Submission to Productivity Commission:

Mental Health and Suicide Prevention Agreement Review

28 March 2025

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Acknowledgement of Country

We respectfully acknowledge the Traditional Custodians of the lands of the many Goori Nations, whose ancestral lands and waters we have the privilege to live and work across, here in South East Queensland.

We pay our deepest respects to their Elders, past and present, and recognise their continuing connection to culture, community, and Country.

We especially honour and value the experiences, strengths, and contributions of Aboriginal and Torres Strait Islander people with lived/living experiences of mental health and suicide. Their voices, stories, and perspectives are crucial in shaping the direction on this work.

Terminology

Throughout this submission, the terms Aboriginal and Torres Strait Islander, First Nations and Indigenous are used interchangeably with respect towards the diversity of cultures and identities across Queensland and Australia.

Aboriginal and Torres Strait Islander cultures are persistent and enduring, continuing unbroken from the past to the present, characterised by resilience and a strong sense of purpose and identity despite the undeniably negative impacts of colonisation and dispossession. Aboriginal and Torres Strait Islander people throughout the country represent a diverse range of people, communities and groups, each with unique identities, cultural practices and spiritualities. We recognise that past and present practices and policies significantly impact the current health status of Aboriginal and Torres Strait Islander people.

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Executive Summary

Thank you for the opportunity to contribute to the Mental Health and Suicide Prevention Agreement Review.

Mental health and substance use disorders are the leading contributors to the burden of disease among Aboriginal and Torres Strait Islander people, and rates of poor mental health, substance use, and suicide are at crisis levels—and data indicates worsening. We need urgent, systemic reform, to close the gap.

Our obligation at the Institute for Urban Indigenous Health (IUIH) is to our Community—to create the enabling environments that support healthy and strong Aboriginal and Torres Strait Islander children, families and communities. Unfortunately, under the current National Mental Health and Suicide Prevention Agreement (NMHSPA), and the associated Bilateral Agreement, we have not experienced the enabling environment to meet the mental health and wellbeing aspirations and priorities of our Community.

While the NMHSPA acknowledges the importance of community-led solutions, the IUIH Network has faced barriers in accessing sustainable and flexible funding, challenges in navigating fragmented commissioning arrangements, and gaps in meaningful engagement with Aboriginal Community Controlled Health Services (ACCHSs) in decision-making processes.

In this submission, we share our examples of evidence-based, culturally safe, community-led models that are effective in improving mental health and wellbeing for our Community. These approaches must be recognised, strengthened, and enabled through Government policy, agreements, and investment strategies.

In alignment with commitments under the National Agreement on Closing the Gap, this submission underscores the urgent need for a sustainably resourced, community-controlled, and culturally responsive approach to mental health and suicide prevention for Aboriginal and Torres Strait Islander peoples.

Opportunities

- **Recognise and include ACCHSs as integral and equal Partners** in governance, planning, and decision-making with the mental health system, in line with Closing the Gap Priority Reform One.
- **Recognise the capability of ACCHSs to deliver the full spectrum of community-based mental health care within a culturally safe model,** including promotion, prevention, early intervention and social and emotional wellbeing programs, psychosocial supports, suicide prevention, and clinical and specialist 'sub-acute' services.
- **Provide ACCHSs with access to sustainable (recurrent) funding mechanisms** along the continuum of care of mental health services, as an alternative to time-limited program funding, including Activity Based Funding for sub-acute mental health care and exploring funding mechanisms, such as bundled payments.
- **Increase investment of mental health funding directly to the ACCHS sector and to community-controlled commissioning organisations,** in line with Closing the Gap Priority Reform Two. Wherever capacity exists (or can be built), allocate funding directly to ACCHSs and regional commissioning bodies like IUIH, avoiding unnecessary intermediaries and placing decision making about services for Aboriginal and Torres Strait Islander people into the hands of Aboriginal and Torres Strait Islander people.
- **Strengthen Indigenous Data Sovereignty and Shared Data Systems,** by supporting regional partnerships, such as the South East Queensland First Nations Health Equity Partnership, to accelerate data-sharing practices that respect Indigenous Data Sovereignty principles, and drive collaborative, transparent system reform.
- **Strengthen transparency and accountability** of how the mental health system is working for Aboriginal and Torres Strait Islander people, by considering how mental health commissions—or other statutory organisations or positions (potentially, a First Nations Mental Health Commissioner) could strengthen the visibility of system performance and outcomes, uphold Indigenous Data Sovereignty, and ensure that First Nations' voices, priorities, and governance are embedded in national mental health policy, funding, and reform efforts.

About the IUIH Network

Established in 2009, the Institute for Urban Indigenous Health (IUIH) is a regional, not-for-profit Community-Controlled Health Organisation constituted by three Community-Controlled Health Organisations in South East Queensland (SEQ):

- Aboriginal and Torres Strait Islander Community Health Service Brisbane
- Kalwun Development Corporation
- Yulu-Burri-Ba Aboriginal Corporation for Community Health

Collectively, these organisations are known as the IUIH Network. Each Organisation of the IUIH Network retains its own governance, with IUIH acting as the regional 'backbone' for the Network. IUIH also operates the Moreton Aboriginal and Torres Strait Islander Health Service and the Pamela Mam Health Centre (Goodna Clinic).

This regional approach is a contemporary renewal of traditional ways of belonging, when for thousands of years, Aboriginal clans, tribes and communities across our region had come together to achieve shared and cross-territorial goals.

The IUIH Network service footprint is in Australia's largest and second fastest growing Indigenous region. Nearly 1 in 8 Aboriginal and Torres Strait Islander people nationally live in SEQ and in 2025 the region has an estimated Aboriginal and Torres Strait Islander population of 127,869 persons, projected to grow to 148,902 persons by 2031.[1]

Through regional planning, service development, advocacy, purchasing and commissioning, alongside a coordinated approach to service delivery known as the *IUIH System of Care*, IUIH works with and for its Network to achieve transformational change for our community. Over the last 15 years, this regional and coordinated approach has delivered unprecedented growth in service provision across the region (**Refer Attachment A**). Key achievements include:

- Growth in primary care clinics from 5 in 2009 to 17 in 2024 (plus five new clinics in the pipeline).
- Growth in active Indigenous client numbers from 8,000 in 2009 to over 39,000 in 2024.
- Growth in completed annual Health Checks from 550 in 2009 to 23,700 in 2024.

The IUIH System of Care ensures seamless service navigation for clients while remaining deeply rooted in Aboriginal Terms of Reference and guided by Aboriginal and Torres Strait Islander community governance and leadership. Together, the IUIH Network provides Aboriginal and Torres Strait Islander families in Southeast Queensland 'one-stop-shop' access to a comprehensive range of health and other social services across the lifespan and for the whole family, including primary health care, specialist and allied health services, family wellbeing services, child protection support, parenting programs, homelessness and housing support, youth support services, justice programs, and cultural support programs, including connection to Elders and cultural healing activities.

IUIH Network Mental and Social Health Services

Within the IUIH System of Care, the IUIH Network organisations provide a range of social health services These services are integrated within primary health care and delivered through community-based and outreach models, encompassing:

- **Staying Deadly Hubs**: Currently being established across the IUIH Network, these Hubs provide culturally safe, community-based mental health and alcohol and other drugs (AOD) services for Aboriginal and Torres Strait Islander people aged 15 years and over. The Hubs offer early intervention, sub-acute mental health support, and post-discharge care, designed to reduce reliance on acute mental health systems. Clients receive timely, holistic, and flexible care, including case management, therapeutic supports, and warm referrals to additional services where needed.

[1]Australian Bureau of Statistics. (2024). Estimates and Projections, Aboriginal and Torres Strait Islander Australians: Estimates and projections of the Aboriginal and Torres Strait Islander population for 2011-2031 (Table 21). Brisbane Indigenous Region (IREG), medium series estimates https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-and-projections-aboriginal-and-torres-strait-islander-australians/latest-release#remoteness-areas-and-indigenous-regions

- **Mental Health Services**: Psychiatry, psychology, counselling, mental health nursing, and psychosocial support.
- **Social and Emotional Wellbeing (SEWB) Services**: Case management, care coordination, crisis intervention, therapeutic programs, and cultural healing activities.
- **Alcohol and Other Drugs Services**: Counselling, harm reduction, and support for individuals and families affected by substance use.
- **Youth and Family Wellbeing**: Dedicated youth wellbeing programs, early intervention and diversion services, family-led decision-making, and parenting support.
- **Justice and Transition Support**: Outreach and reintegration support for individuals transitioning from correctional facilities, including partnerships with Queensland Health and justice agencies.
- **Community Navigation and Referral Pathways**: Centralised access points such as IUIH's Mob Link and Wrap Around Youth Service (WAYS), providing culturally safe triage, referrals, and care coordination across the IUIH Network and wider health system.

These services are delivered by multidisciplinary teams including Aboriginal and Torres Strait Islander Health Workers, psychologists, social workers, counsellors, AOD workers, and peer workers. All services are designed to address the holistic needs of individuals, families, and communities, with a strong emphasis on cultural connection, prevention, and early intervention.

The IUIH Network's coordinated regional approach enables seamless access to support across all life stages and levels of mental health need, from mild-moderate conditions to sub-acute support, through to aftercare for individuals experiencing suicidal crisis. These models are responsive to the unique needs of First Nations people in SEQ and demonstrate the capability of ACCHSs to deliver high-quality, culturally safe mental health care within a community-controlled setting.

Our SEQ Context

Understanding Mental Health and Substance Use Challenges for Aboriginal and Torres Strait Islander People in SEQ

Mental health and substance use disorders contribute significantly to the burden of disease among Aboriginal and Torres Strait Islander peoples in SEQ, accounting for 26.7% of the total burden[2]. The leading contributors include:

- Anxiety disorders (6.19%)
- Suicide and self-inflicted injuries (5.98%)
- Depressive disorders (5.54%)

These conditions represent the top three contributors to the overall burden of disease in the region.

In 2018, it was estimated that more than one in three years of healthy life lost among young First Nations people in SEQ was due to mental health and substance use disorders (36.4% of the total burden).[3]Notably, all of this burden was attributed to years lived with illness rather than premature mortality. This marks a 4% increase from 2011, when these conditions accounted for 32% of the burden of disease.[4]

Suicide and self-inflicted injuries remain the leading cause of disease burden among young First Nations peoples (0-24 years) in SEQ, with a burden rate 3.1 times higher than that of their non-Indigenous peers in Queensland. In contrast, for other young Queenslanders, asthma was the leading cause of disease burden.

A 2022 survey of Indigenous adults residing in SEQ - the Queensland Urban Indigenous Mental Health Survey (QUIMHS) - identified a wide gap in the prevalence of mental disorders, harmful substance use (HSU), and suicidal thoughts and behaviours:

[2] Queensland Health. (2018). Queensland Burden of Disease Study: Aboriginal and Torres Strait Islander Analysis for South East Queensland (unpublished data). Queensland Government.
[3] Ibid.
[4] Ibid.

- 46.5% of respondents met the diagnostic criteria for any mental disorder or harmful substance use (HSU), compared with 21.4% of the Australian population aged 16-85 years
- 55.2% reported lifetime experience of suicidal thoughts, compared with 16.7% of the Australian population
- 26.3% had made a plan to take their own life, compared with 7.7% of the Australian population
- 20.7% had attempted suicide, compared with 4.8% of the Australian population.[20]

In 2023/24, 8.6% of total episodes of admitted patient care for mental disorders were for First Nations patients, who comprise only 3.04% of the total SEQ population.[5] Between 2020/21 and 2023/24 there has been a 7.5% increase in hospitalisations for mental and substance use disorders.[6]

Access to Mental Health Services in SEQ: A First Nations Perspective

A project aimed at understanding mental health service utilisation by Indigenous people in SEQ (mental health service mapping again National Mental Health Service Planning Framework for Indigenous populations in SEQ – ISEQ-NMHSPF) identified large shortfalls in service provision for primary mental health care and community-based mental health services and smaller shortfalls for bed-based mental health services, based on targets derived from the NMHSPF.[7] Furthermore, the ISEQ-NMHSPF report also identified the level of mental health need for Indigenous people with mild-moderate conditions across the lifespan (0-55+ years) in SEQ was 1.5 to 2.5 times higher than for non-Indigenous people.

The patterns of service delivery identified in the project report suggest a particular need to expand engagement with and availability of services within the community to respond to the mental health needs of Indigenous residents, and potentially to address mental health problems earlier and provide supports that may reduce the need for crisis-oriented specialist inpatient and related services.

The findings of the ISEQ-NMHSPF report align with previous research, which shows that Aboriginal and Torres Strait Islander people report greater difficulty accessing services for mental health conditions compared to other health conditions.[8] Furthermore, it has been suggested that Indigenous people tend to avoid accessing mainstream mental health services until a crisis occurs.[9] In general across Australia, representation of Indigenous people within acute mental health care is around three times the rate suggested by the population distribution and access into community-based mental health care is significantly under-represented.[10] The QUIMHS identified that Indigenous people in SEQ expressed a strong preference to access social, emotional and mental health care from ACCHSs rather than mainstream services (71.3% of respondents).

Our Experience Under the National Mental Health and Suicide Prevention Agreement

The National Mental Health and Suicide Prevention Agreement (NMHSPA) was intended to strengthen access to mental health support by improving coordination, investment, and service delivery partnerships. However, IUIH's experience under the current NMHSPA and the associated Queensland Bilateral Agreement highlights the need for greater flexibility and more nuanced service coordination models and responses to enable funding and commissioning models, and policy frameworks that genuinely align with the needs of our urban Aboriginal and Torres Strait Islander communities in SEQ.

[5] Data source: Queensland Health. Queensland Hospital Admitted Patient Data Collection.
[6] Ibid.
[7] Diminic, S., Pagliaro, C., Page, I., & Wailan, M. (2022). *Analysis of mental health service provision for Aboriginal and Torres Strait Islander populations in Southeast Queensland – Final report*. Queensland Centre for Mental Health Research, Brisbane.
[8] Australian Bureau of Statistics. (2018). *National Aboriginal and Torres Strait Islander Social Survey 2014-15.* https://www.abs.gov.au
[9] Vicary, D., & Westerman, T. (2004). 'That's just the way he is': Some implications of Aboriginal mental health beliefs. *Australian e-Journal for the Advancement of Mental Health*, 3(3), 103-112. https://doi.org/10.5172/jamh.3.3.103
[10] Brideson, T., et al. (2014). The Djirrawang Program: Cultural affirmation for effective mental health. In P. Dudgeon, H. Milroy & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice.* Australian Government Department of the Prime Minister and Cabinet. https://www.telethonkids.org.au/ globalassets/media/documents/aboriginal-health/ working-together-second-edition/working-togetheraboriginal-and-wellbeing-2014.pdf

Lack of Alignment Between Government Commitments and On-the-Ground Decision-Making

The disproportionate burden of mental health issues experienced by Aboriginal and Torres Strait Islander communities is well-evidenced, in data and in the day-to-day experience of service providers, yet addressing these inequities is still not a priority in practice.

Implementation of the NMHSPA and Qld-Commonwealth Bilateral is not in line with the commitments under the Closing the Gap Agreement, failing to uphold its core principles of shared decision-making, community control, and self-determination.

The current NMHSPA outlines (Clause 47) the joint responsibility of Australian governments to contribute to the National Agreement on Closing the Gap, particularly the Closing the Gap target of significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander peoples towards zero (Target 14) and priority reform areas, including increasing investment in community-controlled organisations. The NMHSPA commits parties (Clause 110) to collaborate with ACCHSs and to involve ACCHSs in regional planning and commissioning arrangements (Clause 137). The Qld-Commonwealth Bilateral requires the Agreement be 'read together' with the National Agreement on Closing the Gap and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. And while the Agreements have some measures relating to Aboriginal and Torres Strait Islander people's access to services and mental health and wellbeing outcomes, neither Agreement measures the effectiveness of either party in partnering with ACCHSs or investing in ACCHSs.

ACCHSs are not positioned as equal partners at the decision-making table. In IUIH's experience, we are typically consulted when decisions have largely been made or are expected to submit for funds under models already designed without our leadership or input. This approach is fundamentally inconsistent with the principles of shared decision-making, community control, and self-determination that the National Agreement commits all governments to uphold.

There is no formal recognition of ACCHSs leadership, expertise, or the demonstrated effectiveness of our models within the NMHSPA. Instead, we are often required to participate in regional planning committees and working groups without appropriate resourcing, placing significant strain on our capacity. While we value participation, this unfunded engagement leaves ACCHSs at a structural disadvantage, perpetuating power imbalances where government agencies and mainstream providers retain disproportionate control over mental health policy, funding, and service design affecting Aboriginal and Torres Strait Islander peoples.

At IUIH we frequently find ourselves reminding and educating our partners on the importance of upholding commitments made under the National Closing the Gap Agreement, which requires significant time, effort, and resources, and diverts our attention away from the urgent service delivery responses required in SEQ. This is not only frustrating but also highlights that many mainstream partners remain accustomed to working in a certain way, without embedding the systemic shifts needed to reflect genuine prioritisation of the National Agreement on Closing the Gap.

We do want to acknowledge, however, that through our IUIH-led SEQ First Nations Health Equity Partnership (see section on Good Practice Models), we have seen a noticeable shift in the willingness and efforts of our local mainstream partners to genuinely work together. There has been increasing recognition of the value of Aboriginal and Torres Strait Islander leadership, and a more open dialogue around shared priorities and ways to improve cultural capabilities. Being able to provide a local evidence-base (local data), has been an important part of this, as has been the persistent efforts of the IUIH Network to prioritising forming and maintaining relationships with local mainstream funders and providers. While these relationships can be very effective at the strategic level, unfortunately, these relationships often do not filter down to the operational teams on-the-ground and responsible service planning or for day-to-day implementation of models of care.

Ultimately, despite commitments to Aboriginal and Torres Strait Islander peoples, communities and organisations under the NMHSPA, the structural power imbalance remains, as the decision-making authority continues to rest with government (Commonwealth and State) and Primary Health Network (PHN) partners as the fund holders. This dynamic reinforces the need for formal mechanisms that elevate ACCHSs to the position of equal partners, rather than leaving meaningful partnership dependent on goodwill and individual relationships.

Model Rigidity within the Qld-Commonwealth Bilateral

Although the National Agreement and associated Bilateral Agreements express a commitment to local flexibility, in practice, funding remains tightly bound to predetermined models—such as headspace and Head to Health—which limit the capacity for locally driven, culturally safe service design.

IUIH has developed the Staying Deadly model of mental health care (see section on Good Practice Models). Staying Deadly is an example of a community-owned and evidence-based model of care. While practical components of our model could be implemented in many contexts, the integrity of our model lies in its grounding in Aboriginal and Torres Strait Islander Terms of Reference, enabling care by Community for Community, honouring self-determination and agency.

In the context of the NMHSPA, the Qld-Commonwealth Bilateral, and Better Care Together: A plan for Queensland's state-funded mental health, alcohol and other drug services to 2027, IUIH proactively and persistently advocated for funding from the State Government for five Staying Deadly hubs across our region.

In 2023 IUIH secured 4 years funding of $2 million per annum for two hubs, one in Silkstone (near Ipswich) and one in Woolloongabba (inner city Brisbane). The funding secured includes an allocation for a 3-year evaluation, and there is no growth built in across the 2023-2027 funding period. The annual allocation of $1 million per hub is sufficient to operate the "start-up" core model with supplementary MBS funding, where able, but will not be sufficient to manage population growth, the increasing burden of mental illness in the community, and the community demand for this model of care. There is no funding security beyond July 2027. In order to support expansion of our Staying Deadly model, we have looked for other funding programs and opportunities that enable expansion of the model.

In the Queensland 2024 State Budget, and in response to extraordinary intercensal population growth, IUIH advocated for a capital investment and small operational investment to establish new integrated primary health and wellbeing hubs in SEQ, to be owned and operated by our IUIH Network Organisation. We secured an investment of $112.5 million over four years. A portion of the operational funding will be used to ensure we are able to operate the Staying Deadly model out of three of the six new hubs being built.

However, under the NMHSPA, our more typical experience has been that funding of new services is locked into a rigid, mainstream-designed model, and over the last few years at IUIH we have received headspace and Head to Health funding.

Following a government commitment in 2022, the Brisbane North Primary Health Network and headspace national proactively engaged IUIH to discuss the establishment of a headspace service in the Brisbane North catchment. IUIH entered into discussions, aware that (1) significant grant opportunities for mental health and well-being services for young people are extremely limited and largely bound to a headspace model; and (2) that maintaining strict fidelity with the headspace model would potentially pose challenges for IUIH in achieving responsiveness and accessibility for Aboriginal and Torres Strait Islander people locally. Over the course of two years, negotiations resulted in agreement that the service would (1) target Aboriginal and Torres Strait Islander young people, and their close peers and family; (2) be located in the Moreton Bay region, where Indigenous population growth is highest; and (3) operate under a co-named brand – "Staying Deadly | headspace". The service is still in establishment, with doors anticipated to open in the second half of 2025.

Since 2023, and facilitated through a formal partnership arrangement, IUIH and Children's Health Queensland Hospital and Health Service have been collaborating on the delivery of the CHQ Head to Health Kids model for Aboriginal and Torres Strait Islander children in SEQ. This included IUIH participating in development of the Expression of Interest (EOI) submitted by CHQ to secure the Head to Health funding. In 2024, IUIH and CHQ signed a funding agreement for Staying Deadly Jarjums, a shared model of mental health care, funded through Head to Health.

The Qld-Commonwealth Bilateral clearly prioritises implementation of the headspace model and Head to Health model—mainstream models of care. These models are governed by tight fidelity requirements that limit local flexibility, disregarding the need for community-led, culturally safe solutions. The recent independent review of headspace recognised these limitations, acknowledging that the model has not been effective in meeting the needs of Aboriginal and Torres Strait Islander young people.

IUIH understands the importance to model fidelity for headspace and Head to Heath, indeed the fidelity of our models – designed, led and governed by Community for Community – are important to IUIH, to our Community. We also recognise that the NMHSPA and the Qld-Commonwealth Bilateral endeavour to encourage local flexibility. However, accountability mechanisms and measures under these Agreements are geared towards the implementation of mainstream models, to measure of access in the public system, and to the improvement Indigenous mental health outcome measures, with no accountability mechanism or measure to the requirements under the agreements to partner with Aboriginal and Torres Strait Islander peoples, communities and organisations, or the commitment to investing in and empowering Aboriginal and Torres Strait Islander community control. Consequently, even our most willing health system partners are limited in the extent to which they can be flexible, and shift entrenched/institutionalised behaviours within the public health system that are risk adverse to devolving services or partnering in shared care.

In summary, the NMHSPA and Qld-Commonwealth Bilateral create structural impediments to the principles of Closing the Gap, of recognising self-determination and community-control – significant mental health funding is tied to a single, mainstream model, with ACCHSs left to either subcontract under unsuitable parameters, deliver services beyond their community remit, or collaborate under unequal terms with mainstream providers.

Inadequate investment in Community Based Responses to Prevent or Support a Crisis

These structural inequities in funding and decision-making are compounded by chronic underinvestment in prevention and early intervention for First Nations' mental health and suicide prevention.

IUIH recognises the pressing need for 'crisis' capacity in the system, and the pressure governments experience to ensure there are 'safe' places for people in crisis. However, an institutional, hospital-based, response is rarely effective for Aboriginal and Torres Strait Islander people in crisis. IUIH's social health services, including the new Staying Deadly hubs, are experienced in supporting people in crisis in community, applying culturally responsive, trauma-informed approaches to prevention, early intervention and de-escalation.

The current NMHSPA, the Qld-Commonwealth Bilateral and the Queensland's Better Care Together plan, continue to prioritise crisis-driven responses with the public health system, missing opportunities to invest in long-term, community-led strategies that keep people well and connected to culture, family, and community.

Despite consistent evidence that community-controlled, preventative models deliver better outcomes, funding continues to flow predominantly to mainstream-designed, acute services. This reflects the same systemic issues described above: ACCHSs are expected to deliver services within inflexible, mainstream frameworks or as subcontractors, rather than being resourced and trusted to design culturally safe, community-led prevention approaches from the start.

The IUIH Network has consistently demonstrated the effectiveness of comprehensive, preventative approaches through models like the IUIH System of Care (ISoC), which takes a holistic, wrap-around view of social and emotional wellbeing. Yet, there is no systemic support or sustained investment to scale these proven approaches. Instead, short-term, fragmented funding cycles and mainstream-designed models continue to dominate, limiting the ability of ACCHSs to embed long-term solutions that prioritise prevention, early intervention, and cultural safety. Without a meaningful shift in funding priorities—toward long-term, flexible investment in community-led, culturally responsive care—First Nations peoples will continue to face preventable mental health crises, and the burden on the acute system will persist.

The Importance of Community, Connection, and Spiritual Wellbeing

Mental health and suicide prevention for First Nations people goes beyond clinical care, encompassing community, connection, and spiritual wellbeing as essential elements of staying well. However, mainstream funding and service delivery structures fail to adequately support holistic, community-based approaches, limiting the ability of ACCHSs to deliver culturally safe, place-based care.

Despite ongoing misconceptions that ACCHSs only provide Social and Emotional Wellbeing (SEWB) services, the IUIH Network delivers comprehensive, evidence-based mental health care, including:

- Psychiatry services providing diagnosis, medication management, and specialist mental health treatment.
- Psychology services offering therapeutic interventions tailored to First Nations experiences.
- Care coordination ensuring clients receive integrated, wraparound support across health and social services.
- Case management supporting individuals with complex mental health and social needs to navigate systems and access appropriate care.

The previously mentioned Queensland Urban Indigenous Mental Health Survey reaffirms the critical role of ACCHSs in delivering effective, community-led mental health care. Findings from this initiative highlight that First Nations people are more likely to engage with and benefit from mental health services when they are delivered by ACCHSs, where care is provided in a culturally safe and trusted environment.

However, current funding arrangements fail to reflect this reality. Mainstream services continue to receive the majority of mental health investment, while ACCHSs are left to operate within short-term, fragmented, and inadequate funding cycles. This funding insecurity makes it difficult to recruit, secure, and sustain a skilled mental health workforce, despite the proven success of ACCHS models.

ACCHS mental health staff are often required to carry higher caseloads, manage clients with complex trauma, and support individuals from their own communities—all of which contribute to heightened risks of vicarious trauma and cultural load.[11] The lack of dedicated funding for professional development, clinical supervision, and mental health workforce support further exacerbates workforce fatigue and turnover, limiting the capacity of ACCHSs to meet increasing demand and the critical and rising levels of poor mental health discussed earlier. Additionally, mainstream funding streams often impose rigid criteria that are incompatible with community-controlled models, failing to recognise the need for a culturally safe, multidisciplinary, and qualified workforce capable of delivering care that addresses the broader social determinants of mental health.

The Staying Deadly findings reinforce the urgent need for increased, long-term, and flexible investment in ACCHSs. This will ensure these services are resourced to expand their mental health workforce, embed sustainable care coordination, provide culturally responsive supports, and—critically—continue delivering trusted, effective mental health care that addresses the social, emotional, and spiritual wellbeing of First Nations people.

For mental health and suicide prevention strategies to be effective, the NMHSPA must formally recognise and invest in ACCHSs as key providers of mental health care—not just as supplementary or SEWB providers, but as primary mental health service providers with the capability to deliver a full spectrum of care. Addressing these funding disparities is critical to improving outcomes and ensuring that First Nations people have access to the care they need, when and where they need it.

Urgent Need for Sustainable Funding and Community Controlled Commissioning

Australia is facing a mental health crisis, with increasing demand for services, rising suicide rates, and worsening mental health outcomes across the population. However, this crisis is far more severe for Aboriginal and Torres Strait Islander people, who experience disproportionate rates of psychological distress, higher suicide rates, and significant barriers to accessing culturally safe care. The urgent need for accessible, community-led mental health services has never been greater, yet the lack of a sustainable funding stream, and delays in rolling out funding continue to undermine efforts to close the gap in mental health outcomes.

The failure to distribute funds efficiently means that First Nations communities are left waiting for essential mental health care, often until crises escalate to hospitalisation, incarceration, or tragic loss of life. These delays contradict the commitments under the Closing the Gap Agreement, which calls for timely, equitable, and needs-based investment in Aboriginal and Torres Strait Islander-led services.

[11] Cultural load refers to the additional emotional, psychological, and cultural responsibilities experienced by Aboriginal and Torres Strait Islander staff, particularly when working within their own communities. This includes the expectation to provide culturally safe care, maintain cultural obligations, navigate community relationships, and manage the cumulative impact of systemic racism, discrimination, and intergenerational trauma.

A major structural barrier to effective funding distribution is the continued reliance on PHNs as the fund holders for First Nations mental health services. While PHNs play a role in regional commissioning, they lack the cultural expertise and community connections that ACCHSs bring to service delivery. This adds an unnecessary layer of bureaucracy and limits the ability of First Nations organisations to design and implement services that align with the needs of their communities.

The IUIH Network is already a commissioner of services to its Member organisations, with established governance, accountability, and commissioning capacity. As a regional commissioning body, IUIH is well-placed to be a direct commissioner of mental health services in SEQ, removing the need for PHNs as the fund holders for First Nations-specific mental health funding. Directly funding IUIH to commission services for its Member organisations would:

- Reduce delays and inefficiencies associated with PHN-led commissioning.
- Ensure funds are allocated according to community-identified needs, rather than external funding priorities.
- Strengthen the role of ACCHSs as the primary providers of culturally safe mental health care.
- Align with the Closing the Gap Priority Reforms, particularly formal partnerships and shared decision-making.

To address this, funding pathways must be streamlined to prioritise flexibility, sustainability, and rapid allocation to frontline ACCHS services. This includes:

- Ensuring timely disbursement of mental health funding to ACCHSs, preventing unnecessary delays that exacerbate service gaps.
- Removing PHNs as intermediaries for First Nations mental health funding and instead funding IUIH directly as a regional commissioner.
- Providing longer-term, flexible funding agreements that enable ACCHSs to plan, recruit, and scale their mental health services sustainably.
- Exploring Activity Based Funding (ABF) as a 'recurrent' funding source for non-public health services, such as IUIH, who are providing sub-acute mental health services linked to hospital presentations or admissions that, if provided in the public system, would ABF eligible.
- Exploring funding mechanisms that adequately support optimal care pathways, whether this be through 'bundled' payments, innovation funding, or recognising through the MBS or other payment mechanisms the value and cost of care coordination (care connectors/systems integrators).

Transparency and Accountability

While governments frequently emphasise the importance of accountability, this principle is often applied selectively—particularly when it comes to mental health and suicide prevention for Aboriginal and Torres Strait Islander peoples. Institutions such as the National Mental Health Commission play a critical role in driving system improvement. The Commission is tasked with monitoring and reporting on mental health and suicide prevention investment, providing independent, evidence-based policy advice, and acting as a catalyst for change across sectors, including health, education, housing, and employment.

However, the effectiveness of this role is constrained when key data remains inaccessible or insufficiently disaggregated—particularly at regional or local levels. Without visibility of local-level outcomes, Aboriginal and Torres Strait Islander communities and community-controlled organisations cannot meaningfully participate in planning, hold systems to account, or lead responses that reflect the realities on the ground.

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035, developed by Gayaa Dhuwi (Proud Spirit) Australia, reinforces the need for culturally informed, evidence-based approaches underpinned by Indigenous Data Sovereignty. It calls for the development of governance and accountability frameworks to ensure Aboriginal and Torres Strait Islander communities have ownership and oversight of data used to inform and evaluate suicide prevention activity. The Strategy also highlights the importance of regional-level data access to support meaningful and place-based planning.

To improve transparency, the National Mental Health Commission, State/Territory-based Mental Health Commission or other statutory body should be further empowered to act not only as a source of independent advice, but also as a data custodian responsible for maintaining public-facing, disaggregated dashboards.

These tools must provide clear insights into outcomes for Aboriginal and Torres Strait Islander people across regions and be governed in partnership with Indigenous communities in line with data sovereignty principles.

Consideration could also be given to establishing a First Nations Mental Health Commissioner (similar to the First Nations Aged Care Commissioner and the First Nations Children's Commissioner) or an independent body to provide culturally grounded leadership and ensure accountability for improving outcomes in social and emotional wellbeing, mental health, and suicide prevention across all levels of government.

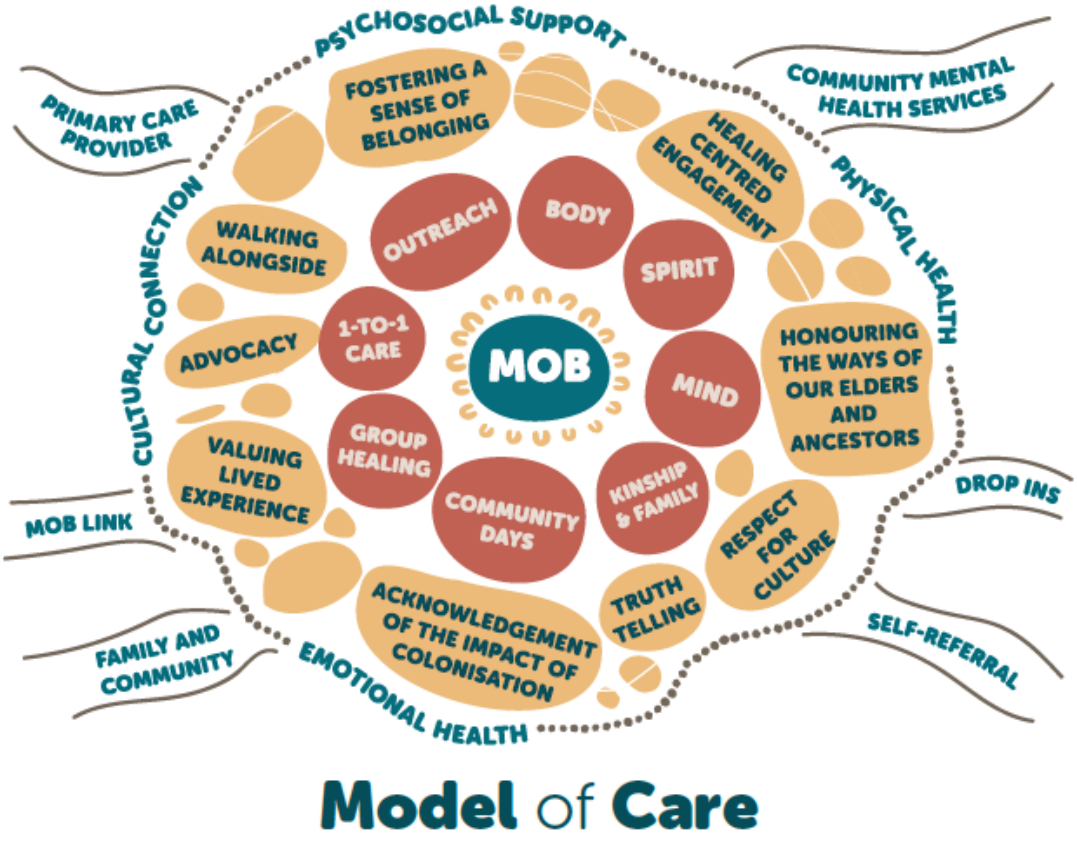
Good Practice Models

The IUIH Network's experience demonstrates that ACCHSs are not only well-positioned but are already delivering innovative, culturally safe, and highly effective models of mental health and social health care. Despite persistent challenges in achieving equitable recognition and sustainable funding under the current NMHSPA and Bilateral Agreement, the IUIH Network continues to innovate preventative, community-led approaches that address the complex mental health and social and emotional wellbeing needs of our people. The following good practice models provide tangible examples of how ACCHSs are delivering integrated, place-based solutions aligned with the principles of Closing the Gap, and why greater investment in these models is urgently needed.

Staying Deadly Hubs

The **Staying Deadly Hubs** provide culturally safe, community-based mental health and AOD support for Aboriginal and Torres Strait Islander people aged 15 years and over. The service is designed to offer timely, holistic support to individuals at various points along the mental health care continuum, specifically targeting:

- People at risk of entering the acute care system if their symptoms remain unmanaged.
- Individuals stepping down from an inpatient episode of care, ensuring they are well-supported in the community and that the risk of relapse is minimised.
- Clients with escalating mental health or AOD needs who do not yet require inpatient care, to prevent unnecessary hospital admissions.
- Individuals voluntarily engaging with mental health and wellbeing supports.



Model of Care

The Staying Deadly Service maintains an open referral pathway, accepting referrals from internal IUIH providers, public and private mental health services, self-referrals, and referrals from family members. The service prioritises reducing barriers to access and ensuring clients receive appropriate, culturally safe care, including facilitating warm referrals to alternative services where needed.

The Staying Deadly Hubs are positioned to support clients experiencing moderate to severe mental health needs and/or high levels of distress, including suicidal distress. The *Staying Deadly* hubs provide

multidisciplinary mental health and AOD treatment services and intensive case management, meeting the client where they are on their journey without judgment.

Each Staying Deadly hub has an assertive outreach team which supports the hardest to reach Aboriginal and Torres Strait Islander people – those who are not connected to health services, who remain invisible to the health system until they are in crisis, who face significant access barriers, who are often excluded from services and regularly come to the attention of police due to challenging behaviours resulting from mental illness, addiction, homelessness and/or for young people, challenging family environments.

By embedding the *Staying Deadly* hubs within the IUIH System of Care, clients have access to the range of health services provided by the IUIH Network, so that both their mental health and co-existing physical health and/or social services needs can be addressed. Staying Deadly staff are often supporting clients with immediate needs, such as food, clothing, Centrelink paperwork, or child safety matters, and finding that clients are in a much better position to consider their mental health and wellbeing once immediate pressures are addressed.

The Staying Deadly Service is not able to provide the following, but assists clients through warm referral pathways to access appropriate supports for:

- residential or bed-based services.
- services targeting children and young people under the age of 15 years, which could be provided more appropriately by children and young people's mental health services.
- services for individuals who require specialist inpatient care or who could not be managed safely within the scope of the Staying Deadly Hubs.
- brokerage of services.

The client journey from referral to transition from the Staying Deadly Hubs is summarised on the next page.

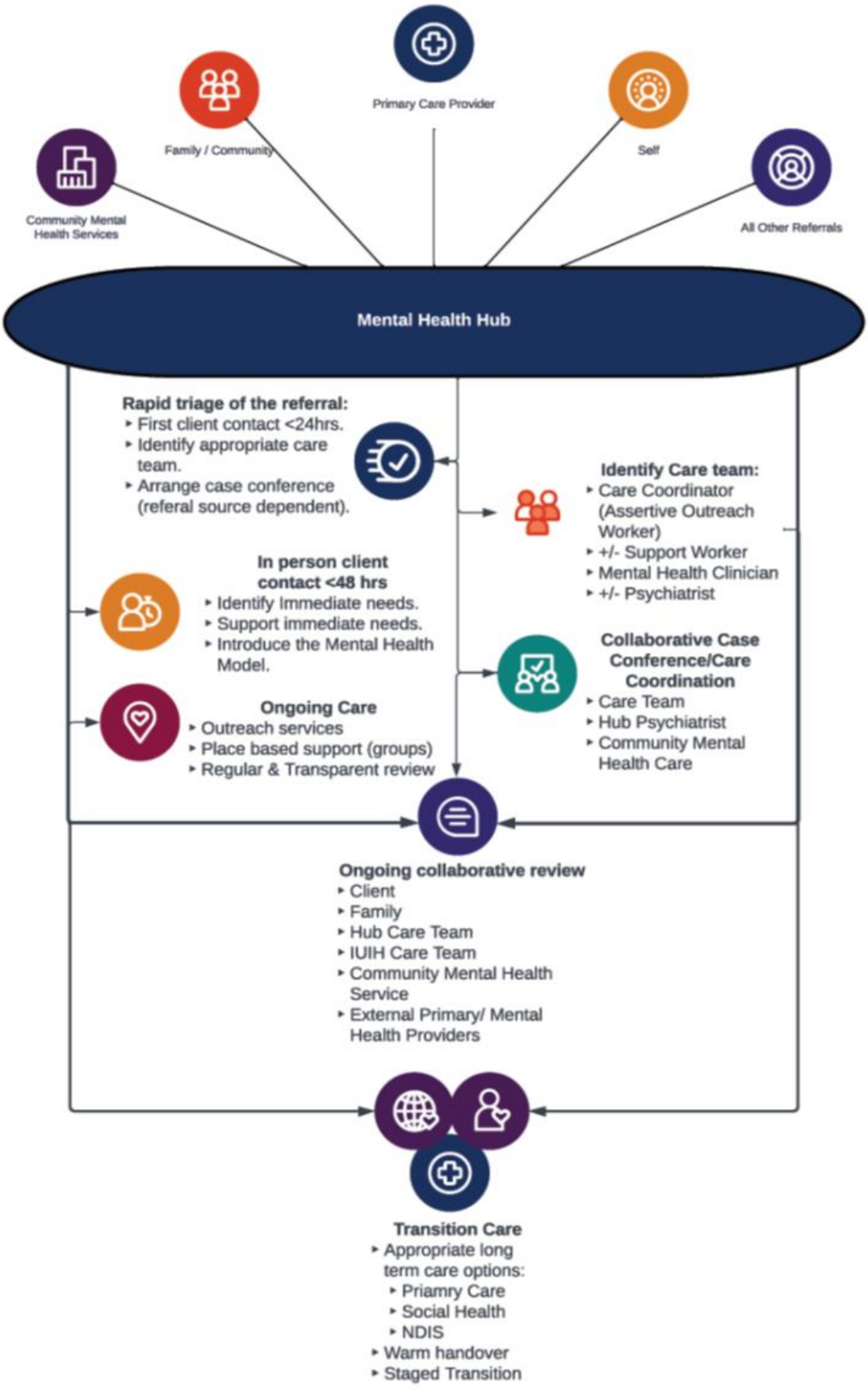
The Staying Deadly Hubs are overseen by the Staying Deadly Service Advisory Committee. The Advisory Committee brings together representatives from IUIH and its member organisations, HHSs and the Queensland Centre for Mental Health Research (QCMHR) and provides strategic oversight of the establishment and operation of the Staying Deadly Hubs. IUIH is partnering with QCMHR to develop an evaluation framework for the Staying Deadly Service.

The Staying Deadly model demonstrates the vital role ACCHSs can play not only in delivering primary mental health care and SEWB services, but also in providing sub-acute, community-based mental health supports. This approach highlights the capacity of ACCHSs to bridge service gaps, reduce pressure on the acute care system, and deliver culturally responsive care aligned with the needs of First Nations people.

The first IUIH Staying Deadly hub at Silkstone became fully operational in February 2024. The hub delivered 1,392 occasions of service between January and June 2024 to 129 clients.

The second IUIH Staying Deadly hub at Woolloongabba has been 'soft launched' while the hub facility is finalised.

Staying Deadly Model: Client journey



To support the growth of the Staying Deadly model, IUIH has worked with other funding partners to contextualise the model within the parameters of 'mainstream' models of care supported under the Qld-Commonwealth Bilateral Agreement.

Staying Deadly | headspace Deception Bay

IUIH has been commissioned by the Brisbane North Primary Health Network to establish and deliver a headspace service tailored for the effective engagement and support of Aboriginal and Torres Strait Islander young people.

Staying Deadly | headspace Deception Bay is being established to respond specifically to the holistic mental health and well-being needs of Aboriginal and Torres Strait Islander young people (12-25 years) in Moreton Bay. It offers early intervention mental health support, alongside physical and sexual health services, alcohol and drug support, and work and study assistance. Designed to be highly accessible and tailored to the needs of Aboriginal and Torres Strait Islander young people, the service operates within a stepped care framework, ensuring flexible and individualised support.

The Staying Deadly | headspace Deception Bay team will walk alongside our young people aged from around 12 to 25 years, offering "no wrong door", supporting access to comprehensive wellbeing care including connection to culture and community, specialised mental health and alcohol and drug services, and connection to training, education and employment supports.

IUIH has recently secured a facility from which to operate the service, staff recruitment is underway, and all aspects of the design and development of both facility and service are advanced in partnership with our young people in the region. We anticipate opening of the service around mid-2025.

Staying Deadly Jarjums (Head to Health Kids)

Staying Deadly Jarjums, currently in establishment, is designed to provide specialist support for children under 12 years of age experiencing developmental, behavioural, or emotional challenges that may affect their mental health and wellbeing. The service is delivered in a family-centred model, addressing the holistic needs of children, families and carers.

Staying Deadly Jarjums is delivered through a partnership between Children's Health Queensland (CHQ) and IUIH, funded through the Qld-Commonwealth Bilateral investment in the Head to Health model, with the aim of contextualising the model for our Community and within the broader IUIH System of Care.

Way Back Support Service

The Way Back Support Service (TWBSS) is a national, non-clinical suicide prevention aftercare program, delivered through a partnership between the Commonwealth Government, Primary Health Networks (PHNs), and Local Health Networks/Hospital and Health Services (LHNs/HHSs). It provides critical follow-up care for people who have experienced suicidal distress or are experiencing suicidal crisis. While the program is implemented nationally, it is most commonly delivered by, or subcontracted to, mainstream non-government organisations.

A 2023 independent evaluation of TWBSS highlighted the program's significant value in reducing suicidal behaviour and improving client outcomes. However, the review also identified key areas for improvement, including the need for expanded referral pathways, improved cultural safety, and greater Aboriginal and Torres Strait Islander engagement and leadership in service design and delivery.[12]

In the Metro North catchment of Brisbane, IUIH delivers TWBSS directly to eligible Aboriginal and Torres Strait Islander clients—an exception within the national landscape. IUIH was initially engaged as a subcontractor to a mainstream NGO, but through strong advocacy and a collaborative relationship with Brisbane North PHN, IUIH was transitioned to a direct contract arrangement. This has enabled the service to be embedded more effectively within the IUIH System of Care and delivered in a culturally safe and trusted environment.

Importantly, this partnership has also allowed for increased flexibility in inward referral pathways, ensuring that the service can be responsive to the specific needs and circumstances of our community. Despite the success of this approach, IUIH's TWBSS service remains the only instance SEQ where an ACCHO has been

[12] The Way Back Support Services Evaluation – Final evaluation report | Australian Government Department of Health and Aged Care

contracted—either directly or via subcontract—to deliver this program. The IUIH TWBSS model demonstrates the benefits of community-led delivery of suicide prevention services and highlights the potential for expansion of this approach across other regions.

Work It Out

The Work It Out program is a flagship initiative delivered by the Institute for Urban Indigenous Health (IUIH), supporting the social, emotional, and physical wellbeing of Aboriginal and Torres Strait Islander adults living with or at risk of chronic conditions. The program combines culturally tailored health education, group-based physical activity, and social connection, delivered within a culturally safe environment by qualified allied health professionals.

Core components include:

- Individualised care plans tailored to each participant's health needs and goals.
- Regular group physical activity sessions designed to improve strength, fitness, and overall health.
- Health education sessions covering chronic disease management, nutrition, mental health, and wellbeing.
- Opportunities to strengthen cultural identity, community connection, and social networks.

Research by Parmenter et al. (2022) on chronic disease self-management programs for Aboriginal and Torres Strait Islander people in urban settings found that participation is strongly influenced by factors such as cultural safety, trust in staff, social connection, flexible service delivery, and transportation access. Participants of the Work It Out Program highlighted that culturally respectful environments supported not only chronic disease management, **but also emotional and mental wellbeing**, reinforcing the importance of culturally tailored, community-led programs like Work It Out as part of prevention and early intervention for mental health and wellbeing.[13]

Community-Controlled Commissioning: Integrated Team Care (ITC) Program

The Integrated Team Care (ITC) Program, funded through the Indigenous Australians' Health Programme (IAHP), supports improved health outcomes for Aboriginal and Torres Strait Islander people with chronic conditions by providing access to coordinated, multidisciplinary, and culturally appropriate care. The program helps individuals manage their conditions and navigate the health system, while also strengthening the cultural capability of mainstream services.

ITC teams—made up of Care Coordinators, Indigenous Health Project Officers, and Outreach Workers—work closely with clients to connect them with the services they need. Care Coordinators also have access to a Supplementary Services fund to arrange urgent allied health, specialist care, or approved medical aids when these are not otherwise available in a timely way.

In SEQ, IUIH acts as a funding commissioner for the ITC Program. IUIH receives funding through the IAHP and distributes it to its member ACCHSs. Through this role, IUIH supports service delivery, ensures consistency and cultural safety, and drives integration between community-controlled and mainstream health services across the region.

SEQ First Nations Health Equity Partnership and Data-sharing Success

The SEQ First Nations Health Equity (FNHE) Partnership has made strong progress in advancing collaborative data-sharing practices to improve transparency, accountability, and drive system reform. While no formal data-sharing agreement exists, partners—including Hospital and Health Services, Primary Health Networks, Mater

[13] Parmenter, J., Basit, T., Nelson, A., Crawford, E., & Kitter, B. (2022). Chronic disease self-management programs for Aboriginal and Torres Strait Islander people: Factors influencing participation in an urban setting. *Health Promotion Journal of Australia*, 33(3), 634–644. https://doi.org/10.1002/hpja.579

Health Service, Queensland Ambulance Service, and Aboriginal and Torres Strait Islander Community Controlled Health Services—are actively sharing data to support joint priorities.

This collaboration has enabled the production of the annual FNHE Performance Report, which provides a comprehensive, shared picture of health outcomes and service access for Aboriginal and Torres Strait Islander people across SEQ. The report includes key indicators such as the proportion of the First Nations population accessing clinical mental health services and psychosocial support services (by region and sub-region), the percentage of National Mental Health Service Planning Framework benchmarks reached (Indigenous, by service type, region, and sub-region), mental health service episodes with community follow-up within 1-7 days of discharge from acute mental health inpatient units (Indigenous/Non-Indigenous, by HHS sub-region), and Emergency Department presentations for mental health and substance use (Indigenous/Non-Indigenous, number and proportion, by HHS sub-region).

In addition to informing the Performance Report, this data sharing also supports the work of dedicated working groups, such as the SEQ FNHE Healthcare Access Data Working Group. Importantly, all collaboration is underpinned by respect for Indigenous Data Sovereignty principles, fostering trust and strengthening collective action to improve health equity. Building on this success, the FNHE Partnership is now working towards the development of a shared data-sharing platform to further enhance integration, support real-time data access, and inform ongoing planning and service delivery improvements.

Building on the foundations of strong data-sharing and collaboration, the SEQ FNHE Mental Health Working Group is leading regional efforts to improve mental health, alcohol and other drug (AOD), and suicide prevention services for Aboriginal and Torres Strait Islander people across SEQ. Co-chaired by ATSICHS Brisbane and Brisbane North PHN, the Working Group and its subcommittees are progressing priority actions under the SEQ First Nations Health Equity Strategy—particularly in the delivery of culturally safe and responsive healthcare. The group has drawn on comprehensive data sets, including findings from the Indigenous SEQ-National Mental Health Service Planning Framework (ISEQ-NMHSPF) project and the Queensland Urban Indigenous Mental Health Survey, to identify key service gaps and guide regional planning. This has informed the development of a suicide response plan for Aboriginal and Torres Strait Islander people in SEQ, and the Culture Care Connect Suicide Prevention Networks Plan (2023–26). In parallel, the group is working towards a joint regional planning approach across all SEQ PHNs and HHSs for mental health, AOD, and suicide prevention services. While partners work together to plan and coordinate services, addressing service gaps is difficult for all partners due to a lack of funding and funding flexibility.

Attachment A – IUIH Network and Clinics