

Part 1 Opening words and scene setting

Slide 1

Thank you Uncle Chicka Madden for your warm welcome to country. I also acknowledge the Gadigal people of the Eora Nation and their Elders past and present. I also recognise their youth and all youth who will be our future leaders and the custodians of our stories, languages, and cultures.

I thank Eddie Bartnik for his words of wisdom and information that sets the scene for some of what I will talk to today, and Commissioner John Feneley for his kind introduction.

I would also like to thank the Commissioner and his team for the tremendous feat of organising this international event and for asking me to speak to you today. And I recognise Chris Holland for his enduring support to Indigenous health.

While I will not repeat the Commissioner's naming of the many noteworthy people in the room, I do acknowledge them.

And can I make special mention of the Indigenous mental health, addiction and disability leaders, experts, consumers and those with a lived experience here today, including those from New Zealand, Canada and the US, who have travelled so far to be with us.

I welcome all of you to the Combined Meeting of the International Initiative for Mental Health Leadership and International Initiative for Disability Leadership 2017 *Leadership Exchange* in Sydney. **Slide 2**

In the past decade, the world has received 'wake-up calls' about mental health and disability crises in its midst.

- Worldwide, depression is estimated by the World Health Organization to affect more than 300 million people.¹
- About 800,000 die due to suicide every year. It is the second leading cause of death in 15 to 29-year olds across the globe.²
- In 2011, the W-H-O reported 1 billion persons live with disability: about 15 percent of the world's population; with 110 - 190 million people having very significant difficulties in functioning.³

Fora like this are an important part of global mental health and disability movements to address global challenges. Such global responses are appropriate given the common impacts of mental health problems and disabilities on populations. **Slide 3**

Tragically today, those living with a mental health problem or disability are increasingly becoming members of an ‘underclass.’ This challenges our societies’ fundamental values of democratic participation, fairness, social justice and equality of opportunity.

How can our communities truly thrive with such growing social exclusion along health, mental health and disability - defined lines?

How many amazing and enriching contributions from people with mental health problems and disabilities will be missed in such circumstances? **Slide 4**

Conversely, our societies’, communities’ and families’ capacity to thrive is challenged when untreated mental health problems manifest as anti-social behaviors, particularly in the young.

Our families’ capacity to thrive is undermined by overwhelming care responsibilities in the in the absence of adequate support services.

We must not forget that our societies and communities thrive when the families and individuals with them thrive, and fail to thrive when families and individuals fail to thrive. **Slide 5**

Please do not imagine that because Australia is one of the wealthiest nations in the world that, somehow, it stands apart from this global situation. No -- this country is but a microcosm of the world when it comes to the scale of the disability and mental health challenges.

- About 18.5 per cent of the population have a disability. Six per cent have severe or profound disability.⁴
- Over 45 per cent of all Australians are expected to experience a common mental health-related condition such as depression, anxiety or a substance use disorder in their lifetime.⁵
- About 600,000 of us are estimated to have a severe mental illness.⁶
- About 2.7 million are in carer roles of varying kinds. That’s around 12 per cent of the population.⁷

And here, too, the mental health and disability burdens in Australia fall heaviest on some of our most vulnerable citizens: our young, our old, our LGBTI, and our Indigenous peoples among them. **Slide 6**

Suicide provides a stark example of how Indigenous Australians also share challenges with their Indigenous peoples across the world.

- Indigenous Australians have double the rate of suicide of the non-Indigenous population, with our kids dying from suicide at up to five and six times the rate of their non-Indigenous peers.⁸
- Canadian First Nations' suicide rates are twice as high as that of non-Indigenous Canadians⁹
- In the United States, suicide rates among Native Americans have been estimated to be at least 1.5 times higher than the national average¹⁰
- In New Zealand, the suicide rate of Maori people is 1.8 times higher than the Pakeha or non-Maori population. And the young persons' suicide rate is 2.4 times the rate for Pakeha.¹¹

These populations all report worse mental health and disability outcomes than their non-Indigenous peers.

For us, when compared to non-Indigenous Australians:

- We have three times the rate of high and very high psychological distress - affecting about 30 per cent of us.¹²
- We are about 20 per cent more likely to have symptoms associated with clinical depression.¹³
- We are hospitalised for mental health conditions at double the rate of our non-Indigenous peers.¹⁴
- While fewer of us drink alcohol when compared to other Australians, those that do are more likely to be problem drinkers or addicted to alcohol.

Disability for us is inherently connected to our significantly poorer health when compared to other Australians:

- There is a well-known ten-year life expectancy gap between Indigenous and non-Indigenous Australia that itself comprises a bundle of health gaps including the mental health ones discussed.

- Chronic disease and particularly diabetes, which we die from at six times the rate of other Australians,¹⁵ is a major cause of disability.
- Communicable trachoma-caused blindness and otitis media-caused deafness in children is relatively common among us.

While we must support those with existing disabilities, an equally important goal must be the prevention of future disabilities.

This fundamentally means closing the health gap and ensuring Indigenous Australians have access to health care.

In 2012, about one in four of us reported a disability compared to about one in five other Australians.¹⁶ Our 0-14 year olds were more than twice as likely as non-Indigenous children to have a disability.¹⁷

And we typically have greater assistance needs, and are almost twice as likely to require assistance with communication.¹⁸

Whatever our differences, however, what unites us as global disability and mental health leaders is far greater.

What I will do in my keynote today is to discuss how Indigenous Australian leaders have responded to our mental health and disability challenges, and distil some key messages that will, I hope, be of use to all of us here – Indigenous and non-Indigenous, and from whichever part of the world you come from. **Slide 7**

Part 2: Indigenous Australia's health, mental health and disability story

Indigenous Australia has a health, disability and mental health story that must start with the geography, history and politics of this country.

Australia is a seven million square kilometre island continent.

For 50,000 years Indigenous Australians successfully inhabited all parts of this vast landscape - with climates ranging from lush tropical jungles to arid deserts and then to snow-capped mountains.

By 1788, an estimated up to one million of us¹⁹ in almost 250 language groups live here.

Key to the phenomenally long-lived success of our traditional ways of living was - and remains today - our cultures. **Slide 8**

The continuing importance of culture to our health and wellbeing is only just starting to be recognised by non-Indigenous Australia.

It is sometimes said that ‘culture is life’, or that ‘culture is health’ – that is how connected they are understood to be.

The slide above is a diagrammatic expression of this ‘cultural, social and emotional wellbeing’ concept, as we refer to it.

Perhaps the key thing to understand is that the country you walk on, the spirit world, and you, your families’ and your communities’ very being are deeply connected.

And to learn more about this concept, I recommend you look at the *Working Together Book*²⁰ that should be in your conference take-home bag. But in a nutshell, the implications are that health practices to us are more than treating the individual’s body or mind in isolation.

Health is ultimately about restoring wholeness and connection.

You’ll notice on the slide the historical and social determinants circling the Self, and against which cultural, social and emotional wellbeing are providing a protective force.

So what are these historical and social determinants, and how have they challenged our health and our mental health?

In 1788, for us the profoundly traumatic events of colonisation began. I use the term ‘traumatic’ deliberately because colonisation occurred within only three to eight generations of Indigenous people living today. By intergenerational and trans-generational transmission, the trauma is still with many of us. **Slide 9**

This ‘first wave’ of colonisation is not a distant historical event. The last officially sanctioned massacre is recorded at Coniston, in the Northern Territory in 1928.²¹

In a ‘second wave’ of colonisation - from the late 1800s to the 1950s-we were subjected to racist legislation that controlled all aspects of our lives. Many of us were further traumatised by being forced off our country and mixed with different cultural groups on reserves controlled by missionaries.

At best, we might be confined to camps outside of towns under various States’ segregation policies. This is what happened to some of our Elder-folk living today, and to our parents, grandparents and great-grandparents.

The other defining experience of this period was the forcible removal of tens of thousands of our children - who are often referred to as our 'Stolen Generations' - to be assimilated into non-Indigenous society.

Slide 10

Many people living today were directly affected and the trauma transmitted down family lines.

From the 1950s on, segregation and reserves were dismantled as anti-racist and decolonization norms took root in the West. **Slide 11**

The last of the residential facilities closed in the early 1980's and a couple of weeks ago it was announced that 71 former residents of a home for Indigenous Stolen Generation children in Darwin who suffered horrific sexual and physical abuse will be compensated in what their lawyer says is the largest class action in the Northern Territory's history.²²

Legal equality and the restoration of our human rights was of course welcome. But a perverse outcome was that it enabled us to access both welfare and alcohol without restriction. And in practice, legal equality on its own did nothing to bring us closer to the economy, services or any other benefits of Australian citizenship.

This scenario led to what my esteemed colleagues Professors Helen Milroy and Ernest Hunter have referred to as 'normative instability' in many communities - where welfare and alcohol dependence were layered upon trauma and distress: dysfunction in other words.²³

Across the country then, we remained apart in deep collective poverty and without access to political power. We were by that point a small minority in our own land. Even today, we comprise only 3 per cent of the total Australian population.²⁴

But by 1967 there was enough disquiet and international embarrassment about our squalid living conditions that a referendum to change the constitution, and provide the federal parliament with the constitutional power to make laws specifically for Aboriginal people passed - with overwhelming and unprecedented public support of 90.77%.²⁵

The promise was the Commonwealth would step in to ensure we received the services and supports that the States had failed to provide, and rectify decades of segregation.

But this did not start to happen until the mid 1990s.

And while there has been much change since the 1967 referendum, racism and social exclusion remain a defining feature of our lives.

In an authoritative 2016 survey, 57 per cent of Indigenous Australians agreed that Australia is a racist country.²⁶

In 2010, almost ten per cent of Indigenous Australians were estimated to suffer deep and persistent social exclusion compared to approximately five per cent in the general population.²⁷

In this situation, social determinants continue to have a much greater impact on our health, mental health and rates of disability.

Injuries and violence also contribute to both disability, trauma and mental health problems. In 2014-15, more than one in five of us reported experiencing physical or threatened violence: 2.5 times the rate for non-Indigenous people.²⁸

The most frequent recorded contributors to high rates of psychological distress are the deaths of a family member or friend; serious illness; unemployment; and mental illness itself.²⁹ Alcohol and drug use and suicide are also problems in many communities.

Racism, too, cannot be ignored. In a 2016 survey, 37 percent of us reported experiencing verbal racial abuse in the previous six months.

Racism has been connected to psychological distress and trauma in the US African American population and there is little reason to doubt a similar impact among us.

All this hits our families hard. Sexual abuse is reported at higher rates in our communities. Our precious children are eight times more likely to be in child protection services than non-Indigenous. Disabling developmental trauma in our children is an emerging problem. **Slide 12**

For some of us, our continuing social exclusion is connected to where we live in Australia. In 2016, the population of Australia was just over 24 million people, about 10 percent smaller than the combined 2013 population of the Netherlands and Belgium, but spread out in an area over 100 times the size of these two countries.

Eighty-two per cent live in just 50 urban centres. Almost half live in just the Sydney and Melbourne areas.³⁰

This leaves ‘remote’ and ‘very remote’ areas, so called because of their distance from urban centres with their established service hubs.

The remote and very remote areas are shown in blue and purple respectively in the map on the left-hand side of the slide above.

Like the general population, about 80 percent of the estimated 750,000 Indigenous Australians alive today also live in major or regional cities, or close to them.

However, 15 per cent or so live in very remote areas (the purple shaded areas), where they comprise about 45 per cent of the population. That’s tens of thousands of Indigenous Australians.³¹

In these areas, the negative impact of the lack of reach of government health, mental health or disability services, let alone market-driven service providers, falls disproportionately on us. **Slide 13**

Yet there are some compensatory factors in remote living. Research suggests the protective force of practicing culture and ceremony, of being with family and community, of walking on country, and nurturing a fiercely proud Indigenous identity develops resilience against the impact of stress and trauma. The ability to do these things is enhanced in remote areas.³²

But nonetheless, to be living with a disability or mental health problem in these areas is a significant challenge.

I am Chair of Ninti One, an organisation that worked with Indigenous Australians with disability and their carers living in remote towns and communities in the Anangu Pitjantjatjara Yankunytjatjara (APY) lands in South Australia in 2015.

Ninti One was engaged to identify the needs of Indigenous Australians in this region as part of the roll out of the National Disability Insurance Scheme - that Eddie Bartnik referred to earlier.

There, although we noticed people with disability also benefitted in ways from remote living, we found poverty and poor housing, let alone housing modified to allow for disability, was commonplace.

Demanding family and spouse carer roles were the norm.

There was almost no expectation of transformative, life changing disability support on the part of Indigenous clients. There were also gaps in the cultural appropriateness of the services being delivered.

And poor disability literacy meant people with roughly identical disabilities received very different supports.

Part 3: How has Australia and Indigenous Australia responded to this situation? Slide 14

From day one of colonisation, Indigenous peoples and their leaders have resisted, gathered, planned to regain control of their lives. Every decade since has had its heroes who struggled for change.

And Indigenous health leaders have responded to the health, disability and mental health challenges we face at three levels:

1. from within our communities;
2. through our community-based and controlled organisations; and
3. at the macro or State and national - level.

In practice, our leaders might begin leadership roles in their community, lead through community organisations, and eventually emerge as a state or national - level leader. For them, there may be no neat delineation across the levels of leadership in which they operate.

Indeed, they make significant contributions as leaders and advocates precisely because they know our communities and can ensure their voices are heard at the national level.

Even when operating at the state or national level, it is critical for us in leadership roles to not lose touch with our communities. An Indigenous leader is always accountable to those they represent.

This is one reason it is important for governments to not 'cherry pick' Indigenous leaders aligned with their political agendas. Instead, they should look to those with genuine support in communities, or who may otherwise spearhead movements with clear Indigenous support.

I am reminded here, again, of some of the work that Ninti One have done with the exceptional women of the Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara (or N-P-Y) Women's Council.

This organisation formed in 1980 to deliver community, family, research and advocacy services in the vast central desert region of Australia.

Ninti One worked with N-P-Y Women's Council to understand the needs of children and young people with disabilities in these areas to inform the National Disability Insurance Scheme roll out there.

And I note that Andrea Mason, the Chair of the N-P-Y Council, also works at the national level, and was just this month appointed to the Prime Ministers' Indigenous Advisory Council - that formally advises the Australian Government on Indigenous issues.

So here is a classic example of how the three levels of Indigenous leadership inter-relate. **Slide 15**

Focusing now on health and mental health, leadership that has also been built from the ground up.

From the late 1960s on - in the absence of effective government action and as an expression of self-determination - Indigenous community leaders in Sydney and Melbourne organised to provide their own health services.

A 'community controlled' model was developed in which local Indigenous boards of management controlled the services.

Over time, Australian governments began to provide financial support such that 150 or so such services now exist.

Some are big urban medical centres that provide holistic and comprehensive primary health care. Others in remoter areas might be clinics that only have a nurse and a visiting GP or physician.

In regional and remoter areas, Aboriginal Community Controlled Health Services are used by both Indigenous and non-Indigenous people.

Each State and Territory also has a community controlled health services peak body. At the national level, the peak body for community controlled health services is the National Aboriginal Community Controlled Health Organisation, or NACCHO. It has, and continues to play, a key leadership role in the Indigenous health movement. **Slide 16**

On these foundations, in 2006 I was honored as the Aboriginal and Torres Strait Islander Social Justice Commissioner of the Australian

Human Rights Commission to help establish, and act as inaugural Chair of, the Close the Gap Campaign for Indigenous Health Equality.

The Campaign aims to close the ten- year life expectancy ‘gap’ between Indigenous and other Australians using a human-rights based approach with non-negotiables including Indigenous leadership, partnership between us and Australian governments, equality based health planning, and the use of equality targets.

The Campaign membership comprises Australia’s peak Indigenous and non-Indigenous health bodies, health professional bodies and human rights organisations – including NACCHO.

Membership was contingent on agreement that Indigenous lead organisations would always have the final say in how the Campaign operated.

The Campaign was founded on a clear articulation of need with goals and principles based on human rights law. It was framed as both a drive for Indigenous health outcome equality and equality of opportunity for a healthy life.

Eventually over 30 Indigenous and non-Indigenous organisations and bodies joined the campaign and they funded it to be independent and operate a dedicated secretariat.

With the support of Oxfam, the campaign implemented a remarkably effective grass roots strategy to garner the support of the media, the public and Indigenous peoples and communities. Today, National Close the Gap Day, celebrated on the 16th of March, is an important fixture on the Indigenous calendar. **Slide 17**

Politically, the Campaign secured multi-partisan political support through the signing of a Close the Gap Statement of Intent by the then Prime Minister and the leaders of all major political parties at both the national and State and Territory levels.

Critical to our advocacy was agreeing (and endlessly repeating) key messages until they began to be repeated back to us from the mouths of politicians and bureaucrats as if their own ideas. We shaped the discourse in other words.

In this way, we succeeded in securing over \$5 billion in additional funding to address our health, housing and other social determinants.

Further, two health targets were set to ‘close the gap’ in life expectancy by 2031, and to half the under 5 child mortality gap by 2018.³³ Further targets for key social determinants have also been set.

Each year in the first week of Parliament, the Australian Prime Minister makes a statement to the nation on these targets. And the Campaign publishes an independent ‘shadow’ report.

Because progress is slow, the campaign constantly must remind politicians and the media that you cannot turn around the disadvantage of Indigenous Australians overnight. Life expectancy will only lift following improvements to outcomes in numerous areas.

And there are real and positive signs of change. One of my ‘hats’ is that of the National Coordinator Tackling Indigenous Smoking. In this role, and through a significantly funded Indigenous-specific anti-smoking campaign, we are seeing smoking rates consistently drop over time, with potentially hugely beneficial health implications. **Slide 18**

In 2006, when we started the Close the Gap Campaign, mental health was a ‘poor cousin’ to physical health.

In part, this was because we were not yet nationally organised as mental health leadership bodies at that time.

The Australian Indigenous Psychologists Association - the peak body for Indigenous psychologists - was not established until 2008, and the Healing Foundation was established in 2009. And I commend the Healing Foundation to you as a great example of an Indigenous-led healing initiative that has supported many community - level healing programs and activities.

Happily, mental health is now at the heart of efforts to achieve health equality more broadly, as well as being understood as a significant challenge in its own right.

The National Health Leadership Forum, that emerged from the Indigenous leadership group of the Close the Gap Campaign in 2011, is now the overarching national Indigenous health peaks forum.

It has successfully partnered with the Australian Government to develop the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* and has ensured that mental health was included in it.³⁴ A Health Plan Implementation Plan has been subsequently developed and a Task Force is now working on operationalising the Implementation Plan and a multi portfolio Social and Cultural Determinants Working Group is developing a blue print to apply a determinants approach to health programs policy.³⁵ **Slide 19**

The start of the Indigenous mental health movement can be dated to the 1995 'Ways Forward' national Indigenous mental health report developed under joint Indigenous and non-Indigenous leadership.

The growing movement was boosted when the 1997 *Bringing them home* report 'brought home' the impact of forcible child removals on our mental health.³⁶

Bringing them home recommended a national Apology that was eventually made by the Australian Government in 2008. I had the privilege to be nominated by the Stolen Generations peoples to provide the formal response to the Apology on their behalf.

Over the past decade, the Governments of the States and Territories have also apologised. More recently, I commended the Australian Psychological Society for its 2016 apology to us for some psychologists' roles in child removals. And it is my hope that other bodies of professions that were also involved – social workers, psychiatrists and so on - will follow their lead.

Another result of *Bringing them home* was the funding of counselling and social and emotional wellbeing services - primarily aimed at the Stolen Generations – and in some community controlled health services.

And today, larger services are likely to employ mental health professionals on site or as visitors. Aboriginal mental health workers are also an established element of the workforce in these services.

However, among Aboriginal community controlled health services overall, about six in ten still report gaps in mental health and social and emotional wellbeing services; and about half report gaps in alcohol and other drugs services.³⁷

Roughly half the Indigenous population uses or relies on community controlled health services. As such, the absence of mental health and other services in them is a significant barrier to treatment.

The Indigenous mental health movement has two main objectives.

- First, building on our community controlled health service model, to establish mental health services controlled by, and specifically for, Indigenous people and that operate within a cultural framework.
- Second, to ensure that general population mental health services are responsive to our often greater and more complex needs, and cultural, experiential and language differences.

Critical to both these efforts is the renewal of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*³⁸ that was initially developed in 2004 by Indigenous cultural, social and emotional wellbeing, mental health and suicide prevention leaders.

And I am pleased to report that the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (or 'ATSIMHSPAG') – a mostly Indigenous body that I co-chair with Professor Pat Dudgeon and that advises the Australian Government on its eponymous subject matters – is charged with this renewal.

Other important related policy that emphasises the need for Indigenous control and Indigenous-specific responses includes the 2013 *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*³⁹ and the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 – 2019*.⁴⁰ Both were developed under Indigenous leadership.

Looking forward, trauma is increasingly being recognised as perhaps the foundation challenge not only to improving Indigenous Australians' mental health, but also to addressing a range of so-called 'wicked problems' that continue to undermine our community life. **Slide 20**

A 'wicked problem' denotes a challenge that is difficult or seems impossible to solve because of contradictory and changing causal factors that are often difficult to recognise in the first place. It is my belief that many such 'wicked problems' have much of their origins in the multiple and compounding layers of trauma in the Indigenous population.

In addition to historical trauma this includes trauma from repeated exposure to life stressors in the present day (as discussed, like racism), and trauma from exposure to violence and childhood stresses, the latter with potential developmental impacts that can lead to disability.

I note with some hope that ATSIMHSPAG has begun to map the beginning of what may be a national, comprehensive response to trauma in Indigenous Australians that includes healing and halting the transmission of past trauma, as well as preventing new trauma. **Slide 21**

Indigenous mental health leadership took a significant step forward with the 2013 establishment of the National Aboriginal and Torres Strait Islander Leadership in Mental Health (or 'NATSILMH'), of which I am also a member, with Professor Pat Dudgeon as Chair.

NATSILMH is independent and operates its own secretariat. It comprises a core group of senior Indigenous people based in, or associated with, national and state-level mental health commissions. But the Healing Foundation, AIPA and NACCHO who I previously referred to are also members.⁴¹

NATSILMH was established to help implement the international 2010 *Wharerātā Declaration* that, as many of you will know, recognises the importance of indigenous leadership in mental health systems to better respond to the mental health needs of their indigenous populations in a culturally appropriate way.⁴²

To that end, NATSILMH developed the 2015 *Gayaa Dhuwi (Proud Spirit) Declaration* as a domestic companion document to the *Wharerātā Declaration*. It comprises five themes including two that focus on the culturally different nature of Indigenous leadership itself.

And I am happy to report that references to the *Declaration* are in draft copies of the *Fifth National Mental Health Plan – Australia's overarching mental health plan* that is currently being renewed. This achievement bodes well for the future of Indigenous mental health leadership in this country.

In parallel with the above, a national Indigenous disability movement can be traced to a 1999 national gathering of Indigenous disability leaders in Alice Springs.

From here, the New South Wales Aboriginal Disability Network was

established in 2002, and in 2010 the First Peoples Disability Network (or F- P - D -N) - with CEO Damian Griffis, who is speaking tomorrow at this event - was established.

Proudly for all Indigenous Australians, this is the only organisation in the world constituted and governed by Indigenous people with disability. It is also an important part of the broader Indigenous health movement in Australia.

In 2014, the F-P-D-N chaired an interagency meeting of government departments to develop an Indigenous disability action plan under the National Disability Strategy and an Indigenous reference group has also been established.

I finish this part of my keynote by including on the slide above what I believe to be some of the key themes of leading change in my experience. **Slide 22**

Part 4: Challenges ahead and closing words

I want to close by looking at a potential challenge to Indigenous community leadership in relation to mental health and disability services. In 2015, 31 Primary Health Networks were established as part of an ongoing reform effort to de-centralise the Australian primary health care 'system'.

PHNs are intended to promote responsive regional-level needs based planning and service delivery.

The Government has agreed to six key priorities for targeted work by PHNs. These include mental health and Indigenous health.

Further to this, PHNs have recently been given the task of overseeing the establishment of a stepped care model of primary mental health care clinical service in their regions, including specific Indigenous mental health and suicide prevention activity.

And PHNs are required to work closely with National Disability Insurance Scheme providers, because of the need for psychiatric disability support services integrated into the stepped mental health care model.

A key PHN role is mapping service gaps and commissioning new services where gaps are identified.⁴³ This requires them to work closely with community controlled services and Indigenous communities.

But it is not clear how Indigenous community leadership will be preserved in this situation. There are concerns that this will amount to consultation rather than negotiation.

A further concern is with the proper role of market driven processes, such as some PHN tender-based commissioning processes: processes that have, historically, not delivered the right services to Indigenous communities.

Too often, tendering has boiled down to a competition as to who could draft the best application, not who offered the best service.

I have been lucky to play a small part in a decades - long Indigenous health and mental health movement involving hundreds and thousands of Indigenous leaders, advocates, experts and stakeholders and their non-Indigenous allies working at all levels.

The cumulative effect of this is, I believe, that we have established the foundations for future Indigenous Australians with mental health problems and disability to lead contributing lives and partake in thriving communities.

Despite the disheartening statistics, my message to you is one of hope – of survival against the odds, of great resilience, and of the value of struggle in the face of adversity.

Our global movement is far from over, and work remains to be done. And like democracy, ensuring our brothers and sisters with mental health problems and disabilities lead the best possible lives is likely to require ‘eternal vigilance.’

It remains to future generations and future leaders to keep those flames alive, and to write the next chapters. I hope this keynote will inspire and support this future. **Slide 23**

And with a view to stimulating a lively discussion, I close with my three challenges to you, as on the slide above and leave you with this message:

“From self respect comes dignity; from dignity comes hope; and from hope comes resilience”.

Thank you.

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