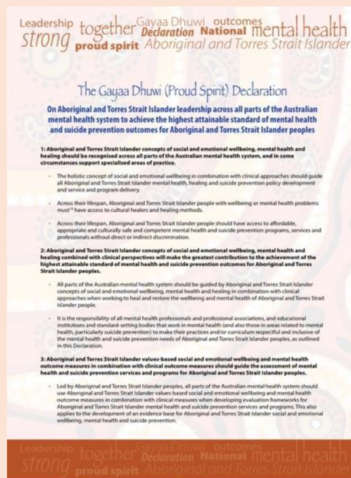
National Aboriginal and Torres Strait Islander
Leadership in Mental Health
Together we are strong

The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

Gayaa Dhuwi (Proud Spirit) Declaration and Indigenous Governance Framework

Combined Report on the State and Territory Implementation Workshops and the FINAL NATIONAL WORKSHOP REPORT

18th November 2019



Leadership together Gayaa Dhuwi outcomes Declaration National mental health strong proud spirit Aboriginal and Torres Strait Islander

The Gayaa Dhuwi (Proud Spirit) Declaration

On Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples

1: Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.

- The holistic concept of social and emotional wellbeing in combination with clinical approaches should guide all Aboriginal and Torres Strait Islander mental health, healing and suicide prevention policy development and service and program delivery.
- Across their lifespan, Aboriginal and Torres Strait Islander people with wellbeing or mental health problems must have access to cultural healers and healing methods.
- Across their lifespan, Aboriginal and Torres Strait Islander people should have access to affordable, appropriate and culturally safe and competent mental health and suicide prevention programs, services and professionals without direct or indirect discrimination.

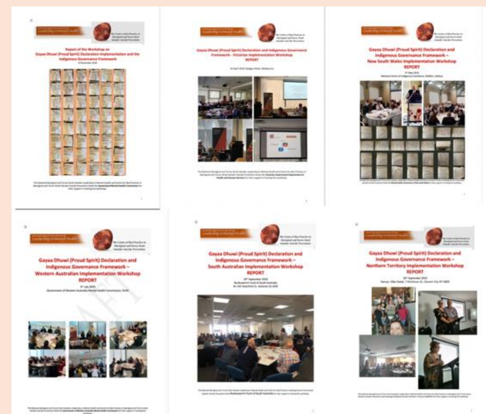
2: Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

- All parts of the Australian mental health system should be guided by Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing in combination with clinical approaches when working to heal and restore the wellbeing and mental health of Aboriginal and Torres Strait Islander people.
- It is the responsibility of all mental health professionals and professional associations, and educational institutions and standard-setting bodies that work in mental health (and also those in areas related to mental health, particularly suicide prevention) to make their practices and/or curriculum respectful and inclusive of the mental health and suicide prevention needs of Aboriginal and Torres Strait Islander peoples, as outlined in this Declaration.

3: Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.

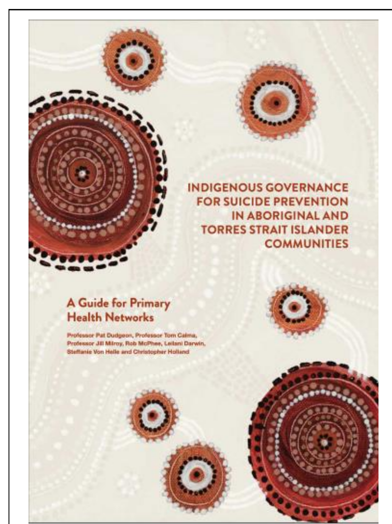
- Led by Aboriginal and Torres Strait Islander peoples, all parts of the Australian mental health system should use Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical measures when developing evaluation frameworks for Aboriginal and Torres Strait Islander mental health and suicide prevention services and programs. This also applies to the development of an evidence base for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention.

Leadership together Gayaa Dhuwi outcomes Declaration National mental health strong proud spirit Aboriginal and Torres Strait Islander



1. Overview

The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) aims to reduce the causes, prevalence and impact of suicide on Indigenous individuals, families and communities. It achieves this by identifying, translating and promoting the adoption of best practice in Indigenous-specific suicide prevention activity, building on the substantial work of the national *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP).*



CBPATSISP in partnership with the Black Dog Institute launched the ***Indigenous Governance Framework*** (IGF) to guide organisations (including Primary Health Networks) working with Indigenous communities and organisations to prevent suicide in 2018. The IGF provides an in-depth discussion of the principles and importance of Indigenous governance in the context of developing, implementing and evaluating suicide prevention programs and services. See: https://www.cbpatsisp.com.au/wp-content/uploads/2019/09/FINAL-WEB-COPY-IGF-v8.pdf

A summary diagram of the Indigenous Governance Framework is included below.

The Indigenous Governance Framework

This Guide's Indigenous Governance Framework is presented in diagram form below. It highlights areas of suicide prevention activity in which Indigenous governance is particularly important in and success factors in this context.

INDIGENOUS GOVERNANCE FRAMEWORK		
INDIGENOUS GOVERNANCE OF SUICIDE PREVENTION ACTIVITY		
LEVEL	ACTIVITIES	SUCCESS FACTORS
All	All	Utilise existing national guidance and standards Working with Indigenous leaders
Regional	Regional identification of need, planning and implementation	Indigenous Health Councils
Service	Cultural safety and cultural competence in services	Working with Aboriginal Community Controlled Health Services and Community Controlled Organisations
Community	Programs and activities operating in communities Culturally/linguistically adapting mainstream activities and programs Cultural activities and programs/healing	Approaching communities with respect Addressing power imbalances Co-design and co-implementation of suicide prevention activity
FOUNDATION: ORGANISATIONAL CAPACITY TO WORK UNDER INDIGENOUS GOVERNANCE		

The **National Aboriginal and Torres Strait Islander Leadership in Mental Health** (NATSILMH) is a core group of senior Aboriginal and Torres Strait Islander people working in the areas of social and

emotional wellbeing, mental health and suicide prevention. Most are based in, or associated with, national and state mental health commissions or other nationally important mental health bodies. NATSILMH's aim is to help restore, maintain and promote the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples by advocating and providing advice and leadership in these areas. It also aims to reduce the high rates of suicide among Aboriginal and Torres Strait Islander people.

NATSILMH developed the ***Gayaa Dhuwi (Proud Spirit) Declaration*** and launched it in August 2015. The Declaration aims to ensure Indigenous Australians can access a 'best of both worlds approach' to mental health care encompassing cultural and clinical care options and within a social and emotional wellbeing framework. It aims to initiate reform and change to that end through promoting Indigenous leadership, presence through employment, and influence across all relevant parts of the mental health system.

National Aboriginal and Torres Strait Islander
Leadership in Mental Health

Gayaa Dhuwi (Proud Spirit) Declaration

A companion declaration to the Wharerātā Declaration for use by Aboriginal and Torres Strait Islander peoples

Introduction

The Wharerātā Group of Indigenous mental health leaders from Canada, the United States, Australia, Samoa and New Zealand developed the *Wharerātā Declaration* in 2010.[1] It comprises five themes on the importance of Indigenous leadership in addressing the common mental health challenges faced by Indigenous peoples around the world. Member countries of the International Initiative for Mental Health Leadership endorsed the *Wharerātā Declaration* in 2010 and now promote it as a key part of their work.[2]

Through the March 2013 *Sydney Declaration*,[3] the *Wharerātā Declaration* was endorsed in Australia by key government mental health agencies including the National Mental Health Commission, the Mental Health Commission of New South Wales, and the Government of Western Australia Mental Health Commission. The Queensland Mental Health Commission, forming later, also supports the *Wharerātā Declaration*.

This endorsement underpinned the formation of the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) in 2013–2014. Guided by the *Wharerātā Declaration*, NATSILMH is an independent entity that is supported by the four Australian mental health commissions to provide national leadership in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, and suicide prevention.

In December 2014, NATSILMH undertook to develop a companion declaration to the *Wharerātā Declaration* for use by Aboriginal and Torres Strait Islander peoples. After the release of a discussion paper and a consultation process, the *Gayaa Dhuwi (Proud Spirit) Declaration* was launched on the 27th of August 2015.

The Name of the Declaration

'Gayaa' means happy, pleased and proud, and 'Dhuwi' means spirit in the Yuwaalaraay and Gamilaraay languages of north-west New South Wales.

NATSILMH thanks the Dharriwaa Elders Group and Virginia Robinson for their agreement to use these words to name the Declaration. NATSILMH also acknowledges the late Mr George Rose OAM, the founding Chairperson of the Dharriwaa Elders Group, for helping to preserve the Yuwaalaraay and Gamilaraay languages to the present day.

NATSILMH was directed to the Dharriwaa Elders Group by Ms Pat Delaney (nee Swan) to seek a name for the Declaration. NATSILMH acknowledges her important contributions to Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing as co-author of the landmark 1995 *Ways Forward* report with Professor Beverley Raphael.[4] The principles from that report are adopted by and appended to the *Gayaa Dhuwi (Proud Spirit) Declaration*.

Gayaa Dhuwi is the official name of this Declaration. In adopting these words, it is acknowledged that different meanings might be attached to these words in another Aboriginal and Torres Strait Islander language. The members of that language group should use other local words that reflect the spirit of the Declaration.

Australian governments have committed to supporting the implementation of the *Gayaa Dhuwi (Proud Spirit) Declaration* under Action 12.3 of the Fifth National Mental Health and Suicide Prevention Plan. To that end (NATSILMH) was funded to deliver four state-level workshops over 2018-2019 by the COAG Mental Health Principal Committee - responsible for 'Fifth Plan' implementation. The five themes of the *Gayaa Dhuwi (Proud Spirit) Declaration* are set out in the text box below. For the Declaration itself see: https://natsilmh.org.au/sites/default/files/WEB_gayaa_dhuwi_declaration_A4-2.pdf.

Five themes of the *Gayaa Dhuwi (Proud Spirit) Declaration*

1: Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.

2: Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

3: Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.

4: Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.

5: Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system

Because of synergies between the *Gayaa Dhuwi (Proud Spirit) Declaration* and the *Indigenous Governance Framework*, NATSILMH and CBPATSISP partnered to deliver eight workshops became possible. a total of eight workshops that promoted both documents were an opportunity that enriched the work of both organisations.

Almost 400 stakeholders attended the workshops including from:

- Indigenous communities
- Aboriginal Community Controlled Health Services
- Indigenous peak bodies
- Primary Health Networks
- Local Hospital Networks
- State and Territory governments' mental health departments
- the Commonwealth Department of Health
- the Commonwealth National Indigenous Australians Agency
- Mainstream mental health and suicide prevention bodies.

The details of the workshops are set out below:

Date	**Place**	**Sponsoring organisation**	**Attendees**
14 Nov 2018	Brisbane	Queensland Mental Health Commission	56
1 March 2019	Sydney (1)	With the COAG Mental Health Expert Reference Committee	14
18 April 2019	Melbourne	Victorian Govt Dept of Health and Human Services	57
3 May 2019	Sydney (2)	Mental Health Commission of NSW	60
3 July 2019	Perth	Western Australian Government Mental Health Commission	64
19 September 2019	Adelaide	Nunkuwarrin Yunti of South Australia	46
26 September 2019	Darwin	Aboriginal Medical Service Northern Territory (AMSANT)	50
18 November 2019	Canberra	National Indigenous Australians Agency (Tasmanian representatives invited)	35

2. The Workshops

The State and Territory workshops followed the same format. Each was opened with a Welcome to Country followed with a presentation on the local context. Presentations on the *Gayaa Dhuwi (Proud Spirit) Declaration* and *Indigenous Governance Framework* then occurred to supplement reading material issued prior to the workshop.

The workshops were then structured around five challenges that relate to *Gayaa Dhuwi (Proud Spirit) Declaration* and *Indigenous Governance Framework* implementation. Particular focus was on delivering the former's 'best of both worlds' approach to Aboriginal and Torres Strait Islander mental health, and its focus on Aboriginal and Torres Strait Islander presence as workers, practitioners and leaders within the mental health system as ways to achieving that goal. The five challenges included:

- Supporting ACCHSs enhanced role in the mental health space.
- Identifying and achieving the required mix and level of Aboriginal and Torres Strait Islander specialist mental health workforce to meet the social and emotional wellbeing and mental health needs of Indigenous people and communities.
- The role of cultural and traditional healers and how Indigenous people and communities can access these healers.
- Supporting and promoting Aboriginal and Torres Strait Islander leadership in the mental health system.
- Ensuring co-design is consistently used in efforts to strengthen Indigenous social and emotional wellbeing and improve mental health.

The workshop also looked at these challenges as they relate to agencies working in the mental health and related space, and how to ensure Indigenous governance is ensured, including by supporting co-design and community control within the mental health sector.

For each of the five challenges, in table-based discussions participants were asked to identify:

- What was already taking place to implement or address the respective challenge.
- What were the barriers to implementation or barriers to addressing the respective challenge.
- What could be done to ensure effective implementation in the short /medium term.

From each workshop a State or Territory-specific report was developed. These are available on the resources page of the CBPATSISP website.

Key ideas from the State and Territory workshops were organised thematically and presented at the national workshop. These are re-issued in Appendix 1.

The aim of the national workshop was not to generate new strategic directions as such, but to explore how the Commonwealth and national bodies could support the strategic directions identified across at least three of the State and Territory workshops and as demonstrating cross-jurisdictional support.

A further aim was to consider the role that Gayaa Dhuwi (Proud Spirit) Australia, the peak Indigenous social and emotional wellbeing, mental health and suicide prevention body announced by the Commonwealth Minister for Health on 9 September 2019, might play in all the above.

NATIONAL WORKSHOP REPORT

1. Supporting ACCHSs enhanced role in the mental health space

<table>
<tr><th>What we heard at the State and Territory workshops</th><th>What we asked the national workshop participants</th><th>What we heard at the national workshop about how the national level could support jurisdictional change and change ‘on the ground’</th></tr>
<tr><td>Place-based service delivery. Services should aim to meet people in their communities and homes. Indigenous led partnerships with mainstream services to deliver and support mental health services in ACCHSs. Co-locate mainstream service mental health and related staff in ACCHSs. Such staff should receive local community approved ‘cultural training’.</td><td rowspan="5">How can we cement place-based service delivery, including by ACCHSs, as a non-negotiable in Indigenous mental health service delivery? What levers do we have available at the national level?</td><td rowspan="5">Service capacity and staffing levels are largely one and the same thing (but with potential additional requirements for capital works and equipment). (This then connects with ‘3. Expanding the mental health workforce’ below.)
As already set out in Strategy 1A of the National Aboriginal and Torres Strait Islander Health Plan Implementation Plan (2015), under Indigenous leadership:
Develop national ACCHSs place-based service models for different sized communities (2500, 1000, 500, 100) but that are otherwise flexible enough to account for local difference and needs related to particular challenges. For example: in general, for each 500 Indigenous residents there is one place based, culturally competent psychologist, but with additional weighting for areas with high rates of suicide and further opportunities for community-level tailoring.
Identify gaps at the community-level based on the above by comparing models with actual service capacity. This then feeds to regional-level and national level needs identification.
Plan to systematically meet those gaps within ambitious yet realistic timeframes including through the below.</td></tr>
<tr><td>ACCHSs as a platform for care coordination - across the steps of the ‘stepped care’ mental health system – coordinating outreach psychiatrists/ GPs/ social supports in recovery. Telehealth based in ACHHSs. Cross agency case management to be coordinated from ACCHS,</td></tr>
<tr><td>Building community level capacity around mental health – proactive training of non-clinical workers MHFA. Services including ACCHSs are only one part of the mix of responses needed.</td></tr>
<tr><td>Funding models appropriate to ACCHSs providing long-term, integrated support work in SEWB, mental health and suicide prevention as well as physical health. Move beyond the fee for service model where appropriate (such as an annual fee per client, per family, per community).</td></tr>
<tr><td>PHN commitment to support ACCHSs based mental health and suicide prevention programs through Reconciliation Action Plans</td></tr>
<tr><td>ACCHSs-based Social and Emotional Wellbeing and Mental Health (SEWB&MH) Teams should be supported to be flexible and genuinely client centred. They should break down ‘local siloes’ and connect up existing local organisations to support their work. This might include co-locating and place staff from other organisations to ACCHSs as Team members (i.e. a weekly ‘clinic’ with housing support officers). Teams should have access to funds to enable them to work flexibly and outside of siloes. For example, if someone requires time on Country to help with their SEWB and mental health, a Team should be able to provide them transport to Country if that is deemed appropriate. Teams should be formally connected to relevant cultural healers and leaders to enhance their work and effectiveness.</td><td>How can we best enable the national roll out of Mental Health and Social and Emotional Wellbeing Teams in ACCHS? What levers do we have available at the national level?</td><td>Direct funding streams to ACCHS from the DOH and PM&C/NIAA provide a good place to start and exercise leverage. Additional funding is required – for example, for the upskilling existing workers to take up positions within teams.
Further, DoH-PHN contracts could be leveraged to require the commissioning of services with conditions that staff are co-located within ACCHSs SEWB&MH Teams for set periods.
National support (DoH/ NIAA?) in commissioning identifying and disseminating best practice in SEWB&MH Teams.</td></tr>
</table>

2. Mainstream mental health service delivery to Indigenous communities

<table>
<tr><th>What we heard at the State and Territory workshops</th><th>What we asked the national workshop participants</th><th>What we heard at the national workshop about how the national level could support jurisdictional change and change ‘on the ground’</th></tr>
<tr><td>Accountability to Indigenous service users is key. Not all Indigenous people use ACCHSs/AMSs. This should be acknowledged within any overarching approach to mental health service delivery for Indigenous people. As such mainstream service accountability to Indigenous people must be enhanced. In particular:
Communities need to know how well PHNs and LHDs are operating in the space already. How is dedicated Australian Government Indigenous mental health and suicide prevention funding intended for them being spent? What are the gaps remaining?
Indigenous led, national standardised assessment of service cultural safety and staff cultural competence in mainstream services should be developed.
Community members should have a role in the evaluation of services that work in their communities.
Indigenous client feedback should be sought independently and taken as the basis for action and in acknowledgement of their lived experience of a service.
Culturally safe service delivery should be linked to mainstream mental health service contracts, key staff KPIs.</td><td>How do we ensure that PHNs are accountable for the Indigenous mental health and suicide prevention funding they receive? What levers do we have available at the national level?</td><td>Agreed national checkpoints/ steps for PHN’s to follow at all stages of service commissioning in Indigenous communities (needs assessment/ planning/ commissioning/ implementation/ evaluation) that demonstrate how communities have codesigned services and otherwise are involved in ongoing governance.
DoH - PHN service contracts/ schedules are an effective leverage point for the above and for Gayaa Dhuwi (Proud Spirit) Declaration implementation including by use of KPIs to ensure Indigenous access to the ‘best of both worlds’ in mental health care (cultural and clinical responses). For example, access to cultural healers.
Best practice guidelines, mentoring and so on could be provided to support the above and other mainstream-focused ‘best of both worlds’ initiatives.
National template for contracts re: PHN commissioning of services for Indigenous communities developed with NACCHO and Gayaa Dhuwi (Proud Spirit) Australia
Formal and publicly available evaluations against the above that allow for transparency and show where Indigenous specific funding is going, and how much mainstream funding can be identified as reaching Indigenous people, Indigenous employment resulting and so on.
See employment and leadership below.</td></tr>
<tr><td>Cultural safety and competence should include mainstream service/ staff familiarity with local Indigenous language/ Plain English ways to describe symptoms of mental health difficulties. Mainstream service staff need training to work with families not just individuals.</td><td rowspan="2">How do we develop an Indigenous-led, national standardised assessment of service cultural safety and staff cultural competence in mainstream services? What levers do we have available at the national level?</td><td rowspan="2">Gayaa Dhuwi (Proud Spirit) Australia, NACCHO and the Commonwealth partner to lead COAG towards the adoption of standardised cultural safety assessment tools for use by (a) PHNs in commissioning and evaluating services (b) Local Hospital Networks (c) Professional bodies in relation to the cultural competence of staff (d) as required.
Evaluation processes must be centred on the experience of Indigenous service users.
Publicly accessible report cards on service cultural safety should be available to guide Indigenous service users and otherwise to stimulate change at the service level.</td></tr>
<tr><td>Work is required to support services and identify cultural needs of clients in a consistent way – e.g. including through guidelines developed through an Indigenous-led process and with Indigenous staff in place to make assessments.</td></tr>
</table>

3. Expanding the Indigenous mental health workforce

What we heard at the State and Territory workshops	What we asked the national workshop participants	What we heard at the national workshop about how the national level could support jurisdictional change and change 'on the ground'
Positions and offices requiring Indigenous specialist mental health workers are made 'identified" positions according to 1. co-designed, state-wide or national criteria and 2. co-design process that involve communities and people with lived experience and address particular community needs.	**How do we enable a significant affirmative action program to employ Indigenous staff at all levels of the mental health system at least population parity? What levers do we have available? What role do worker-population ratios, identified positions, quotas, and targets have to play in this program? What is the role of the professional colleges?**	• A significant increase in dedicated funding for the training of indigenous MH workers and professionals within a national strategic approach and with regional and community-level focuses is required. • Workforce reform should support place-based service delivery. • LHN and DoH - PHN service contracts/ schedules are an effective leverage point for Gayaa Dhuwi (Proud Spirit) Declaration implementation including employment. E.g.: PHN-commissioned services for indigenous communities must be with indigenous service providers and/or delivered by providers to ensure Indigenous people are employed in at least 50% of key roles • In turn, within PHNs, staff KPIs could support the above. • The success of the LIME Network in increasing the graduation of Indigenous doctors from Australian medical schools to population parity levels (i.e. 3 per cent) provides a minimum target as a starting point and potential template for similar programs across social work and the mental health professions (psychology, psychiatry and so on). See: https://www.limenetwork.net.au/ • Gayaa Dhuwi (Proud Spirit) Australia, relevant Indigenous peaks (such as the Australian Indigenous Psychologists Association) and the Commonwealth partner with each profession/ professional college to develop and help implement a profession-specific national plan to achieve population parity with ambitious yet realistic targets for achievement. Accountability for achievement. • As affirmative action, further increased support packages for Indigenous students (cultural safety in education spaces, scholarships, accommodation, mentoring and financial support) should be considered. Whole new ways of place-based working should also be considered that meets Indigenous students where they are should be a part of the above - i.e. university presence in communities/ recruitment drives from within communities, schools and so on. • Consistent approach to retention of Indigenous staff is also critical. Here too, national standards of cultural safety in service delivery are important (see above) in addition to allowing and accommodating additional needs and stresses experienced by Indigenous staff in some settings, (cultural leave and so on). Professional colleges should
Co-designed population - worker ratios at national, state, Territory, regional and even community levels based on need. Link to targets and ensure accountability for reaching targets.		
Recognise lived, cultural and community experience to help Indigenous people gain access to mental health employment opportunities.		
Incentives and flexible arrangements for attracting and retaining remote and rural mental health staff. Housing, TOIL, additional pay, holidays and other incentives. Consideration should be given to Indigenous specific leave for cultural matters. The pay scale of Indigenous workers should be reconsidered with greater weight and remuneration for lived, cultural and community experience.		
Burn out of staff must be addressed: Annual Indigenous mental health worker needs assessments and training to meet needs and avoid burn out should be a condition of employment.		
Universities and professional colleges should embark on a mental health professional training program based on the LIME model that has achieved and maintained Indigenous population parity for entry into medical schools. Medical colleges proactively recruiting suitable people in communities – reaching out to communities to identify candidates for training.		
Significantly expand Indigenous scholarship programs for mental health qualifications		
Recognise lived, cultural and community experience to help Indigenous people gain access to educational opportunities.		
Mentors and trainers are employed within ACCHSs for the upskilling of, existing Indigenous workers on site, and so training does not result in staff shortages.		

		be required to address Indigenous support needs on a profession-by-profession basis. • National new and emerging workforce professional qualifications should be further supported and developed. Examples include the narrative therapy courses offered through Nunkuwarrin Yunti and the Djirruwang Program at Charles Sturt University. • Connecting Indigenous workforces (i.e. annual national conferences, networks, communities of practice) should be supported. • All services and relevant parties (including professions) should be required to publish their Indigenous workforce levels, targets and information demonstrating what they are doing to meet those targets.

4. Cultural healers

At the state and regional levels, how do we ensure Indigenous people and communities are able to access cultural and traditional healers?

What we heard at the State and Territory workshops	What we asked the national workshop participants	What we heard at the national workshop about how the national level could support jurisdictional change and change ‘on the ground’
Evaluation of the above *WA Mental Health Act* and the *SA Mental Health Act*, funding models, programs and experience with a view to national roll out of legislation and programs to ensure access to cultural healers. Work to ensure the adoption of consistent legislation across the country.	**How can Indigenous access to cultural healers be supported from the national level? What levers do we have available?**	• Cultural healers, Gayaa Dhuwi (Proud Spirit) Australia and the Commonwealth partner to lead the adoption of a non-prescriptive but – as much as possible - consistent legislative and/or regulatory framework around cultural healers that empowers communities to identify and support their cultural healers and otherwise supports their remuneration and integration into the mental health system. Community processes to identify cultural healers is critical to community ‘buy in’ and the most effective way of managing risk in this space. • Trial national funding options including through the MBS. • Promote integrated clinical treatment and cultural healing in national strategic responses. Support research in these areas • Support clinicians and cultural healers to work together effectively with clients – best practice guidelines, training and so on. Support research in these areas
The knowledge (collective intellectual property) underpinning cultural healing and practice should be protected by legislation. The continuation of cultural healing traditions should be supported.		
Cultural healers should be remunerated appropriately including by being supported through health insurance, the MBS and brokerage programs (e.g. SA Traditional Healers Brokerage Program)		
PHN-commissioned service and LHD or equivalent staff should be trained/ resources to identify potential need for cultural healers/ work with cultural healers/ referral pathways.		
Communities must be empowered to identify cultural healers. Otherwise, the systems around cultural healing should be respectful/not be overly bureaucratic. The balance between community control and recognition for governmental purposes must be struck.		
State-wide registers of cultural healers under control of Indigenous State/ Territory Indigenous health peak bodies		

5. Indigenous Leadership Across the Mental Health System

Design a five-year program to identify and fill relevant mental health governance and leadership positions within government, Health and Hospital Networks, and PHNs with suitably qualified Indigenous people.

<table>
<tr><td>Positions and offices requiring Indigenous leadership are identified at the national, state and territory, regional, community - level by co-design-based processes that involve communities and people with lived experience and that at the local level address particular community needs. Support with legislation if necessary. Link matching those positions to Indigenous employees to KPIs/ PHN and HHS service contracts. Connect to targets/ succession planning. Link a 5-year program to the national mental health plan five-year cycle and national leadership in implementing the program -- achieve program through the 5 years of the '6th National Mental Health and Suicide Prevention Plan'?</td><td rowspan="4">What do we need to ensure Indigenous leadership at all levels and in relevant parts of the mental health system? Consider - legislation, policy, contractual arrangements, KPIs, targets/ succession planning, training and mentoring programs and so on.</td><td rowspan="4">• LHN and DoH - PHN service contracts/ schedules are an effective leverage point for Gayaa Dhuwi (Proud Spirit) Declaration implementation including in relation to Indigenous leadership – e.g. LHN and PHN Boards must include a senior representative from local ACCHSs.
• Consistent approach to retention of Indigenous leaders is also critical (e.g. cultural safety, accommodating additional stresses experienced by Indigenous leaders in some settings, cultural leave and so on.
• Connecting Indigenous leaders (i.e. annual national conferences, networks, communities of practice) should be supported.</td></tr>
<tr><td>Support unique needs of Indigenous leaders - cultural leave recognised for Elders in leadership roles, time 'yarning' with communities, and other community, cultural strengthening activities. Shared leadership roles an option.</td></tr>
<tr><td>Training and mentoring programs offered to people, Elders and emerging Elders to occupy leadership positions, i.e. director training for working on Boards and other committees. Training and mentoring offered to emerging young Indigenous leaders.</td></tr>
<tr><td>Require a balance of male and female Indigenous / ACCHSs Board leadership representation on PHNs and LHDs or their equivalents. Link to PHN and LHD service contracts/ senior staff KPIs.</td></tr>
</table>

6. Co-design

Identify planning and development processes that should be co-designed with Indigenous communities, governing bodies, consumers and lived experience groups. With reference to CBPATSISP's Indigenous Governance Framework, design a framework to ensure co-design is consistently used in efforts to improve Indigenous social and emotional wellbeing and mental health

<table>
<tr><td>ALL SEWB, mental health and suicide prevention policies, services, funding models, programs aimed at indigenous people and communities. Looking Forward Project – exemplary WA example</td><td rowspan="2">Develop the outline of a framework for a national process whereby Indigenous-specific mental health services for Indigenous consumers are co-designed and implemented.</td><td rowspan="2">• Is co-design or self-determination the right framework? National level Indigenous mental health consumer network to oversee a national approach (with regional and community level flexibility) to mental health and related service co-design. The network could be organised by Gayaa Dhuwi (Proud Spirit) Australia with additional funding as required.
• ILO Convention 169 could be ratified to support a human rights approach to Indigenous-specific service delivery that includes the co-design of services</td></tr>
<tr><td>ACCHS expanded role in mental health service delivery - Development of MH&EWB Teams responsive to community needs (scope and key roles). Addressing community concerns with privacy re: ACCHSs and mental health service delivery</td></tr>
</table>

APPENDIX 1: STATE AND TERRITORY WORKSHOP SUMMARIES ARRANGED UNDER SIX THEMES

The below represents a thematic analysis of workshop outcomes and consolidation of outcomes where possible. Where more than three workshops mentioned a particular response as a way to implement the *Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* or *Indigenous Governance Framework* it is highlighted in the far-right column with green shading. The question of national support for and/or implementation of the thrice supported strategic directions underpinned the national workshop.

1. Supporting ACCHSs enhanced role in the mental health space
How do we achieve a state-wide and regional mental health system where ACCHS play a much greater role in promoting, preventing, detecting and treating mental health challenges, and in recovery, in Indigenous settings, including through building ACCHS-based Mental Health & Social and Emotional Wellbeing Teams?

	QLD	MHERP	Vic	NSW	WA	SA	NT	3+
Place based service delivery – ACCHSs operations								
ACCHSs' enhanced formal mental health and suicide prevention roles should be driven from within governments by suitably qualified Indigenous people employed at senior levels.							*	
Grow services from the ground up, build on success. In cases where ACCHS do not exist, existing ACCHSs should be considered for providing expanded outreach service provision to these areas rather than establishing new services at first instance.	*						*	
Place-based service delivery. Services should aim to meet people in their communities and homes. Indigenous led partnerships with mainstream services to deliver and support mental health services in ACCHSs. Co-locate mainstream service mental health and related staff in ACCHSs. Such staff should receive local community approved 'cultural training'.	*				*		*	
ACCHSs work to a 'no wrong door' policy. As appropriate, ACCHSs supported to provide 24/7 mental health support for people or families as a culturally safe alternative to hospital EDs.			*		*			
ACCHSs as a platform for care coordination - across the steps of the 'stepped care' mental health system – coordinating outreach psychiatrists/ GPs/ social supports in recovery. Telehealth based in ACHHSs. Cross agency case management to be coordinated from ACCHS,	*				*		*	
Indigenous-specific SEWB and mental health assessment tools and resources to be evaluated and/or developed for use in ACCHSs.			*					
Strength based approach. Evaluate, document and promote ACCHSs success stories in MH&SEWB/ suicide prevention work.					*		*	

ACCHSs contribute to ‘real time’ suicide data collection on actual, attempted, threatened suicide(s) in communities to galvanise assistance to those communities.					*			
Building community level capacity around mental health – proactive training of non-clinical workers MHFA. Services including ACCHSs are only one part of the mix of responses needed.					*	*	*	
More young people should be employed in ACCHSs to encourage peers to use services.							*	
Australian governments								
Funding models appropriate to ACCHSs providing long-term, integrated support work in SEWB, mental health and suicide prevention as well as physical health. Move beyond the fee for service model where appropriate (such as an annual fee per client, per family, per community).	*			*	*	*	*	
MBS reform to support enhanced ACCHSs role.					*	*		
Embed the *Gayaa Dhuwi (Proud Spirit) Declaration* in all future mental health policy at all levels as a guiding set of principles including the renewed *National Mental Health Policy.*		*						
Implement existing national policy re: enhanced ACCHS role in mental health (i.e. *Fifth National Mental Health and Suicide Prevention Plan National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017- 2023*)	*				*			
Role of PHNs								
Document relationships where PHN- allocated mental health and suicide prevention funding (Indigenous specific and otherwise) has been successfully used to support enhanced ACCHS-based mental health and suicide prevention programs. Extract learnings for wider application	*							
PHN commitment to support ACCHSs based mental health and suicide prevention programs through Reconciliation Action Plans	*					*	*	
Establish and promote an Indigenous procurement agency or body to support Indigenous entrepreneurs and smaller organisations including ACCHSs compete for PHN contracts in commissioning processes.					*			
Utilising ‘ACCHSs as preferred providers of mental health services in communities’- principle. Get PHNs ‘on board’. Staff training about ACCHSs.						*	*	
ACCHSs-based Mental Health and Social and Emotional Wellbeing Teams (Teams)								
Teams should be supported to be flexible and genuinely client centred. They should break down ‘local siloes’ and connect up existing local organisations to support their work. This might include co-locating and place staff from other organisations to ACCHSs as Team	*				*		*	

	QLD	MHERP	Vic	NSW	WA	SA	NT	3+
members (i.e. a weekly 'clinic' with housing support officers). Teams should have access to funds to enable them to work flexibly and outside of siloes. For example, if someone requires time on Country to help with their SEWB and mental health, a Team should be able to provide them transport to Country if that is deemed appropriate. Teams should be formally connected to relevant cultural healers and leaders to enhance their work and effectiveness.								
Diversity in ACCHSs staff/ team memberships (such as LGBTIQ, youth, lived experience) and capacity to provide customised care pathways to different cohorts. Teams must be able to work effectively with people with disabilities	*				*			

2. Mainstream mental health service delivery to Indigenous communities

	QLD	MHERP	Vic	NSW	WA	SA	NT	3+
Accountability to Indigenous service users is key. Not all Indigenous people use ACCHSs/AMSs. This should be acknowledged within any overarching approach to mental health service delivery for Indigenous people. As such mainstream service accountability to Indigenous people must be enhanced. In particular: • Communities need to know how well PHNs and LHDs are operating in the space already. How is dedicated Australian Government Indigenous mental health and suicide prevention funding intended for them being spent? What are the gaps remaining? • Indigenous led, national standardised assessment of service cultural safety and staff cultural competence in mainstream services should be developed. • Community members should have a role in the evaluation of services that work in their communities. • Indigenous client feedback should be sought and taken as the basis for action and in acknowledgement of their lived experience of a service. • Culturally safe service delivery should be linked to mainstream mental health service contracts, key staff KPIs.	*			*	*	*		
GPs and primary health care providers need far more attention as a 'front line' where Indigenous people and non-Indigenous health staff/ mental health staff interact.						*		
An enhanced role for ACCHSs does not mean relinquishing the stepped care model of mental health service delivery with all parts of the overall system continuing to playing their part. In other words, an enhanced role for ACCHSs does not mean that people with severe and	*				*			

complex mental health needs, or when in crisis, are referred to ACCHSs at first instance and when other parts of the model have responsibilities for them.								
Cultural safety and competence should include mainstream service/ staff familiarity with local Indigenous language/ Plain English ways to describe symptoms of mental health difficulties. Mainstream service staff need training to work with families not just individuals.		*			*	*	*	
Work is required to support services and identify cultural needs of clients in a consistent way – e.g. including through guidelines developed through an Indigenous-led process and with Indigenous staff in place to make assessments.			*		*	*		

3. Expanding the Indigenous mental health workforce								
	QLD	**MHERP**	**Vic**	**NSW**	**WA**	**SA**	**NT**	**3+**
The need for joint male and female workers roles to meet gendered cultural needs should be assumed unless otherwise indicated in services.	*					*		
Workers should be trauma-informed/ trained as a core qualification.	*					*		
Indigenous workers are particularly important for working with people in the critical window after a suicide attempt where suicide made be re-attempted without appropriate or sensitive care.	*							
Peer workers have been recognised as essential to effective mental health treatment and it's important that they are recognised as core workforce members and not merely a 'support program'.		*						
Affirmative action to expand the Indigenous specialist mental health workforce								
At the State-Territory level, appoint a dedicated Indigenous officer with responsibility to coordinate and support indigenous mental health worker and professional recruitment.				*	*			
Positions and offices requiring Indigenous specialist mental health workers are made 'identified" positions according to 1. co-designed, state-wide or national criteria and 2. co-design process that involve communities and people with lived experience and address particular community needs.	*			*	*	*		
The *National Mental Health Workforce Strategy* must include increasing the Indigenous mental health workforce as a priority area, in alignment with Indigenous mental health being a 'Fifth Plan' priority.		*		*				

Co-designed population - worker ratios at national, state, Territory, regional and even community levels based on need. Link to targets and ensure accountability for reaching targets.	*	*	*	*	*	*		
Achieving the targets should include by linking them to PHN and LHD or equivalent service contracts/ senior staff KPIs. Standing item on PHN and LHD or equivalent relevant committees and Boards.	*		*					
Mandate Indigenous employment quota levels in mainstream services (i.e. 6- 10% of clinical staff must be Indigenous).						*		
Recruitment and retention								
Recognise lived, cultural and community experience to help Indigenous people gain access to mental health employment opportunities.	*		*	*		*		
Multiple and flexible recruitment models. Apprenticeship/ cadetship models from communities to services as a pathway into mental health. Supervision key.				*		*		
Incentives and flexible arrangements for attracting and retaining remote and rural mental health staff. Housing, TOIL, additional pay, holidays and other incentives. Consideration should be given to Indigenous specific leave for cultural matters. The pay scale of Indigenous workers should be reconsidered with greater weight and remuneration for lived, cultural and community experience.	*		*	*	*	*		
Longer term service funding models, in turn, supports recruitment and retention of staff more likely to commit to working in remoter areas and for longer periods.				*				
Burn out of staff must be addressed: Annual Indigenous mental health worker needs assessments and training to meet needs and avoid burn out should be a condition of employment.				*		*	*	
Establish State and Territory communities of practice to support Indigenous mental health workers/ conferences, and other opportunities.			*					
Indigenous people and community representatives should control and otherwise oversee recruitment processes for services and programs intended for them. Workers should be assessed as to the effectiveness of their practical work in real community situations.	*							
Education and Training								
Universities and professional colleges should embark on a mental health professional training program based on the LIME model that has achieved and maintained Indigenous population parity for entry into medical schools. Medical colleges proactively recruiting suitable people in communities – reaching out to communities to identify candidates for training.	*			*		*	*	

<u>Build confidence before competence</u>. Start while young! Identify promising child and youth candidates, promote training and higher education at school, school visits to ACCHSs and mainstream services; promoting Indigenous role models; involving parents, families, kin and whole communities in opening up possibilities for mental health and health training and higher education. Build and build on aspiration. Actively promote careers in mental health to Indigenous younger people; get families on board (i.e. Nunkuwarrrin Yunti training programs)						*	*	
Significantly expand Indigenous scholarship programs for mental health qualifications			*			*	*	
Recognise lived, cultural and community experience to help Indigenous people gain access to educational opportunities.	*		*			*	*	
Mentors and trainers are employed within ACCHSs for the upskilling of, existing Indigenous workers on site, and so training does not result in staff shortages.	*					*	*	
Spcialised training institutions (an Indigenous University) with outreach for remote community education. Specialised Indigenous mental health education should be developed with AHPRA e.g. Psychology (Aboriginal psychology) as a qualification; diploma qualifications in narrative therapy.					*	*		
More emphasis on educating/training non-Indigenous staff to work effectively with Indigenous clients <u>and within ACCHSs</u> while in university/ training, rather than from the workforce. Placements in ACCHSs while training.						*	*	

4. Cultural healers

At the state and regional levels, how do we ensure Indigenous people and communities are able to access cultural and traditional healers?

	QLD	MHERP	Vic	NSW	WA	SA	NT	3+
Legislative and government support								
Evaluation of the above *WA Mental Health Act* and the *SA Mental Health Act*, funding models, programs and experience with a view to national roll out of legislation and programs to ensure access to cultural healers. Work to ensure the adoption of consistent legislation across the country.	*	*	*	*			*	
At the state and regional levels, cultural healing opportunities should be mapped against the stepped system of mental health care.	*							
The knowledge (collective intellectual property) underpinning cultural healing and practice should be protected by legislation. The continuation of cultural healing traditions should be supported.	*		*		*		*	

Cultural healers should be remunerated appropriately including by being supported through health insurance, the MBS and brokerage programs (e.g. SA Traditional Healers Brokerage Program)	*	*	*		*		*	
PHN-commissioned service and LHD or equivalent staff should be trained/ resources to identify potential need for cultural healers/ work with cultural healers/ referral pathways.	*	*	*	*		*	*	
Role of cultural healers in suicide prevention should be explored.						*		
Community focused								
Cultural healers should be connected to ACCHSs wherever possible.					*	*		
Communities must be empowered to identify cultural healers. Otherwise, the systems around cultural healing should be respectful/not be overly bureaucratic. The balance between community control and recognition for governmental purposes must be struck.	*	*	*				*	
State-wide registers of cultural healers under control of Indigenous State/ Territory Indigenous health peak bodies			*	*			*	
Healing places and bush medicine should also be recognised and incorporated into an overall cultural healing approach.	*							
Recognition of and healing of sites where massacres occurred might play an important role in community healing.					*			
The establishment of healing centres in communities to support Indigenous peoples' access to cultural healers and healing should be considered.	*							
Promotion of and pathways to cultural healing to Indigenous young people – i.e. through football				*				

5. Indigenous Leadership Across the Mental Health System

Design a five-year program to identify and fill relevant mental health governance and leadership positions within government, Health and Hospital Networks, and PHNs with suitably qualified Indigenous people.

	QLD	MHERP	Vic	NSW	WA	SA	NT	3+
Treaty is the ultimate context of restoring Indigenous self-governance and control over life - including for Indigenous leadership within relevant parts of the mental health system and in suicide prevention.						*		
State level Indigenous mental health leadership groups.				*	*			
Positions and offices requiring Indigenous leadership are identified at the national, state and territory, regional, community - level by co-design-based processes that involve communities	*		*	*	*	*		

and people with lived experience and that at the local level address particular community needs. Support with legislation if necessary. Link matching those positions to Indigenous employees to KPIs/ PHN and HHS service contracts. Connect to targets/ succession planning. Link a 5-year program to the national mental health plan five-year cycle and national leadership in implementing the program -- achieve program through the 5 years of the '6th National Mental Health and Suicide Prevention Plan'?								
Support unique needs of Indigenous leaders - cultural leave recognised for Elders in leadership roles, time 'yarning' with communities, and other community, cultural strengthening activities. Shared leadership roles an option.	*		*			*		
Training and mentoring programs offered to people, Elders and emerging Elders to occupy leadership positions, i.e. director training for working on Boards and other committees. Training and mentoring offered to emerging young Indigenous leaders.	*		*	*	*	*	*	
Document and promote Indigenous leadership in mental health success stories.				*				
Indigenous Governance Framework (IGF) – leadership in the mainstream								
The IGF should be promoted to PHNs and LHDs or equivalents. It provides clear guidance on how to work with Indigenous bodies and communities in leadership positions and includes guidance on co-design and other empowering processes that place Indigenous bodies and communities in positions of real power and influence in service delivery.		*						
Require a balance of male and female Indigenous / ACCHSs Board leadership representation on PHNs and LHDs or their equivalents. Link to PHN and LHD service contracts/ senior staff KPIs.	*		*	*		*		
Local community Elders/cultural mentors for PHN/ LHD and equivalent CEOs, Boards (e.g. 'Elders in residence" model of the WA Mental Health Commission			*			*		

6. Co-design

Identify planning and development processes that should be co-designed with Indigenous communities, governing bodies, consumers and lived experience groups. Design a framework to ensure co-design is consistently used in efforts to improve Indigenous social and emotional wellbeing and mental health

	QLD	**MHERP**	**Vic**	**NSW**	**WA**	**SA**	**NT**	**3+**
Codesign at the community level requires a commitment from Australian governments to decentralise further down from the regional to community level.			*					

Reflecting its importance, co-design processes should aim to remunerate those involved.				*		*		
MOUs between ACCHSs/ PHNs/ LHDs or equivalent to help support co-design processes. Co-design must be inclusive of diverse cohorts within the Indigenous population.						*		
Co-design in a two-way process and requires transparency and information sharing around budgets and other matters often considered sensitive.					*		*	
What should be co-designed?								
ALL SEWB, mental health and suicide prevention policies, services, funding models, programs aimed at indigenous people and communities. Looking Forward Project – exemplary WA example			*		*	*	*	
Culturally safe mainstream mental health service environments including details such as staff uniforms; the physical environment – utilisation of artwork, logos and signage; use of Indigenous language terms, and other markers. Looking Forward Project – exemplary WA example.				*	*			
Websites, resources, educational packages aimed at indigenous people				*				
ACCHS expanded role in mental health service delivery - Development of MH&EWB Teams responsive to community needs (scope and key roles). Addressing community concerns with privacy re: ACCHSs and mental health service delivery	*		*		*	*	*	
A range of new worker roles tailored to meet the needs of Indigenous communities within ACCHSs (also mainstream).						*		
Emergency departments/ police – how these services deal with clients experiencing suicide ideation or psychosis. How they relate to ACCHSs.	*							
Gender and LGBTIQ-specific responses, co-design responses aimed at particular groups with diverse groups of people. (More broadly, ACCHSs should have advisory groups for particular consumer cohorts - LGBTIQ, Elders,youth, lived experience and so on)	*							

APPENDIX 2: PROGRAM AND ATTENDEES AT THE NATIONAL WORKSHOP

PROGRAM: Gayaa Dhuwi (Proud Spirit) Declaration Implementation and the Indigenous Governance Framework

18th November 2019

Venue: Hotel Kurrajong,
8 National Circuit, Barton ACT 2600

Facilitator: Professor Kerry Arabena

Time	Item
10.00	**Arrival and registration** (Coffee/tea)
10.15	**Welcome to Country**
10.20	**Attendee Introductions** Led by Professor Kerry Arabena
10.30	**An introduction to:** • NATSILMH, *the Gayaa Dhuwi (Proud Spirit) Declaration*, and the *Fifth National Mental Health and Suicide Prevention Plan* -- • CBPATSISP and the *Indigenous Governance Framework* - • Overview of national workshops • *Gayaa Dhuwi (Proud Spirit) Australia* NATSILMH Chair Mr Tom Brideson and CBPATSISP Director Professor Pat Dudgeon
11.00	Break/ morning tea
11.15	**Session 1: Gayaa Dhuwi (Proud Spirit) Declaration implementation** What we heard in the workshops – Mr Tom Brideson Group work – What can the Australian Government and national-level stakeholders do to support the implementation of: • A 'best of both worlds' (cultural and clinical excellence) in Indigenous mental health service delivery • Improved Indigenous access to cultural healers within mental health service contexts • Improved Indigenous presence and employment across the mental health system • Improved Indigenous leadership in relevant parts of the mental health system What is the role of Primary Health Networks in the above?
1.00	Lunch
1.30	**Session 2: Working Effectively within an Indigenous Governance Framework** What we heard in the workshops – Professor Pat Dudgeon Group work: • Co-design at the national level • Working with Gayaa Dhuwi (Proud Spirit) Australia
3.15	**Next steps**
3.30	**Close**

Attendees in first name alphabetical order

- Ms Adele Cox, CEO, NICRS
- Mr Blair Excell, Manager – Health and Wellbeing Branch, National Indigenous Australians Agency
- Ms Carmen D'Costa, Primary Health Networks Strategy Branch, Australian Government Department of Health
- Mr Chris Holland, NATSILMH EO
- Ms Christine Morgan, Suicide Prevention Adviser to the Prime Minister
- Ms Danielle Dyall, Team Leader - Social Emotional Wellbeing & Trauma Informed Care Support, AMSANT
- Ms Eleanor Donovan, Head of Diversity and Inclusion, Beyond Blue
- Ms Elizabeth Story, Sr Adviser, Mental Health Commission NSW
- Ms Emily Jones, Senior Adviser, Mental Health and Suicide Prevention Section, National Indigenous Australians Agency
- Ms Fadwa Al Yaman, Group Head, Social and Indigenous Group, AIHW
- Professor Helen Christensen, Director, Black Dog Institute
- Professor Ian Ring, Adviser to NATSILMH and CBPATSISP
- Ms Jaelea Skehan, Special Adviser, National Suicide Prevention Taskforce
- Mr Jason Trethowan, CEO of headspace National
- Ms Jessica Foote, Group Manager – Education, Community Safety and Health Division, National Indigenous Australians Agency
- Ms Julie Robotham, CBPATSISP
- Dr Kerry Arabena, Facilitator
- Mr Lance Reilly, Nunkuwarrin Yunti
- Mr Lang Baulch, Principal Project Officer, System Policy and Integration, Mental Health Branch, Victorian Department of Health and Human Services
- Ms Leilani Darwin, Head, Aboriginal and Torres Strait Islander Lived Experience Network
- Mr Mark Roddam, First Assistant Secretary, Mental Health Division
- Australian Government Department of Health
- Mary Guthrie, Australian Indigenous Doctors Association
- Ms Monica Barolits-McCabe, CEO Australian Indigenous Doctors Association
- Ms Monica Saunders, Queensland Mental Health Commission
- Professor Pat Dudgeon CBPATSISP Director
- Mr Rob McPhee, representing Ms Pat Turner, NACCHO
- Dr Ros Knight, Australian Psychological Society President
- Ms Sally Bishop, Director – Suicide Prevention Section, Mental Health Division, Australian Government Department of Health
- Dr Siva Balaratnasingam, RANZCP Aboriginal and Torres Strait Islander Mental Health Committee
- Ms Suz Punch, National Suicide Prevention Taskforce
- Ms Thilini Perera, Lifeline Executive Director Strategy and Stakeholder Engagement
- Mr Tom Brideson, NATSILMH Chair