

# Response to the Productivity Commission's June 2025 Report:

Mental Health and Suicide Prevention Agreement Review Interim Report



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Ensuring that the voices of First Nations people are heard

# Wes Morris Individual Response to the Productivity Commission's June 2025 Mental Health and Suicide Prevention Agreement Review Interim Report.

#### Paper #1

Redesigning the system to focus on the needs of users, rather than providers, with a special focus on the role of Peer Support Workers in the Mental Health System. Echoing the National Mental Health Commission's Recommendations from 2014 to rebalance the system to provide more emphasis on upstream prevention. Further, suggesting that Co-design is very unlikely to deliver systemic change unless it is preceded by transformative paradigm shifts within Government, endorsed at Ministerial level.

A detailed discussion of these themes is presented in the paper that follows, herein.

#### Paper #2

For as long as First Nations suicide is treated as an individual mental health issue [with clinical interventions], and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

This is a second, standalone, sister paper which was submitted to the Productivity Commission on Thursday 31 July. 31 July 2025

Selwyn Button and Angela Jackson, Commissioners Productivity Commission, Wurundjeri, Woi wurrung country, Level 8, Two Melbourne Quarter 697 Collins Street Docklands Vic 3008

Dear Commissioner's Button and Jackson,

Sincere congratulations to yourselves, and to all at the Commission, on the publication in June 2025 of the *Mental Health and Suicide Prevention Agreement Review Interim Report*. The *Interim Report* has considerable merit and it sets out a possible pathway towards much-needed, and long-overdue, systemic and structural change in the Mental Health and Suicide Prevention system.

In February 2007, in my work capacity as Coordinator [General Manager] of a small but significant Aboriginal Community Controlled Organisation in the Kimberley, I wrote to the then WA Coroner, the hon. Justice Alistair Hope. I requested that Justice Hope undertake a major Coronial Inquiry in order to investigate the alarming rate of Aboriginal suicide in the Kimberley. The Coroner wholeheartedly embraced this request and in 2008 he delivered a major Coronial Inquest Report in regards to the deaths by suicide of 22 Aboriginal persons in the Kimberley. However, as the Commission's 2025 *Interim Report* finds:

The data available shows that one in three Aboriginal and Torres Strait Islander people experience high psychological distress and suicide rates are worsening.<sup>1</sup>

Between 2006 and 2025 I have participated in countless processes and spent literally thousands of hours involved in endeavours to bring about systemic and structural change. The outcomes of my 20 years of work in this space are so miniscule as to be almost non-existent.

And it from this perspective, a perspective of 20 years of witnessing a mental health and suicide prevention system that is static and insulated from any and all endeavours to change its fundamental structures, that I present to you today two separate submissions in response to the *Interim Report*. I wholeheartedly endorse and embrace the directions that you have set out in the *Interim Report*. However, I believe that the Commission has not given sufficient regard to this key issue of structural stasis, and I hope that my suggestions and recommendations in that regard are of assistance to and of use to the Commission.

In the following pages I present for your consideration a number of recommendations. These recommendations have been informed by each of the following:

- **Experience:** my 20 years of experience in this field, oftentimes playing a leadership role at the Regional level, if not the State and National level;
- Literature: consideration of the academic literature in this field;
- Earlier Reports: consideration of important reports by bodies such as the National Mental Health Commission, and the many recommendations over the last two decades which have not been enacted as yet;

• **Relationships:** my extremely close personal relationships with some people who work in this field, both in the clinical domain and in the community services/ lived experience domain.

But of the various recommendations presented to you today, I ask that the Productivity Commission give particular consideration to the following three recommendations:

- No Co-design Process to be Commenced Without First Achieving Two Prerequisites.
  - A clear and detailed statement from Government, at the Ministerial level, setting out how the Government of the day views Co-design operating within the constraints of, and within the context of, a Westminster democracy;
  - 2. A clear Co-design resourcing and empowerment strategy, with a specific focus on how the non – Government sector and the non – Government participants in the proposed Co-design process would be resourced and empowered to enable them to participate in the Co-design process as full equals to the Government participants.
- That the Productivity Commission Make Specific Findings and Recommendations Around Rebalancing Expenditure, Reflecting the Recommendations Contained Within the National Mental Health Commission's 2014 Contributing Lives Report, as follows:

"We need system reform to:

- > redesign the system to focus on the needs of users rather than providers
- redirect Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity
- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community."
- Endorsing Draft Recommendation 4.14 Within the Interim Report ie Develop a Scope of Practice for the Peer Workforce.

Regards,

#### **Wes Morris**

Brisbane, Qld.

## **Overview**

Australia, when measured against comparable countries ie Western liberal democracies like the UK and Canada, performs poorly in regards to investing in preventative solutions to health <a href="https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/">https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/</a> If we then look at the pattern of expenditure in regards to preventative approaches to Aboriginal social and wellbeing issues, then the situation is much worse still ie the investments in this domain are heavily skewed towards the downstream <a href="https://www.wa.gov.au/system/files/202504/aboriginal.engagement.strategy.policy.guide\_.pdf">https://www.wa.gov.au/system/files/202504/aboriginal.engagement.strategy.policy.guide\_.pdf</a> And in regards to the Mental Health system, the National Mental Health Commission recommended as follows, on page four of its Contributing Lives Report in the year 2014:

We need system reform to:

- redesign the system to focus on the needs of users rather than providers
- redirect Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity
- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training
- repackage funds spent on the small percentage of people with the most severe and persistent
- mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care
- reform our approach to supporting people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia's wealth.

https://www.mentalhealthcommission.gov.au/publications/contributing-lives-review-2014

There is considerable merit to be found in the Productivity Commission's *Mental Health and Suicide Prevention Agreement Review Interim Report* of June 2025. However, it is suggested in this submission that there are a number of areas where significant work remains to be done by the Productivity Commission. It is suggested that the Review and the *Interim Report* could be strengthened in the following areas:

- Historical Context and Background [General]: There
  is little point in critiquing the current MH Agreement
  without first examining reports such as the 2014
  Contributing Lives Report;
- Historical Context and Background [Aboriginal]:
   There is little point in critiquing the current MH
   Agreement without first examining the plethora of reports relating to First Nations Wellbeing;
- Impediments to Systemic Change: From the first two points, above, there is little point in critiquing the current MH Agreement without first examining the impediments to systemic change;
- Impediments to Co-design: There is little point in recommending Co-design approaches without examining the massive structural impediments to Codesign and the need for paradigm changes;
- Impediments to Prevention: The Productivity Commission's 5 Pillars Inquiry is examining the lack of emphasis on Prevention. Prevention should be more strongly reflected in this current MH Review;
- Improving Productivity in MH: The Productivity
   Commission's 5 Pillars Inquiry is examining
   Productivity in the Care Economy. Productivity should
   be more strongly reflected in this current MH Review.

These areas for improvement are canvassed herein, and a number of specific recommendations are made around suggested improvements to be incorporated in to the *Final Report* from the Commission.

# **Recommendations**

Recommendations Around Reshaping the Mental Health System So As to:

- 1. Rebalance the System Towards Upstream, Preventative Strategies to Promote Mental Health and Wellbeing; and
- 2. Refocus the System on Peer Support and Lived Experience.

# Recommendations Designed to Refocus the System Towards Upstream, Preventative Strategies to Promote Mental Health and Wellbeing

 Develop Historical and Background Context Around the Mental Health and Suicide Prevention System

The *Final Report* should provide greater detail around the historical context and background to the current Mental Health and Suicide Prevention system, giving particular consideration to the findings and recommendations contained with earlier systemic reviews including, but not limited to, the National Mental Health Commission's 2014 *Contributing Lives Report.* 

 Develop Historical and Background Context Around the Mental Health and Suicide
 Prevention System- as it Applies to First Nations Communities.

The *Final Report* should provide greater detail around the historical context and background, giving particular consideration to the plethora of reports relating to First Nations Wellbeing [see Part B.2 herein] and noting the consistent theme across this plethora of reports around the need to support cultural resilience as the foundation for First Nations Wellbeing.

 Develop greater detail around the impediments to systemic and structural change.

From #1 and # 2 above, the *Final Report* should provide greater detail around the impediments to systemic and structural change. The *Final Report* should give particular consideration to the 5 focus areas articulated in the 2014 *Contributing Lives Report* [these 5 areas are cited in this submission], and should give specific consideration as to why such little progress has been made in regards to these 5 focus areas.

 Develop an Understanding of the Barriers to Co-design, Especially as Described by the Productivity Commission and as Described by the Lowitja Institute The *Final Report* should provide much greater detail around the systemic, structural, and political barriers to the successful implementation of any genuine Codesign process for systemic change.

 Develop an Understanding of Impediments to Preventative Programs Being Implemented in Australia.

In coming weeks [July – August 2025] the Productivity Commission will release its *Delivering quality care more efficiently*. In this report the Commission will make initial findings in regards to impediments to preventative strategies in Australia.

The Productivity Commission's Interim Findings from the *Delivering quality care more efficiently Inquiry*, in relation to the impediments to Preventative strategies being funded, should be carefully considered within this present Inquiry in to Mental Health and Suicide Prevention.

 Develop an Understanding of How to Improve Productivity, Efficiency and Effectiveness in the Care Economy in Australia, And Make Pertinent Recommendations Around That Understanding.

In coming weeks [July - August 2025] the Productivity Commission will release its *Interim Report on Delivering quality care more efficiently* 

In this forthcoming report the Productivity
Commission will make Initial Findings in regards to improving productivity in the Care Economy. These interim findings around improving productivity should be carefully considered within this present Inquiry in to Mental Health and Suicide Prevention, and should be considered in the light of the recommendations from the National Mental Health Commission in 2014 in regards to rebalancing expenditure in the Mental Health and Suicide Prevention system.
Continuing a pattern of investment in to hugely expensive upstream, clinical programs is extremely unproductive, so why is it that we continue to invest the majority of resources in to unproductive

modalities, despite the Mental Health Commission in 2014 urging us to make structural changes and to invest in more productive modalities?

 That the Productivity Commission significantly revise its Theory of Change -

The Commission should significantly revise its theory of systemic change, such that a revised theory of change is heavily informed by the National Mental Health Commission's *Contributing Lives Report* and such that a revised theory of change materially and comprehensively addresses key impediments to systemic and structural change in the Mental Health and Suicide Prevention System. In particular, a revised theory of change should, consistent with the Productivity Commission's own current *Inquiry in to the Care Economy*, seriously address the key issue of Governments' profound and persistent reluctance to invest in preventative programs.

The *Final Report on Mental Health and Suicide Prevention* should be greatly informed by the
Findings and Recommendations contained within the
Productivity Commission's *Care Economy Interim Report.* 

That the Productivity Commission Make Specific Findings and Recommendations Around Rebalancing Expenditure, Echoing and Repeating the Recommendations Contained Within the National Mental Health Commission's 2014 Contributing Lives Report, as follows: "We need system reform to:

- redesign the system to focus on the needs of users rather than providers
- redirect Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity
- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community."
- No Co-design Process to be Commenced Without First Achieving Two Prerequisites.

No Co-design process should be commenced without the following first occurring:

- A clear and detailed statement from Government, at the Ministerial level, setting out how the Government views Co-design operating within the constraints of, and within the context of, a Westminster democracy;
- A clear Co-design resourcing and empowerment strategy, with a specific focus on how the non – Government sector, and the non – Government participants in the proposed Co-design process, would be resourced and empowered so as to enable them to participate in the Co-design process as full equals to the Government participants.

#### Recommendations To Refocus the System on Peer Support and Lived Experience

Funding Research to be Led by Mental Health Peer Workers:

That funding be allocated towards the advancement of research undertaken by Peer Support Workers about the work of Peer Support Workers.

 Develop Case Studies of Success in Regards to Peer Support Mental Health Workers by Contacting Mental Health Service Providers Which Are Already Successfully Employing Mental Health Support Workers

In order to access useful case studies showcasing the work of Peer Support Workers, the Productivity Commission can and should contact each of the following [or if not these organisations, then similar organisations alternatively chosen by the Commission]:

- Acute Clinical Care, Queensland Health The Queensland Health Lived Experience (Peer) Workforce Framework
- Clinical, Non Hospital Settings Brisbane South PHN

https://bsphn.org.au/community-health/suicide-prevention/suicide-prevention-services#suicide-prevention-services and also

- > Brook RED's alt2su group https://www.brookred.org.au/supportingsuicidality
- Mixed Modality Community Support Richmond Fellowship Queensland https://www.rfq.com.au/about-rfq/

 Endorsing Draft Recommendation 4.14 - develop a scope of practice for the peer workforce.

There is considerable merit to be found in the Productivity Commission's *Mental Health and Suicide Prevention Agreement Review Interim Report* of June 2025. I note in particular the following:

Draft recommendation 4.14, Page 26

The next agreement should commit governments to develop a scope of practice for the peer workforce

The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce, in consultation with the peer workforce, that:

- > promotes safer work practices for peer workers
- contributes to better outcomes for people accessing mental health and suicide prevention peer support
- improves public understanding of the profession, allowing for greater recognition of peer workers' capabilities and contributions.

Based on my reading of the literature, as cited herein, and based on my limited discussions with those who work in both clinical and community settings, I endorse this draft recommendation and encourage the Productivity Commission to move forward in developing this as a recommendation to be contained in the *Final Report*.

# **Recommendations Around Reducing Suicide Rates in First Nations Communities**

Note: A second, stand-alone, sister paper will be submitted to the Productivity Commission, as follows:

#### Paper #2

For as long as First Nations suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

That separate, stand - alone paper contains recommendations pertinent to First Nations Communities.

## A Note About the Author

# 1. vis-à-vis Centring Lived Experience in Suicide Prevention and

# 2. vis-à-vis First Nations Culture and Wellbeing

In February 2008 the Hon Alistair Hope, the then WA Coroner, brought down his *Kimberley Findings Report*, being a 224-page long report on the deaths by suicide of 22 Aboriginal people in the Kimberley region of WA. In his opening acknowledgements to that *Findings Report* the Coroner states as follows:

The drive for the inquest came, importantly, from the Aboriginal people themselves and the ongoing support of KALACC was of fundamental importance in obtaining evidence from many Aboriginal people. In that context I am indebted to Mr Joe Brown, KALACC Chairman, and Mr Wes Morris, KALACC Coordinator, for their ongoing support for the process.

Mr Joe Brown was a very senior Walmajarri cultural boss and in February 2007 Mr Brown and I wrote to the Coroner, calling on him to investigate the alarming rate of suicide in the Kimberley. We then contacted the Federal Government, and we secured funding with which to engage Legal Counsel to assist the families involved in this harrowing process. The Productivity Commission's Mental Health and Suicide Prevention Agreement Review Interim Report of June 2025 notes that the rate of First Nations suicide in Australia continues to worsen. This fact comes as a surprise to no one who has worked in the First Nations cultural space. For as long as suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

Between February 2007 and the present time, a period of 18 years, my professional involvement in regards to the issue of First Nations Suicide included the following:

- Coronial Inquiries: Played a leadership role in regards to four major Coronial Inquiries;
- Suicide Prevention Programs: For 18 years I had management - oversight of a significant Aboriginal youth suicide prevention program based around building cultural resilience;
- Regional Suicide Prevention Trials: Participated in monthly meetings for close on 10 years;
- Developing Co-design Guides: Had management oversight of the development of Co-design Guides for 1). Aboriginal Youth Wellbeing and for 2). Aboriginal Youth Justice Diversion;
- Advocacy and Inquiries: Made submissions to, and appeared before, countless Federal and State Inquiries.

For more than18 years I have witnessed the enhancement of resourcing to, and empowerment around, Aboriginal Community Controlled Health Organisations. This is a most welcome development. However, I repeat as above, for as long as First Nations suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia. In the last 18 years I have seen little material action from Government regarding the central role of Aboriginal Culture in regards to First Nations wellbeing, despite a raft of Government – commissioned reports all calling for cultural solutions. The words 'Aboriginal' and 'Culture' are not synonyms. Neither are the words 'Health'

and 'Culture.' Cultural solutions are delivered by Cultural organisations, not Health organisations.

Beyond the professional capacity outlined above, in my private life I have significant personal relationships with people who work professionally in the Mental Health space in Queensland. This relates both to those who work in a clinical [psychological] mental health setting and those who work, through a lived experience framework, in the community mental health setting. These very close

personal relationships have informed my comments, herein, in regards to issues such as empowering Peer Support Workers in the Mental Health system. In regards to this, I note once again that the 2014 *Contributing Lives Report* recommended that we "redesign the system to focus on the needs of users rather than providers." In the intervening 10 plus years, there has been some expansion in the role of Peer Support Workers, but little overall structural reform.

# **Part A: Response to Interim Report**

# Response to the Productivity Commission's Interim Report on the National Mental Health and Suicide Prevention National Partnership Agreement

#### A.1 Productivity is a Meaningful Prism Through Which to Enact Changes

Perhaps Productivity is a Meaningful Prism Through Which to Enact Long Overdue Structural Changes to the Mental Health and Suicide Prevention systems in Australia

Given the number of existing reports in to the Mental Health and Suicide Prevention system in Australia, including the Productivity Commission's own *Mental health Inquiry Report* of November 2020, one can be forgiven for asking why we need yet another such report. Indeed, this present submission to the Productivity Commission makes repeated references to the *Contributing Lives Report* which the national Mental Health Commission released in 2014, and to the very limited systemic and structural change that has occurred since that time. Yet, perhaps, that lack of change and the number of existing reports is the very reason for this current Inquiry by the Productivity Commission.

Coming up in Parliament House Canberra across 19 to 21 August 2025 there will be a significant Productivity Summit, and this Summit will address three key themes, these being:

- Resilience
- Productivity
- Sustainability.

Alongside of the upcoming Productivity Summit, the Productivity Commission is currently undertaking what it calls its 5 Pillars Productivity Inquiry. Looking backwards we can readily identify a period known as the 'COVID period', followed by a more recent period known as the 'Cost of Living period'. And we are told now that the main national discussion going forward will be around Productivity, reminiscent of Paul Keating's oft - quoted

comment about the resident galah in the pet shop discussing micro- economic policy.

If indeed Productivity is the prism for driving change in Government policy and programs in this current era, then there is much that can, and should, be changed about the structures of the Mental Health and Suicide Prevention systems in Australia.

Part A to this submission is the main body of Paper #1 and it relates to Redesigning the Mental Health and Suicide Prevention system to focus on the needs of users, rather than providers, with a special focus on the role of Peer Support Workers in the Mental Health System. That, and a consideration of rebalancing the system from acute downstream services to preventative upstream services. Part A is then followed by Part B, which consists of information on a broader, more general consideration of a couple of topics of current interest to the Productivity Commission, especially:

- Prevention: How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?; and
- Empowering Users: Ensuring that the voices of First Nations people are heard and acted upon.

#### **B.2** The theory of change articulated within the *Interim* Report

I respectfully suggest that the theory of change articulated within the *Interim Report* is in fact unlikely to materially address two of the key impediments to change, as articulated by the National Mental Health Commission in 2014.

Both of these recommendations from the NMHC in 2014 relate to shifting expenditure away from downstream, acute services and moving the investment upstream in to preventative programs. Such a measure would be very consistent with the Productivity Commission's own current Inquiry in to the Care Economy. That other current Productivity Inquiry is examining how to shift the pattern of Government investments so that a greater proportion of Government funding is allocated to preventative programs and strategies – which was exactly what the NMHC Recommended in 2014.

There is considerable merit to be found in the Productivity Commission's *Mental Health and Suicide Prevention Agreement Review Interim Report* of June 2025. However, it is suggested in this present submission that there are a number of areas where significant work remains to be done by the Productivity Commission. It is suggested that the Review and the *Interim Report* could be strengthened in the following areas:

- Historical Context and Background [General]: There
  is little point in critiquing the current MH Agreement
  without first examining reports such as the 2014
  Contributing Lives Report;
- Historical Context and Background [Aboriginal]:
   There is little point in critiquing the current MH
   Agreement without first examining the plethora of reports relating to First Nations Wellbeing;
- Impediments to Systemic Change: From the first two points, above, there is little point in critiquing the current MH Agreement without first examining the full range and gamut of impediments to systemic and structural change which have been identified across the many earlier reports;
- Impediments to Co-design: There is little point in recommending Co -Design approaches without examining the massive structural impediments to Co -Design and the need for massive transformation in the way that Government does business;
- Impediments to Prevention: The Productivity Commission's 5 Pillars Inquiry is examining the lack of emphasis on Prevention. The National Mental Health Commission in 2014 delivered a report recommending a significant reconfiguration of Government expenditures on Mental Health. The Interim Report would be greatly enhanced if it reflected NMHC Recommendations from 2014 and reflected the Productivity Commission's own current interest in building investments in to preventative programs in the Care Economy;

Improving Productivity in MH: The Productivity Commission's 5 Pillars Inquiry is examining Productivity in the Care Economy. This should be more strongly reflected in this current MH Review. As above, current investments are heavily skewed to upstream, preventative treatments. Not only is this expensive, but it is also highly unproductive.

The present author's experience provides a perspective of 20 years of witnessing a mental health and suicide prevention system that is largely static, and which is heavily insulated from all endeavours to change its fundamental structures. The directions set out in the Interim Report are laudable and commendable and the present author wholeheartedly endorses the intentions set out by the Productivity Commission, and the broad directions set out by the Productivity Commission. However, I believe that the Commission has not given sufficient regard to the key issue of structural stasis and intransigence. Key recommendations relating to structural reform, dating back to 2014 and earlier, are yet to be acted upon. It is hoped that the suggestions and recommendations set out herein in regard to this issue of structural statis are of assistance to, and of use to, the Commission as it develops its Final Report.

On page four of the *Contributing Lives Report*, published by the National Mental Health Commission in the year 2014, we can read as follows:

We need system reform to:

- redesign the system to focus on the needs of users rather than providers
- redirect Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity
- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community

support, stable housing and participation in employment, education and training

- repackage funds spent on the small percentage of people with the most severe and persistent
- mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care
- reform our approach to supporting people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia's wealth.

https://www.mentalhealthcommission.gov.au/publications/contributing-lives-review-2014

It is immediately evident to the reader that the directions being espoused in 2025 by the Productivity Commission are almost identical to the directions espoused and recommended by the National Mental Health Commission in 2014, as we can see in the following juxtaposition:

- National Mental Health Commission, 2014: We need system reform to redesign the system to focus on the needs of users rather than providers; and
- Productivity Commission, 2025: We need system reform to be effective, the new policy architecture should be developed by governments in a process of co-design with people with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin as well as service providers and practitioners.

In looking at the almost identical nature of the recommendations from 2014 and 2025, one immediately asks oneself why so little has changed in the intervening 11 years. Sadly, the *Interim Report* doesn't explicitly set out to address that question, and it is this author's view that the Review Process and the *Final Report* would be much stronger if the Productivity Commission did set out to answer that hugely consequential question. In the absence of the Productivity Commission providing any explicit answer to that question, one is left to examine what is said in the *Interim Report* and to then draw inferences from that.

In examining the *Interim Report*, one immediately sees that the Productivity Commission has made a Draft Finding that "The Agreement has not led to progress in system reform" [Draft finding 2.2, page 19]. And in order

to bring about meaningful systemic reform, the *Interim Report* sets out four specific actions, as follows:

Draft recommendation 4.2
 Building the foundations for a successful agreement

The current National Mental Health and Suicide Prevention Agreement, including funding commitments, should be extended until June 2027, to give sufficient time to develop the foundations of the next agreement and renew the National Mental Health Strategy.

#### To support the next agreement:

- the National Mental Health Commission should run a co-design process with people with lived and living experience, and their supporters, families, carers and kin to identify relevant and measurable mental health and suicide prevention objectives and outcomes
- the Department of the Prime Minister and Cabinet should convene negotiations with the support of the National Mental Health Commission, and facilitate engagement between the Australian, state and territory governments on their shared priorities
- commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the agreement rather than a separate schedule. Governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration
- the Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention. Implementation plans to develop any new indicators should be in place within 12 months of the agreement being signed. [Page 21]

The theory of change that the Productivity Commission is articulating in the *Interim Report* is, in the opinion of this author, necessary but not sufficient. The following Key Points within the *Interim Report* are noted:

#### **Key points**

- The actions in the Agreement do not advance system reform.
- A new policy architecture is needed to articulate the collective actions that will deliver

changes to the mental health and suicide prevention system and improve outcomes.

- The next agreement should formalise the role of the National Mental Health Commission as the entity responsible for independent assessment and reporting on progress [Page 2].
- Notwithstanding the considerable merit in the theory of change as articulated by the Productivity Commission, I would once again reference the Contributing Lives Report in the year 2014. And I draw the reader's particular attention to the following two NMHC Recommendations from 2014:
- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training
- repackage funds spent on the small percentage of people with the most severe and persistent
- mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care.

I respectfully suggest that the theory of change articulated within the *Interim Report* is in fact unlikely to materially address two of the key impediments to change, as articulated by the National Mental Health Commission in 2014.

In Part B of this current document, section B1 addresses the issue of investing in Preventative programs. This is in fact a key issue of concern to the Productivity Commission in its current 5 Pillars Inquiries ie it is a key line of inquiry within the Productivity Commission's current Inquiry in to the Care Economy. And the reality in Australia as noted above and restated now is that:

Australia, when measured against comparable countries ie Western liberal democracies like the UK and Canada, performs poorly in regards to investing in preventative solutions to health.

https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/

In Part B of this current document I reference the following insightful book *Why Isn't Government Policy More Preventive?* by Cairney and St Denny -

https://global.oup.com/academic/product/

why-isnt-government-policy-more-preventive-9780198793298?cc=au&lang=en&

In their book Cairney and St Denny identify three forms of preventative strategy:

- Primary prevention. Focus on the whole population to stop a problem occurring by investing early and/ or modifying the social or physical environment. Common examples are whole-population immunizations.
- Secondary prevention. Focus on at-risk groups to identify a problem at a very early stage to minimize harm. Targeted breast cancer screenings are a classic example in health, while social policy can be based on behavioural indicators of risk.
- Tertiary prevention. Focus on affected groups to stop a problem getting worse. Examples in health are interventions to manage chronic conditions, such as diabetes or dementia. In social policy, crisis intervention may be designed to prevent family homelessness.

Investments in to Mental Health and in to Suicide Prevention Programs can typically be grouped in to three main categories:

- Universal/ Community Wide, whole of population and very upstream preventative programs
- Selective programs aimed at At Risk Groups and tailored to meet the needs of such specific groups
- Indicated programs for At Risk Individuals ie highly intensive, acute programs provided to a relatively smaller number of individuals who are diagnosed as needing intensive care and assistance.

To repeat, once again, the NMHC's *Contributing Lives Report* of 2014, recommended that as a nation we:

- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention
- repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care.

Eleven years later there has been very minimal progress in regards to those two NMHC recommendations.

If we return now to Cairney and St Denny and their book on *Why Isn't Government Policy More Preventive?*, they write further, as follows:

Indeed, health provides the classic case of high but unfulfilled commitment based on:

- vague ambitions
- uncertainty about how to describe and address the determinants of health inequalities
- the dispiriting appearance of overwhelming policy problems that seem impossible to solve simply by reconfiguring health and related services
- the lack of technically or politically feasible solutions
- the tendency for acute services to command more attention and money to solve the short-term and salient issues that people tend to relate to a government's competence.

I have seen no suggestion from anyone that the Australian government's finances are in any position to countenance any new investments in to the Mental Health or Suicide Prevention system. Rather, there is widespread commentary to the effect that the Australian federal budget is in structural deficit, and recent smallish surpluses were the result of nothing other than somewhat unexpectedly high mining royalties.

- So, the macro financial situation is that of fiscal constraint, and the Grattan Institute puts things thus:
  - > Budget expectation management is a perennial rite of autumn. But with the fiscal situation even more dire than usual, it's probably serious this time. Grattan Institute analysis has shown that the federal budget has a deep structural deficit that may grow to \$70 billion over the next decade. It will likely persist for decades after that unless spending is cut and taxes are raised. Many state budgets are also deep in the red.
  - News about some victims of impending cuts is starting to leak out. Last week, community health providers in Victoria were told there would be a cut to prevention programs that aim to reduce obesity and vaping. Premier Andrews has said that the funding was duplicated, and the cuts had been announced before. But spending on prevention in Australia should be

going up, not down.

https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/

As a nation we need to be spending more, much more, on prevention. We spend much less on prevention that comparable countries. We live in a fiscally constrained time - period, and it is highly unlikely that any significant new funding for Mental Health or Suicide Prevention will be forthcoming. And as Cairney and St Denny have stated, there is a "tendency for acute services to command more attention and money to solve the short-term and salient issues that people tend to relate to a government's competence." Cairney and St Denny are writing in a United Kingdom context. But there is no escaping the fact that in 2014 the National Mental Health Commission called for a rebalancing of expenditure in Mental Health ie a deliberate, sustained and protracted reduction in funding to downstream acute services and a commensurate long-term increase in funding to upstream, preventative programs. Australian Governments between 2014 and 2025 have not acted on that recommendation. And there can be no assumption of any kind that Australian Governments will, of their own volition, be predisposed to increasing funding for preventative programs going forward beyond 2025.

In the context of First Nations Suicide Prevention, Canadian Professor Michael J Chandler posed this question back in 2015: **'Still More Counsellors?'** The point that Chandler was making was that the demand for counsellors, psychologists, psychiatrists and clinicians of all manner is a totally bottomless pit. It is literally insatiable and endless. And it will continue to be insatiable and endless until Governments choose to stop buying in to the logic that investments in to Mental Health and Suicide Prevention must be investments into either:

- Acute clinical care and treatment delivered by the mainstream health system; or
- Community based health services, including counselling, and a variety of therapies provided through community health providers.

Unless, and until, we as a nation listen to the NMHC's recommendations from 2014 to rebalance expenditures and redirect expenditures, it is very unlikely that the benefits to be derived from the better coordination of Governments will deliver the actual community health outcomes that we are all seeking.

## Recommendation

That the Productivity Commission significantly revise its Theory of Change Such That a Revised Theory of Change is heavily informed by the National Mental Health Commission's Contributing Lives Report and That Any Revised Theory of Change Materially and Comprehensively Addresses Key Impediments to Systemic and Structural Change in the Mental

Health and Suicide Prevention System. In Particular, A New Theory of Change Should, Consistent With the Productivity Commission's Own Current Inquiry in to the Care Economy, Seriously Address the Key Issue of Government's Profound Reluctance to Invest in Upstream, Preventative Programs.

#### **A.3** True Co-design Requires Transformative Change From Governments

Experience and Evidence Strongly Suggest That True Co-design Requires Transformative Change From Governments That Are Wedded to 'Business As Usual' Modalities. No Co-design process should be even commenced without firstly receiving a clear and detailed statement from Government, at the Ministerial level, setting out how the Government of the day views Co-design operating within the constraints of, and within the context of, a Westminster democracy.

In the previous section of this submission it was held that there was a substantial and significant risk of structural stasis, and the potential for a failure to truly develop a new Mental Health and Suicide Prevention system, if the pathway forward relied essentially on rewriting the systemic architecture but failed to address the absolutely fundamental issue of restructuring expenditures so as to favour preventative programs. It was held that these points have been made since at least 2014 and yet are not evident within the *Interim Report*.

Similarly, in this section it is noted that the *Interim* **Report** postulates and recommends that the Mental Health and Suicide Prevention architecture change can be affected and can be enacted through a Co-design process which centres the voices of the services - users ie those with lived experience of mental illness. But this author holds that the process of Co-design, as it is described within the *Interim Report*, fails to sufficiently recognise and address the critical fact that Governments are consistently loathe to, and highly reticent to, engage in meaningful Co-design processes. This deep and abiding reluctance is because true Co-design requires transformational changes and complete paradigm shifts in the way that Governments in a Westminster Democracy undertake business. And Governments are highly reluctant to engage in such transformational change or paradigm shifts.

The Productivity Commission's *Mental Health and Suicide Prevention Agreement Review Interim Report*of June 2025 states as follows:

Co-design, including with people with lived experience

Through co-design, governments, consumers, carers and service providers will be able to articulate the long-term objectives of the system, the outcomes it seeks to achieve and the priority action areas for the next agreement.

But successful co-design needs adequate time and resourcing to enable people with lived and living experience to take part. Under the current Agreement, policy design and service commissioning often do not allow sufficient time for genuine co-design, and this can have detrimental consequences.

Very short time frames make important aspects of service development such as co-design and evaluation unviable, particularly in terms of meaningfully embedding the views of people with lived experience as per the Agreement's commitments, which risks reducing these commitments to tokenism.

The rushed approach to co-design diminishes these activities to merely consultative exercises and makes the needed time to develop trust and effective engagement with key populations, such as culturally and linguistically diverse communities or people in rural and remote areas largely impossible. When there is also no requirement for co-design results to be utilised by the service, this risks undermining community confidence further. (Roses in the Ocean, sub. 19, p. 4)

The co-design process underpinning the next agreement should avoid the pitfalls of the current approach.

Peak bodies should be sufficiently resourced to take an active role in co-design, which should have a balanced representation of people with lived and living experience of mental ill health and suicide, alongside supporters, families, carers and kin. Successful co-design also requires government agencies to be genuinely willing to share decisionmaking power. This is likely to require a substantial shift in organisational cultures within government [Page 14]

The most important aspect of this commentary from the Productivity Commission is the last two sentences, which bear repeating now:

Successful co-design also requires government agencies to be genuinely willing to share decision-making power. This is likely to require a substantial shift in organisational cultures within government.

Indeed, yes, undertaking such a process is not just likely to require a substantial shift in organisational cultures within government but in fact has no hope whatsoever of success, and is a process best not even commenced, in the absence of an up – front commitment from Government, at Ministerial level, to undertaking paradigm shifts and transformational changes in organisational cultures within government.

Whilst I have very limited direct experience of Co-design practices in the mainstream Mental Health and Suicide Prevention space, I have very considerable experience of Co-design in the Aboriginal Wellbeing space and in the Aboriginal Justice space. I had management - oversight of the development of the following two Co-design documents:

 Kimberley Co-Design Guide For The Kimberley Aboriginal Youth Wellbeing Partnership; October 2022.

https://www.pc.gov.au/\_\_data/assets/pdf\_file/0005/353318/sub023-closing-the-gap-review-attachment1.pdf

 'Nothing About Us Without Us': Co-Designing Youth Justice In The Kimberley

https://www.thecentrehki.com.au/wp-content/uploads/2021/05/2020.12.09-KALACC-Co-Designing-Youth-Outcomes-in-the-Kimberley-FINAL-2.pdf

I also have some fairly detailed understandings of the overall WA State Government approach to Co-design, as set out in the following: *State Commissioning Strategy for Community Services* <a href="https://www.wa.gov.au/organisation/department-of-treasury-and-finance/state-commissioning-strategy-community-services">https://www.wa.gov.au/organisation/department-of-treasury-and-finance/state-commissioning-strategy-community-services</a>

In Western Australia the previous Department for Aboriginal Affairs was disbanded over a decade ago, as part of a larger 'machinery of Government' change, a process that resulted in far fewer Departments than had been the case ie a process of Departmental amalgamations. At present, and in recent years, the majority of strategic Aboriginal matters have sat within the province of the Aboriginal Policy Unit with the Department of Premier and Cabinet. When I enquired three years ago about the lack of progress on Co-design, the response from the WA Government Department of Premier and Cabinet was as follows:

- Co-design processes were inconsistent with, and incompatible with, the Government business processes and Governance structures within a Westminster democracy;
- The specific request for equitable resourcing to enable the non – Government participants to come to the table as equals with Government was rejected out of hand.

Staying in the Aboriginal space, I note the following comments from the Productivity Commission itself, in its January 2024 *Review of the National Agreement on Closing the Gap Study report*:

The Commission's overarching finding is that there has been no systematic approach to determining what strategies need to be implemented to disrupt business-as-usual of governments. What is needed is a paradigm shift. Fundamental change is required, with actions based on a clear logic about how they will achieve that change.

It is too easy to find examples of government decisions that contradict commitments in the Agreement, that do not reflect Aboriginal and Torres Strait Islander people's priorities and perspectives and that exacerbate, rather than remedy, disadvantage and discrimination. [page 3] https://www.pc.gov.au/inquiries/completed/closing-the-gap-review#report

Characterisations such as the one offered above by the Productivity Commission of the *National Agreement* on *Closing the Gap* need to be understood in a context in which that particular National Agreement is couched entirely in the language of 'Partnership', as expressed a multitude of times in the Agreement documentation, including this one particular articulation of the importance of 'Partnership':

For the first time, the National Agreement has been developed in genuine partnership between Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations (the Coalition of Peaks).

The *National Partnership Agreement* contains some four Priority Reforms, the first of which is as follows:

Strengthen and establish formal partnerships and shared decision-making

https://www.closingthegap.gov.au/national-agreement

Four years after the signing of the *National Partnership Agreement*, the Productivity Commission concluded that:

there has been no systematic approach to determining what strategies need to be implemented to disrupt business-as-usual of governments. What is needed is a paradigm shift.

If we then fast forward from 2024 through to June 2025, it is worth noting that the Lowitja Institute has recently concluded that the situation has not improved between 2024 and 2025. In June 2025 the Lowitja Institute published a paper with the following title: Codesign Versus Faux-design of Aboriginal and Torres Strait Islander Health Policy: A Critical Review. This document states as follows, on page one:

while co-design terminology is increasing in Australian health policymaking, many cases apply only tokenistic or superficial co-design practices; an approach that we term 'faux-design'.

https://www.lowitja.org.au/wp-content/uploads/2025/06/Lowitija-Institute-Co-design-Review.pdf

The National Partnership Agreement on Closing the Gap contains some 17 Targets, across Health, Housing, Justice, Early Years, Education and Employment. But Closing the Gap has, since its inception and from the outset in 2007, been first and foremost about First Nations Health. So, if the Lowitja Institute concludes in June 2025 that Australian Governments' approaches to Co-design in the Health domain are tokenistic and superficial, you can be assured that approaches to Co-design in other sectors and other domains are at best facile and at worst are disingenuous. One can point to the existence of various 'Policy Partnerships.' But one questions the value of the Aboriginal Justice Policy Partnership when at least three State Governments are engaged in a 'race to the bottom' on youth justice ie seemingly engaged in a race to see which of them can come up with the most punitive approach to Aboriginal juvenile offenders. It is self - evidently true that Aboriginal people have not been invited to sit at the table and Co-design the justice system with Government. And the same is true of housing, education, employment and Culture. [There may be some green shoots in terms of Co-designing the Early Years.]

In its *Interim Report*, the Productivity Commission raises this following concern:

Successful co-design also requires government agencies to be genuinely willing to share decision-making power. This is likely to require a substantial shift in organisational cultures within government.

But the Interim Report doesn't interrogate that significant concern and doesn't explore the validity of its own logic. Surely the concern raised by the Productivity Commission necessarily begs the following question: What is the appetite of Government, and the willingness of Government, to undertake substantial shifts in organisational cultures within Government? All of the available evidence demonstrates that Co-design requires a complete paradigm shift. And the evidence equally demonstrates that Governments uniformly and consistently refuse to participate in such a paradigm shift. With all due respect, it would seem to be foolhardy to recommend systemic change through Co-design when there is such a mountain of evidence suggesting that Governments operating within a governance structure of Westminster Ministerial responsibility view 'community engagement' to equate with Consultation, not Co-design.

The *Interim Report* from the Productivity Commission contains the following draft recommendation, relating to Co-design:

- raft recommendation 4.1
   Developing a renewed National Mental Health Strategy
  - A National Mental Health Strategy is needed to articulate a clear vision, objectives and collective priorities for long-term reform in the mental health system over the next 20-30 years. The National Mental Health Commission should oversee the development of this Strategy and undertake a co-design process with people with lived and living experience, their supporters, families, carers and kin. [page 20]

The present author was told by the WA Department of Premier and Cabinet that Co-design was not being progressed because it was contrary to the principles and practices of a Westminster democratic system of government. It is certainly this present author's lived experience across more than a decade and across the Justice, Health and Community Services Portfolios, that State Governments engage in Faux Co-design processes. And it is certainly this present author's experience, over the last two decades, that well -intentioned Commonwealth commitments to Regional Partnerships or to Organisational Partnerships evaporate once they progress from the theoretical level to the draft operational

level. These personal experience are consistent with recent findings from the Productivity Commission itself.

All that is offered above in this section of this present submission strongly indicates that the Productivity Commission's Draft Recommendation 4.1, as it is currently worded, and as it currently stands, is problematic. There are myriad instances of supposed Co-design processes in which community participants have engaged in such processes in good faith, only to realise one, two or three years in to the process that they had in fact merely be involved in some form of Consultation, but certainly not a Co-design.

The present author is of the view that the Final Report from the Productivity Commission should avoid advocating for a Co-design Process, unless it includes in the final recommendation, very clear and comprehensive Findings and Recommendations around the inherent political and structural impediments to Co-design. In doing so, the Productivity Commission could readily draw on work which the Commission itself has undertaken on the Closing the Gap Review [2024] and the recent Lowitja Institute Report on Faux – design.

## Recommendation

No Co-design process should be even commenced without the following first occurring:

 A clear and detailed statement from Government, at the Ministerial level, setting out how the Government of the day views Co-design operating within the constraints and within the context of a Westminster democracy; and

#### A.4 Strengthening the Alignment With the Productivity Commission

Strengthening the Alignment With the Productivity Commission's *5 Pillars* Inquiries, Especially the Inquiry into the Care Economy

In Part B of this present document, information is provided on a couple of the broader, more general topics of current interest to the Productivity Commission ie:

- How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?; and
- Ensuring that the voices of First Nations people are heard and acted upon.

For now, here, in considering the relationship between the Commission's Mental Health Inquiry and the Commission's Care Economy Inquiry, I once again reference the NMHC's *Contributing Lives Report* of 2014. Once again I draw the reader's particular attention to the following two NMHC recommendations:

- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training
- repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead

contributing lives and keep them out of avoidable high-cost care.

As noted earlier, it is troubling that the *Interim Report* does not materially address these two recommendations from the National Mental Health Commission from 2014. On Page 7 of the Productivity Commission's document *Pillar 4, Delivering quality care more efficiently, Consultation questions, May 2025* https://engage.pc.gov.au/projects/quality-care/page/pillar-4-responses one can read as follows:

A national framework to support government investment in prevention

Evidence-based prevention programs can drive productivity in the care sector and the wider economy by providing services that aim to reduce a person's future demand for care services.

When they're working well, prevention programs reduce risk factors before problems arise (primary prevention), help detect issues early (secondary prevention) or slow the progression of disease or other issues during initial stages (tertiary prevention).

Despite their benefits, governments are often reluctant to invest in prevention programs. Funding decisions tend to prioritise immediate needs and align with the responsibilities of specific departmental portfolios. Prevention requires governments to spend upfront while benefits can take time to be realised, are hard to measure and can span different parts or tiers of government. For example, investment in support services for people at risk or experiencing homelessness can lead to long-term savings through improved health outcomes and reduced future demand for other services.

A framework that measures and incorporates the long-term benefits of prevention could encourage greater investment in evidence-based prevention programs. Such an approach could improve outcomes for people through timely and effective support and enhance the sustainability of the care economy.

#### Our approach

We will consider the features of a framework that would allow for investment in prevention based on a broad and long-term assessment of potential benefits.

We are particularly interested in:

- barriers to government investment or scaling up of effective prevention programs
- the extent to which inadequate funding and the short-term or limited assessment of benefits has restricted effective prevention
- the extent to which the benefits of prevention accrue across different sectors and/or tiers of government
- policy actions that could support greater investment in prevention activities.

**The Care Economy Interim Report** from the Productivity Commission will be published by the PC on Wednesday 13 August 2025 <a href="https://www.pc.gov.au/inquiries/current/five-productivity-inquiries">https://www.pc.gov.au/inquiries/current/five-productivity-inquiries</a>.

In other words, that *Care Economy Interim Report* will be published by the Productivity Commission shortly after the closing date for public submissions on the Interim Report on Mental Health and Suicide Prevention.

Thus, one would hope and one would expect that the development of the *Final Report on Mental Health and Suicide Prevention* would be greatly informed by the findings and recommendations within the *Care Economy Interim Report*.

For now, I once again refer to the *Contributing Lives Report* of 2014 and I once again reference the fact that the National Mental Health Commission's

recommendations from 2014 that the system needed to be rebalanced in favour of prevention and early intervention services has still not been enacted.

And in regards to First Nations Wellbeing and Suicide Prevention I once again reference the words of Professor Michael J Chandler – 'Still More Counsellors?'. I note that Chandler was first and foremost a statistician, an actuary of suicide and self-harm statistics. And this is what the actuary concluded, based on his 30 years of studying the phenomenon of First Nations suicide:

"if suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counsellors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives."

#### Professor Michael J Chandler

Cultural Wounds Require Cultural Medicines.

Chandler spoke at length on this topic in a speaking tour in Canberra in August 2012. Thirteen years later the Australian Government has not taken any action in this regard.

The Productivity Commission's *Mental Health and Suicide Prevention Agreement Review Interim Report* of June 2025 notes that the rate of First Nations suicide in Australia continues to worsen. This fact comes as a surprise to no one who has worked in the First Nations cultural space. For as long as suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

Professor Michael J Chandler, in consideration of the issue of efficacy and productivity in First Nations Suicide Prevention programs, put things thus:

"whenever we are moved to minister to such troubles, the usual impulse — the common intervention or treatment strategy — is to somehow buck-up the flagging spirits of those singular symptom bearers who are counted as most disheartened or undone. Picking away at such troubles one 'patient' at a time, we council and drug them, we bolster their flagging self-esteem, and otherwise do whatever seems appropriate to shore up their supposed personal shortcomings. In short, while many of our ills are acknowledged to sometimes be social or cultural in origin, when moved to intervene, Western

society has customarily proceeded by attempting to redeem one lost soul at a time. A prime example of this individualistic approach to 'treatment' is to be found in standard responses to the so-called "epidemic" of suicides ascribed to the residents of many Indigenous communities. Those individuals somehow deemed to be at special risk are taken aside and variously bucked-up, all in the hope of somehow making each one of them personally better adjusted and less forlorn. This chapter will work to make the case that such applications of so-called individualized "medical models" of suicide prevention are mistaken at every turn, insisting instead that cultural wounds require cultural medicines." https://www.thecentrehki.com.au/resource/culturalwounds-require-cultural-medicine/

#### Professor Michael J Chandler

Cultural Wounds Require Cultural Medicines.

Once again, what Chandler is saying to us, based on his thirty-year body of work as an actuary and examiner of First Nations suicide statistics, is that individualized "medical models" of suicide prevention are mistaken at every turn, and that what is required instead are cultural medicines delivered at the collective community level. Once again, if the unit of intervention is the individual person and if the modality of intervention is medical in nature [whether that be delivered in an acute clinical setting or whether that be delivered in a more community based setting], then Chandler, in that same paper, says we would then be "fishing in the wrong pond."

Elsewhere, we can find very similar sentiments expressed by Mohawk Professor Taiaiake Alfred - <a href="https://taiaiake.net/">https://taiaiake.net/</a> Professor Alfred explains and illustrates present day First Nations psychological trauma, and the basis of the high rates of suicide in Canada, through the use

of a metaphor, of a rock that has been worn down by the processes of colonisation. That rock, which is now a small pebble, used to be a giant boulder. His grandfather stood on a solid boulder of Mohawk ceremony and Culture, whereas he and his tribe today lack that solid foundation.

As the National Mental Health Commission recommended in 2014, we desperately need to rebalance the system so that it prioritises prevention and early intervention, both in the mainstream community and in the First Nations community. And in the First Nations context, a system that prioritises prevention and early intervention cannot be delivered through a Health paradigm, whether that be through mainstream health or through community health. Mohawk Professor Taiaiake Alfred puts it thus:

"Because we've shown, in a number of studies that we've looked at, in the Canadian context, and particularly – I'll use the example of the Cree people, in Northern Quebec, where the young people in that community, in that nation, that had survived and could withstand the ongoing effects of colonisation the best were those that benefited from programs that were set up by the Cree nation to relink them to their traditional cultural practice, to support the maintenance of their language fluency, and, even though it was seasonal and it wasn't a permanent state, to surround them and have them experience life in a traditional cultural community."

#### Professor Taiaiake Alfred — Mohawk

Transcript of a speech delivered at the Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, in 2015. Transcript available upon request.

# **Recommendation:**

That the Final Report on Mental Health and Suicide Prevention be greatly informed by the findings and recommendations within the Productivity Commission's Care Economy Interim Report in regards to investing in Preventative Programs.

#### A.5 Place People With Lived Experience at the Centre of the System

If the Concept is to Recentre the System and Place People With Lived Experience at the Centre, Then What Is It That People With Lived Experience Are Currently Saying to Us About How to Change the System? The First Person Authorial Voice of Peer Workers Is Not Strongly Evident in the Available Literature.

I am lodging this submission with the Mental Health Commission because I have taken the view that there are a number of areas for improvement in the current *Interim Report*. However, it needs to be acknowledged that there are a number of strengths to the *Interim Report*, and the Commission deserves commendation on those strengths. One such strength is the wealth of information that the Commission has garnered directly from those with lived experience. In noting this as a strength, I particularly acknowledge the following:

- 'Alienating, inadequate, ill-informed, and underresourced': consumers, carers and practitioners reflect on the mental health and suicide prevention system. [Page 3, Box 1]
- Review participants have told the PC the Agreement was developed with limited input from people with lived and living experience, their supporters, families, carers and kin, as well as service providers. Consumers and carers have limited involvement in governance arrangements. [Page 5]
- Co-design, including with people with lived experience. [Page 14]
- Seeking information from Lived Experience. [Page 23]
- People with lived and living experience were not involved in the negotiation and design of the Agreement. [Pages 116-117]
- Co-design brings substantial benefits if done well.
   [Page 118, Box 3.2]
- Recognising the contribution of peer workers.
   [Pages 160-161]
- Draft recommendation 4.14 The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce. [Page 162]

Having acknowledged that this is a strength of the *Interim Report*, the main additional point that I would make is that my limited review of the available literature suggest that the authorial voice of Peer Workers is not strongly evident in the available literature. There is a veritable tsunami of literature on mental health systems around the world. And there is quite a lot of available

literature written by authors with lived experience of mental health. But I have struggled to find many firsthand journal articles written by Peer Workers in the Mental Health system and describing their experiences of working as a Peer Worker in Mental Health.

In reality, I was only able to find one such journal article, this being the following:

Assault and Exploitation: My Peer Worker Experience <a href="https://www.madinamerica.com/2021/03/assault-exploitation-peer-worker-experience/">https://www.madinamerica.com/2021/03/assault-exploitation-peer-worker-experience/</a>

This particular journal article is a first-hand account ie a journal article actually written by the Peer Support worker. This worker had had very poor experiences as a patient in the Mental Health system, and she describes those experiences in the article. And then she had a very poor experience as a Peer Support Worker in an Acute Mental Health hospital setting, and she describes those experiences in this article. At the very end of the article there is a short paragraph suggesting that she had had better experiences as a Peer Support Worker in a different, subsequent setting. But that whole paragraph only runs to some 5-6 lines in total. As such, we are not provided with any insights to what that more positive experience may have looked like. So, this article really only serves to highlight the risks associated with Peer Support Worker roles being a poorly defined afterthought in a complex system.

I did additionally find this following journal article:

The impact of working as a peer worker in mental health services: a longitudinal mixed methods study <a href="https://bmcpsychiatry.biomedcentral.com/">https://bmcpsychiatry.biomedcentral.com/</a> articles/10.1186/s12888-022-03999-9

This is a very useful article. But, of course, it is not in any way a first- hand authorial account of the role of a Peer Support Worker. Rather, the basis of the study is a number of diaries developed by Peer Support Workers. The study is described as follows:

"In a longitudinal mixed methods study, 32 peer workers providing peer support for discharge from inpatient to community mental health care - as part of a randomised controlled trial - undertook in-depth qualitative interviews conducted by service user researchers, and completed measures of wellbeing, burnout, job satisfaction and multi-disciplinary team

working after completing training, and four and 12 months into the role....Peer workers felt valued, empowered and connected in the role, but could find it challenging to adjust to the demands of the job after initial optimism. Supervision and being part of a standalone peer worker team was supportive, although communication with clinical teams could be improved....Peer workers seem no more likely to experience negative impacts of working than other healthcare professionals but should be well supported as they settle into post, provided with in-work training and support around job insecurity. Research is needed to optimise working arrangements for peer workers alongside clinical teams."

As useful and as informative as that article is, I was originally interested in finding articles written by Peer Support Workers themselves. And in regards to that, I was quite unsuccessful in locating such material.

There is research which is currently being undertaken by Peer Support Workers who work for a Queensland organisation called The Richmond Fellowship. RFQ describes itself in the following terms:

We are a leader in the provision of professional recovery-oriented psychosocial services throughout Queensland, and through national telehealth services.

https://www.rfq.com.au/

In no way do I speak for or on behalf of RFQ. I simply take this opportunity to note that there currently sems to be a shortage of published research and extended journal articles written by Peer Support Workers about Peer Support Workers. Having access to such material would be immensely useful in terms of the overall quest to empower Peer Workers within a process of Systemic and Structural Reform.

Having written all of the above, very late in the day in this writing process I have become aware of and am starting to familiarise myself with the work of Lived Experience Leadership — <a href="https://livedexperienceleadership.com">https://livedexperienceleadership.com</a>.

au/who-are-we/ — I won't delete and I won't correct what I have written above, but I do note that the Lived Experience Leadership Website has the following drop down headings —

https://livedexperienceleadership.com.au/

- What is the Lived Experience Workforce?
- Our research
- Audio and Visual Resources

- Additional Resources
- Who are we?

It is now clear to me that there is a veritable wealth of information available from this group. And I note that available via the Our Research drop down there are a number of articles written by this Lived Experience group. In the immediate context of the current inquiry from the Productivity Commission I draw particular attention to the following:

Strategies for Effective Peer (Lived Experience)
Employment within Multidisciplinary
Organizations: Model for Best Practice — https://
livedexperienceleadership.com.au/model-effectiveemployment-of-peers/

#### Take Home Messages

- Best practice in employing Lived Experience workers involves a whole of organisation approach.
- Senior leadership of the organisation need to understand and value the work and demonstrate this valuing.
- Best practice requires organisational commitment which is long-term and provides adequate financial support.
- > Best practice requires an organisational culture that values and supports Lived Experience workers as well as mutual respect and collaboration.
- Organisational strategies support effective employment of Lived Experience workers, such as Lived Experience workers in senior roles, Lived Experience led supervision and whole of workplace training on the value and role of Lived Experience.
- Best practice approaches support authentic Lived Experience work that contributes to more recovery-oriented and person-driven services.

Further, on that same webpage I note further that:

Why is this Research Important? Employment in a work environment that does not understand, value or collaborate with Lived Experience workers is damaging to the workers and limits the potential benefits of Lived Experience work. I thoroughly agree with this sentiment. A close friend of mine, someone who has long worked in the Lived Experience community support context, and who has long demonstrated leadership in the development of Peer Support Networks, said to me recently that the language used by medical professionals is an alien language to those with Lived Experience. So, yes, most [but not all] research is good research. And most research makes a contribution to society. But it is the research led by and

written by those with Lived Experience which will be the research which most genuinely reflects the language and the world view of those with Lived Experience. And thus there is a very valuable role for and opportunity for new research to be undertaken by Peer Workers about Peer Workers.

## **Recommendation:**

That funding be allocated towards the advancement of research undertaken by Peer Support Workers about the work of Peer Support Workers.

#### A.6 Employing Peer Support Workers in a Complex Mental Health System

What the Literature Suggests About the Keys to Success in Employing Peer Support Workers in a Highly Structured, Complex and Rigid Mental Health System. Clear Position Descriptions, Clear Work Roles and Clear Lines of Reporting and Accountability Are Critical.

- Draft recommendation 4.14, Page 26
   The next agreement should commit governments to develop a scope of practice for the peer workforce
- The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce, in consultation with the peer workforce, that:
  - > promotes safer work practices for peer workers
  - contributes to better outcomes for people accessing mental health and suicide prevention peer support
  - improves public understanding of the profession, allowing for greater recognition of peer workers' capabilities and contributions.

The points I make here about the keys to success in Employing Peer Support Workers, comes from the first article cited above ie The impact of working as a peer worker in mental health services: a longitudinal mixed methods study <a href="https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-022-03999-9">https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-022-03999-9</a>

And what I note from this article is the following:

"A wider literature explores the impact of implementation issues and organisational environment on peer support in mental health services [10], suggesting that the potential benefits for people offered peer support - can become diluted where key aspects of how peer support is put into practice are poorly defined [11]. Notably, it has been identified that a clear peer worker role description [12], role specific training and support [13, 14], preparation for clinical teams working alongside peer workers [15], and shared expectations of the peer worker role across peer workers and their clinical colleagues [11] all facilitate successful delivery of peer support. Poor quality implementation, in particular in relation to the role of the peer worker as part of the multi-disciplinary clinical team, has also been shown to impact outcomes for peer workers. A qualitative interview study based in an inpatient setting in Germany showed that peer workers experienced pressure to succeed as pioneers in a new role, had to negotiate identity issues with existing professional staff - as colleague, rival or patient - and had to navigate unfamiliar issues around information sharing, boundaries and professionalism [16]. In Canada, Voronka [17], an experienced peer worker and researcher, writes of the demands on peer workers of having to perform a marginalised, experiential identity while at the same time following professional rules and regulations - to pass simultaneously as both normal and disabled - echoing research from the UK [18]. A qualitative interview study with 23 peer workers and 11 'nonpeer' mental health workers in the US suggests that levels of job satisfaction among peer workers are contingent on role clarity, a sense of autonomy in the role and acceptance by non-peer co-workers [19]."

So, the various keys that the authors of that article identify, based on the diaries kept by some 32 peer

workers providing peer support for discharge, from inpatient to community mental health care, are as follows:

- A clear Role Description for Peer Workers
- Role specific training and support
- Preparation for clinical teams working alongside peer workers
- Shared expectations of the peer worker role across peer workers and their clinical colleagues.

There are numerous articles relating to the role of Peer Support Workers in the Mental Health system, and in no ways have I undertaken anything like a proper, comprehensive, Literature Study or Environmental Scan. But in searching what was publicly available a few articles jumped out and caught my eye, including this one ie Diary of a Mental Health Peer Worker: Findings From a Diary Study Into the Role of Peer Work in a Clinical Mental Health Setting <a href="https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2020.587656/full">https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2020.587656/full</a> Some of the reasons why this article caught my attention were:

- Queensland, Australia, location: This article describes things that happened in Queensland ie Metro South in the decade 2010 – 2020;
- Research Based On Diaries Kept by Peer Support Workers: The main form of primary research and evidence was work diaries kept by a cohort of some 36 Peer Support Workers.

Within this article I note in particular the following:

The employment of peer workers reflects wider policy reform that recognizes recovery as foundational to mental health service delivery (6). Peer roles exemplify the possibility of recovery for people experiencing mental health distress (3, 7). Understanding recovery for people affected by mental health challenges requires a holistic approach with emphasis on principles such as hope, autonomy, informed choice, social connection, and the strengths of the individual (8, 9).

Foci of care are living skills development (e.g., budgeting, cooking, and cleaning) and community integration (e.g., interpersonal effectiveness, social problem solving, and citizenship) (11). Therapeutic interventions available on site include cognitive behavior therapy, cognitive remediation, and social cognition and interaction training (12). The peer workforce in two CCU's was envisioned to be a distinct speciality. The role did not encompass

clinical care but focussed on using lived experience to help engage residents with a focus on relationship and community inclusion (13). It was envisioned that the peer workforce, under supervision from senior peer workers, would iteratively co-design their roles over time. This was an attempt to mitigate the power imbalance between the mental health service employer and employee and to try to avoid distorting the unique value of the peer workforce by the "contrived and constrained world that is mental health services" (14).

Three themes were identified, namely: (1) Having time and space to engage with residents; (2) Connecting and sharing similar experiences; and, (3) Providing a peer perspective.

What we can take from this information are some clear pointers in regards to how the Peer Support Worker Role and Position Description is developed ie 'iteratively through Co-design' and what the foci for the Peer Support Worker roles could, and should, be.

The need for clear work roles is yet again picked up in this third article: Strategies and supports used by mental health peer workers to facilitate role performance and satisfaction — <a href="https://www.tandfonline.com/doi/full/10.1080/18387357.2023.2237">https://www.tandfonline.com/doi/full/10.1080/18387357.2023.2237</a> 135#abstract — What we can read in this article is the following:

"Second, role clarity has been a perennial issue for peer workers. Quantitative studies suggest that role clarity is associated with higher rates of job satisfaction and reduced burnout for peer workers (Abraham et al., Citation2021; Edwards, Citation2020; Jenkins et al., Citation2018). However, peer workers often experience unclear and ambiguous role definitions, influencing effective implementation of their tasks (Chisholm & Petrakis, Citation2020; Ibrahim et al., Citation2020; Moran et al., Citation2013; Vandewalle et al., Citation2016). Peer workers report experiencing difficulty understanding the parameters of their role due to the lack of governing body or registration requirements (Roennfeldt & Byrne, Citation2021). Peer workers feel that this can result in inappropriate allocation of tasks and competition with other non-peer mental health professionals, who feel that their role is being replaced (Vandewalle et al., Citation2016). Peer workers may also experience uncertainty regarding setting boundaries and self-disclosure due to this role ambiguity (Ibrahim et al., Citation2020)."

From the three articles I have cited herein, it is evident that there is a great need to define Peer Support Work

Roles because vagueness or ambiguity around the work roles serves to completely undermine the status and the validity of these roles. Thankfully, this seems to be a message that the Productivity Commission has already heard loudly and clearly in its consultations to date.

Time has gotten away from me, and I do not have time to explore this in further depth. However, I do draw attention to this following article: Lived Experience Practitioners and the Medical Model: World's Colliding? by Byrne, L., Happell, B., & Reid-Searl, K. (2016) and available here — <a href="https://livedexperienceleadership.com.au/lived-experience-practitioners-and-the-medical-model/">https://livedexperienceleadership.com.au/lived-experience-practitioners-and-the-medical-model/</a> In particular, I note the following comments within that paper:

#### **Take Home Messages**

- The dominance of the medical model is a significant barrier to the success of the lived Experience workforce.
- Medical model thinking leads to a culture of unequal relationships between health professionals and consumers, with Lived Experience workers experiencing discrimination because of their status as mental health consumers.
- The Recovery approach and medical model are philosophically opposed and unable to exist together.
- Lived Experience work cannot be separated from recovery principles - they are mutually informed and developed.
- We question the capacity for mental health reform while the medical model approach continues to dominate mental health service delivery.

In regards to First Nations suicide prevention I have referenced the work of Canadian Professors Chandler and Alfred and I have said in that context that the Western, individualised, medical modern was 'wrong at every turn' as an approach for First Nations wellbeing. And, similarly, in this present context, with reference to centring the

views of those with Lived Experience, Byrne, Happell, and Reid-Searl are similarly asserting as follows:

We question the capacity for mental health reform while the medical model approach continues to dominate mental health service delivery.

In regards to the draft recommendation relating to a Peer Workforce Scope of Practice, I do note the following resources which are available online via the Lived Experience Leadership website:

- Strategies for Effective Peer (Lived Experience)
   Employment within Multidisciplinary
   Organzations: Model for Best Practice <a href="https://livedexperienceleadership.com.au/model-effective-employment-of-peers/">https://livedexperienceleadership.com.au/model-effective-employment-of-peers/</a>
- Workplace Culture https://livedexperienceleadership. com.au/workplace-culture/
- Organisational Commitment <a href="https://">https://</a>
   livedexperienceleadership.com.au/organisational-commitment/
- Taking a Gamble for High Rewards? Management Perspectives - What are management views on the benefits and limitations of Lived Experience workers? <a href="https://livedexperienceleadership.com.au/management-perspectives/">https://livedexperienceleadership.com.au/management-perspectives/</a>
- Identifying Barriers to Change Why do some organisations have more Lived Experience roles than others? <a href="https://livedexperienceleadership.com">https://livedexperienceleadership.com</a>. au/barriers-to-change/

Whilst I do not work directly within, and whilst I have limited direct understanding of, the work of Peer Support Workers in the Mental Health system, it is self – evident that an authentic and user – centred system would position Peer Support Workers at the very centre of system design. And in the process of writing this submission it has become increasingly evident to me that there is now a considerable body of material that already exists and which could lay the platform for the development of a Peer Worker Scope of Practice.

## **Recommendation**

There is considerable merit to be found in the Productivity Commission's Mental Health and Suicide Prevention Agreement Review Interim Report of June 2025. I note in particular the following:

- Draft recommendation 4.14: The next agreement should commit governments to develop a scope of practice for the peer workforce [Page 26]
- The next agreement should commit governments to develop a nationally consistent scope of

practice for the peer workforce, in consultation with the peer workforce, that:

- promotes safer work practices for peer workers
- contributes to better outcomes for people accessing mental health and suicide prevention peer support

improves public understanding of the profession, allowing for greater recognition of peer workers' capabilities and contributions.

Based on my reading of the literature, as cited herein, and based on my limited discussions with those who work in both clinical and community settings, I endorse this draft recommendation and encourage the Productivity Commission to move forward in developing this as a recommendation to be contained in the Final Report.

#### A.7 Best Practice, Integrating Peer Workers In Clinical Mental Health Settings

"The Productivity Commission is looking for case studies to highlight best practice in integrating peer workers in clinical mental health settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?" [Pages 160/161]

Detailed Position Descriptions are certainly available from the following:

- Clinical Settings: Queensland Health; and Brisbane South PHN;
- Community Settings: Richmond Fellowship Queensland.

The Productivity Commission is currently seeking information about case studies which could serve to highlight best practice in regards to employing Peer Workers, especially in relation to integrating Peer Workers in to clinical mental health settings. There are three quite distinct contexts in which Peer Support Workers are employed in the Mental Health system, these being:

- Acute Hospital Based Clinical Settings: The employer in such instances is typically a State Government ie owner and operator of a Public Hospital or, alternatively, a Privately Run Hospital, often owned and operated by a Church.
- Clinical, Non Hospital, Settings: The employer in many of these instances is a Primary Health Network. There are some 31 PHNs in Australia. Or perhaps more correctly the employer will be a Not for Profit entity that has been commissioned by the PHN. So, the PHN could be Brisbane South PHN and the commissioned service provider where the Peer Support Workers are employed would be a Not for Profit such as BrookRed - https://www.brookred.org. au/what-is-peer-support
- Community Based Mixed Modality Settings: The employer in such instances is typically a Non Government, Not for Profit Care Provider, and typically being a Charity registered with the Australian Charities and Not-for-profits Commission. Richmond Fellowship Queensland is one such service provider.

I do note the Productivity Commission's particular interest in clinical mental health settings. I am not in a position to comment on the role of Peer Support Workers in the Acute Hospital Based Clinical Setting. But I can offer some comments and observations around Clinical, Non – Hospital settings, and around Community Based, Mixed Modality Work Roles for Peer Support Workers.

The Queensland Health Lived Experience (Peer)
Workforce Framework <a href="https://www.health.qld.gov.">https://www.health.qld.gov.</a>
<a href="https://www.health.qld.gov.">au/\_\_data/assets/pdf\_file/0033/1297059/lived-experience-framework-2023.pdf</a>, which runs to some 54 pages in length, provides a wealth of information around best practice procedures for employing Peer Support Workers in the Mental Health space. This Framework document is structured as follows:

- Defining Lived Experience, Pages 8-10
- Core values and Guiding Principles, Pages 12-14
- Supporting the workforce, Pages 16-18
- Professional Development, Page 19
- Core competencies, Page 20
- Roles and responsibilities, Page 21
- Specialisation, Page 22
- Sample Position Descriptions, Page 23-40
- Developing a Wellbeing Plan, Pages 40-44
- Sample Onboarding Document, Page 45-48
- Memo re Identification of positions, Page 49

I am in no position to comment on how effectively these systems and structures work in practice. However, at face value, this document certainly appears to address each of the main concerns that Peer Support Workers have expressed in the literature, and as expressed to the Productivity Commission to date. The Framework document, being a Qld Health document, very much encapsulates and covers the clinical settings scope which is of particular interest to the Productivity Commission.

In regards to the second context, that of Clinical, Non – Hospital settings, I once again draw attention to this publication - Diary of a Mental Health Peer Worker: Findings From a Diary Study Into the Role of Peer Work in a Clinical Mental Health Setting. https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2020.587656/full

I note in particular the conclusions drawn in that study, as follows:

Supervision guidelines have been developed for non-clinical settings, but there is still relatively little information on the types of supervision support needed by PSWs within a clinical setting (24). The diaries however suggest that to be able to work effectively within a community-based rehabilitation setting, it is critical to maintain the lived/living experience aspect of the roles. This can be achieved by regular peer supervision around their roles. In the HHS where this study was undertaken, the peer support workers, in addition to being supervised by their team leaders, also report to the Director of Social Inclusion and receive supervision from the lived experience workforce. This structure is intended to mitigate against some of the issues raised in the literature to date of perceived power imbalance of peers with clinicians, of aligning too closely with clinicians and losing their peer identity. Results from this study indicate that supervision is needed to guide the peer workers to not only maintain a lived experience focus, but also to work within the scope and the boundaries of their role. For the role of a peer support worker to be effective, it is important that this role is equally valued and understood by the team and the organization at large. Consequently, implementing peer roles within clinical settings necessitates a whole of workplace approach with a focus on organizational culture and supervision in effectively integrating peer workers within the service

I am in no position to comment on how effectively these systems and structures work in practice. However, the study methodology seems to be of a high quality and the conclusions and findings seems to be both cogent and intuitively reflective of likely realities within the mental health system.

The third and final context in which we find Peer Mental Health Workers is that of the Community Based Mixed Modality Settings. In regards to this particular setting, I take the opportunity now to share some publicly available information about the role of Peer Support Workers within one particular Community Mental Health Service Provider in the greater Brisbane Area ie Richmond Fellowship Queensland.

General Information Available Online About the Role of Peer Support Workers at RFQ:

#### Key aspects of RFQ's Peer Support roles:

- Lived Experience: Peer Support Workers at RFQ draw upon their own experiences to connect with and support others.
- Recovery Focus: They work with individuals to develop and implement recovery plans, building resilience and fostering hope.
- Community Engagement: Peer Support Workers connect individuals with relevant community resources and support networks.
- Crisis Support: Some roles, like the Peer Carer Support Facilitator, focus on supporting individuals and their families during times of crisis, including suicidal ideation.
- Diverse Roles: RFQ offers various Peer Support roles, including those within the Transitional Recovery Service (TRS) and as part of the Hospital to Home program.

#### Examples of RFQ's Peer Support roles:

- Peer Carer Support Facilitator: Supports family, friends, and significant others of individuals at risk of suicide, according to job postings on EthicalJobs.com. au.
- Recovery Support Worker: Provides support to individuals in their recovery journey, potentially including administrative duties and mentoring of other staff
- Advanced Recovery Support Worker: May involve mentoring and supporting day-to-day operations within a specific program like Hospital to Home.
- Recovery Mentor: May assist individuals with their mental health journey and help them make a difference in the lives of others.

#### RFQ's commitment to Peer Support:

- RFQ emphasizes a supportive and collaborative environment for its staff.
- They provide training and support for Peer Support Workers, including opportunities for professional development.
- RFQ's services are recovery-oriented and evidence-based, with a focus on empowering individuals.

[Source- the above information is sourced from a Google AI search]

Peer Carer Support Facilitator- Richmond Fellowship -Part Time Job Ad (Currently Up on Seek.Com) https://www.seek.com.au/Richmond-Fellowship-Queensland-jobs/at-this-company?jobId=85098399&typ e=standard

#### Your Next Role!

- RFQ are currently recruiting for a Fixed-Term, Part-Time Peer Carer Support Facilitator for 22.8 hours per week, for the Support for Family, Friends and Significant Others of People at risk of suicide program. The initial contract is until 30 June 2026, with the possibility of extension. The program is a psychosocial support service, delivered in the form of community outreach; focusing on supporting and empowering clients to build resilience and respond to crisis with the available supports within their community.
- The Peer Carer Support Facilitator provides support to carers, family members, and friends of individuals at risk of Suicide. If you have Lived experience of caring for an individual experiencing a suicidal crisis and/or a suicide attempt, please continue reading.

#### Why RFQ?

- At RFQ, we are committed to providing a supportive, collaborative, and empowering environment, where everyone can thrive, by joining us you will:
- Be part of a program that values lived experience, personal growth, empowerment and lifelong learning.
- Have access to competitive hourly rates: \$37.35 -\$40.05 per hour, depending on experience.
- Salary packaging benefits, enhance your take home pay with salary packaging of up to \$15,900 on general living expenses and additionally up

- to \$2,650 annual entertainment benefits. This includes access to novated leasing. Explore your cost-of-living savings HERE!
- Opportunities for a wide range of career and professional development.
- No day is the same, but it may include:
  - Connecting individuals with appropriate mental health resources and assisting with access to services.
  - Offering empathetic listening and emotional support to carers, family members, and friends, and where appropriate, education regarding mental health, suicide prevention, and coping strategies.
  - Sharing personal experiences to foster understanding and connection.
  - Maintaining accurate and timely written records in accordance with organisational requirements, ensuring privacy and confidentiality.

#### You will need:

- Relevant qualifications (Certificate IV in Mental Health Peer Work) or relative experience in a similar role.
- Lived experience of supporting someone who is or had a suicidal crisis and/or a suicide attempt.
- Ability to facilitate support groups or workshops.
- Cultural Competency: Awareness and sensitivity to diverse cultural backgrounds.
- Knowledge of local mental health resources and services.
- Communication Skills: Excellent verbal and written communication skills.
- Problem-solving Skills: Ability to navigate complex situations and offer practical solutions.

In no way am I authorised in any way to speak on behalf of Richmond Fellowship, and the information that I have provided to you about is simply information that is readily available in the public domain. What I do note, however, is that within RFQ there is a diversity of Peer Support Worker Roles, and these include as follows:

- Peer Carer Support Facilitator
- Recovery Support Worker

- Advanced Recovery Support Worker
- Recovery Mentor.

Not being formally associated with RFQ in any way I am not able to speak about their employment practices or their staffing strategies. However, anecdotally and informally I have come to believe that in some of the Carer

Support roles there is a staffing ratio of one clinician to five Lived Experience Peer Carer roles.

In conclusion to this section, Peer Support Workers play useful and significant roles in three distinct workplace contexts. I have provided herein some clear pointers as to where and how the Productivity Commission can find case studies which point to the success of employing Peer Support Workers.

## Recommendation

- In order to access useful case studies showcasing the work of Peer Support Workers, the Productivity Commission can and should contact each of the following [or if not these organisations, then similar organisations alternatively chosen by the Commission]:
  - Acute Clinical Care Queensland Health [The Queensland Health Lived Experience (Peer) Workforce Framework]
- Clinical, Non-Hospital Settings Brisbane South PHN https://bsphn.org.au/communityhealth/suicide-prevention/suicide-preventionservices#suicide-prevention-services and also Brook RED's alt2su group https://www.brookred. org.au/supporting-suicidality
- Mixed Modality Community Support Richmond Fellowship Queensland <a href="https://www.rfq.com.au/about-rfq/">https://www.rfq.com.au/about-rfq/</a>

# Part B: Foreshadowing later submissions to the Care Inquiry

A key theme of this submission to the Productivity Commission is that Australia currently does a poor job of the following:

- Prevention: investing in strengths based and preventative approaches to well – being;
- Empowering People: empowering communities at risk, and empowering those with lived experiences, and their families and friends, to be the focus of solutions to the problems that they face.

At present we pathologise social problems and create hugely unsuccessful and hugely expensive care systems that fail to deliver outcomes because those that are empowered at present primarily are not those personally experiencing the problems, and we invest the great majority of our resources in to downstream clinical and pathological responses to social problems.

#### **B.1** Recentering Systems Towards Prevention and Upstream Solutions.

How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

The Grattan Institute tells us that, as a nation, we do a very poor job of investing in preventative strategies and programs:

Australia lags far behind other countries in prevention spending, and far behind commitments that our own governments have made. We spend less than 2 per cent of our healthcare budget on prevention, well short of the average among OECD countries. Our spending is half the level of the UK's and a third the level of Canada's.

Australia's National Prevention Strategy, agreed by the federal government and all the states, aspires to raise our spending to 5 per cent of the health budget by 2030. We're not even close, and the Victorian budget news is one sign that we might be about to go backwards.

Experience here and around the world shows that when budgets are cut, prevention is often the first on the chopping block. Prevention is less painful to slash than other kinds of healthcare, because the payoff from prevention spending is in the future, when current Treasurers and Ministers will be long gone.

https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/

Indeed, if we hop outside of the health sector and look at other sectors, such as justice, then we do an abysmal job of investing in preventative programs in that space. Sure, one can identify a large number of programs called 'diversionary'. But when one examines the definitions in place there, then it turns out that 'diversionary' is a very

narrow, legalistic term that has very little at all to do with any concept of upstream prevention.

Many would argue that States such as Western Australia, Queensland and the Northern Territory are currently engaged in a 'race to the bottom' when it comes to youth justice - <a href="https://www.abc.net.au/news/2025-07-11/youth-justice-advocates-warn-nt-winning-race-to-bottom/105517194">https://www.abc.net.au/news/2025-07-11/youth-justice-advocates-warn-nt-winning-race-to-bottom/105517194</a> The inevitable result of such races to the bottom are rising rates of incarceration, ever expanding justice budgets and, from a productivity perspective, much lower rates of productivity.

The Productivity Commission's current Delivering Quality Care More Efficiently Inquiry presents this following issue and problem to us:

Despite their benefits, governments are often reluctant to invest in prevention programs. Funding decisions tend to prioritise immediate needs and align with the responsibilities of specific departmental portfolios. Prevention requires governments to spend upfront while benefits can take time to be realised, are hard to measure and can span different parts or tiers of government. https://www.pc.gov.au/inquiries/current/quality-care#interim

At the conceptual level, a big thank you to Cairney and Denny for their deeply insightful 50-page book on this topic ie Why Isn't Government Policy More Preventive?. <a href="https://paulcairney.wordpress.com/wp-content/uploads/2023/02/cairney-st.denny-2020-why-isnt-government-policy-more-preventive-intro-and-conclusion.pdf">https://paulcairney.wordpress.com/wp-content/uploads/2023/02/cairney-st.denny-2020-why-isnt-government-policy-more-preventive-intro-and-conclusion.pdf</a>

Prior to reading Cairney and Denny's book I had a somewhat simplistic view, relating to political motivations. Certainly, it is exceedingly easy to point to political slogans which win elections on the basis of NOT investing in preventative programs ie eg between August and October 2024, Queensland's Courier Mail Newspaper [a Newscorp publication] published 173 articles about youth crime in just 90 days. These articles amplified the mantra Adult Crime, Adult Time, and it was an election – winning mantra for Queensland's LNP. But beyond those obvious political motivations, Cairney and Denny do analyse a range of complex factors which serve to individually and collectively work against investing in preventative measures.

The Productivity Commission will in July or August 2025 publish its Interim Report on the Delivering quality care more efficiently <a href="https://www.pc.gov.au/inquiries/current/quality-care#interim">https://www.pc.gov.au/inquiries/current/quality-care#interim</a> Members of the public will then be invited to provide feedback on that Interim Report and will asked to lodge their submissions by September 2025. Within that context and within that timeframe I will have more to say, in detail, on the following topics:

- barriers to government investment or scaling up of effective prevention programs
- the extent to which inadequate funding and the short-term or limited assessment of benefits has restricted effective prevention
- the extent to which the benefits of prevention accrue across different sectors and/or tiers of government
- policy actions that could support greater investment in prevention activities.
  - https://www.pc.gov.au/inquiries/current/quality-care#interim

So, it is exceedingly easy to identify instances, such as the above example of youth justice, where State Governments deliberately decide to not invest in preventative strategies and, for reasons of political capital and political advantage, see considerable benefit in investing greater and greater resources in to upstream, punitive responses based around incarceration. And in the Health system what State Government in its right mind would argue against the need for more [and yet further more] hospital beds?

Nonetheless, Cairney and St Denny's book is enlightening and they point to the following multifactorial reasons for underinvestment in to prevention:

The scale of the task becomes overwhelming;

- There is competition for policymaking resources such as attention and money;
- The benefits are difficult to measure and see;
- Problems are 'wicked'. Getting to the 'root causes' of problems is not straightforward;
- Performance management is not conducive to prevention;
- Governments face major ethical dilemmas;
- One aspect of prevention may undermine the other;
- Someone must be held to account.
   https://paulcairney.wordpress.com/wp-content/uploads/2023/02/cairney-st.denny-2020-why-isnt-government-policy-more-preventive-intro-and-conclusion.pdf

Time and space do not permit of an exploration of each of those elements in this present context. However, in the August – September context and timeframe I will take the opportunity of exploring those various obstacles and impediments to greater investment in preventative programs in Australia, with specific examination of how those elements relate to the following fields:

- Mental Health and Suicide Prevention
- Aboriginal Social and Emotional Wellbeing, And Its Relationship To Strong Culture.

Whilst that extended examination and discussion will have to wait until that later juncture, I did want today to offer some initial thoughts with reference to First Nations policy in Australia.

And the best answers to the questions around Government under – investment in the preventative space come from the Productivity Commission itself, as expressed in its January 2024 report Review of the National Agreement on Closing the Gap Study report. This Productivity Commission Report contains the following Recommendations:

- 1. Power needs to be shared
- Indigenous Data Sovereignty needs to be recognised and Supported
- 3. Mainstream systems and culture need to be fundamentally Rethought
- 4. Stronger accountability is needed to drive behaviour change [Pages 7 9]

The point here of course is that without genuine power sharing, there will be little or no incentive to change from the status quo, and the status quo is heavily biased in favour of downstream, clinical, resource – intensive modalities. This remains the case no matter if Governments choose to pour more and more and endlessly more resources in to existing modalities, irrespective of the paucity of actual outcomes. Once again I reference Professor Chandler's query: 'Still more counsellors?' Endlessly, still more counsellors, psychologists, psychiatrists, and clinicians of all manner and all sorts.

Focusing on the Productivity Commission's interest in Preventative Programs, one can read the following words on page 33 of the WA Government's Aboriginal Empowerment Strategy Policy Guide of 2021:

Currently, State Government expenditure in relation to Aboriginal people is skewed towards the crisis category. These services are more costintensive, depend more on involuntary or coercive engagement, and involve higher risks. If current trends continue, demand for these "downstream" services is set to increase significantly in coming years.

Preventative and early intervention initiatives can bring about positive changes that reduce the need for crisis responses. Initiatives in this category proactively build up resilience, capability, healing, and independence – in short, self-determination.

https://www.wa.gov.au/organisation/department-ofthe-premier-and-cabinet/aboriginal-empowermentstrategy-western-australia-2021-2029

Notwithstanding this lovely set of words, between 2021 and mid 2024 I had a front row seat and was exceptionally well placed to see what, if any, progress was being made in shifting towards 'Putting Culture at the Heart', as per pages 24 – 26 of the Aboriginal Empowerment Strategy Policy Guide. In that time I was unable to identify any significant or meaningful progress from the WA Government, or from the Commonwealth. I no longer have that front row seat, but I have not been furnished with any evidence or any reason to think or even suspect that things might have changed and improved since mid-2024.

Indeed, in the public realm, one can readily find this following very recent information:

 Culture at the Heart Forum: strengthening Aboriginal leadership in government

- The Western Australian Government proudly supports the Culture at the Heart Forum, an initiative led by the Aboriginal Advisory Council of WA to foster collaboration among Aboriginal Advisory Groups across State Government agencies.
- Starting today, the two-day event focuses on Priority Reform 3: Transforming Government. Through dynamic workshops and targeted discussions, participants will explore new ways to enhance government accountability and responsiveness in Aboriginal affairs.
- By positioning culture at the heart and working in partnership with Aboriginal people and communities, the forum aims to reshape how government engages with Aboriginal leadership, fostering a more effective, culturally informed approach to policymaking and service delivery. https://www.wa.gov.au/government/media-statements/ Cook%20Labor%20Government/Culture-at-the-Heart-Forum:-strengthening-Aboriginal-leadership-ingovernment--20250626

To be clear, the present author is not suggesting for a moment that the work which took place in that recent two day workshop was unimportant or that it was not important for Aboriginal people to have a direct say in regards to such matters. But what were the matters discussed? The Minister's Media Statement makes clear that the purpose of the two-day workshop was Closing the Gap National Partnership Agreement Priority Reform 3: Transforming Government. And where does Culture fit in to this? The Minister's Media Statement advises as follows:

the forum aims to reshape how government engages with Aboriginal leadership, fostering a more effective, culturally informed approach to policymaking and service delivery.

One can very readily, all-too-readily, identify references in Government policy statements to the terms 'Culturally – informed' or 'Culturally – Safe'. Once again, the present author is not suggesting that either of those concepts is in any way unimportant or not necessary. What is being suggested is that when we look at the concepts of 'Prevention' and 'Early Intervention' a whole other space opens up ie a domain called 'Culturally – Embedded' or, alternatively, 'Culturally – Based.'

To understand this 'Culturally – based' domain, especially as it relates to First Nations Wellbeing, once again we turn to the works of Professor Michael Chandler:

if suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counsellors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives.

Cultural Wounds Require Cultural Healing.

What Chandler is describing there are activities that are not best labelled as being 'culturally – informed' or 'culturally – safe.' Chandler is describing activities that are 'culturally – based' or 'culturally – embedded.'

Elsewhere, we can find very similar sentiments expressed by Mohawk Professor Taiaiake Alfred - https://taiaiake.net/ Professor Alfred explains and illustrates present day First Nations psychological trauma, and the basis of the high rates of suicide in Canada, through the use of a metaphor, of a rock that has been worn down by the processes of colonisation. That rock, which is now a small pebble, used to be a giant boulder. His grandfather stood on a solid boulder of Mohawk ceremony and Culture, whereas he and his tribe today lack that solid foundation.

As the National Mental Health Commission recommended in 2014, we desperately need to rebalance the system so that it prioritises prevention and early intervention, both in the mainstream community and in the First Nations community. And in the First Nations context, a system that prioritises prevention and early intervention cannot be delivered through a Health paradigm, whether that be through mainstream health or through community health. Mohawk Professor Taiaiake Alfred puts it thus:

Because we've shown, in a number of studies that we've looked at, in the Canadian context, and particularly – I'll use the example of the Cree people, in Northern Quebec, where the young people in that community, in that nation, that had survived and could withstand the ongoing effects of colonisation the best were those that benefited from programs that were set up by the Cree nation to relink them to their traditional cultural practice, to support the maintenance of their language fluency, and, even though it was seasonal and it wasn't a permanent state, to surround them and have them experience life in a traditional cultural community.

Transcript of a speech delivered at the Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, in 2015. Transcript available upon request.

In May 2016 the WA Department of Culture and the Arts published a 50 – page long discussion paper, DCA Reference 15/751, with the following title:

Investing in Aboriginal Culture: The role of culture in gaining more effective outcomes from WA State Government services

On page four of this WA DCA Discussion Paper one reads as follows:

- This paper reviews the outcome of Government expenditure on Aboriginal culture and arts, and assesses how that investment can contribute to positive outcomes for Aboriginal people across employment, culture, education, mental health, and general health and wellbeing.
- In terms of broad socio-economic outcomes, there is a substantial and growing body of academic and case evidence that Government programs or services targeted towards improving outcomes for Aboriginal people on a range of social and economic issues will be more effective if delivered within an environment where Aboriginal culture is recognised, valued and resilient.
- This paper proposes that a consolidated and targeted approach to the investment in Aboriginal culture and arts will increase cultural attachment, increasing subjective wellbeing for individuals and communities, leading to improved socio-economic outcomes.

Nearly ten years later, and there is to this day no implementation of any of the key proposals described in this May 2016 WA DCA report.

Current patterns of Government expenditure are hugely unproductive and expensive. If the Productivity Commission truly wishes to explore the issue of Productivity in regards to the Care Economy, as it pertains to Indigenous Australians, then the Productivity Commission has to get serious about exploring the huge barriers to Governments investing in First Nations cultural programs [delivered by Cultural organisations, not Health organisations], which are the cornerstone of First Nations primary prevention and community resilience.

In the year 2021 the WA Department of Premier and Cabinet wrote as follows:

Currently, State Government expenditure in relation to Aboriginal people is skewed towards

the crisis category. These services are more costintensive, depend more on involuntary or coercive engagement, and involve higher risks.

In July 2025 the WA Department of Premier and Cabinet held a two day workshop on Transforming Government, and they gave that two day workshop the title of 'Culture at the Heart.'

And in 2016 the WA Department of Culture and the Arts proposed:

A consolidated and targeted approach to the investment in Aboriginal culture and arts will increase cultural attachment, increasing subjective wellbeing for individuals and communities, leading to improved socio-economic outcomes.

None of the actions or recommendations in the 2016 paper have been acted upon. As such, it is little wonder that the current situation remains that "State Government expenditure in relation to Aboriginal people is skewed towards the crisis category. These services are more cost-intensive, depend more on involuntary or coercive engagement, and involve higher risks."

Australia has an exceedingly poor record when it comes to investing in Preventative programs. But when it comes to Preventative programs in regards to Aboriginal Social and Emotional Wellbeing the situation is truly dire. In November 2019 the WA Parliament Standing Committee on Health and Education published

Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas. What the Parliamentary Committee found in that *Message Stick Report* is as follows:

The various reports and inquiries the Committee considered during this Inquiry made a broad range of recommendations. Perhaps the most important, yet least enacted, were about the role of Aboriginal culture, both as a primary protective factor building resilience in young people, and also ensuring that programs and services are culturally appropriate.

#### [Chairman's Foreword]

Previous reports and inquiries have recommended that this can be achieved through various means, primary of which is culturally-based programs, such as on-country camps and activities. By necessity, these programs must be owned and led by local communities. Yet the lack of priority given to these programs by government indicates that their importance continues to be overlooked.

[Executive Summary]

- Finding 8: There is increasing evidence that culturally-based programs have the greatest impact in preventing suicide; however, the Western Australian Government has demonstrated reluctance in funding programs of this nature. [Page 57]
- Finding 9: By their very nature, culturally-based programs must be tailored to suit the particular community that will be using the program. [Page 57]
- Recommendation 7: That Western Australian
   Government agencies recognise the importance of cultural knowledge as a protective factor preventing Aboriginal youth suicide. [Page 57]
- Recommendation 8: That the Western Australian Government set aside an appropriate portion of grant expenditure to fund more culture-embedded programs for Aboriginal young people across the state. [Page 57]

Funding for Aboriginal Cultural organisations to deliver Aboriginal Cultural Programs with the aim of building cultural resilience and fostering wellbeing remains at an almost non – existent level to this day.

For as long as First Nations suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

A juvenile justice system based on a successful, election – winning slogan of 'Adult Crime, Adult Time' is certain to lead to increased juvenile incarceration. That is the whole point of the words 'Adult Time.' Such a system will be hugely expensive and hugely unproductive and an ineffective and inefficient use of public resources and public monies. But as a nation Australia greatly underperforms comparable countries in regards to its investments in to preventative programs. At present there is little cause for any optimism that this situation will improve in the foreseeable future.

If the upcoming Productivity Summit, or the current Inquiry in to Mental Health, or the current 5 Pillars Inquiry, including the Inquiry in to Delivering quality care more efficiently can lead to systemic change and can lead to the nation seriously considering raising its level of investments in to Preventative programs, then that will be a wonderful thing.

But noting once again the words of Cairney and St Denny, there is a strong "tendency for acute services to command more attention and money to solve the short-term and salient issues that people tend to relate to a government's competence." It requires a complete transformation, a complete paradigm shift to think that funding cultural programs could be more productive, more preventative, more efficient and more efficient than

employing 'still more counsellors." And as a nation we seem to be a very long way away from embracing such paradigm shifts at this present moment.

# **B.2** Where are the voices to speak for 'Culturally-based' and 'Culturally-embedded' Programs

Ensuring that the voices of First Nations people are heard and acted upon. Where are the voices to speak for 'Culturally-based' and Culturally-embedded' Programs (as distinct from 'Culturally-informed' or 'Culturally-safe' Health Programs?

[Note: a second, standalone, sister paper which was submitted to the Productivity Commission on Thursday 31 July, as follows:

Paper #2: For as long as First Nations suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.]

# Ensuring that the voices of First Nations people are heard and acted upon.

## Where are the voices to speak for 'Culturally-Based' and Culturally-Embedded' Programs (as distinct from 'Culturally-informed' or 'Culturally-safe' Health Programs?

This section in no way seeks to speak for any First Nations person. Rather, the simple proposition in this section is that if Government is serious about listening to the voice of First Nations peoples in regards to reducing Indigenous suicide rates in Australia, then it should listen to the voices of First Nations peoples who have consistently called for 'Culturally – embedded' and 'culturally – based solutions'. A short list of such reports is as follows:

#### **Timeline of reports from 2012 to 2023**

There have been a number of significant Australian reports released in recent years on the need for investment in cultural determinants of Indigenous health. See table below with details.

Dec 2012	Elders Report The Elders' Report into Preventing Indigenous Self-harm and Youth Suicide	People Culture Environment
Feb 2018	My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations December 2017	Dept of Health
Jun 2020	' Country Can't Hear English' - A Guide To Implementing Cultural Determinants	Professor Kerry Arabena
Feb 2021	Culture is Key: Towards cultural determinants-driven health policy	Lowitja Institute)
Dec 2021	The National Aboriginal and Torres Strait Islander Health Plan 2021-2031	Dept of Health)
Sep 2022	Connected Lives: Creative solutions to the mental health crisis	Creative Australia*
Mar 2023	Strong Culture, Strong Youth: Our Legacy, Our Future	Close the Gap Campaign Report 2023
Oct 2024	Links between Aboriginal and Torres Strait Islander language use and wellbeing	Mayi Kuwayu Study
2025	Strong Culture, Strong Place, Strong Families Research and Evaluation Project: Final Report	ANU Centre for Indigenous Policy Research

The reports in this table are simply a list of mainly Commonwealth Government-developed reports or, if not, then reports that speak to a national context. The list above doesn't include a myriad of State level reports. The WA Parliament's November 2019 *Message Stick Report in to Aboriginal Youth Suicide* starts by providing a list of some 40 earlier reports, the majority of which have as their top priority calls for supporting Cultural programs.

On that basis, one can be safe in asserting that there is something in the order of 50 or so reports published over the last two decades, each having as its first priority

a recommendation relating to supporting cultural programs. Not health programs. Cultural programs.

On 06 June 2025 I received an email from the Commonwealth Department of Health. I had written to the Department, pointing out that the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* states that there would be two Implementation Plans developed over that 10 year Plan period and pointing out that *Implementation Plan #1* was to have covered the period 2021 – 2025. I then pointed out that, since we were now well in to the year 2025, one would have anticipated that

*Implementation Plan #1* [2021 – 2025] would have been developed long ago and that actual implementation of the *Aboriginal Health Plan* would have commenced years ago. (see below)

There are three problems with this advice from the Department of Health:

- Indigenous Voices Over the Last 15 Years:
   It is exceedingly far from clear how the Department is choosing to listen to the voices of First Nations people, as captured within and as expressed within the reports listed above, over the last 15 years;
- 2. Why, Five Years into the Aboriginal Health Plan, Is There Still No Implementation Plan #1: The email from the Department clearly states that the Department is engaged in what it describes as a Co Design process. As I have not studied that Co Design process, I won't comment on that per se. Beyond that I do note the reference to the COVID 19 period. Having read and understood those advices, it is still far from clear to me why exactly five years after the Aboriginal Health

- **Plan** was released there is still no Implementation Plan #1. The COVID lock down period was years ago.
- 3. Cultural Voices?: A list of names for the members of the First Nations Health Governance Group can be found here <a href="https://www.health.gov.au/committees-and-groups/first-nations-health-governance-group-fnhgg">https://www.health.gov.au/committees-and-groups/first-nations-health-governance-group-fnhgg</a> I have not the slightest doubt that the members of this group are very well suited and very able to speak for issues of First Nations Health, and quite likely, for matters relating to 'cultural safety' and 'culturally informed' health programs.

But, the 50 or so reports referenced above are not about 'cultural safety' and they are not about 'culturally – informed' programs. The 50 or so reports referenced above are about 'culturally – embedded' and 'culturally – based' programs. And it is far from clear to me how the First Nations Health Governance Group is constituted to speak for or about 'culturally – embedded' and 'culturally – based programs.'
Where are the voices to speak for 'culturally – based' programs, not health programs?

#### Dear Mr Morris,

Thank you for reaching out to the Health Plan and Systems Section of the First Nations Health Division. Our Section oversees implementation of the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 (the Health Plan) in partnership with the First Nations Health Governance Group (FNHGG).

The FNHGG is a genuine partnership between the Department of Health, Disability and Ageing and First Nations health experts and leaders, with the members of the FNHGG representing diverse Aboriginal and Torres Strait Islander leadership from across Australia – you can find the names of the members on the website. The FNHGG will co-design and share decision making by embedding expert and First Nations perspectives in the department's policy design, delivery, and advice to government, including the implementation of the Health Plan and its elements.

The FNHGG is considering implementation planning after significant delays due to COVID-19 and the Aboriginal and Torres Strait Islander Voice referendum. The FNHGG is also currently co-designing an Accountability Framework in line with the Health Plan and considering mid-point evaluation

We hope this helps and if you have any other questions, please do not hesitate to reach out.

Kind regards,

Health Plan and Systems Section

Policy, Partnerships and Performance Branch First Nations Health Division | Strategy and First Nations Group Australian Government Department of Health, Disability and Ageing IndigenousPolicy@Health.gov.au



# Response to the Productivity Commission's June 2025 Report

MHSPA Review Interim Report: First Nations Cultural Resilience is the Key to Suicide Prevention



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## Wes Morris Individual Response to the Productivity Commission's June 2025 Mental Health and Suicide Prevention Agreement Review Interim Report.

#### Paper #2

For as long as First Nations suicide is treated as an individual mental health issue [with clinical interventions], and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

[Note: A second, separate, stand – alone sister paper (Paper #1) will be submitted to the Productivity Commission at the same time as this paper (Paper #2) is submitted, as follows:

#### Paper #1

Redesigning the system to focus on the needs of users, rather than providers, with a special focus on the role of Peer Support Workers in the Mental Health System. Echoing the National Mental Health Commission's Recommendations from 2014 to rebalance the system to provide more emphasis on upstream prevention. Further, suggesting that Co-design is very unlikely to deliver systemic change unless it is preceded by transformative paradigm shifts within Government, endorsed at Ministerial level.]

Aboriginal and Torres Strait Islander people should be aware that this document contains names of deceased persons

31 July 2025

Selwyn Button and Angela Jackson, Commissioners Productivity Commission, Wurundjeri, Woi wurrung country, Level 8, Two Melbourne Quarter 697 Collins Street Docklands Vic 3008

Dear Commissioner's Button and Jackson,

Sincere congratulations to yourselves, and to all at the Commission, on the publication in June 2025 of the *Mental Health and Suicide Prevention Agreement Review Interim Report*.

In February 2007, in my work capacity as Coordinator [General Manager] of a small but significant Aboriginal Community Controlled Organisation in the Kimberley, I wrote to the then WA Coroner, the hon. Justice Alistair Hope. I requested that Justice Hope undertake a major Coronial Inquiry in order to investigate the alarming rate of Aboriginal suicide in the Kimberley. The Coroner wholeheartedly embraced this request and in 2008 he delivered a major *Coronial Inquest Report* in regards to the deaths by suicide of 22 Aboriginal persons in the Kimberley. However, as the Commission's 2025 *Interim Report* finds:

"The data available shows that one in three Aboriginal and Torres Strait Islander people experience high psychological distress and suicide rates are worsening." [page 27]

Between 2006 and 2025 I have participated in countless processes and spent literally thousands of hours involved in endeavours to bring about systemic and structural change. The outcomes of my 20 years of work in this space are so miniscule as to be almost non – existent. Systemic stasis persists.

The core reason for the systemic stasis is the policy prevalence of a medical model which pathologizes suicide. In 2014 the National Medical Health Council delivered the following recommendation:

"rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention."

**Contributing Lives Report** 

The Commission's 2025 *Interim Report* points towards a systemic move away from the medical model. And the *Interim Report* also grapples with the issue of where Suicide Prevention belongs in the systemic architecture. This present submission to the Commission presents the view that First Nations suicide is best viewed as not being an individual mental health issue, and that prevention strategies should not focus on health programs. Drawing on over 50 earlier reports, I present the view that First Nations suicide is best understood as being a collective, community issue reflective of a Culture under stress. Prevention and early intervention are best viewed in the following light – *'Cultural Wounds Require Cultural Healing'*.

In the following pages I present for your consideration a number of recommendations. These recommendations have been informed by each of the following:

- **Experience:** my 20 years of experience in this field, oftentimes playing a leadership role at the Regional level, if not the State and National level;
- Literature: consideration of the academic literature in this field;

Earlier Reports: consideration of 50 earlier reports on Indigenous wellbeing, each of which has
as its prime focus and key recommendation the need for investments in to cultural strength and
resilience.

But of the various recommendations presented to you today, I ask that the Productivity Commission give particular consideration to the following recommendations:

 All Indigenous suicide prevention activity should prioritise cultural renewal and cultural resilience programs.

This is based on the following **ATSISPEP Report** Recommendation # Two:

- All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care.
- That Governments recognise the importance of cultural knowledge as a protective factor preventing Aboriginal youth suicide
  - That Governments recognise the importance of cultural knowledge as a protective factor preventing Aboriginal youth suicide and that Governments respect the three decades of First Nations advocacy around this issue. That Governments endorse the efficacy of culturally based prevention approaches to First Nations suicide and that, consistent with a focus on productivity and prevention, focus future investments on upstream, culturally based preventative programs.
- No Co-design Process to be Commenced Without First Achieving Two Prerequisites.

No Co-design process should be even commenced without the following first occurring:

- A clear and detailed statement from Government, at the Ministerial level, setting out how the Government of the day views Co-design operating within the constraints of, and within the context of, a Westminster democracy;
- A clear Co-design resourcing and empowerment strategy, with a specific focus on how the non – Government sector and the non – Government participants in the proposed Co-design process would be resourced and empowered to enable them to participate in the Co-design process as full equals to the Government participants.

Regards,

#### **Wes Morris**

Brisbane, Qld.

#### **Overview**

Australia performs poorly in regards to investing in preventative solutions to health — <a href="https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/">https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/</a>
If we look at the pattern of expenditure in regards to preventative approaches to Aboriginal social and wellbeing issues, then the situation is much worse still ie the investments in this domain are heavily skewed towards the downstream — <a href="https://www.wa.gov.au/system/files/202504/aboriginal.engagement.strategy.policy.guide\_.pdf">https://www.wa.gov.au/system/files/202504/aboriginal.engagement.strategy.policy.guide\_.pdf</a> And in regards to the Mental Health system, the National Mental Health Commission recommended as follows, on page four of its Contributing Lives Report in the year 2014:

We need system reform to:

rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training.

https://www.mentalhealthcommission.gov.au/publications/contributing-lives-review-2014

Within the *Interim Report*, we note *Figure 6.1 – 'A national model for suicide prevention in Australia'*, sourced from the recently released *National Suicide Prevention Strategy 2025–2035*. This strategy is endorsed by the Productivity Commission. If we look at Figure 6.1 then the very first thing that we note is the dichotomous headings at the top of that figure. These two headings are as follows:

- Prevention
- Support.

The National Mental Health Commission recommended in 2014 that we invest more in prevention.

Within this present submission some 50 reports are referenced, written over the last 25 years, addressing the issue of First Nations suicide in Australia. Not a single one of these 50 reports is even mentioned or referenced in any way in the *Interim Report*. This silence and this absence is cause for considerable concern. The *ATSISPEP Report* was first published in November 2016 – *Solutions That Work: What Evidence and Our People Tell Us; Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report* — <a href="https://www.

niaa.gov.au/sites/default/files/documents/publications/ solutions-that-work-suicide-prevention.pdf On page four of the *ATSISPEP Report* we read the following:

Recommendation #Two: All Indigenous suicide prevention activity should include community-specific and communityled upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care.

As a nation we need to be investing much more than we currently do in upstream, preventative programs and strategies. We have available to us some 50 different reports describing what success would look like in regards to preventative approaches to First Nations suicide. The prevention strategies advocated and promoted across these 50 reports reside primarily outside of the health system, and they are located primarily in the space of cultural strength and resilience. In November 2016 the WA Parliament published its *Message Stick Report*, which contains the following finding:

Aboriginal youth suicide is indicative of a distressed community and effective solutions must be community focussed. Aboriginal culture and identity has been degraded by colonisation and discrimination. Restoring this culture and sense of identity has been consistently identified as a key protective factor.

# Part A: Response to the *Interim Report* — First Nations Suicide Prevention

#### **First Nations Voices**

#### **Aboriginal Culture Is Peripheral**

Aboriginal Culture Is Peripheral and Marginalised and Is Not Even Recognised in the Policy Landscape

"As First Australians, Aboriginal and Torres Strait Islander peoples have a remarkable living history. For 60,000 years plus we have sustained a cohesive and resilient society. We have the most extensive kinship network in the world and through a system of law, ceremony and song we have transferred a huge body of knowledge, including important principles of collective and common humanity, from generation to generation. There is much to celebrate but it is not celebrated – it is not even recognised."

https://www.theguardian.com/australia-news/2020/jan/31/june-oscars-2020s-vision-reaching-our-potential-as-a-nation-begins-with-truth-telling

#### June Oscar - Bunuba

Former Social Justice Commissioner

"It is time that Australia recognises that caring for this high culture in remote Australia is every bit as important as looking after mainstream high culture in the cities... Many messages about the importance of culture have been given by Aboriginal peoples, over the years. We need them to be heard and acknowledged."

#### Djambawa Marawili AM — Yolnu ANKA ARTS BACKBONE Magazine August 2018

"While previous generations have fought for life and for land, and this must and will continue, this must also be the time to fight for the centrality of our culture, because it is in the elevation and celebration of this most sacred practice that our wellbeing and Country flourish. First Nations arts and culture often get overlooked in the context of other needs resulting from intergenerational trauma, but our arts and culture give us our strength, our foundation, our identity, our hope; they give us our connection, our healing, our pride, our wellbeing."

https://creative.gov.au/sites/creative-australia/files/documents/2025-03/NIACA-Consolidated-Report.pdf

#### Creative Australia

Bringing it Forward, 2022, page 7

#### **Centrality of Culture to Wellbeing**

Aboriginal Culture and the Centrality of Culture to Wellbeing

"In Australia, nearly 35 per cent of the health gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians is attributable to the social determinants of health, including the physical, social, emotional and cultural wellbeing of individuals and their community. This gap rises to 53.2 per cent when combined with behavioural risk factors such as tobacco and alcohol use, dietary factors and physical inactivity (Australian Government 2017b:4). It is proposed that an antidote to this experience is the adoption of a whole-of-life view that encompasses regeneration and renewal, health and wellbeing, and an acknowledgment of the vitality that culture provides Aboriginal and Torres Strait Islander peoples."

https://www.karabenaconsulting.com/resources/country-cant-hear-english

#### Professor Kerry Arabena — Meriam

'...Country can't hear English...' A Guide supporting the implementation of cultural determinants of health and wellbeing with Aboriginal and Torres Strait Islander peoples

"Today our young people are increasingly likely to miss out on their cultural education that directly affects their connection to country. There is a clear imbalance between efforts to provide a westernised education, and access to traditional cultural knowledge.

Learning how to live on country and having access to traditional knowledge and culture strengthens and reinforces a positive sense of identity, it provides young people a cultural foundation and helps protect them from feelings of hopelessness, isolation and being lost between two worlds. Giving young people this support is critical to their survival and the survival of our culture."

https://cultureislife.org/wp-content/uploads/2024/02/ Elders-Report.pdf

#### Mick Gooda — Gangulu

Former Social Justice Commissioner

The Elders' Report into Preventing Indigenous Self-harm & Youth Suicide

"For Indigenous people, cultural identity is the foundation of who we are. Despite years of assimilationist policy, and the loss of so many of our customs and languages, Aboriginal people have demonstrated extraordinary cultural resilience. In my time, I have been privileged to witness what I see as a cultural renaissance of Aboriginal Australia. Culture has become life-giving medicine for our people, closing the wounds of the past and standing us strong to face the future."

https://cultureislife.org/wp-content/uploads/2024/02/ Elders-Report.pdf

#### Professor Pat Dudgeon — Bardi

Co-chair, Aboriginal Mental Health and Suicide Prevention Advisory Group The Elders' Report into Preventing Indigenous Self-harm & Youth Suicide

#### **Australian First Nations Research**

Australian First Nations Research in to the Relationship Between Culture and Wellbeing.

- The Mayi Kuwayu Study the largest national study of Aboriginal and Torres Strait Islander culture, health and wellbeing - https://mkstudy.com.au/
- Centre for Indigenous Policy Research, ANU Strong Culture, Strong Place, Strong Families Research and Evaluation Project

https://cipr.cass.anu.edu.au/research/publications/ strong-culture-strong-place-strong-families-researchand-evaluation-project

## **Research Publications From the MK Study:**

 Exposure to the Family Wellbeing program and associations with empowerment, health, family and cultural wellbeing outcomes for Aboriginal and Torres Strait Islander peoples: a crosssectional analysis.

Williamson, L.M., Baird, L., Tsey, K., Cadet-James, Y., Whiteside, M., Hunt, N. & Lovett R. (2023). BMC Public Health 23, 1569. https://doi.org/10.1186/s12889-023-16450-9

 Relationship of Aboriginal family wellbeing to social and cultural determinants, Central Australia: 'Waltja tjutangku nyakunytjaku'. Family Medicine and Community Health

Wright, A., Davis, V. N., Brinckley, M.-M., Lovett, R.,

Thandrayen, J., Yap, M., Sanders, W., & Banks, E. (2022). 10(4), e001741.

https://doi.org/10.1136/fmch-2022-001741

## Research from the ANU Centre for Indigenous Policy Research

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#### **Cultural Resurgence and Wellbeing**

**Cultural Resurgence and Wellbeing: the Canadian Experience** 

"Because we've shown, in a number of studies that we've looked at, in the Canadian context, and particularly – I'll use the example of the Cree people, in Northern Quebec, where the young people in that community, in that nation, that had survived and could withstand the ongoing effects of colonisation the best were those that benefited from programs that were set up by the Cree nation to relink them to their traditional cultural practice, to support the maintenance of their language fluency, and, even though it was seasonal and it wasn't a permanent state, to surround them and have them experience life in a traditional cultural community."

https://taiaiake.net/

#### Professor Taiaiake Alfred - Mowhawk

Transcript of a speech delivered at the Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, in 2015. Transcript available upon request.

"Although the foundational importance of selfdetermination and culture to wellness has been obvious to First Nations, Inuit and Métis Peoples in Canada (Assembly of First Nations and Thunderbird Partnership, 2015; Inuit Tapiriit Kanatami, 2014; Métis Nation, 2023), and to Indigenous Peoples around the world (Bourke et al., 2018), empirical evidence is still necessary when advocating to policymakers or service providers who may not find these connections so evident. Indigenous peoples are still fighting for self-determination and culturebased approaches to wellness, highlighting the continued importance of work that brings together developmental, social, and cultural perspectives. The lessons learned from this interdisciplinarity and pluralism have implications for mental health promotion around the world.

Cultural continuity, identity, and resilience among Indigenous youth: Honoring the legacies of Michael Chandler and Christopher Lalonde; Journal of Transcultural Psychiatry"

https://journals.sagepub.com/doi/full/10.1177/136346 15241257349

**Professor Michael J Chandler — Non indigenous** University of British Columbia

#### **Consistent First Nations Messaging**

Consistent Messages Delivered by First Nations People As Expressed Within 50 Reports Over the Last Three Decades

In November 2016 the WA Parliament Education and Health Standing Committee published a report entitled: Learnings from the message stick - The report of the Inquiry into Aboriginal youth suicide in remote areas. On pages 213ff of that report one can read a list of some 40 prior reports and inquiries in to Aboriginal youth suicide and Aboriginal wellbeing in general. The Executive Summary to the Message Stick Report includes these words:

Over the years there have been a plethora of inquiries undertaken, reports written and recommendations made which attempt to address the crisis of Aboriginal youth suicide. Significant amounts of government funds have been spent providing a variety of programs and services to address the complex and interrelated risk factors which may contribute to a young person suiciding. It was important to the Committee to not just repeat what has been done in the past. As such, it decided to analyse relevant recommendations of previous inquiries, over 40 reports, to see if they had been effectively implemented. In many cases we found that they had not. The rising rates of suicide clearly confirm this.

In addition to the 40 Reports referenced in the *Message Stick Report*, I note these further, additional reports and inquiries into Aboriginal youth suicide and Aboriginal wellbeing in general:

The Elders' Report into Preventing Indigenous Selfharm & Youth Suicide: 2012

- Solutions That Work: What Evidence and Our People Tell Us; Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report; November 2016
- Learnings From The Message Stick The Report Of The Inquiry Into Aboriginal Youth Suicide In Remote Areas. November 2016
- My Life My Lead Report on the national consultations, (2018, Department of Health)
- 'Country Can't Hear English': A Guide supporting the implementation of cultural determinants of health and wellbeing with Aboriginal and Torres Strait Islander peoples, (2020, Arabena)
- Culture is Key: Towards cultural determinantsdriven health policy (Lowitja Institute, 2021)
- National Suicide Prevention Trial Final Evaluation Report; December 2020
- Kimberley Suicide Prevention Trial, Final Evaluation Report, 2021
- National Aboriginal and Torres Strait Islander Health Plan 2021-2031 (2021, Dept of Health)
- Connected Lives: Creative solutions to the mental health crisis (Australia Council- Now Creative Australia); Sept 2022
- Strong Culture, Strong Youth: Our Legacy, Our Future (Close the Gap Campaign Report 2023) March 2023
- Links Between Aboriginal And Torres Strait Islander Language Use And Wellbeing (Mayi Kuwayu Study, October 2024)
- Strong Culture, Strong Place, Strong Families
   Research and Evaluation Project: Final Report (ANU Centre for Indigenous Policy Research, 2025)

Cultural resilience and cultural strength is the main theme and the main priority consistently expressed across these 50 or so reports and inquiries. A few of the critically important comments, findings and recommendations in the *Message Stick Report* are the following:

The various reports and inquiries the Committee considered during this Inquiry made a broad range of recommendations. Perhaps the most important, yet least enacted, were about the role of Aboriginal culture, both as a primary protective factor building

resilience in young people, and also ensuring that programs and services are culturally appropriate.

#### [Chairman's Foreword]

- Aboriginal youth suicide is indicative of a distressed community and effective solutions must be community focussed. Aboriginal culture and identity has been degraded by colonisation and discrimination. Restoring this culture and sense of identity has been consistently identified as a key protective factor. [Executive Summary]
- Previous reports and inquiries have recommended that this can be achieved through various means,
- primary of which is culturally-based programs, such as on-country camps and activities. By necessity, these programs must be owned and led by local communities. Yet the lack of priority given to these programs by government indicates that their importance continues to be overlooked. [Executive Summary]
- Finding 8: There is increasing evidence that culturally-based programs have the greatest impact in preventing suicide; however, the Western Australian Government has demonstrated reluctance in funding programs of this nature. [Page 57]

#### **Findings / Observations / Propositions**

 There is increasing evidence that culturally-based programs have the greatest impact in preventing First Nations suicide. This observation is based on the following:

Finding 8 Page 57

There is increasing evidence that culturallybased programs have the greatest impact in preventing suicide; however, the Western Australian Government has demonstrated reluctance in funding programs of this nature.

WA Parliament Message Stick Report, Nov 2016

Up Until November 2016 there had been at least 40 reports written about the rising rates of Aboriginal Youth Suicide

This observation is based on the following:

Over the years there have been a plethora of inquiries undertaken, reports written and recommendations made which attempt to address the crisis of Aboriginal youth suicide. Significant amounts of government funds have been spent providing a variety of programs and services to address the complex and interrelated risk factors which may contribute to a young person suiciding. It was important to the Committee to not just repeat what has been done in the past. As such, it decided to analyse relevant recommendations of previous inquiries, over 40 reports, to see if they had been effectively implemented. In many cases we found that they had not. The rising rates of suicide clearly confirm this.

WA Parliament *Message Stick Report*, November 2016

From the myriad of reports, the most important, yet least enacted recommendations were about the role of Aboriginal culture

This observation is based on the following:

Perhaps the most important, yet least enacted, were about the role of Aboriginal culture, both as a primary protective factor building resilience in young people, and also ensuring that programs and services are culturally appropriate. Similarly, many recommendations advocated for greater engagement of Aboriginal people in developing strategies, programs and services, yet the Committee was presented with little evidence demonstrating the government was meaningfully consulting or partnering with Aboriginal communities.

WA Parliament *Message Stick Report*, Nov 2016

- 4. There are at least 50 Reports now written about Aboriginal Social and Emotional Wellbeing ie the forty reports cited in the *Message Stick Report* of 2016, plus at least a further 10.
- The *Interim Report* seemingly equates health interventions with suicide prevention – in toto – with no reference to the 50 reports referenced herein relating to Culturally Based approaches to First Nations Suicide.

The *Interim Report* states as follows, on page 198:

The areas of the suicide prevention system distinct from mental health include assessment and management of suicidal behaviours, means restriction and aftercare and postvention services (PC 2020a).

The present author entirely accepts that he may not properly understand the nature of the comment above from page 198 of the *Interim Report*. But what is fully understood is that the general topic of discussion at that point [page 198] is the topic of suicide prevention. And in that quite fulsome discussion of suicide prevention, at no point is there even the beginning of a reference to any of the 50 Reports on Aboriginal suicide prevention which are listed herein.

[It is recognised that on page 166 there is a very brief discussion of the concept of Social and Emotional Wellbeing as it pertains to First Nations peoples in Australia. However, the conclusion drawn by the Productivity Commission, on page 167 relates to the concept of 'cultural safety' and makes no mention of concepts of 'cultural resilience.' Thus, the Commission's conclusions run contrary to the focus of the 50 reports referenced herein.]

# **Recommendations Relating to Aboriginal Suicide Prevention**

 All Indigenous suicide prevention activity should include cultural renewal and cultural resilience programs.

This recommendation is based on *ATSISPEP Report* Recommendation # Two:

- All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care.
- That Governments recognise the importance of cultural knowledge as a protective factor preventing Aboriginal youth suicide and respect the three decades of advocacy around this. That Governments endorse the efficacy of

culturally - based prevention approaches to First Nations suicide and that, consistent with a focus on productivity and prevention, focus future investments in this space on upstream, culturally - based preventative programs.

This recommendation is based on *Message Stick Report*, WA Parliament:

- Recommendation 7 Page 57 That Western Australian Government agencies recognise the importance of cultural knowledge as a protective factor preventing Aboriginal youth suicide.
- Recommendation 8 Page 57 That the Western Australian Government set aside an appropriate portion of grant expenditure to fund more culture-embedded programs for Aboriginal young people across the state.

#### **Recommendations — Refocus the System**

#### Recommendations Designed to Refocus the System Towards Upstream, Preventative Strategies to Promote Mental Health and Wellbeing

- Develop Historical and Background Context
   Around the Mental Health and Suicide Prevention
   System
  - The *Final Report* should provide greater detail around the historical context and background to the current Mental Health and Suicide Prevention system, giving particular consideration to the findings and recommendations contained with earlier systemic reviews including, but not limited to, the National Mental Health Commission's 2014 *Contributing Lives Report.*
- Develop Historical and Background Context Around the Mental Health and Suicide
   Prevention System- as it Applies to First Nations Communities.

The *Final Report* should provide greater detail around the historical context and background, giving particular consideration to the plethora of reports relating to First Nations Wellbeing and noting the consistent theme across this plethora of reports

- around the need to support cultural resilience as the foundation for First Nations Wellbeing.
- Develop greater detail around the impediments to systemic and structural change.
  - From #1 and # 2 above, the *Final Report* should provide greater detail around the impediments to systemic and structural change. The *Final Report* should give particular consideration to the 5 focus areas articulated in the 2014 *Contributing Lives Report*, and should give specific consideration as to why such little progress has been made in regards to these 5 focus areas.
- Develop an Understanding of the Barriers to Co-design, Especially as Described by the Productivity Commission and as Described by the Lowitja Institute

The *Final Report* should provide much greater detail around the systemic, structural, and political barriers to the successful implementation of any genuine Codesign process for systemic change.

 Develop an Understanding of Impediments to Preventative Programs Being Implemented in Australia.

On Wednesday 13 August 2025 the Productivity Commission will release its *Delivering quality care more efficiently.* In this report the Commission will make initial findings in regards to impediments to preventative strategies in Australia.

The Productivity Commission's Interim Findings from the *Delivering quality care more efficiently Inquiry*, in relation to the impediments to Preventative strategies being funded, should be carefully considered within this present Inquiry in to Mental Health and Suicide Prevention.

 Develop an Understanding of How to Improve Productivity, Efficiency and Effectiveness in the Care Economy in Australia, And Make Pertinent Recommendations Around That Understanding.

On Wednesday 13 August 2025 the Productivity Commission will release its Interim Report on **Delivering quality care more efficiently** 

In this forthcoming report the Productivity Commission will make Initial Findings in regards to improving productivity in the Care Economy. These interim findings around improving productivity should be carefully considered within this present Inquiry in to Mental Health and Suicide Prevention, and should be considered in the light of the recommendations from the National Mental Health Commission in 2014 in regards to rebalancing expenditure in the Mental Health and Suicide Prevention system. Continuing a pattern of investment in to hugely expensive upstream, clinical programs is extremely unproductive, so why is it that we continue to invest the majority of resources in to unproductive modalities, despite the Mental Health Commission in 2014 urging us to make structural changes and to invest in more productive modalities?

 That the Productivity Commission significantly revise its Theory of Change -

The Commission should significantly revise its theory of systemic change, such that a revised theory of change is heavily informed by the National Mental Health Commission's *Contributing Lives Report* and such that a revised theory of change materially and comprehensively addresses key impediments to systemic and structural change in the Mental Health and Suicide Prevention System. In particular, a revised theory of change should, consistent with the

Productivity Commission's own current *Inquiry in to the Care Economy*, seriously address the key issue of Governments' profound and persistent reluctance to invest in preventative programs.

The *Final Report on Mental Health and Suicide Prevention* should be greatly informed by the Findings and Recommendations contained within the Productivity Commission's *Care Economy Interim Report*.

 That the Productivity Commission Make Specific Findings and Recommendations Around Rebalancing Expenditure, Echoing and Repeating the Recommendations Contained Within the National Mental Health Commission's 2014 Contributing Lives Report.

"We need system reform to:

- redesign the system to focus on the needs of users rather than providers
- redirect Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity
- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community."
- No Co-design Process to be Commenced Without First Achieving Two Prerequisites.

No Co-design process should be commenced without the following first occurring:

- A clear and detailed statement from Government, at the Ministerial level, setting out how the Government views Co-design operating within the constraints of, and within the context of, a Westminster democracy;
- A clear Co-design resourcing and empowerment strategy, with a specific focus on how the non – Government sector, and the non – Government participants in the proposed Co-design process, would be resourced and empowered so as to enable them to participate in the Co-design process as full equals to the Government participants.

#### A Note About the Author

#### 1. vis-à-vis Centring Lived Experience in Suicide Prevention and

## 2. vis-à-vis First Nations Culture and Wellbeing

In February 2008 the Hon Alistair Hope, the then WA Coroner, brought down his *Kimberley Findings Report*, being a 224-page long report on the deaths by suicide of 22 Aboriginal people in the Kimberley region of WA. In his opening acknowledgements to that *Findings Report* the Coroner states as follows:

The drive for the inquest came, importantly, from the Aboriginal people themselves and the ongoing support of KALACC was of fundamental importance in obtaining evidence from many Aboriginal people. In that context I am indebted to Mr Joe Brown, KALACC Chairman, and Mr Wes Morris, KALACC Coordinator, for their ongoing support for the process.

Mr Joe Brown was a very senior Walmajarri cultural boss and in February 2007 Mr Brown and I wrote to the Coroner, calling on him to investigate the alarming rate of suicide in the Kimberley. We then contacted the Federal Government, and we secured funding with which to engage Legal Counsel to assist the families involved in this harrowing process. The Productivity Commission's Mental Health and Suicide Prevention Agreement Review Interim Report of June 2025 notes that the rate of First Nations suicide in Australia continues to worsen. This fact comes as a surprise to no one who has worked in the First Nations cultural space. For as long as suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

Between February 2007 and the present time, a period of 18 years, my professional involvement in regards to the issue of First Nations Suicide included the following:

- Coronial Inquiries: Played a leadership role in regards to four major Coronial Inquiries;
- Suicide Prevention Programs: For 18 years I had management - oversight of a significant Aboriginal youth suicide prevention program based around building cultural resilience;

- Regional Suicide Prevention Trials:
   Participated in monthly meetings for close on 10 years;
- Developing Co-design Guides: Had management

   oversight of the development of Co-design Guides
   for 1). Aboriginal Youth Wellbeing and for 2). Aboriginal
   Youth Justice Diversion;
- Advocacy and Inquiries: Made submissions to, and appeared before, countless Federal and State Inquiries.

For more than 18 years I have witnessed the enhancement of resourcing to, and empowerment around, Aboriginal Community Controlled Health Organisations. This is a most welcome development. However, I repeat as above, for as long as First Nations suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia. In the last 18 years I have seen little material action from Government regarding the central role of Aboriginal Culture in regards to First Nations wellbeing, despite a raft of Government - commissioned reports all calling for cultural solutions. The words 'Aboriginal' and 'Culture' are not synonyms. Neither are the words 'Health' and 'Culture.' Cultural solutions are delivered by Cultural organisations, not Health organisations.

Beyond the professional capacity outlined above, in my private life I have significant personal relationships with people who work professionally in the Mental Health space in Queensland. This relates both to those who work in a clinical [psychological] mental health setting and those who work, through a lived experience framework, in the community mental health setting. These very close personal relationships have informed my comments, herein, in regards to issues such as empowering Peer Support Workers in the Mental Health system. In regards to this, I note once again that the 2014 Contributing Lives Report recommended that we "redesign the system to focus on the needs of users rather than providers." In the intervening 10 plus years, there has been some expansion in the role of Peer Support Workers, but little overall structural reform.

#### **Part A: Response to Interim Report**

# Response to the Productivity Commission's Interim Report on the National Mental Health and Suicide Prevention National Partnership Agreement

## A.1 All Indigenous suicide prevention should include community-specific programs

All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal.

ATSISPEP Report Recommendation #Two:

All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health

First Nations suicide is best viewed as not being an individual mental health issue. And First Nations suicide prevention strategies should not focus on health programs. The WA Parliament's November 2016 *Message Stick Report* puts it thus:

Aboriginal youth suicide is indicative of a distressed community and effective solutions must be community focussed. Aboriginal culture and identity has been degraded by colonisation and discrimination. Restoring this culture and sense of identity has been consistently identified as a key protective factor.

[Learnings from the message stick - The Report Of The Inquiry Into Aboriginal Youth Suicide In Remote Areas. Executive Summary]

Drawing on over 50 reports, including the *Message Stick Report*, I present herein the view that First Nations suicide is best understood as being a collective, community issue reflective of a Culture under stress. Prevention and early intervention are best viewed in the following light – 'Cultural Wounds Require Cultural Healing'.

On page 167 of the *Interim Report* we read as follows:

In 2022-23, one in three Aboriginal and Torres Strait Islander people (30.2%) experienced high or very high levels of psychological distress (figure 5.1). This represents a slight increase compared to 2004-05.

This statistic, this piece of data, is then followed by the following discussion, on page 169, about the delivery of health services such as the following:

- SEWB: These services can provide tailored care to meet the needs of the local population, including:
  - psychological therapies
  - complex mental health support
  - > case management
  - clinical care coordination (DoHAC 2025a).

The information contained across pages 166 to 180 of the *Interim Report* does canvass the notion of Social and Emotional Wellbeing at various points, but at no point in these 14 pages of text is there even once any mention of even one of 50 reports on Aboriginal Suicide Prevention and Wellbeing that are referenced in this present submission.

The information contained across pages 166 to 180 of the *Interim Report* tells us that fully one third of the First Nations community experiences 'experienced high or very high levels of psychological distress' and that this figure has slightly increased over the last two decades. One would have imagined immediately that the logical conclusion, indeed pretty much the only logical conclusion from this data, is the conclusion which the WA Parliament's Education and Health Standing Committee reached in November 2019:

Aboriginal youth suicide is indicative of a distressed community and effective solutions must be community focussed. Aboriginal culture and identity has been degraded by colonisation and discrimination. Restoring this culture and sense of identity has been consistently identified as a key protective factor.

[The Report Of The Inquiry Into Aboriginal Youth Suicide In Remote Areas Executive Summary]

Despite this finding from the WA Parliament being pretty much the only logical conclusion that one can reach, it seems that the Productivity Commission has failed to reach that conclusion, and has instead chosen to focus on the health sector and to focus on psychological therapies; complex mental health support; case management; and clinical care coordination.

The proposition being presented in this submission, is supported by some 50 earlier reports and it holds that

for as long as First Nations suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

In December 2024 the *National Aboriginal And Torres*Strait Islander Suicide Prevention Strategy 2025-2035

was released. This Strategy contains some six Core Priorities, including the following:

- Priority 2: Thriving communities
- Outcome: Aboriginal and Torres Strait Islander
   Communities are supported to thrive through culture
   and deep connection to family, community, and
   Country

This priority focusing on culture and deep connect to family, community and country represents a continuation of consistent advocacy that has existed over the last three decades. As part of that reality, this priority is entirely consistent with Recommendation # 2 within the *ATSISPEP Report* of 2016. It is long overdue for Governments to heed the great many expressions of this same sentiment, and it is long overdue for Governments to actually support Aboriginal and Torres Strait Islander Communities to thrive through promoting strong Culture.

## **A.2** A Dichotomy in Suicide Prevention System Architecture: Prevention and Support

Wherein 'Prevention' in the First Nations Context is Best Understood as Relating to Cultural Programs, and 'Support' is Best Understood as Relating to Health Interventions, Being Both Community Health and Clinical Health. Professor Michael J Chandler held that "individualized "medical models" of suicide prevention are mistaken at every turn."

The Productivity Commission's *Interim Report* seeks to develop a "new policy architecture" and states that:

- To be effective, the new policy architecture should be developed by governments in a process of co-design with people with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin as well as service providers and practitioners. [Page 2] and;
- In the development of the next agreement, governments should realise their commitment to embed the voices of people with lived and living experience and supporters, carers, families and kin across the system. [Page 10]

So, in its *Interim Report* the Productivity Commission is reflecting, and is strongly echoing, the recommendations from 2014 from the National Mental Health Commission, which in that year recommended in its *Contributing Lives Report* that we should as a nation:

rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention.

It is the medical service delivery model which provides 'services that indicate system failure'. It is the investment

in to hugely expensive, intensive and acute health services that are the "services which indicate system failure." Services such as 'psychological therapies; complex mental health support; case management; and clinical care coordination' are all 'services that indicate system failure'.

The "evidence-based services like prevention and early intervention" lie entirely outside of the acute end of the domain of medical service delivery models, and lie largely outside of the medical services domain in its totality. As is indicated in some 50 earlier reports in to First Nations wellbeing and First Nations suicide prevention, it is cultural programs, delivered by First Nations Cultural organisations, which from an evidentiary perspective are best placed to provide effective preventative approaches to suicide. In November 2019 the WA Parliamentary Standing Committee on Health and Education put things thus:

Previous reports and inquiries have recommended that this can be achieved through various means, primary of which is culturally-based programs, such as on-country camps and activities. By necessity, these programs must be owned and led by local communities. Yet the lack of priority given to these

programs by government indicates that their importance continues to be overlooked.

Learnings From The Message Stick - The Report Of The Inquiry Into Aboriginal Youth Suicide In Remote Areas. [Executive Summary]

This lack of recognition of, and lack of priority to, culturally -based programs was true back in 2012 when *The Elders' Report into Preventing Indigenous Self-harm & Youth Suicide* — https://cultureislife.org/wp-content/uploads/2024/02/Elders-Report.pdf was first published. This lack of recognition of, and lack of priority to, culturally -based programs was true back in 2019 when the *Message Stick Report* was published. And this lack of recognition of, and lack of priority to, culturally -based programs persists through to July 2025 ie the present time and is very evident in the huge knowledge gaps to be found in the *Interim Report*.

In general, in terms of both the Mental Health and Suicide Prevention systems, we as a nation pathologise suicide and we preference and prioritise clinical and medical interventions. Such clinical and medical interventions have as their unit of intervention, the individual human being. Canadian Professor Michael J Chandler put things thus:

"whenever we are moved to minister to such troubles, the usual impulse — the common intervention or treatment strategy — is to somehow buck-up the flagging spirits of those singular symptom bearers who are counted as most disheartened or undone. Picking away at such troubles one 'patient' at a time, we council and drug them, we bolster their flagging self-esteem, and otherwise do whatever seems appropriate to shore up their supposed personal shortcomings. In short, while many of our ills are acknowledged to sometimes be social or cultural in origin, when moved to intervene, Western society has customarily proceeded by attempting to redeem one lost soul at a time. A prime example of this individualistic approach to 'treatment' is to be found in standard responses to the so-called "epidemic" of suicides ascribed to the residents of many Indigenous communities. Those individuals somehow deemed to be at special risk are taken aside and variously bucked-up, all in the hope of somehow making each one of them personally better adjusted and less forlorn. This chapter will work to make the case that such applications of so-called individualized "medical models" of suicide prevention are mistaken at every turn, insisting instead that cultural wounds require cultural medicines."

#### Professor Michael J Chandler; Cultural Wounds Require Cultural Medicines

Document is accessible via the Centre For Healthcare Knowledge & Innovation, A Northern NSW Coast Consortium including the North Coast PHN. https://www.thecentrehki.com.au/wp-content/uploads/2021/05/Cultural-Wounds-Require-Cultural-Medicine-Michael-J.-Chandler.pdf

Emeritus Professor Patrick Sullivan spent a lifetime of professional anthropological work in the Kimberley region of Western Australia. And reflecting on the relatively recent arrival of the phenomenon of Aboriginal suicide in the Kimberley, Sullivan wrote as follows in September 2016:

"Government investments in response to Aboriginal suicide are heavily weighted towards clinical interventions which are predicated on an individualised conception....

I think that it is no coincidence that things have got worse psychologically for Aboriginal people as they have become better in material terms. The things that bind Aboriginal people together in social solidarity – shared language, sacred areas, religious ceremonies, ancient land-related values – have been consistently undermined. These are not part of the wider society's economic development agenda, or are believed to actively undermine it. At the same time, Aboriginal material conditions, land ownership and shares in the fruits of economic enterprises – those things that make Aboriginal people "more like us" – have improved greatly since the 1980s.

Poverty itself does not cause suicide, but the resilience needed to confront poverty daily can often be lacking. Many of the at-risk group between fifteen and thirty-five years of age reach back for a handhold in the culture of their communities and find it doesn't have the weight to support them anymore."

#### Emeritus Professor Patrick Sullivan A hope-led recovery?

https://insidestory.org.au/a-hope-led-recovery/

Very little has changed since Sullivan wrote those words back in 2016. The prospect, back in 2016, of the WA Government committing to a regional cultural strategy vanished like a mirage, like so many other culturally – based solutions presented to the WA Government.

Consistently we witness Governments investing in anything but cultural solutions. As former Social Justice Commissioner June Oscar put it:

"We have the most extensive kinship network in the world and through a system of law, ceremony and song we have transferred a huge body of knowledge, including important principles of collective and common humanity, from generation to generation. There is much to celebrate but it is not celebrated – it is not even recognised."

To promote a model of suicide prevention that resides and sits within the health system, to the exclusion and omission of Culturally – based programs, is to ignore some 50 earlier reports which position First Nations culture as being the bedrock and foundation of social and emotional wellbeing and which, as such, is the key plank for any productive and effective approach to preventing first nations suicide.

#### A.3 Placing First Nations Suicide Prevention Within Policy Architecture

Locating and Placing First Nations Suicide Prevention Within the Policy Architecture for Suicide Prevention in Australia is crucial.

The Productivity Commission's *Interim Report* states as follows in regards to suicide prevention:

- There has been a shift towards an integrated, whole-of-government approach addressing the social and emotional factors affecting suicidality and recognises the suicide prevention system as sitting alongside the mental health system, not within it [page 186]
- The recently released National Suicide Prevention Strategy 2025-2035 sets out the pathway to achieve a comprehensive approach to suicide prevention, with the aim of aligning expenditure and activity with evidence and insights about what works (NSPO 2024d, p. 17). It does this by adopting a model focusing on the prevention of suicidal distress and supports for people experiencing suicidality and those who care for them, and by identifying the critical enablers of an effective suicide prevention system (figure 6.1). [Page 197]

Figure 6.1 – 'A national model for suicide prevention in Australia' is sourced from the recently released National Suicide Prevention Strategy 2025–2035 and this strategy is endorsed by the Productivity Commission in its *Interim Report*. If we look at Figure 6.1 then the very first thing that we note is that there are two headings at the top of the figure:

- Prevention
- Support

Yes. And again, yes. In other words, Prevention and Support are dichotomous and there are at least 50 reports over three decades all making recommendations around the central role of First Nations Cultural resilience as being the bedrock of First Nations suicide prevention.

Further in to the *Interim Report*, on page 199, we see a Venn Diagram ie Figure 6.2 – The relationship between

mental health and suicide prevention. And the key point which the Productivity Commission is making in that diagram is the overlap between the Mental Health and Suicide Prevention systems. This overlap is fairly incontrovertible and I would imagine that it is largely uncontested. But if we fully accept this overlap, then it nonetheless stands that the majority of the two systems remain distinct and very different. The Mental Health system has long operated within a medical model of service delivery. There is exceptionally strong evidence for the need for the Suicide Prevention system to largely NOT operate within a medical model of service delivery. And within the suicide prevention system, the Figure 6.1 – 'A national model for suicide prevention in Australia' is based on the following dichotomy:

- Prevention
- Support.

The Interim Report then states further, as follows:

- The recently released National Suicide Prevention Strategy 2025-2035 sets out the pathway to achieve a comprehensive approach to suicide prevention, with the aim of aligning expenditure and activity with evidence and insights about what works (NSPO 2024d, p. 17). It does this by adopting a model focusing on the prevention of suicidal distress and supports for people experiencing suicidality and those who care for them, and by identifying the critical enablers of an effective suicide prevention system (figure 6.1). [page 197] and;
- The areas of the suicide prevention system distinct from mental health include assessment and management of suicidal behaviours, means restriction and aftercare and postvention services (PC 2020a). [Page 198]

The present author entirely accepts that he may not properly understand the nature of the comment above. But it appears, at face value, to be deeply troubling and to be terribly ill – informed. [Happy to receive clarification and happy to be corrected]. What is fully understood is that the general topic of discussion at that point ie on page 198 of the *Interim Report* is the topic of suicide prevention. And in that quite fulsome discussion of suicide prevention at no point is there even the beginning of a reference to any of the 50 reports on Aboriginal suicide prevention which are listed herein.

Professor Michael J Chandler was writing in the Canadian context. But Chandler undertook three separate speaking tours of Australia. And the *ATSISPEP Report* cites Chandler's work, and comments that his findings are broadly applicable to Australia. When we seek to locate and place First Nations suicide prevention within the policy landscape for Australia, consideration should be given to these following words from Chandler:

"not withstanding the untold millions of dollars invested, there is not a single shred of confidence-inspiring evidence that any of these exploratory, publicly funded suicide-prevention projects has actually 'worked' to prevent a single death....

while suicide can be (and most commonly is) approached as a private problem hidden away in the secret hearts and minds of troubled individuals, it will prove more useful and coherent to undertake to re-envision suicide (especially Indigenous suicide) at the level of whole communities or cultural groups....

The more collective and culture-based alternative that is being militated for here (the next best thing, if you will) turns upon setting aside all of our earlier and failed hopes of picking out and somehow patching up all of those forlorn individuals with suicide on their private minds, and to argue that what is needed instead are community-level initiatives that

have as their purpose both helping to rehabilitate those frayed connections that so many Indigenous communities struggle to maintain with their traditional pasts, and joining them in their ambitions to enjoy a measure of local control over their own uncertain futures...

if suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counsellors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives."

#### **Professor Michael J Chandler**

Cultural Wounds Require Cultural Medicines.

If we are to be guided by the evidence in hand, and if we are to be responsive at all to some 50 reports over the last three decades, then going forward First Nations suicide prevention – if it actually has the goal of statistically decreasing rates of First Nations suicide in Australia, will seek to locate First Nations suicide prevention primarily in the Cultural domain, not the Health domain. If fully one third of the Indigenous community in Australia is suffering from high or very high levels of psychological distress, then the provision of medicalised, individualised interventions provided through the Health system is clearly necessary. But by the same token, a simple understanding of logic, combined with basic levels of understanding of sociology, anthropology and statistics would dictate that such interventions, whilst necessary, are not sufficient, and will not lead to statistically lower levels of First Nations suicide in the future. Meanwhile, there are some 50 reports all pointing towards Culturally - embedded programs as being fundamental to statistically improving First Nations wellbeing in Australia.

#### A.4 November 2016 ATSISPEP Report and Primordial Prevention

Recommendations Around Primordial Prevention Delivered at the Universal / Indigenous Community Wide Level

None of the above, and nothing that follows, is offered here to the exclusion of the important roles and contributions of medical and health services and interventions in people's lives. Various people have exceptionally differing needs and requirements and in response to such varying needs a mature policy framework would seek to provide for a suite of varying interventions.

The provision of 'culturally - informed', 'culturally - safe' and 'culturally - appropriate' health services to

Indigenous Australians is absolutely critical. But there are some 50 reports which speak to a different aspect of service need. Creative Australia puts things thus:

While previous generations have fought for life and for land, and this must and will continue, this must also be the time to fight for the centrality of our culture, because it is in the elevation and celebration of this most sacred practice that our wellbeing and Country flourish. First Nations arts and culture often get overlooked in the context of other needs

resulting from intergenerational trauma, but our arts and culture give us our strength, our foundation, our identity, our hope; they give us our connection, our healing, our pride, our wellbeing.

https://creative.gov.au/sites/creative-australia/files/documents/2025-03/NIACA-Consolidated-Report.pdf

Bringing it Forward, Creative Australia, 2022, page 7

The November 2016 *ATSISPEP Report* proposes a suite of services, programs and interventions, all of which are important, and each of which addresses a different aspect and dimension of wellbeing within First Nations communities in Australia. Herein, I seek to focus on the ATSISPEP Recommendations around what it calls Primordial Prevention, delivered through programs that are provided at the universal ie Indigenous community – wide level.

The ATSISPEP Report was first published in November 2016 - Solutions That Work: What Evidence and Our People Tell Us; Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report —

https://www.niaa.gov.au/sites/default/files/documents/publications/solutions-that-work-suicide-prevention.pdf

As it happens, I was physically present in the garden/courtyard of Parliament House Canberra for the launch of the *ATSISPEP Report*. The *ATSISPEP Report* doesn't employ the dichotomous structure which shapes the current *National Suicide Prevention Plan*. Rather the *ATSISPEP Report* employs a visualisation based on a continuum of Success Factors Identified by ATSISPEP [page 3]:

- Universal/ Indigenous Community Wide
  - > Primordial prevention
  - Primary prevention
- Selective At Risk Groups
  - School age
  - > Young people
- Indicated At Risk Individuals
  - Clinical elements

At the preventative end of the spectrum, the *ATSISPEP Report* describes interventions and success factors as follows:

- Primordial prevention
  - Addressing community challenges, poverty, social determinants of health

- Cultural elements building identity, SEWB, healing
- Alcohol /drug use reduction

On Page Four of the *ATSISPEP Report* we read the following:

- Recommendation # Two:
  - All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care.

On page 12 of the **ATSISPEP Report** we read the following:

- A further challenge was posed by the studies of Chandler and Lalonde who examined suicide among British Columbian (Canadian) First Nations' young people. Their findings have been broadly considered to be applicable in an Indigenous Australian context. Two Chandler and Lalonde studies, which focus on the protective effects against suicidal behaviours of what was coined 'cultural continuity', are discussed in Text Box 2 (below).
- TEXT BOX 2: Cultural continuity and the research of Chandler and Lalonde

Chandler and Lalonde examined cases of suicide among young First Nations people of British Columbia and the protective effects of 'cultural continuity' against suicide.

In their first study (1987–92) cultural continuity was defined according to six key indicators of self-determination and cultural maintenance:

- > Achievement of a measure of self-government
- Have litigated for Aboriginal title to traditional lands
- Accomplished a measure of local control over health
- Accomplished a measure of local control over education
- Accomplished a measure of local control over policing services

- Had created community facilities for the preservation of culture.
- Chandler and Lalonde mapped suicides in all 197 communities or 'bands' in British Columbia and found that communities that achieved all six markers had no cases of suicide among young First Nations people. Conversely, where communities achieved none of these protective markers, youth suicide rates were many times higher than the national average (Chandler and Lalonde, 1998).
- A second study (1993-2000) included two other indicators and found similar results to those of the first study. The additional indicators were:
  - A measure of local control over child welfare services
  - That they are characterised by having elected band councils composed of more than 50% women (Chandler and Lalonde, 2008).
- If thematic elements can be drawn from the Chandler and Lalonde studies, the first is community empowerment: supporting communities' agency to make real choices and change their experience for the better. This could be through education and awareness raising, the emergence of leadership and decision-making structures, the devolution of decision-making power to such structures, and the presence of services and support organisations to assist in achieving goals and/or the provision of resources. Cultural maintenance and renewal was another thematic element. More broadly, the studies suggested that primordial prevention - upstream interventions that may have little directly to do with suicide as such - had an important place in Indigenous suicide prevention.
- In fact, the work of Chandler and Lalonde has already influenced suicide prevention activity in Australian Indigenous communities. In particular, the ongoing National Empowerment Project (NEP) that aims to empower communities through education in identifying and addressing challenges (including those associated with suicide) and supporting community capacity for self-governance and organisation to address those challenges. Echoing Chandler and Lalonde's work, the NEP also places a strong emphasis on leveraging cultural strengths and supporting a community's cultural renewal on its own terms.

To be clear, although neither Chandler nor La Londe are alive any longer, both of them kept writing beyond November 2016 when the *ATSISPEP Report* was published. I particularly note again the following, which Chandler wrote at around the same time as *ATSISPEP* was released ie in 2016:

if suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counsellors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives.

#### Cultural Wounds Require Cultural Medicines.

This is the challenge that Chandler puts before us – if our serious goal is indeed suicide prevention ie the statistical reduction in rates of First Nations suicide rates – then continuing to invest in hiring 'Still More Counsellors', to the ongoing exclusion of Culturally – based programs delivered at the whole of community level, is never going to achieve that goal. Psychological therapies and interventions are warranted and they are necessary. But if our serious goal is to statistically reduce rates of First Nations suicide, then Chandler tells us that medicalised interventions delivered at the individual level are, in his words, 'fishing in the wrong pond.'

It is only through a paradigm shift, and it is only through listening to, and responding meaningfully to the 50 earlier reports, and by investing in culturally based services delivered at the whole of Indigenous community level, that we will actually witness a decrease, not a continued increase, in rates of First Nations suicide in Australia.

None of the above should be interpreted in any way as being a contradiction to recommendations contained in the *Interim Report*, such as the following:

- Draft recommendation 5.1
- An Aboriginal and Torres Strait Islander schedule in the next Agreement [page 184]

In regards to Aboriginal Suicide Prevention the *Interim Report* I note once again that on pages 221 ff of the *Message Stick Report* of November 2016 there is a list of some 40 earlier reports in to Aboriginal youth suicide. None of those 40 reports are even mentioned in the *Interim Report*. Nor is any mention made of any of the following reports::

 The Elders' Report into Preventing Indigenous Selfharm & Youth Suicide; 2012

- Solutions That Work: What Evidence and Our People Tell Us; Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report; November 2016
- Learnings from the message stick- The report of the Inquiry into Aboriginal youth suicide in remote areas; November 2016
- My Life My Lead Report on the national consultations; 2018, Department of Health
- Country Can't Hear English; 2020, Arabena
- Culture is Key: Towards cultural determinantsdriven health policy; Lowitja Institute, 2021
- National Suicide Prevention Trial Final Evaluation Report; December 2020
- Kimberley Suicide Prevention Trial, Final Evaluation Report; 2021
- National Aboriginal and Torres Strait Islander Health Plan 2021-2031; 2021, Dept of Health
- Connected Lives: Creative solutions to the mental health crisis (Australia Council - Now 'Creative Australia'); Sept 2022
- Strong Culture, Strong Youth: Our Legacy, Our Future (Close the Gap Campaign Report 2023); March 2023
- Links between Aboriginal and Torres Strait Islander language use and wellbeing (Mayi Kuwayu Study, October 2024)
- Strong Culture, Strong Place, Strong Families
   Research and Evaluation Project: Final Report (ANU Centre for Indigenous Policy Research, 2025)

The complete silence around, and the complete absence of, any references whatsoever to any of the reports listed above is really quite astonishing and more than a little concerning. It is not entirely clear to this present author how the Productivity Commission can be promoting the notion of listening to, and responding to, First Nations voices when three decades of speaking and advocacy on the issue of Aboriginal suicide prevention is completely missing from the *Interim Report*. The *Interim Report* instead chooses to focus its attention on present day actions and processes in regards to Aboriginal Health, in preference to listening and responding to three decades of advocacy around cultural strength and resilience. In the context of that silencing, I note once again the words of June Oscar:

"We have the most extensive kinship network in the world and through a system of law, ceremony and song we have transferred a huge body of knowledge, including important principles of collective and common humanity, from generation to generation. There is much to celebrate but it is not celebrated – it is not even recognised."

#### June Oscar

Whilst this complete failure to reference any of the 50 reports referenced herein is really quite shocking, perhaps the most astonishing of these 50 omissions is the lack of even a single reference in the *Interim Report* to the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031* – https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031?language=en

#### Health Plan Vision

A diagram of the *Health Plan Vision*, outlined in abovementioned document (See following page). The foundation to this diagram is stated, thus:

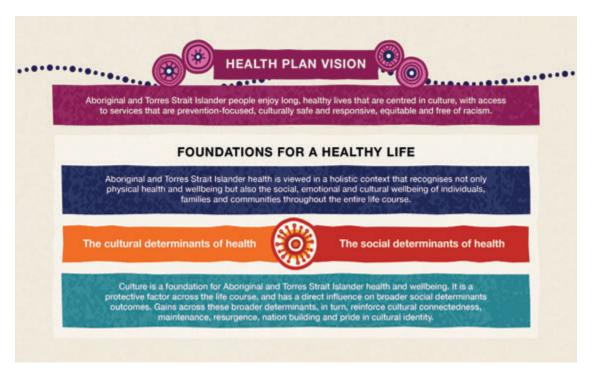
Culture is a foundation for Aboriginal and Torres Strait Islander health and wellbeing. It is a protective factor across the life course and has a direct influence on broader social determinants outcomes. Gains across these broader determinants, in turn, reinforce cultural connectedness, maintenance, resurgence, nation building and pride in cultural identity

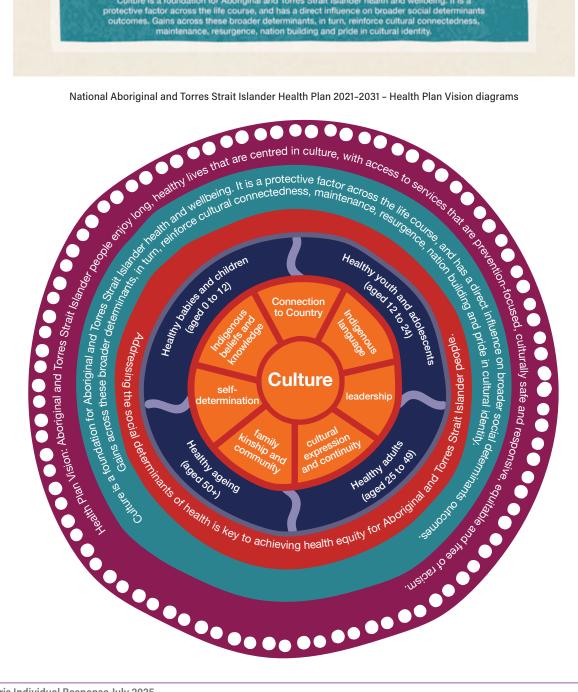
#### Circular Framework

And on Page 17 of this report, one can also find *Circular Framework* [Figure 3] (See following page). At the very centre of this diagram, are the following words:

- Culture
  - Connection to Country
  - Indigenous language
  - Leadership
  - > Cultural expression and continuity
  - > Family, kinship and community
  - > Self determination
  - Indigenous beliefs and knowledge.

It is to be sincerely hoped that the Productivity Commission in its *Final Report* will rectify and will redress the significant gaps and omissions which exist in the *Interim Report*.





## **A.5** Aboriginal Culture and Wellbeing vis-à-vis the Productivity Commission's Net Impact Considerations

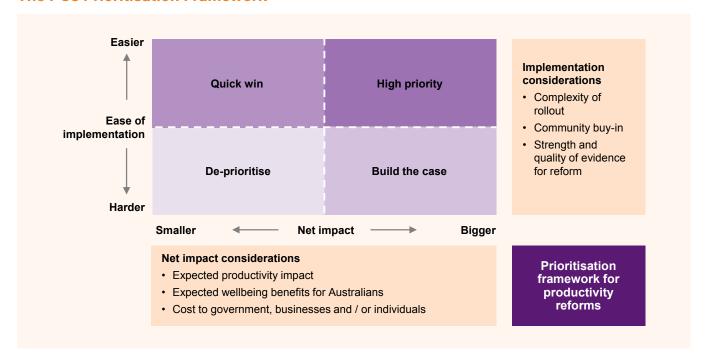
This section is based around the Productivity Commission's publication - Growth mindset: how to boost Australia's productivity 5 productivity inquiries

https://www.pc.gov.au/inquiries/current/fiveproductivity-inquiries/growth-mindset.pdf In this PC document we read as follows:

...governments' time and resources are limited.
They must select the most beneficial ideas and make tough choices on what to prioritise. That is why these inquiries have focused on proposing a small number of reforms that provide bang for buck. They build on existing policy reform efforts, such as the National Competition Policy reforms, to show how governments can emphasise growth in their choices. They also provide a stepping stone for more

comprehensive productivity enhancing reforms, including those previously recommended by the PC in our Advancing Prosperity report (PC 2023c). In prioritising these choices, the PC has preferred options that: • have a sizeable net benefit - a high expected economic dividend or significant benefit to community or individual wellbeing, relative to costs, and • are practical - relatively straightforward to implement, less complex to roll out, produce higher levels of community understanding and support, and are backed up by high-quality evidence (figure 7). For the most part, we have recommended reforms that meet both criteria and therefore sit in the 'high priority' quadrant in our decision-making framework (figure 7) below.

#### The PCs Prioritisation Framework



Sadly, the reality is that the prospect of Governments choosing to invest in Culturally- based solutions to First Nations wellbeing in Australia could in no way be described as being a "quick win." Governments have consistently and continually ignored the role of First Nations Culture within Australia, and there is no reason to think that that situation would change any time soon.

However, if we look at the four quadrants within Figure 7, present author strongly suggests that whilst investing in culturally based solutions to First Nations wellbeing is not a "quick win" it is does absolutely sit within the "high

priority" quadrant. The Productivity Commission tells us that fully one third of Indigenous people in Australia suffer from either high or extremely high levels of psychological distress. As written above, health and medical responses to this situation are clearly very much needed. But, having acknowledged the health need, one also needs to acknowledge the productivity agenda and the role of prevention within that productivity agenda. If the real and genuine goal relates to prevention, then as fully 50 reports have stated, then the pathway forward for that agenda lies in building and fostering Cultural strength

and Cultural resilience, by supporting the work of First Nations Cultural organisations.

#### **Part B: Response to the Interim Report**

#### Structural Reform of the Mental Health and Suicide Prevention System

#### **B.1** Productivity is a Meaningful Prism

Perhaps Productivity is a Meaningful Prism Through Which to Enact Long Overdue Structural Changes to the Mental Health and Suicide Prevention systems in Australia

Given the number of existing reports in to the Mental Health and Suicide Prevention system in Australia, including the Productivity Commission's own *Mental health Inquiry Report* of November 2020, one can be forgiven for asking why we need yet another such report. Indeed, this present submission to the Productivity Commission makes repeated references to the *Contributing Lives Report* which the national Mental Health Commission released in 2014, and to the very limited systemic and structural change that has occurred since that time. Yet, perhaps, that lack of change and the number of existing reports is the very reason for this current Inquiry by the Productivity Commission.

Coming up in Parliament House Canberra across 19 to 21 August 2025 there will be a significant Productivity Summit, and this Summit will address three key themes, these being:

- Resilience
- Productivity
- Sustainability.

Alongside of the upcoming Productivity Summit, the Productivity Commission is currently undertaking what it calls its 5 Pillars Productivity Inquiry. Looking backwards we can readily identify a period known as the 'COVID period', followed by a more recent period known as the

'Cost of Living period'. And we are told now that the main national discussion going forward will be around Productivity, reminiscent of Paul Keating's oft - quoted comment about the resident galah in the pet shop discussing micro- economic policy.

If indeed Productivity is the prism for driving change in Government policy and programs in this current era, then there is much that can, and should, be changed about the structures of the Mental Health and Suicide Prevention systems in Australia.

Part A to this submission is the main body of Paper #1 and it relates to Redesigning the Mental Health and Suicide Prevention system to focus on the needs of users, rather than providers, with a special focus on the role of Peer Support Workers in the Mental Health System. That, and a consideration of rebalancing the system from acute downstream services to preventative upstream services. Part A is then followed by Part B, which consists of information on a broader, more general consideration of a couple of topics of current interest to the Productivity Commission, especially:

- Prevention: How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?; and
- Empowering Users: Ensuring that the voices of First Nations people are heard and acted upon.

#### **B.2** The theory of change articulated within the *Interim* Report

I respectfully suggest that the theory of change articulated within the *Interim Report* is in fact unlikely to materially address two of the key impediments to change, as articulated by the National Mental Health Commission in 2014.

Both of these recommendations from the NMHC in 2014 relate to shifting expenditure away from downstream, acute services and moving the investment upstream in to preventative programs. Such a measure would be very consistent with the Productivity Commission's own current *Inquiry in to the Care Economy*. That other current Productivity Inquiry is examining how to

shift the pattern of Government investments so that a greater proportion of Government funding is allocated to preventative programs and strategies - which was exactly what the NMHC Recommended in 2014.

There is considerable merit to be found in the Productivity Commission's *Mental Health and Suicide Prevention* 

Agreement Review Interim Report of June 2025. However, it is suggested in this present submission that there are a number of areas where significant work remains to be done by the Productivity Commission. It is suggested that the Review and the Interim Report could be strengthened in the following areas:

- Historical Context and Background [General]: There
  is little point in critiquing the current MH Agreement
  without first examining reports such as the 2014
  Contributing Lives Report;
- Historical Context and Background [Aboriginal]:
   There is little point in critiquing the current MH
   Agreement without first examining the plethora of reports relating to First Nations Wellbeing;
- Impediments to Systemic Change: From the first two points, above, there is little point in critiquing the current MH Agreement without first examining the full range and gamut of impediments to systemic and structural change which have been identified across the many earlier reports;
- Impediments to Co-design: There is little point in recommending Co -Design approaches without examining the massive structural impediments to Co -Design and the need for massive transformation in the way that Government does business;
- Impediments to Prevention: The Productivity Commission's 5 Pillars Inquiry is examining the lack of emphasis on Prevention. The National Mental Health Commission in 2014 delivered a report recommending a significant reconfiguration of Government expenditures on Mental Health. The Interim Report would be greatly enhanced if it reflected NMHC Recommendations from 2014 and reflected the Productivity Commission's own current interest in building investments in to preventative programs in the Care Economy;
- Improving Productivity in MH: The Productivity Commission's 5 Pillars Inquiry is examining Productivity in the Care Economy. This should be more strongly reflected in this current MH Review. As above, current investments are heavily skewed to upstream, preventative treatments. Not only is this expensive, but it is also highly unproductive.

The present author's experience provides a perspective of 20 years of witnessing a mental health and suicide prevention system that is largely static, and which is heavily insulated from all endeavours to change its fundamental structures. The directions set out in the *Interim Report* are laudable and commendable and the

present author wholeheartedly endorses the intentions set out by the Productivity Commission, and the broad directions set out by the Productivity Commission. However, I believe that the Commission has not given sufficient regard to the key issue of structural stasis and intransigence. Key recommendations relating to structural reform, dating back to 2014 and earlier, are yet to be acted upon. It is hoped that the suggestions and recommendations set out herein in regard to this issue of structural statis are of assistance to, and of use to, the Commission as it develops its *Final Report*.

On page four of the *Contributing Lives Report*, published by the National Mental Health Commission in the year 2014, we can read as follows:

- We need system reform to:
  - redesign the system to focus on the needs of users rather than providers
  - redirect Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity
  - rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training
  - repackage funds spent on the small percentage of people with the most severe and persistent
  - mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care
  - reform our approach to supporting people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia's wealth.

https://www.mentalhealthcommission.gov.au/publications/contributing-lives-review-2014

It is immediately evident to the reader that the directions being espoused in 2025 by the Productivity Commission are almost identical to the directions espoused and recommended by the National Mental Health Commission in 2014, as we can see in the following juxtaposition:

- National Mental Health Commission, 2014:
   We need system reform to:
  - redesign the system to focus on the needs of users rather than providers; and
- Productivity Commission, 2025:We need system reform to:
  - To be effective, the new policy architecture should be developed by governments in a process of co-design with people with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin as well as service providers and practitioners.

In looking at the almost identical nature of the recommendations from 2014 and 2025, one immediately asks oneself why so little has changed in the intervening 11 years. Sadly, the *Interim Report* doesn't explicitly set out to address that question, and it is this author's view that the Review Process and the *Final Report* would be much stronger if the Productivity Commission did set out to answer that hugely consequential question. In the absence of the Productivity Commission providing any explicit answer to that question, one is left to examine what is said in the *Interim Report* and to then draw inferences from that.

In examining the *Interim Report*, one immediately sees that the Productivity Commission has made a Draft Finding that "The Agreement has not led to progress in system reform" [Draft finding 2.2, page 19]. And in order to bring about meaningful systemic reform, the *Interim Report* sets out four specific actions, as follows:

Draft recommendation 4.2
 Building the foundations for a successful agreement

The current National Mental Health and Suicide Prevention Agreement, including funding commitments, should be extended until June 2027, to give sufficient time to develop the foundations of the next agreement and renew the National Mental Health Strategy.

To support the next agreement:

the National Mental Health Commission should run a co-design process with people with lived and living experience, and their supporters, families, carers and kin to identify relevant and measurable mental health and suicide prevention objectives and outcomes

- > the Department of the Prime Minister and Cabinet should convene negotiations with the support of the National Mental Health Commission, and facilitate engagement between the Australian, state and territory governments on their shared priorities
- commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the agreement rather than a separate schedule. Governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration
- the Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention. Implementation plans to develop any new indicators should be in place within 12 months of the agreement being signed. [Page 21]

The theory of change that the Productivity Commission is articulating in the *Interim Report* is, in the opinion of this author, necessary but not sufficient. The following Key Points within the *Interim Report* are noted:

- Key points
  - The actions in the Agreement do not advance system reform.
  - A new policy architecture is needed to articulate the collective actions that will deliver changes to the mental health and suicide prevention system and improve outcomes.
  - The next agreement should formalise the role of the National Mental Health Commission as the entity responsible for independent assessment and reporting on progress [Page 2].

Notwithstanding the considerable merit in the theory of change as articulated by the Productivity Commission, I would once again reference the *Contributing Lives Report* in the year 2014. And I draw the reader's particular attention to the following two NMHC Recommendations from 2014:

 rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care.

I respectfully suggest that the theory of change articulated within the *Interim Report* is in fact unlikely to materially address two of the key impediments to change, as articulated by the National Mental Health Commission in 2014.

In Part B of this current document, section B1 addresses the issue of investing in Preventative programs. This is in fact a key issue of concern to the Productivity Commission in its current 5 Pillars Inquiries ie it is a key line of inquiry within the Productivity Commission's current *Inquiry in to the Care Economy*. And the reality in Australia as noted above and restated now is that:

Australia, when measured against comparable countries ie Western liberal democracies like the UK and Canada, performs poorly in regards to investing in preventative solutions to health

https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/

In Part B of this current document I reference the following insightful book *Why Isn't Government Policy More Preventive?* by Cairney and St Denny — <a href="https://global.oup.com/academic/product/why-isnt-government-policy-more-preventive-9780198793298?cc=au&lang=en&">https://global.oup.com/academic/product/why-isnt-government-policy-more-preventive-9780198793298?cc=au&lang=en&</a>

In their book Cairney and St Denny identify three forms of preventative strategy:

- Primary prevention. Focus on the whole population to stop a problem occurring by investing early and/ or modifying the social or physical environment. Common examples are whole-population immunizations.
- 2. Secondary prevention. Focus on at-risk groups to identify a problem at a very early stage to minimize harm. Targeted breast cancer screenings are a classic example in health, while social policy can be based on behavioural indicators of risk.
- 3. Tertiary prevention. Focus on affected groups to stop a problem getting worse. Examples in health are interventions to manage chronic conditions, such as diabetes or dementia. In social policy, crisis intervention may be designed to prevent family homelessness.

Investments in to Mental Health and in to Suicide Prevention Programs can typically be grouped in to three main categories:

- Universal / Community Wide, whole of population and very upstream preventative programs
- 2. Selective programs aimed toward At-risk Groups and tailored to meet the needs of such specific groups
- Indicated programs for At-risk Individuals ie highly intensive, acute programs provided to a relatively smaller number of individuals who are diagnosed as needing intensive care and assistance.

To repeat, once again, the NMHC's *Contributing Lives Report* of 2014, recommended that as a nation we:

- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention
- repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care.

Eleven years later there has been very minimal progress in regards to those two NMHC recommendations.

If we return now to Cairney and St Denny and their book on *Why Isn't Government Policy More Preventive?*, they write further, as follows:

- Indeed, health provides the classic case of high but unfulfilled commitment based on:
  - vague ambitions
  - uncertainty about how to describe and address the determinants of health inequalities
  - the dispiriting appearance of overwhelming policy problems that seem impossible to solve simply by reconfiguring health and related services
  - the lack of technically or politically feasible solutions
  - the tendency for acute services to command more attention and money to solve the shortterm and salient issues that people tend to relate to a government's competence.

I have seen no suggestion from anyone that the Australian government's finances are in any position to countenance any new investments in to the Mental Health or Suicide Prevention system. Rather, there is widespread commentary to the effect that the Australian federal budget is in structural deficit, and recent smallish surpluses were the result of nothing other than somewhat unexpectedly high mining royalties.

So, the macro financial situation is that of fiscal constraint, and the Grattan Institute puts things thus:

Budget expectation management is a perennial rite of autumn. But with the fiscal situation even more dire than usual, it's probably serious this time. Grattan Institute analysis has shown that the federal budget has a deep structural deficit that may grow to \$70 billion over the next decade. It will likely persist for decades after that unless spending is cut and taxes are raised. Many state budgets are also deep in the red.

News about some victims of impending cuts is starting to leak out. Last week, community health providers in Victoria were told there would be a cut to prevention programs that aim to reduce obesity and vaping. Premier Andrews has said that the funding was duplicated, and the cuts had been announced before. But spending on prevention in Australia should be going up, not down. https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/

As a nation we need to be spending more, much more, on prevention. We spend much less on prevention that comparable countries. We live in a fiscally constrained time – period, and it is highly unlikely that any significant new funding for Mental Health or Suicide Prevention will be forthcoming. And as Cairney and St Denny have stated, there is a "tendency for acute services

to command more attention and money to solve the short-term and salient issues that people tend to relate to a government's competence." Cairney and St Denny are writing in a United Kingdom context. But there is no escaping the fact that in 2014 the National Mental Health Commission called for a rebalancing of expenditure in Mental Health ie a deliberate, sustained and protracted reduction in funding to downstream acute services and a commensurate long-term increase in funding to upstream, preventative programs. Australian Governments between 2014 and 2025 have not acted on that recommendation. And there can be no assumption of any kind that Australian Governments will, of their own volition, be predisposed to increasing funding for preventative programs going forward beyond 2025.

In the context of First Nations Suicide Prevention,
Canadian Professor Michael J Chandler posed this
question back in 2015: 'Still More Counsellors?' The
point that Chandler was making was that the demand
for counsellors, psychologists, psychiatrists and
clinicians of all manner is a totally bottomless pit. It is
literally insatiable and endless. And it will continue to be
insatiable and endless until Governments choose to stop
buying in to the logic that investments in to Mental Health
and Suicide Prevention must be investments in to either:

- Acute clinical care and treatment delivered by the mainstream health system; or
- 2. Community based health services, including counselling, and a variety of therapies provided through community health providers.

Unless, and until, we as a nation listen to the NMHC's recommendations from 2014 to rebalance expenditures and redirect expenditures, it is very unlikely that the benefits to be derived from the better coordination of Governments will deliver the actual community health outcomes that we are all seeking.

#### Recommendation

That the Productivity Commission significantly revise its Theory of Change Such That a Revised Theory of Change is heavily informed by the National Mental Health Commission's Contributing Lives Report and That Any Revised Theory of Change Materially and Comprehensively Addresses Key Impediments to Systemic and Structural Change in the Mental Health and Suicide Prevention System.

In Particular, A New Theory of Change Should, Consistent With the Productivity Commission's Own Current Inquiry in to the Care Economy, Seriously Address the Key Issue of Government's Profound Reluctance to Invest in Upstream, Preventative Programs.

#### **B.3** True Co-design Requires Transformative Change From Governments

Experience and Evidence Strongly Suggest That True Co-design Requires Transformative Change From Governments That Are Wedded to 'Business As Usual' Modalities. No Co-design process should be even commenced without firstly receiving a clear and detailed statement from Government, at the Ministerial level, setting out how the Government of the day views Co-design operating within the constraints of, and within the context of, a Westminster democracy.

In the previous section of this submission it was held that there was a substantial and significant risk of structural stasis, and the potential for a failure to truly develop a new Mental Health and Suicide Prevention system, if the pathway forward relied essentially on rewriting the systemic architecture but failed to address the absolutely fundamental issue of restructuring expenditures so as to favour preventative programs. It was held that these points have been made since at least 2014 and yet are not evident within the *Interim Report*.

Similarly, in this section it is noted that the *Interim Report* postulates and recommends that the Mental Health and Suicide Prevention architecture change can be affected and can be enacted through a Co-design process which centres the voices of the services - users ie those with lived experience of mental illness. But this author holds that the process of Co-design, as it is described within the Interim Report, fails to sufficiently recognise and address the critical fact that Governments are consistently loathe to, and highly reticent to, engage in meaningful Co-design processes. This deep and abiding reluctance is because true Co-design requires transformational changes and complete paradigm shifts in the way that Governments in a Westminster Democracy undertake business. And Governments are highly reluctant to engage in such transformational change or paradigm shifts.

The Productivity Commission's *Mental Health and Suicide Prevention Agreement Review Interim Report* of June 2025 states as follows:

#### Co-design, including people with lived experience

Through co-design, governments, consumers, carers and service providers will be able to articulate the long-term objectives of the system, the outcomes it seeks to achieve and the priority action areas for the next agreement.

But successful co-design needs adequate time and resourcing to enable people with lived and living experience to take part. Under the current Agreement, policy design and service commissioning often do not allow sufficient time for genuine co-design, and this can have detrimental consequences.

Very short time frames make important aspects of service development such as co-design and evaluation unviable, particularly in terms of meaningfully embedding the views of people with lived experience as per the Agreement's commitments, which risks reducing these commitments to tokenism.

The rushed approach to co-design diminishes these activities to merely consultative exercises and makes the needed time to develop trust and effective engagement with key populations, such as culturally and linguistically diverse communities or people in rural and remote areas largely impossible. When there is also no requirement for co-design results to be utilised by the service, this risks undermining community confidence further. (Roses in the Ocean, sub. 19, p. 4)

The co-design process underpinning the next agreement should avoid the pitfalls of the current approach.

Peak bodies should be sufficiently resourced to take an active role in co-design, which should have a balanced representation of people with lived and living experience of mental ill health and suicide, alongside supporters, families, carers and kin.

Successful co-design also requires government agencies to be genuinely willing to share decision-making power. This is likely to require a substantial shift in organisational cultures within government. [Page 14]

The most important aspect of this commentary from the Productivity Commission is the last two sentences, which bear repeating now:

Successful co-design also requires government agencies to be genuinely willing to share decisionmaking power. This is likely to require a substantial shift in organisational cultures within government.

Indeed, yes, undertaking such a process is not just likely to require a substantial shift in organisational cultures within government but in fact has no hope whatsoever of success, and is a process best not even commenced, in the absence of an up – front commitment from Government, at Ministerial level, to undertaking paradigm

shifts and transformational changes in organisational cultures within government.

Whilst I have limited direct experience of Co-design practices in the mainstream Mental Health and Suicide Prevention space, I have very considerable experience of Co-design in the Aboriginal Wellbeing space and in the Aboriginal Justice space. I had management - oversight of the development of the following two Co-design documents:

- Kimberley Co-Design Guide For The Kimberley Aboriginal Youth Wellbeing Partnership; October 2022. https://www.pc.gov.au/\_\_data/assets/pdf\_ file/0005/353318/sub023-closing-the-gap-reviewattachment1.pdf
- 'Nothing About Us Without Us': Co-Designing Youth Justice In The Kimberley https://www.thecentrehki. com.au/wp-content/uploads/2021/05/2020.12.09-KALACC-Co-Designing-Youth-Outcomes-in-the-Kimberley-FINAL-2.pdf

I also have some fairly detailed understandings of the overall WA State Government approach to Co-design, as set out in the following: **State Commissioning Strategy for Community Services** — <a href="https://www.wa.gov.au/organisation/department-of-treasury-and-finance/state-commissioning-strategy-community-services">https://www.wa.gov.au/organisation/department-of-treasury-and-finance/state-commissioning-strategy-community-services</a>

In Western Australia the previous Department for Aboriginal Affairs was disbanded over a decade ago, as part of a larger 'machinery of Government' change, a process that resulted in far fewer Departments than had been the case ie a process of Departmental amalgamations. At present, and in recent years, the majority of strategic Aboriginal matters have sat within the province of the Aboriginal Policy Unit with the Department of Premier and Cabinet. When I enquired three years ago about the lack of progress on Co-design, the response from the WA Government Department of Premier and Cabinet was as follows:

- Co-design processes were inconsistent with, and incompatible with, the Government business processes and Governance structures within a Westminster democracy;
- The specific request for equitable resourcing to enable the non – Government participants to come to the table as equals with Government was rejected out of hand.

Staying in the Aboriginal space, I note the following comments from the Productivity Commission itself, in its January 2024 *Review of the National Agreement on Closing the Gap Study report*:

The Commission's overarching finding is that there has been no systematic approach to determining what strategies need to be implemented to disrupt business-as-usual of governments. What is needed is a paradigm shift. Fundamental change is required, with actions based on a clear logic about how they will achieve that change.

It is too easy to find examples of government decisions that contradict commitments in the Agreement, that do not reflect Aboriginal and Torres Strait Islander people's priorities and perspectives and that exacerbate, rather than remedy, disadvantage and discrimination. [page 3] https://www.pc.gov.au/inquiries/completed/closing-the-gap-review#report

Characterisations such as the one offered above by the Productivity Commission of the *National Agreement on Closing the Gap* need to be understood in a context in which that particular National Agreement is couched entirely in the language of 'Partnership', as expressed a multitude of times in the Agreement documentation, including this one particular articulation of the importance of 'Partnership':

For the first time, the National Agreement has been developed in genuine partnership between Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations (the Coalition of Peaks).

The *National Partnership Agreement* contains some four Priority Reforms, the first of which is as follows:

Strengthen and establish formal partnerships and shared decision-making

https://www.closingthegap.gov.au/national-agreement

Four years after the signing of the *National Partnership Agreement*, the Productivity Commission concluded that:

there has been no systematic approach to determining what strategies need to be implemented to disrupt business-as-usual of governments. What is needed is a paradigm shift.

If we then fast forward from 2024 through to June 2025, it is worth noting that the Lowitja Institute has recently concluded that the situation has not improved between 2024 and 2025. In June 2025 the Lowitja Institute published a paper with the following title: *Co-design Versus Faux-design of Aboriginal and Torres Strait Islander Health Policy: A Critical Review*. This document states as follows, on page one:

while co-design terminology is increasing in Australian health policymaking, many cases apply only tokenistic or superficial co-design practices; an approach that we term 'faux-design'.

https://www.lowitja.org.au/wp-content/uploads/2025/06/Lowitija-Institute-Co-design-Review.pdf

The National Partnership Agreement on Closing the Gap contains some 17 Targets, across Health, Housing, Justice, Early Years, Education and Employment. But Closing the Gap has, since its inception and from the outset in 2007, been first and foremost about First Nations Health. So, if the Lowitja Institute concludes in June 2025 that Australian Governments' approaches to Co-design in the Health domain are tokenistic and superficial, you can be assured that approaches to Co-design in other sectors and other domains are at best facile and at worst are disingenuous. One can point to the existence of various 'Policy Partnerships.' But one questions the value of the Aboriginal Justice Policy Partnership when at least three State Governments are engaged in a 'race to the bottom' on youth justice ie seemingly engaged in a race to see which of them can come up with the most punitive approach to Aboriginal juvenile offenders. It is self - evidently true that Aboriginal people have not been invited to sit at the table and Co-design the justice system with Government. And the same is true of housing, education, employment and Culture. [There may be some green shoots in terms of Co-designing the Early Years.]

In its *Interim Report*, the Productivity Commission raises this following concern:

Successful co-design also requires government agencies to be genuinely willing to share decision-making power. This is likely to require a substantial shift in organisational cultures within government.

But the *Interim Report* doesn't interrogate that significant concern and doesn't explore the validity of its own logic. Surely the concern raised by the Productivity Commission necessarily begs the following question: What is the appetite of Government, and the willingness of Government, to undertake substantial shifts in organisational cultures within Government? All of the available evidence demonstrates that Co-design requires a complete paradigm shift. And the evidence equally demonstrates that Governments uniformly and consistently refuse to participate in such a paradigm shift. With all due respect, it would seem to be foolhardy to recommend systemic change through Co-design when there is such a mountain of evidence suggesting that Governments operating within a governance

structure of Westminster Ministerial responsibility view 'community engagement' to equate with Consultation, not Co-design.

The *Interim Report* from the Productivity Commission contains the following draft recommendation, relating to Co-design:

- Draft recommendation 4.1
   Developing a renewed National Mental Health Strategy
  - A National Mental Health Strategy is needed to articulate a clear vision, objectives and collective priorities for long-term reform in the mental health system over the next 20-30 years. The National Mental Health Commission should oversee the development of this Strategy and undertake a co-design process with people with lived and living experience, their supporters, families, carers and kin. [page 20]

The present author was told by the WA Department of Premier and Cabinet that Co-design was not being progressed because it was contrary to the principles and practices of a Westminster democratic system of government. It is certainly this present author's lived experience across more than a decade and across the Justice, Health and Community Services Portfolios, that State Governments engage in Faux Co-design processes. And it is certainly this present author's experience, over the last two decades, that well -intentioned Commonwealth commitments to Regional Partnerships or to Organisational Partnerships evaporate once they progress from the theoretical level to the draft operational level. These personal experience are consistent with recent findings from the Productivity Commission itself.

All that is offered above in this section of this present submission strongly indicates that the Productivity Commission's Draft Recommendation 4.1, as it is currently worded, and as it currently stands, is problematic. There are myriad instances of supposed Co-design processes in which community participants have engaged in such processes in good faith, only to realise one, two or three years in to the process that they had in fact merely be involved in some form of Consultation, but certainly not a Co-design.

The present author is of the view that the *Final Report* from the Productivity Commission should avoid advocating for a Co-design Process, unless it includes in the final recommendation, very clear and comprehensive Findings and Recommendations around the inherent

political and structural impediments to Co-design. In doing so, the Productivity Commission could readily draw on work which the Commission itself has undertaken on the *Closing the Gap Review* [2024] and the recent Lowitja Institute Report on Faux – design.

I once again note the Productivity Commission's publication - *Growth mindset: how to boost*Australia's productivity 5 productivity inquiries

https://www.pc.gov.au/inquiries/current/five-productivity-inquiries/growth-mindset.pdf And within that document I once again note Figure 7, (See page 22 of this document):

Sadly, the reality is that undertaking a Co Design process to develop an entirely new Mental Health and Suicide Prevention National Partnership Agreement could in no way be described as being a "quick win." The present author believes that the Productivity Commission is on the right path when it advocates for such a Co Design process. But it needs to be understood that in doing so, the process that the Productivity Commission is advocating resides not in the "quick win" quadrant, but rather in either the "High Priority" or "Build the Case" quadrants, and quite likely the latter. In both instances the possible and likely impacts are enormous. However, in regards to the 'ease or implementation' dimension, genuine Co Design would absolutely be very difficult. The Productivity Commission just needs to ask the Productivity Commission about that ie I refer once again to the Closing the Gap Review <a href="https://www.pc.gov.au/inquiries/completed/closing-the-gap-review#report">https://www.pc.gov.au/inquiries/completed/closing-the-gap-review#report</a>

#### **Recommendation:**

No Co-design process should be even commenced without the following first occurring:

- A clear and detailed statement from Government, at the Ministerial level, setting out how the Government of the day views Co-design operating within the constraints and within the context of a Westminster democracy; and
- A clear Co-design resourcing and empowerment strategy, with a specific focus on how the non – Government sector and the non – Government participants in the proposed Co-design process would be resourced and empowered to enable them to participate in the Co-design process as full equals to the Government participants.

#### **B.4** Strengthening the Alignment With the Productivity Commission

Strengthening the Alignment With the Productivity Commission's *5 Pillars* Inquiries, Especially the Inquiry into the Care Economy

In Part B of this present document, information is provided on a couple of the broader, more general topics of current interest to the Productivity Commission ie:

- How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?; and
- Ensuring that the voices of First Nations people are heard and acted upon.

For now, here, in considering the relationship between the Commission's Mental Health Inquiry and the Commission's Care Economy Inquiry, I once again reference the NMHC's *Contributing Lives Report* of 2014. Once again I draw the reader's particular attention to the following two NMHC recommendations:

 rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support,

- stable housing and participation in employment, education and training
- repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care.

As noted earlier, it is troubling that the *Interim Report* does not materially address these two recommendations from the National Mental Health Commission from 2014. On Page 7 of the Productivity Commission's document *Pillar 4, Delivering quality care more efficiently, Consultation questions, May 2025* <a href="https://engage.pc.gov.au/projects/quality-care/page/pillar-4-responses">https://engage.pc.gov.au/projects/quality-care/page/pillar-4-responses</a> one can read as follows:

A national framework to support government investment in prevention

Evidence-based prevention programs can drive productivity in the care sector and the wider economy by providing services that aim to reduce a person's future demand for care services.

When they're working well, prevention programs reduce risk factors before problems arise (primary prevention), help detect issues early (secondary prevention) or slow the progression of disease or other issues during initial stages (tertiary prevention).

Despite their benefits, governments are often reluctant to invest in prevention programs. Funding decisions tend to prioritise immediate needs and align with the responsibilities of specific departmental portfolios. Prevention requires governments to spend upfront while benefits can take time to be realised, are hard to measure and can span different parts or tiers of government. For example, investment in support services for people at risk or experiencing homelessness can lead to long-term savings through improved health outcomes and reduced future demand for other services.

A framework that measures and incorporates the long-term benefits of prevention could encourage greater investment in evidence-based prevention programs. Such an approach could improve outcomes for people through timely and effective support and enhance the sustainability of the care economy.

#### Our approach

We will consider the features of a framework that would allow for investment in prevention based on a broad and long-term assessment of potential benefits.

We are particularly interested in:

- barriers to government investment or scaling up of effective prevention programs
- the extent to which inadequate funding and the short-term or limited assessment of benefits has restricted effective prevention
- the extent to which the benefits of prevention accrue across different sectors and/or tiers of government
- policy actions that could support greater investment in prevention activities.

The Care Economy Interim Report from the Productivity Commission will be published by the PC on Wednesday

13 August 2025 https://www.pc.gov.au/inquiries/current/five-productivity-inquiries.

In other words, that *Care Economy Interim Report* will be published by the Productivity Commission shortly after the closing date for public submissions on the Interim Report on Mental Health and Suicide Prevention.

Thus, one would hope and one would expect that the development of the *Final Report on Mental Health and Suicide Prevention* would be greatly informed by the findings and recommendations within the *Care Economy Interim Report*.

For now, I once again refer to the *Contributing Lives Report* of 2014 and I once again reference the fact that the National Mental Health Commission's recommendations from 2014 that the system needed to be rebalanced in favour of prevention and early intervention services has still not been enacted.

And in regards to First Nations Wellbeing and Suicide Prevention I once again reference the words of Professor Michael J Chandler – 'Still More Counsellors?'. I note that Chandler was first and foremost a statistician, an actuary of suicide and self-harm statistics. And this is what the actuary concluded, based on his 30 years of studying the phenomenon of First Nations suicide:

"if suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counsellors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives."

#### Professor Michael J Chandler

Cultural Wounds Require Cultural Medicines.

Chandler spoke at length on this topic in a speaking tour in Canberra in August 2012. Thirteen years later the Australian Government has not taken any action in this regard.

The Productivity Commission's *Mental Health and Suicide Prevention Agreement Review Interim Report* of June 2025 notes that the rate of First Nations suicide in Australia continues to worsen. This fact comes as a surprise to no one who has worked in the First Nations cultural space. For as long as suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

Professor Michael J Chandler, in consideration of the issue of efficacy and productivity in First Nations Suicide Prevention programs, put things thus:

"whenever we are moved to minister to such troubles, the usual impulse — the common intervention or treatment strategy — is to somehow buck-up the flagging spirits of those singular symptom bearers who are counted as most disheartened or undone. Picking away at such troubles one 'patient' at a time, we council and drug them, we bolster their flagging self-esteem, and otherwise do whatever seems appropriate to shore up their supposed personal shortcomings. In short, while many of our ills are acknowledged to sometimes be social or cultural in origin, when moved to intervene, Western society has customarily proceeded by attempting to redeem one lost soul at a time. A prime example of this individualistic approach to 'treatment' is to be found in standard responses to the so-called "epidemic" of suicides ascribed to the residents of many Indigenous communities. Those individuals somehow deemed to be at special risk are taken aside and variously bucked-up, all in the hope of somehow making each one of them personally better adjusted and less forlorn. This chapter will work to make the case that such applications of so-called individualized "medical models" of suicide prevention are mistaken at every turn, insisting instead that cultural wounds require cultural medicines." https://www.thecentrehki.com.au/resource/culturalwounds-require-cultural-medicine/

#### **Professor Michael J Chandler**

Cultural Wounds Require Cultural Medicines.

Once again, what Chandler is saying to us, based on his thirty-year body of work as an actuary and examiner of First Nations suicide statistics, is that individualized "medical models" of suicide prevention are mistaken at every turn, and that what is required instead are cultural medicines delivered at the collective community level. Once again, if the unit of intervention is the individual person and if the modality of intervention is medical in nature [whether that be delivered in an acute clinical setting or whether that be delivered in a more community

based setting], then Chandler, in that same paper, says we would then be "fishing in the wrong pond."

Elsewhere, we can find very similar sentiments expressed by Mohawk Professor Taiaiake Alfred - <a href="https://taiaiake.net/">https://taiaiake.net/</a> Professor Alfred explains and illustrates present day First Nations psychological trauma, and the basis of the high rates of suicide in Canada, through the use of a metaphor, of a rock that has been worn down by the processes of colonisation. That rock, which is now a small pebble, used to be a giant boulder. His grandfather stood on a solid boulder of Mohawk ceremony and Culture, whereas he and his tribe today lack that solid foundation.

As the National Mental Health Commission recommended in 2014, we desperately need to rebalance the system so that it prioritises prevention and early intervention, both in the mainstream community and in the First Nations community. And in the First Nations context, a system that prioritises prevention and early intervention cannot be delivered through a Health paradigm, whether that be through mainstream health or through community health. Mohawk Professor Taiaiake Alfred puts it thus:

"Because we've shown, in a number of studies that we've looked at, in the Canadian context, and particularly – I'll use the example of the Cree people, in Northern Quebec, where the young people in that community, in that nation, that had survived and could withstand the ongoing effects of colonisation the best were those that benefited from programs that were set up by the Cree nation to relink them to their traditional cultural practice, to support the maintenance of their language fluency, and, even though it was seasonal and it wasn't a permanent state, to surround them and have them experience life in a traditional cultural community."

#### Professor Taiaiake Alfred - Mohawk

Transcript of a speech delivered at the Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, in 2015. Transcript available upon request.

#### **Recommendation:**

That the Final Report on Mental Health and Suicide Prevention be greatly informed by the findings and recommendations within the Productivity Commission's Care Economy Interim Report in regards to investing in Preventative Programs.

# Part C: Foreshadowing Later Submissions to the Care Inquiry

A key theme of this submission to the Productivity Commission is that Australia currently does a poor job of the following:

- Prevention: investing in strengths based and preventative approaches to well - being;
- Empowering People: empowering communities at risk, and empowering those with lived experiences, and their families and friends, to be the focus of solutions to the problems that they face.

At present we pathologise social problems and create hugely unsuccessful and hugely expensive care systems that fail to deliver outcomes because those that are empowered at present primarily are not those personally experiencing the problems, and we invest the great majority of our resources in to downstream clinical and pathological responses to social problems.

## Re-centering Systems Towards Prevention and Upstream Solutions.

How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?;

The Grattan Institute tells us that, as a nation, we do a very poor job of investing in preventative strategies and programs:

Australia lags far behind other countries in prevention spending, and far behind commitments that our own governments have made. We spend less than 2 per cent of our healthcare budget on prevention, well short of the average among OECD countries. Our spending is half the level of the UK's and a third the level of Canada's.

Australia's National Prevention Strategy, agreed by the federal government and all the states, aspires to raise our spending to 5 per cent of the health budget by 2030. We're not even close, and the Victorian budget news is one sign that we might be about to go backwards.

Experience here and around the world shows that when budgets are cut, prevention is often the first on the chopping block. Prevention is less painful to slash than other kinds of healthcare, because the payoff from prevention spending is in the future, when current Treasurers and Ministers will be long gone.

https://grattan.edu.au/news/cuts-to-preventive-health-are-a-false-economy/

Indeed, if we hop outside of the health sector and look at other sectors, such as justice, then we do an abysmal job of investing in preventative programs in that space. Sure, one can identify a large number of programs called 'diversionary'. But when one examines the definitions in place there, then it turns out that 'diversionary' is a very narrow, legalistic term that has very little at all to do with any concept of upstream prevention.

Many would argue that States such as Western Australia, Queensland and the Northern Territory are currently engaged in a 'race to the bottom' when it comes to youth justice — <a href="https://www.abc.net.au/news/2025-07-11/youth-justice-advocates-warn-nt-winning-race-to-bottom/105517194">https://www.abc.net.au/news/2025-07-11/youth-justice-advocates-warn-nt-winning-race-to-bottom/105517194</a> The inevitable result of such races to the bottom are rising rates of incarceration, ever expanding justice budgets and, from a productivity perspective, much lower rates of productivity.

The Productivity Commission's current *Delivering Quality Care More Efficiently Inquiry* presents this following issue and problem to us:

Despite their benefits, governments are often reluctant to invest in prevention programs. Funding decisions tend to prioritise immediate needs and align with the responsibilities of specific departmental portfolios. Prevention requires governments to spend upfront while benefits can take time to be realised, are hard to measure and can span different parts or tiers of government. https://www.pc.gov.au/inquiries/current/quality-care#interim

At the conceptual level, a big thank you to Cairney and Denny for their deeply insightful 50-page book on this topic ie *Why Isn't Government Policy More Preventive?*. https://paulcairney.wordpress.com/wp-content/uploads/2023/02/cairney-st.denny-2020-why-isnt-government-policy-more-preventive-intro-and-conclusion.pdf

Prior to reading Cairney and Denny's book I had a somewhat simplistic view, relating to political motivations. Certainly, it is exceedingly easy to point to political slogans which win elections on the basis of NOT investing in preventative programs ie eg between August and October 2024, Queensland's *Courier Mail Newspaper* [a Newscorp publication] published 173 articles about youth

crime in just 90 days. These articles amplified the mantra Adult Crime, Adult Time, and it was an election – winning mantra for Queensland's LNP. But beyond those obvious political motivations, Cairney and Denny do analyse a range of complex factors which serve to individually and collectively work against investing in preventative measures.

The Productivity Commission will on Wednesday 13
August 2025 publish its *Interim Report on the Delivering quality care more efficiently* https://www.pc.gov.au/inquiries/current/quality-care#interim Members of the public will then be invited to provide feedback on that *Interim Report* and will asked to lodge their submissions by September 2025. Within that context and within that timeframe I will have more to say, in detail, on the following topics:

- barriers to government investment or scaling up of effective prevention programs
- the extent to which inadequate funding and the short-term or limited assessment of benefits has restricted effective prevention
- the extent to which the benefits of prevention accrue across different sectors and/or tiers of government
- policy actions that could support greater investment in prevention activities.

https://www.pc.gov.au/inquiries/current/quality-care#interim

So, it is exceedingly easy to identify instances, such as the above example of youth justice, where State Governments deliberately decide to not invest in preventative strategies and, for reasons of political capital and political advantage, see considerable benefit in investing greater and greater resources in to upstream, punitive responses based around incarceration. And in the Health system what State Government in its right mind would argue against the need for more [and yet further more] hospital beds?

Nonetheless, Cairney and St Denny's book is enlightening and they point to the following multifactorial reasons for underinvestment in to prevention:

- The scale of the task becomes overwhelming;
- There is competition for policymaking resources such as attention and money;
- The benefits are difficult to measure and see;
- Problems are 'wicked'. Getting to the 'root causes' of problems is not straightforward;

- Performance management is not conducive to prevention;
- Governments face major ethical dilemmas;
- One aspect of prevention may undermine the other;
- Someone must be held to account.
   https://paulcairney.wordpress.com/wp-content/uploads/2023/02/cairney-st.denny-2020-why-isnt-government-policy-more-preventive-intro-and-conclusion.pdf

Time and space do not permit of an exploration of each of those elements in this present context. However, in the August – September context and timeframe I will take the opportunity of exploring those various obstacles and impediments to greater investment in preventative programs in Australia, with specific examination of how those elements relate to the following fields:

- Mental Health and Suicide Prevention
- Aboriginal Social and Emotional Wellbeing, And Its Relationship To Strong Culture.

Whilst that extended examination and discussion will have to wait until that later juncture, I did want today to offer some initial thoughts with reference to First Nations policy in Australia.

And the best answers to the questions around Government under – investment in the preventative space come from the Productivity Commission itself, as expressed in its January 2024 report *Review of the National Agreement on Closing the Gap Study report*. This Productivity Commission Report contains the following **Recommendations**: [Pages 7-9]

- 1. Power needs to be shared
- Indigenous Data Sovereignty needs to be recognised and Supported
- Mainstream systems and culture need to be fundamentally Rethought
- Stronger accountability is needed to drive behaviour change

The point here of course is that without genuine power sharing, there will be little or no incentive to change from the status quo, and the status quo is heavily biased in favour of downstream, clinical, resource – intensive modalities. This remains the case no matter if Governments choose to pour more and more and endlessly more resources in to existing modalities,

irrespective of the paucity of actual outcomes. Once again I reference Professor Chandler's query: 'Still more counsellors?' Endlessly, still more counsellors, psychologists, psychiatrists, and clinicians of all manner and all sorts.

Focusing on the Productivity Commission's interest in Preventative Programs, one can read the following words on page 33 of the WA Government's *Aboriginal Empowerment Strategy Policy Guide* of 2021:

Currently, State Government expenditure in relation to Aboriginal people is skewed towards the crisis category. These services are more costintensive, depend more on involuntary or coercive engagement, and involve higher risks. If current trends continue, demand for these "downstream" services is set to increase significantly in coming years.

Preventative and early intervention initiatives can bring about positive changes that reduce the need for crisis responses. Initiatives in this category proactively build up resilience, capability, healing, and independence – in short, self-determination. https://www.wa.gov.au/organisation/department-of-the-premier-and-cabinet/aboriginal-empowerment-strategy-western-australia-2021-2029

Notwithstanding this lovely set of words, between 2021 and mid 2024 I had a front row seat and was exceptionally well placed to see what, if any, progress was being made in shifting towards 'Putting Culture at the Heart', as per pages 24 – 26 of the *Aboriginal Empowerment Strategy Policy Guide*. In that time I was unable to identify any significant or meaningful progress from the WA Government, or from the Commonwealth. I no longer have that front row seat, but I have not been furnished with any evidence or any reason to think or even suspect that things might have changed and improved since mid-2024.

Indeed, in the public realm, one can readily find this following very recent information:

## Culture at the Heart Forum: strengthening Aboriginal leadership in government

The Western Australian Government proudly supports the Culture at the Heart Forum, an initiative led by the Aboriginal Advisory Council of WA to foster collaboration among Aboriginal Advisory Groups across State Government agencies.

Starting today, the two-day event focuses on Priority Reform 3: Transforming Government. Through dynamic workshops and targeted discussions, participants will explore new ways to enhance government accountability and responsiveness in Aboriginal affairs.

By positioning culture at the heart and working in partnership with Aboriginal people and communities, the forum aims to reshape how government engages with Aboriginal leadership, fostering a more effective, culturally informed approach to policymaking and service delivery.

https://www.wa.gov.au/government/media-statements/Cook%20Labor%20Government/Culture-at-the-Heart-Forum:-strengthening-Aboriginal-leadership-ingovernment--20250626

To be clear, the present author is not suggesting for a moment that the work which took place in that recent two day workshop was unimportant or that it was not important for Aboriginal people to have a direct say in regards to such matters. But what were the matters discussed? The Minister's Media Statement makes clear that the purpose of the two-day workshop was Closing the Gap National Partnership Agreement Priority Reform 3: Transforming Government. And where does Culture fit in to this? The Minister's Media Statement advises as follows:

the forum aims to reshape how government engages with Aboriginal leadership, fostering a more effective, culturally informed approach to policymaking and service delivery.

One can very readily, all-too-readily, identify references in Government policy statements to the terms 'Culturally – informed' or 'Culturally – Safe'. Once again, the present author is not suggesting that either of those concepts is in any way unimportant or not necessary. What is being suggested is that when we look at the concepts of 'Prevention' and 'Early Intervention' a whole other space opens up ie a domain called 'Culturally – Embedded' or, alternatively, 'Culturally – Based.'

To understand this 'Culturally – based' domain, especially as it relates to First Nations Wellbeing, once again we turn to the works of Professor Michael Chandler:

"if suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counsellors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives."

#### **Professor Michael Chandler**

Cultural Wounds Require Cultural Medicines.

What Chandler is describing there are activities that are not best labelled as being 'culturally – informed' or 'culturally – safe.' Chandler is describing activities that are 'culturally – based' or 'culturally – embedded.'

Elsewhere, we can find very similar sentiments expressed by Mohawk Professor Taiaiake Alfred - https://taiaiake.net/ Professor Alfred explains and illustrates present day First Nations psychological trauma, and the basis of the high rates of suicide in Canada, through the use of a metaphor, of a rock that has been worn down by the processes of colonisation. That rock, which is now a small pebble, used to be a giant boulder. His grandfather stood on a solid boulder of Mohawk ceremony and Culture, whereas he and his tribe today lack that solid foundation.

As the National Mental Health Commission recommended in 2014, we desperately need to rebalance the system so that it prioritises prevention and early intervention, both in the mainstream community and in the First Nations community. And in the First Nations context, a system that prioritises prevention and early intervention cannot be delivered through a Health paradigm, whether that be through mainstream health or through community health. Mohawk Professor Taiaiake Alfred puts it thus:

Because we've shown, in a number of studies that we've looked at, in the Canadian context, and particularly – I'll use the example of the Cree people, in Northern Quebec, where the young people in that community, in that nation, that had survived and could withstand the ongoing effects of colonisation the best were those that benefited from programs that were set up by the Cree nation to relink them to their traditional cultural practice, to support the maintenance of their language fluency, and, even though it was seasonal and it wasn't a permanent state, to surround them and have them experience life in a traditional cultural community.

Transcript of a speech delivered at the Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, in 2015. Transcript available upon request.

In May 2016 the WA Department of Culture and the Arts published a 50 – page long discussion paper, DCA Reference 15/751, with the following title:

Investing in Aboriginal Culture: The role of culture in gaining more effective outcomes from WA State Government services

On page four of this WA DCA Discussion Paper one reads as follows:

This paper reviews the outcome of Government expenditure on Aboriginal culture and arts, and assesses how that investment can contribute to positive outcomes for Aboriginal people across employment, culture, education, mental health, and general health and wellbeing.

In terms of broad socio-economic outcomes, there is a substantial and growing body of academic and case evidence that Government programs or services targeted towards improving outcomes for Aboriginal people on a range of social and economic issues will be more effective if delivered within an environment where Aboriginal culture is recognised, valued and resilient.

This paper proposes that a consolidated and targeted approach to the investment in Aboriginal culture and arts will increase cultural attachment, increasing subjective wellbeing for individuals and communities, leading to improved socio-economic outcomes.

Nearly ten years later, and there is to this day no implementation of any of the key proposals described in this May 2016 WA DCA report.

Current patterns of Government expenditure are hugely unproductive and expensive. If the Productivity Commission truly wishes to explore the issue of Productivity in regards to the Care Economy, as it pertains to Indigenous Australians, then the Productivity Commission has to get serious about exploring the huge barriers to Governments investing in First Nations cultural programs [delivered by Cultural organisations, not Health organisations], which are the cornerstone of First Nations primary prevention and community resilience.

In the year 2021 the WA Department of Premier and Cabinet wrote as follows:

Currently, State Government expenditure in relation to Aboriginal people is skewed towards the crisis category. These services are more costintensive, depend more on involuntary or coercive engagement, and involve higher risks.

In July 2025 the WA Department of Premier and Cabinet held a two day workshop on Transforming Government, and they gave that two day workshop the title of 'Culture at the Heart.'

And in 2016 the WA Department of Culture and the Arts proposed:

A consolidated and targeted approach to the investment in Aboriginal culture and arts will increase cultural attachment, increasing subjective wellbeing for individuals and communities, leading to improved socio-economic outcomes.

None of the actions or recommendations in the 2016 paper have been acted upon. As such, it is little wonder that the current situation remains that "State Government expenditure in relation to Aboriginal people is skewed towards the crisis category. These services are more cost-intensive, depend more on involuntary or coercive engagement, and involve higher risks."

Australia has an exceedingly poor record when it comes to investing in Preventative programs. But when it comes to Preventative programs in regards to Aboriginal Social and Emotional Wellbeing the situation is truly dire. In November 2019 the WA Parliament Standing Committee on Health and Education published *Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas.* What the Parliamentary Committee found in that *Message Stick Report* is as follows:

- The various reports and inquiries the Committee considered during this Inquiry made a broad range of recommendations. Perhaps the most important, yet least enacted, were about the role of Aboriginal culture, both as a primary protective factor building resilience in young people, and also ensuring that programs and services are culturally appropriate. [Chairman's Foreword]
- Previous reports and inquiries have recommended that this can be achieved through various means, primary of which is culturally-based programs, such as on-country camps and activities. By necessity, these programs must be owned and led by local communities. Yet the lack of priority given to these programs by government indicates that their importance continues to be overlooked. [Executive Summary]
- Finding 8 Page 57 There is increasing evidence that culturally-based programs have the greatest impact in preventing suicide; however, the Western Australian Government has demonstrated reluctance in funding programs of this nature.
- Finding 9 Page 57 By their very nature, culturally-based programs must be tailored to suit the particular community that will be using the program.

- Recommendation 7 Page 57
   That Western Australian Government agencies recognise the importance of cultural knowledge as a protective factor preventing Aboriginal youth suicide.
- Recommendation 8 Page 57 That the Western Australian Government set aside an appropriate portion of grant expenditure to fund more culture-embedded programs for Aboriginal young people across the state.

Funding for Aboriginal Cultural organisations to deliver Aboriginal Cultural Programs with the aim of building cultural resilience and fostering wellbeing remains at an almost non – existent level to this day.

For as long as First Nations suicide is treated as an individual mental health issue, and not as a collective, community issue reflective of a Culture under stress, then there can be no realistic expectation of statistical improvements in the rates of First Nations suicide in Australia.

A juvenile justice system based on a successful, election – winning slogan of 'Adult Crime, Adult Time' is certain to lead to increased juvenile incarceration. That is the whole point of the words 'Adult Time.' Such a system will be hugely expensive and hugely unproductive and an ineffective and inefficient use of public resources and public monies. But as a nation Australia greatly underperforms comparable countries in regards to its investments in to preventative programs. At present there is little cause for any optimism that this situation will improve in the foreseeable future.

If the upcoming Productivity Summit, or the current Inquiry in to Mental Health, or the current 5 Pillars Inquiry, including the Inquiry in to Delivering quality care more efficiently can lead to systemic change and can lead to the nation seriously considering raising its level of investments in to Preventative programs, then that will be a wonderful thing.

But noting once again the words of Cairney and St Denny, there is a strong "tendency for acute services to command more attention and money to solve the short-term and salient issues that people tend to relate to a government's competence." It requires a complete transformation, a complete paradigm shift to think that funding cultural programs could be more productive, more preventative, more efficient and more efficient than employing 'still more counsellors." And as a nation we seem to be a very long way away from embracing such paradigm shifts at this present moment.

# Ensuring that the voices of First Nations people are heard and acted upon.

## Where are the voices to speak for 'Culturally-Based' and Culturally-Embedded' Programs (as distinct from 'Culturally-informed' or 'Culturally-safe' Health Programs?

This section in no way seeks to speak for any First Nations person. Rather, the simple proposition in this section is that if Government is serious about listening to the voice of First Nations peoples in regards to reducing Indigenous suicide rates in Australia, then it should listen to the voices of First Nations peoples who have consistently called for 'Culturally – embedded' and 'culturally – based solutions'. A short list of such reports is as follows:

#### **Timeline of reports from 2012 to 2023**

There have been a number of significant Australian reports released in recent years on the need for investment in cultural determinants of Indigenous health. See table below with details.

Dec 2012	Elders Report The Elders' Report into Preventing Indigenous Self-harm and Youth Suicide	People Culture Environment
Feb 2018	My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations December 2017	Dept of Health
Jun 2020	' Country Can't Hear English' - A Guide To Implementing Cultural Determinants	Professor Kerry Arabena
Feb 2021	Culture is Key: Towards cultural determinants-driven health policy	Lowitja Institute)
Dec 2021	The National Aboriginal and Torres Strait Islander Health Plan 2021-2031	Dept of Health)
Sep 2022	Connected Lives: Creative solutions to the mental health crisis	Creative Australia*
Mar 2023	Strong Culture, Strong Youth: Our Legacy, Our Future	Close the Gap Campaign Report 2023
Oct 2024	Links between Aboriginal and Torres Strait Islander language use and wellbeing	Mayi Kuwayu Study
2025	Strong Culture, Strong Place, Strong Families Research and Evaluation Project: Final Report	ANU Centre for Indigenous Policy Research

The reports in this table are simply a list of mainly Commonwealth Government-developed reports or, if not, then reports that speak to a national context. The list above doesn't include a myriad of State level reports. The WA Parliament's November 2019 *Message Stick Report in to Aboriginal Youth Suicide* starts by providing a list of some 40 earlier reports, the majority of which have as their top priority calls for supporting Cultural programs.

On that basis, one can be safe in asserting that there is something in the order of 50 or so reports published over the last two decades, each having as its first priority

a recommendation relating to supporting cultural programs. Not health programs. Cultural programs.

On 06 June 2025 I received an email from the Commonwealth Department of Health. I had written to the Department, pointing out that the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* states that there would be two Implementation Plans developed over that 10 year Plan period and pointing out that *Implementation Plan #1* was to have covered the period 2021 – 2025. I then pointed out that, since we were now well in to the year 2025, one would have anticipated that

Implementation Plan #1 [2021 – 2025] would have been developed long ago and that actual implementation of the Aboriginal Health Plan would have commenced years ago. (see below)

There are three problems with this advice from the Department of Health:

- Indigenous Voices Over the Last 15 Years: It
  is exceedingly far from clear how the Department is
  choosing to listen to the voices of First Nations people,
  as captured within and as expressed within the
  reports listed above, over the last 15 years;
- 2. Why, Five Years into the Aboriginal Health Plan, Is There Still No Implementation Plan #1: The email from the Department clearly states that the Department is engaged in what it describes as a Co Design process. As I have not studied that Co Design process, I won't comment on that per se. Beyond that I do note the reference to the COVID 19 period. Having read and understood those advices, it is still far from clear to me why exactly five years after the *Aboriginal Health Plan*

- was released there is still no Implementation Plan #1. The COVID lock down period was years ago.
- 3. Cultural Voices?: A list of names for the members of the First Nations Health Governance Group can be found here <a href="https://www.health.gov.au/committees-and-groups/first-nations-health-governance-group-fnhgg">https://www.health.gov.au/committees-and-groups/first-nations-health-governance-group-fnhgg</a> I have not the slightest doubt that the members of this group are very well suited and very able to speak for issues of First Nations Health, and quite likely, for matters relating to 'cultural safety' and 'culturally informed' health programs.

But, the 50 or so reports referenced above are not about 'cultural safety' and they are not about 'culturally – informed' programs. The 50 or so reports referenced above are about 'culturally – embedded' and 'culturally – based' programs. And it is far from clear to me how the First Nations Health Governance Group is constituted to speak for or about 'culturally – embedded' and 'culturally – based programs.'
Where are the voices to speak for 'culturally – based' programs, not health programs?

#### Dear Mr Morris,

Thank you for reaching out to the Health Plan and Systems Section of the First Nations Health Division. Our Section oversees implementation of the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 (the Health Plan) in partnership with the First Nations Health Governance Group (FNHGG).

The FNHGG is a genuine partnership between the Department of Health, Disability and Ageing and First Nations health experts and leaders, with the members of the FNHGG representing diverse Aboriginal and Torres Strait Islander leadership from across Australia – you can find the names of the members on the website. The FNHGG will co-design and share decision making by embedding expert and First Nations perspectives in the department's policy design, delivery, and advice to government, including the implementation of the Health Plan and its elements.

The FNHGG is considering implementation planning after significant delays due to COVID-19 and the Aboriginal and Torres Strait Islander Voice referendum. The FNHGG is also currently co-designing an Accountability Framework in line with the Health Plan and considering mid-point evaluation

We hope this helps and if you have any other questions, please do not hesitate to reach out.

Kind regards,

Health Plan and Systems Section
Policy, Partnerships and Performance Branch
First Nations Health Division | Strategy and First Nations Group
Australian Government Department of Health, Disability and Ageing
IndigenousPolicy@Health.gov.au