedly to realise change. Estimates suggest that over 60% of people with a mental health disorder are also experiencing AOD dependence[8], and up to 75% of people entering AOD treatment have a co-occurring mental health disorder.[9]

There is a range of evidence that demonstrates the prevalence of mental illness and AOD dependence, which are often identified as risk factors for self-harm and suicide. Risk factors for suicide can include mental health conditions, lifestyle factors, or chronic diseases that can interact and increase the 'risk' of suicide. In 2023, Australians who died by suicide had an average of four risk factors present at the time of their death, with psychological risk factors (such as a mental health disorder) being the most reported, present in 67.4% of deaths by suicide.[10]

The prevalence of comorbidity for Aboriginal and Torres Strait Islander people is even more pronounced. An investigation[11] by the Victorian Coroner revealed that 87.5% of Aboriginal people who passed by suicide between 2018-2022 had substance abuse as a contextual stressor; a further 71.6% had been diagnosed with co-occurring mental illness and substance abuse disorders prior to their death.

From an early intervention and prevention perspective, it is imperative that the new Agreement understands and embeds a harm minimisation approach that adequately captures and addresses the risk factors associated with suicide.

[8] Alcohol and Drug Foundation. (2024. Alcohol and other drugs and mental health, Alcohol and other drugs and mental health - Alcohol and Drug Foundation

[9] Marel C, Siedlecka E, Fisher A, Gournay K, Deady M, Baker A, Kay-Lambkin F, Teesson M, Baillie A, Mills KL. (2022). Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (3rd edition). Sydney, Australia: Matilda Centre for Research in Mental Health and Substance Use, The University of Sydney.

[10] Australian Bureau of Statistics. (2024). Causes of death, Australia. Causes of Death, Australia, 2023 | Australian Bureau of Statistics

[11] Coroner's Court of Victoria. (2023). Suicides of Aboriginal and Torres Strait Islander people, 2018-2022, Report 1

The comorbidity of mental illness, suicide and AOD dependence and the need to address health holistically has been noted as a priority in a range of Victorian strategies and frameworks including:

- The Victorion Suicide Prevention and Response Strategy 2024-34, acknowledgment of AOD as a contributing factor and the need to support workforces who meet people experiencing suicidal distress and crisis (such as family violence, alcohol and other drug, employment, legal aid, gambling and financial services and frontline workers in sectors like transport). Priority area 1: Build and support connected systems, acknowledges the need to *'Increase the accessibility of the mental health, alcohol and other drug and suicide prevention and response systems.'* however lacks insight into 'how' this integration may occur.
- Balit Murrup: Aboriginal social emotional wellbeing framework 2017-2027 Acknowledges that *'Mental health and alcohol and other drug services for Aboriginal Victorians are designed around the needs and expectations of individuals, families and communities rather than service providers.'*

  'Development of joined-up approaches to social and emotional wellbeing support, mental health, suicide prevention, and alcohol and drug services.'

  Supporting healing models and therapeutic responses (pg.17) 'A further $17 million has been allocated for specialist family violence advisors in major mental health and alcohol and other drug services to identify and respond to alcohol, drug and mental health issues'

- Aboriginal Health and Wellbeing Agreement and Action Plan: Identifies AOD dependence as a health-based priority that needs to be addressed holistically in an Aboriginal health response, with specific actions to build the AOD sectors ability to provide culturally safe care for Aboriginal community members.
- Royal Commission into Victoria's Mental Health System: Noted the prevalence of co-occurring AOD dependence and mental health issues, and the poor coordination and/or integration of the service system was negatively impacting individuals, families and communities. They identified a need for an integrated and holistic approach to mental health service delivery and coordination across services.

Service delivery and program funding are largely siloed and non-complimentary, despite the prevalence of co-occurring mental health and substance use disorders. Multi-disciplinary service delivery teams, although heralded as best practice, are often not the reality of how services are funded or delivered. Our service systems are still very segmented and siloed, where those seeking support are required to access and be referred to multiple organisations to receive care, treatment, and support for co-occurring issues. This presents many challenges in service provision, particularly for people in distress, with SUD, and/or mental illness who are required to navigate multiple systems, continually

retelling their story, and sometimes receive counterintuitive advice from different service providers.

In the past, Victoria has delivered designated 'dual diagnosis' programmes, equipped with clinicians trained to work with people experiencing co-occurrence of mental illness and SUD. Unfortunately, these positions were sparse, poorly funded, and clinicians often worked in isolation; currently there are very few dual diagnosis programs and/or identified positions in Victoria.

From an Aboriginal SEWB perspective there is an urgent need to address these factors holistically as often they are interconnected and codependent (i.e. people using AOD to deal with mental illness and/or trauma and vice versa). The model of care utilised across the ACCO sector is one that represents a best practice multi-disciplinary approach to service delivery that the mainstreams sector strives for.

The Victorian ACCO model[12] not only supports people with co-occurring mental health and SUD to prevent further deterioration and suicide but also support the Community with a range of social determinant needs such as housing, legal aid, employment assistance, childcare and family support, and physical health needs. This blended best-practice model of care enables Community members to receive care, treatment and support in one place, removing the barriers associated with navigating multiple systems and/or services. Despite the success of the ACCO model in supporting communities, they are marginally funded compared to mainstream health and community health services, competing for funding that is siloed, piecemeal and accompanied by strict and overburdensome reporting requirements.

For meaningful change and outcomes, funding distribution and resourcing for mental health, suicide and AOD needs to be reconsidered. Although much of the funding allocation for mental health, AOD support, and suicide prevention sits within the same department across jurisdictions, the funding and delivery of programs across each area is largely independent and non-cooperative. Teams working across the AOD and mental health division are largely working in siloes and although collaborate when needed, do not have the authority or ability to link-up programs or funding to enable streamlined service delivery across portfolio areas. This disconnection results in service providers being required to compete against each other for funding, making it extremely difficult to streamline service delivery when the funding is often received from different buckets, each requiring their own reporting streams, systems and processes.

[12] The Victorian ACCO Model - VACCHO

These structural challenges are significant for the service delivery sector who are required to report on funding through pre-determined quantitative criteria. A common theme VACCHO hears from our Member organisations is the many hours of 'invisible' work that they provide to the Community that goes unrecognised or unreported to the department; for example, an ACCO may be funded for 1 FTE mental health position and only required to report on these episodes of care but are also supporting people with their AOD dependence, legal matters, family protection orders and so on. Much of this work is unfunded and not required or captured in data by the department.

This siloing of funding and service provision is not just burdensome for reporting and service delivery but can result in severe, life altering consequences. The passing of Aunty Veronica Nelson in a Victorian prison in 2020, noted as "harrowing and preventable" by Coroner McGregor, who found that Veronica was denied access to any mental health, AOD, or cultural support, and if she had received the support she was calling for, she would still be alive today. By addressing AOD dependence and mental health holistically we move away from a punitive justice response for AOD use and the minor criminality (e.g. theft) sometimes associated with addiction. Alcoholism and SUD more broadly need to be understood and treated as diseases and elicit a health-based response that supports people towards care, treatment, and support, not criminalises them.

Barriers to the genuine participation and influence of people with lived and living experience in governance forums

Lived and living experience representation should be embedded for the successful development, implementation and monitoring of programs, policies and services. In the last decade Victoria has made significant improvements to ensure lived and living experience representation is considered across many policy platforms. Currently, most forums and advisory groups have adequate lived and living experience participation, yet it is imperative that this participation is meaningful, not tokenistic, and representatives are renumerated appropriately for their knowledge. Participation of lived and living experience should occur at the inception of a forum or advisory group to enable meaningful engagement and advise throughout, not as a tick-box exercise after a policy or decision has been made.

It is also essential that organisations who employ lived and living experience representatives should ensure that they're able to support people, not just financially but also by equipping them with the skills, tools and knowledge they require to act as representatives on forums and advisory groups. This can include through professional

development, social emotional support such as debriefing, and adequate training prior to commencing their roles.

Successful inclusion of people with lived and living experience in governance forums that also establish equal decision-making authority to all members. Although many forums have lived and living experience representation, the decision-making and agenda-setting authority sits within government leadership who ultimately decide on direction, defeating the intent of representation. Decision making processes within governance forums should enable participatory decision-making and utilise an approach that promotes and upholds community-led decision-making principles.

Measuring lived and living experience participation should consider the impact and effectiveness of representation. Aboriginal sector leaders participate in a range of governance forums across different health and wellbeing domains. Each governance forum comes with accompanying working and sub-working groups, proposals for consideration, and meetings, requiring hours of weekly commitment. Participation in these forums is often marginally resourced (or not resourced at all) and can work against achieving outcomes.

VACCHO has identified a clear imbalance of responsibilities and resourcing for Aboriginal people participating in governance forums, limiting the sectors' ability to participate meaningfully. Moreover, this lack of resourcing and time required by forums is impeding implementation of many CtG actions and Priority Reforms as it diverts workforce resources away from service delivery in order to participate in forums and advisory groups.

Measuring successful inclusion of lived and living experience representation on governance forums needs to consider whether:

a) Lived and living experience representation is fostering change in government decision-making processes
b) Representation is resulting in better outcomes for communities
c) People's participation in forums and effective service deliver should not be mutually exclusive; such that, the value of people participating in governance forums should harvest valuable and tangible insights and actions
d) The reality of participating in multiple forums across different health and wellbeing domains is helpful or hinders progress to achieving outcomes. Would governance forums be more proactive spaces if a whole-of-government approach was utilised to health and wellbeing?

The Mental Health Commission in NSW have developed a toolkit[13] for evaluating lived experience inclusion in leadership with some practical tools and guidelines for organisations.

The value and feasibility of having a public dashboard to track and report on progress under the next Agreement

Indigenous Data Governance and Sovereignty should be embedded for all data pertaining to Aboriginal and Torres Strait Islander people. As set out in Maiam Nayri Wingara's framework[14], Indigenous Data Sovereignty (IDS) refers to 'the right of Indigenous people to exercise ownership over Indigenous Data'. Indigenous Data Governance (IDG) 'refers to the right of Indigenous peoples to autonomously decide what, how and why Indigenous Data are collected, accessed and used.' Exercising and upholding the principles of IDG and IDS enables Aboriginal and Torres Strait Islander people to accurately reflect their stories and experiences. It provides the tools necessary to identify what works and what does not, enabling First Nations people to make decisions that support the needs and aspirations of their Communities.

Outcomes and data metrics relating to Aboriginal health and wellbeing should be self-determined by Aboriginal communities. As stipulated in Maiam Nayri Wingara's IDG and IDS principles, data collected about Aboriginal people should be self-determined where outcome measures reflect Aboriginal ways of Knowing, Being, and Doing.

For example, Outcome 14 of CtG Agreement is stated as 'Aboriginal people enjoy high levels of Social Emotional Wellbeing' which is currently measured as 'a reduction in suicide'. Although suicide is something that deeply effects First Nations communities, it misrepresents and fails to capture the entire story. 'High levels of social emotional wellbeing' is far greater than poor mental health or suicide, and data indicators for this outcome should integrate aspects from the SEWB framework components and include measures such as 'connections to Country, culture and Community' and incorporate Indigenous data capturing methodologies such as language, stories, yarning, Lore, and art.

Capturing data that is self-determined by Aboriginal communities will shift the deficit narrative. The narrative about First Nations people is currently determined by the available

[13] Leading the Change Toolkit.pdf

[14] Maiam nayri Wingara. (2018). Indigenous Data Sovereignty Communique Indigenous Data Sovereignty Summit 20th June 2018, Canberra, ACT. Available

data being collected, which influences the story being told. Most data about First Nations people is focused on capturing disparities around health, housing, justice involvement, and child protection. Although this is important data to capture, it only tells part of a story, reinforcing a deficit narrative and a homogenous view of First Nations people. By only capturing part of a story, we leave crucial knowledge and stories untold, and culture remains invisible. These narratives shape public views, opinions and understandings of First Nations people, contributing to racism and discrimination across facets of public and private life. By capturing self-determined data to generate evidence to showcase the triumphs, strengths and diverse cultures of First Nations people, we can also shift the public narrative and negative views that may be held about First Nations people, resulting in increased cultural safety, pride and improved social emotional wellbeing for Communities.

A public data dashboard should consider alignment with other outcomes frameworks. The Commission's Report has noted the disconnection and misalignment between the National Agreement and other policy documents and agreements across jurisdictions.

The Commission should consider the following in assessing whether there is feasibility in a data dashboard for the Agreement.

a) Whether each Agreement should have their own public dashboard. Are there better ways to collect and disseminate data that will often be interlinked and crossover? Is there feasibility for a whole of government data dashboard?
b) When establishing targets and data metrics – strategies and agreements should speak to each other to ensure data capturing isn't contradictory or misleading

Best practice in integrating peer workers in clinical mental health and suicide prevention settings

Peer workers are an essential part of multidisciplinary teams and should be adequately supported to excel in their roles. Although the terms 'peer worker' and 'lived experience' are often conflated, they refer to two distinct concepts. Lived experience is the knowledge and skills a person develops from having lived through a particular experience[15]. This might be from facing a particular challenge or being part of a certain community group. Peer workers are people who are trained to support others by providing practical, emotional and psychosocial support and can be employed across a range of disciplines. Therefore, peer workers have unique knowledge and are able to draw on their own experience, service use

[15] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.

and journey of recovery to support other people currently experiencing similar circumstances[16].

Victoria's ACCO sector successfully integrates peer workers in various roles across the organisation, often supporting them to study relevant qualifications throughout their employment. Ensuring peer workers are equipped with appropriate support and mentoring is essential to maintaining and growing a strong peer workforce.

Some ways organisations can support their peer workforce include:

a) Providing peer workers with clinical and cultural supervision – many workers do not receive this or opportunities to debrief which significantly impacts their ability to support community and their own wellbeing
b) Promote training, peer supervision and career development for peer workers in partnership with relevant community mental health organisations, state/territory government agencies, and local consumer and carer networks
c) Providing opportunities for career development – often peer worker roles are paid on the lower end, and it becomes an unsustainable form of employment without possibilities of career progression. This often results in workforce leaving the sector.
d) Colonial load payment: Support is essential for Aboriginal and Torres Strait Islander people working in mainstream organisations, particularly if they are in lived experience / peer worker roles. Often, they are the only First Nations person in the organisation, and can easily become over-burdened by cultural/colonial load or expectations placed on them to 'represent' their Community. We recommend organisations employing First Nations people in identified roles to consider 'cultural/colonial load payments' which are designed to enable First Nations people working in these roles to look after their social emotional wellbeing, which can be impacted as a direct result of working in these roles. We also recommend First Nations employees working in any sector have access to additional leave entitlements for Sorry Business, cultural and ceremonial commitments.

Opportunities for clinicians to improve their awareness of the peer workforce include:

a) Networking through participation in forums, conferences and workforce gatherings related to mental health, suicide prevention, AOD, and Aboriginal health. VACCHO and the BDDC host a range of forums and events for the Aboriginal health workforce
b) Proactively participate in lived and living experience and peer support events and meetings when opportunities arise

[16] ibid

c) VACCHO currently chairs a range of Communities of Practice (CoP) which often comprise both clinical and peer-work level roles. These spaces allow for open and honest dialogue, sharing experiences, and information. Recent feedback received from our Mental Health CoP which has over 50 members in varied clinical and non-clinical roles has been overwhelmingly positive and beneficial for their work.

Concluding remarks

VACCHO and the BDDC appreciate the Commissions effort in reviewing the National Agreement and the development a National Strategy that aims to address mental health, AOD dependence, and suicide prevention holistically. We welcome the draft findings and recommendations of the Commissions Interim Report and hope that our recommendations are considered further.

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