From: Professor Pat Dudgeon  
Chair, National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH)  
c/o Mr Christopher Holland  
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To: The Senate Select Committee on Health  
PO Box 6100  
Parliament House  
Canberra ACT 2600

6 February 2015

Dear Senators and committee members

Submission of the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH)

Summary of main points

• Closing the Aboriginal and Torres Strait Islander mental health gap should be a national priority.

• A preventative approach to Aboriginal and Torres Strait Islander mental health requires a broad address to social and emotional wellbeing. This includes an address to identity, physical health, family, culture and community life as well as a consideration of employment, access to education and community safety. Further, an overall approach based on empowerment is required.

• Significantly more primary mental health care services and programs are required to meet the greater mental health needs of Aboriginal and Torres Strait Islander peoples. The rebalancing of funding towards promotion, prevention and primary health care away from hospitalisation for preventable mental health conditions and also from reinvestment from other areas should occur over time.

• The current package of mental health services and programs for Aboriginal and Torres Strait Islander peoples is ineffective at the system level because of problems at the service and programme level: because of how individual services and programs are designed and how the services and programs work together.

• Aboriginal and Torres Strait Islander peoples should be partners in the design and delivery of mental health service and programs. At the national level, a credible Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention leadership and stakeholder partnership mechanism is required.

• Mental Health and Social and Emotional Wellbeing Teams should be fully integrated in Indigenous Primary Health Care Organisations and ACCHS as a part of their existing comprehensive primary health care service package.

• Additional dedicated Aboriginal and Torres Strait Islander specialist mental health services to support patient transitions across the mental health system and ensure the cultural appropriateness of services at different stages of their transition are required.
• General population mental health, suicide prevention, and alcohol and other drug use prevention professionals (including general practitioners) should be made accountable for better mental health outcomes for Aboriginal and Torres Strait Islander peoples including by providing culturally competent services, and ensuring their services are culturally safe.

• Training and employing the Aboriginal and Torres Strait Islander workforce needed to populate the additional services proposed and to change the culture of mainstream services is an important element of any overall national effort to close the mental health gap.

• The vehicle for the above should be a dedicated, national Aboriginal and Torres Strait Islander mental health plan to be developed and implemented in partnership with Aboriginal and Torres Strait Islander leaders, experts and stakeholders. Such should occur through the implementation of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-19* alongside with the *National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023*, the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013* and the *National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy*.

Thank you for agreeing to an extension to the deadline for receipt of our submission.

By way of introduction, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) comprises a core group of senior Aboriginal and Torres Strait Islander people working in leadership positions in social and emotional wellbeing, mental health and suicide prevention. Most are based in, or associated with, the Australian mental health commissions or other nationally important mental health bodies. Additionally, the National Aboriginal Community Controlled Health Organisation and the National Aboriginal and Torres Strait Islander Healing Foundations are members. For further information about NATSIMLH, including biographical information about our members, please see Appendix 1 to this submission.

We write to address terms of reference (d) – (h):

- the interaction between elements of the health system, including between aged care and health care;
- improvements in the provision of health services, including Indigenous health and rural health;
- the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
- health workforce planning; and
- any related matters.

However, in this submission we will not address each term separately, rather we will discuss how improvements to Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention could be secured through reform at the system-level. This will include reference to the above points.

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**Background**

There is an entrenched mental health crisis among Aboriginal and Torres Strait Islander peoples that must be addressed. Mental health problems, self-harm and suicide have been reported at double the rate of that of non-Indigenous people for at least a decade. Recent data suggests the situation is getting worse, as set out below:

- **Psychological Distress:** In 2012–13, 30 per cent of respondents to the Australian Bureau of Statistics (ABS) *Australian Aboriginal and Torres Strait Islander Health Strategy* (ATSIHS 2012-13) over 18 years of age reported high or very high psychological distress levels in the 4 weeks before the survey interview. That is nearly 3 times the non-Indigenous rate. In 2004-05, high and very high psychological distress levels were reported by 27 percent of respondents suggesting an increase in Aboriginal and Torres Strait Islander psychological distress rates over the past decade.
• Mental Health Conditions: Over the period July 2008 to June 2010, Aboriginal and Torres Strait Islander males were hospitalised for mental health-related conditions at 2.2 times the rate of non-Indigenous males; and Aboriginal and Torres Strait Islander females at 1.5 times the rate of non-Indigenous females. Rates of psychiatric disability (including conditions like schizophrenia) are double that of non-Indigenous people.

• Suicide: The overall Aboriginal and Torres Strait Islander suicide rate was twice the non-Indigenous rate over 2001-10. Around 100 Aboriginal and Torres Strait Islander deaths by suicide per year took place over that decade. In 2011, 117 suicides were reported. The Overcoming Indigenous Disadvantage 2014 report finds that hospitalisations for intentional self-harm increased by 48 percent since 2004-2005.

NATSILMH believe that the high rates of mental health problems reported among Aboriginal and Torres Strait Islander peoples underpin a range of other problems and disadvantage. This includes higher rates of chronic disease, unemployment, family breakdown, alcohol and other drug abuse, smoking, and the high rates of imprisonment and crime victimisation. Further, that improving the mental health of Aboriginal and Torres Strait Islander peoples, as well as being an important issue in its own right, is important to achieving the Indigenous Affairs priorities of the Australian Government (improved education, employment and community safety outcomes), as well as the COAG Closing the Gap Strategy. For example:

• Among adults who reported high/very high levels psychological distress, 38 percent were unable to work or carry out their normal activities for significant periods of time because of their feelings in the 2008 ABS National Aboriginal and Torres Strait Islander Social Survey (NATSISS 2008).

• In the NATSISS 2008, adults with high/very high levels of psychological distress were also more likely to drink at chronic risky/high risk levels (21 percent compared with 16 percent with low/ moderate levels of psychological distress) and to have used illicit substances in the previous 12 months to the survey (27 percent compared with 18 percent). Substance abuse is a community safety issue and is associated with violence, child maltreatment, high rates of imprisonment, and other challenges facing communities.

• Promoting social and emotional wellbeing and resilience should also contribute to improving school attendance and performance because it will support children cope with bullying and racism.

Research over the past decade also suggests a chain of causation may be present between serious psychological distress and chronic disease. The 2014 ‘Reeve Study’ correlated data from the 2004-2005 ABS National Aboriginal and Torres Strait Islander Health Survey and the NATSISS 2008 to make some significant findings as to what was required to close the diabetes gap. In doing so, it found an association between people who self-reported diabetes and those who reported the forced removal of relatives (including Stolen Generations Survivors). It described the finding as “consistent with emerging evidence that serious psychological stress contributes to a range of health problems and may be involved in the development of risk factors for metabolic syndrome, including raised blood glucose.”

Such emerging evidence includes that from a 2006 international review of evidence on the association between stress and chronic disease for Indigenous populations and African Americans by Yin Paradies. While the review found the strongest associations between serious psychological distress resulting from racism and mental health conditions, it also identified studies that associated such psychological distress with high blood pressure, hypertension, impaired immune function, heart disease, pre-term births, increased heart rate and the thickening of arterial walls. There is now a well-established link between racism and poor mental and physical health outcomes, including anxiety, depression, overweight and obesity, smoking, substance misuse and alcohol misuse.

NATSILMH proposes that the separation between mental health and chronic disease should be perceived differently, and the relationship should be recognised. Aboriginal and Torres Strait Islander mental health must be addressed not only as a priority in its own right, but also as an important part of addressing chronic disease.
Understanding Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing

For Aboriginal and Torres Strait Islander peoples, there are specific cultural, historical, and political considerations that contribute to the higher prevalence of mental health conditions among them, and that require the rethinking of conventional models and assumptions.

In particular, Aboriginal and Torres Strait Islander peoples conceive of physical and mental health in different terms to other Australians – as part of a broader concept called social and emotional wellbeing (SEWB). The SEWB concept is not limited to Aboriginal and Torres Strait Islander peoples, but their concepts of SEWB are broader than non-Indigenous concepts.

For Aboriginal and Torres Strait Islander peoples, SEWB is a ‘whole of life’ perspective on wellbeing that includes mental health, but is not limited or equivalent to it. Thus, as for non-Indigenous people, the Aboriginal and Torres Strait Islander SEWB concept acknowledges the importance of employment, housing and education to wellbeing. xvi However, additionally, it takes into account:

• the unique historical events and impacts associated with colonisation, and the resulting present day social determinants faced by Aboriginal and Torres Strait Islander people; and

• cultural differences, in particular the unique structures and belief systems underpinning family, community, culture and cultural practice, relationships to country and spirituality (including ancestors). xviii

For Aboriginal and Torres Strait Islander mental health, SEWB is critically important for two reasons:

• First, as a source of resilience. xix Resilience is important because Aboriginal and Torres Strait Islander peoples experience adverse childhood experiences and stressful life events at higher rates than non-Indigenous people. Further, these stressful and traumatic life experiences tend to occur concurrently and have a cumulative impact. xxi This high exposure to stressful life events is associated with deep and entrenched poverty and results in the higher rates of psychological distress reported among Aboriginal and Torres Strait Islander peoples.

• Second, because as with Aboriginal and Torres Strait Islander health in general, a holistic ‘whole of person’ approach that includes working with cultural needs should underpin mental health service and programme delivery for Aboriginal and Torres Strait Islander peoples. This includes, but is not limited to, ensuring mainstream mental health practitioners, services and programs are culturally competent and culturally safe.

NATSILMH proposes that strengthening SEWB, building resilience and reducing psychological distress is of direct import to achieving better mental health outcomes for Aboriginal and Torres Strait Islander peoples. That is, in addition to a focus on expanding culturally appropriate mental health services and programmes.

Such a ‘whole-of-government’ preventative emphasis requires a consideration of employment, access to education and community safety – the current priorities of the Australian Government. Further, it requires a broader address identity, physical health, family, culture and community life aligned with the Aboriginal and Torres Strait Islander concept of SEWB. And critically, an overall approach based on empowerment is required. For Aboriginal and Torres Strait Islander peoples, just as disempowerment is associated with greater vulnerability to psychological distress and mental health issues, so empowerment is associated with resilience and better mental health.

For Aboriginal and Torres Strait Islander people mental health promotion (and prevention) is about strengthening SEWB, empowerment and addressing disadvantage to provide the resilience needed to cope with the unique and greater rates of stressful life events that they face. Further, it is also critical to work in a Whole of Government way to reduce the influence of those stressors.
Challenges for Aboriginal and Torres Strait Islander mental health services and programmes

(a) Significantly more primary mental health care services and programs are required to meet need

The burden of mental health problems and mental illness is far greater than the services and programs currently available. And in particular for Aboriginal and Torres Strait Islander peoples, a lack of focus on primary mental health care - including promotion, prevention early detection and treatment in primary health care settings - leads to significantly higher per capita levels of expenditure on acute inpatient care, the most expensive part of mental health treatment.

This is illustrated by the ratio of Aboriginal and Torres Strait Islander per capita hospital expenditure for mental health conditions compared with other Australians in 2010-11. This was:

- 2.68 to 1 for all mental health and behavioural disorder hospital separations ($336 per capita Aboriginal and Torres Strait Islander people; $125 per capita non-Indigenous):
- 1.65 to 1 for anxiety and depression hospital separations ($53: $32):
- 3.97 to 1 for alcohol dependence and other harmful use ($37: $9); and
- 2.58 to 1 for self-inflicted injuries, an indicator of attempted suicide ($19: $7). xxii

In 2012-2013, 260 services delivered primary health-care, substance-use rehabilitation and treatment services, and SEWB (including Bringing Them Home and Link-Up counselling and family reunion) services primarily to Aboriginal and Torres Strait Islander people. They report to the Australian Government and these services reports are published regularly. xxiii Of these, 205 are defined as Indigenous Primary Health Care Organisations (IPHCOS) including 175 Aboriginal Community Controlled Health Services (ACCHS). xxiv

With their model of comprehensive primary health care and community governance, ACCHS have reduced barriers to access to health care, and are progressively improving individual health outcomes for Aboriginal and Torres Strait Islander people. Clinical services, health promotion, cultural safety, community engagement all underpinned by research, evaluation and planning activity are the essential components in these models. xxv

In their 2014 analysis of the performance of ACCHS, Panaretto and colleagues looked at the evidence supporting Aboriginal and Torres Strait Islander peoples’ relative use of ACCHS and general practice in Queensland by comparing ABS 2011 Census data and ACCHS service use data. They report that ‘access to services is critical and, where ACCHSs exist, the community prefers to and does use them’. xxvi

Yet mental health and related services gaps in these services are evident. In the abovementioned service report for 2012-2013, the most common service gaps reported by all 260 organisations, including ACCHS, were around mental health and SEWB (62 percent of organisations). xxvii Nearly half of all 260 organisations reported alcohol, tobacco and other drugs (48 percent) and youth services (47 percent) as service gaps. xxviii That these gaps exist provides support for an increased focus on expanding mental health and social and emotional wellbeing services within these services.

That these services are expanded and otherwise properly resourced as primary mental health services is important because mainstream GPs and frontline mental health services are not meeting the remaining need. Yet, at time of writing, approximately 50% of the Aboriginal and Torres Strait Islander population are reliant on GPs and other service providers for primary mental health care. xxx As such the ability of GPs and other front line mainstream mental health services to provide a culturally competent service is critical to how the mental health system responds to greater Aboriginal and Torres Strait Islander mental health needs.
(b) The current package of services and programs is ineffective at the system level because of problems at the service and program level

The above includes because of:

• **How individual services and programs are designed.** In particular, many do not work within a broader context of SEWB. As noted, this requires consideration not only to the mental health of individuals, but to their broader wellbeing and the wellbeing of their families, communities and cultures. For this reason, good planning processes for Aboriginal and Torres Strait Islander mental health and related services should test mainstream assumptions and policy directions and involve Aboriginal and Torres Strait Islander leaders, experts and stakeholders as partners. This is especially important when designing and implementing services and programmes for particular communities and groups of communities.

• **How the services and programs work together.** In short, they do not ensure a connected transition through the mental health system for Aboriginal and Torres Strait Islander peoples. In particular, between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services components (mainly delivered by the States and Territories). NATSILMH recommend that there be a greater focus on ensuring patient transitions from family and community to primary and specialist mental health care, and then back into the community. Further, that a particular focus of policy makers should be addressing the lack of dedicated Aboriginal and Torres Strait Islander specialist care that is able to support the above patient transition and otherwise help ensure transitions across culturally appropriate parts of the mental health system.

**Ways forward**

NATSILMH proposes that a rebalancing of funding towards promotion, prevention and primary health care away from hospitalisation for preventable mental health conditions, and also from reinvestment from other areas, should occur over time. For example, re-investing at least some of costs of imprisonment of Aboriginal and Torres Strait Islander people into mental health services as a justice reinvestment measure. Change may also require assessment of what funding from mainstream programs could be diverted into the new approach to offset costs. This must be subject to the outcome of individual program reviews.

In the meantime, given the scale of issues and the size of the mental health gap, there must be no cuts to funding of any program that specifically targets the needs of Aboriginal and Torres Strait Islander people such as the Access to Allied Psychological Services Tier 2 program. Further, there should be an assumption that - until evidence is in place to say otherwise – that having any program or service in place is better than having none. In particular, NATSILMH recommend that suicide prevention spending commitments should be quarantined including for the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

NATSILMH also recommends that the following elements should be included in any overall, system-wide approach to improving Aboriginal and Torres Strait Islander mental health:

(a) **Make closing the Aboriginal and Torres Strait Islander mental health gap a national priority.**

NATSILMH recommend that this could occur by agreeing an additional COAG Closing the Gap target specifically for mental health using a range of indictors including rates of psychological distress, hospitalisation for mental health conditions and suicide.

(b) **A credible Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention leadership and stakeholder partnership mechanism.**

The basis of this should be the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) that advised the Minister for Indigenous Affairs, Minister for Health, and Assistant Minister for Health in these areas. The future of this body is, however, uncertain as its mandate expired in December 2014.
(c) Mental Health and Social and Emotional Wellbeing Teams being fully integrated in Indigenous Primary Health Care Organisations and ACCHS as a part of their existing comprehensive primary health care service package.

The above integrated teams will provide access to:

- medical care, including pharmacotherapies and preventive health care and health checks to promote, maintain and treat physical health;
- structured interventions using evidence based therapy; and
- social and cultural support., including access to housing, support with issues of cultural identity and support from local Aboriginal people via Aboriginal Health Workers and Aboriginal Mental Health Workers.

(d) Additional dedicated Aboriginal and Torres Strait Islander specialist mental health services to support patient transitions across the mental health system and ensure the cultural appropriateness of services at different stages of their transition.

In particular, the transition from primary mental health care settings into mainstream specialist mental health services and programs needs greater focus. Some jurisdictions could choose to establish such services along the lines of the Western Australian State-wide Specialist Aboriginal Mental Health Service model. Regardless, all Aboriginal and Torres Strait Islander people admitted to a specialist (mainstream) mental health service should be in the target group for this service and NATSILMH recommend that the following features/capabilities should be standard:

- ensuring each referred/admitted patient is linked from IPHCOS/ACCHS to the mainstream service and back again on discharge;
- cultural support during admission;
- access to traditional healers and healing services;
- maintain links to family; and
- facilitatation of patient access to community support on return to community.

(e) General population (mainstream) mental health, suicide prevention, and alcohol and other drug use prevention professionals (including general practitioners) are accountable for better mental health outcomes for Aboriginal and Torres Strait Islander peoples including by providing culturally competent services, and ensuring their services are culturally safe.

The entire mental health system is accountable for better Aboriginal and Torres Strait Islander mental health, suicide prevention, and related outcomes. Therefore, the delivery of primary and other mental health services to Aboriginal and Torres Strait Islander people outside of IPHCOS/ACCHS settings and specialist Aboriginal and Torres Strait Islander mental health services and programs needs to be culturally competent and culturally safe.

Every jurisdiction should consider ways to make such services more accountable for delivering better mental health outcomes for Aboriginal and Torres Strait Islander people. These may include:

- Legislative, and/or policy approaches;
- Development of quality and professional standards with professional organisations;
- Setting targets and key performance indicators in funding agreements as a way of holding mainstream service providers accountable for the development of culturally responsive services;
• Partnership agreements being established at a local level between the leadership of mainstream services and the IPHCOs/ACCHS;

• Requirements to develop Aboriginal mental health service plans and/or professional development strategies;

• Developing clinical pathways in partnership with the local IPHCOs/ACCHS for mental health patients defining how the services will support patients in their transition from primary care to acute care and the provision of ongoing care for people with a chronic mental illness as part of a mental health cycle of care; and

• Ensure professional development programs are being delivered to support mainstream staff develop cultural competencies.

This initiative should be complemented by a commitment from all levels of government to publish annual information on the proportion of resources they allocate to supporting Aboriginal and Torres Strait Islander people’s mental health needs. The report card should encompass both specialist Aboriginal and Torres Strait Islander and mainstream services and include funding and activity data.

(f) Training and employing the Aboriginal and Torres Strait Islander workforce needed to populate the additional services proposed and to change the culture of mainstream services.

This should involve:

• identifying minimal mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention personnel requirements per population catchment area;

• setting and achieving national training and employment targets based on the above;

• strengthening opportunities for Aboriginal and Torres Strait Islander health workers to attain advanced qualifications by strengthening educational pathways from the Vocational Education Training sector to the university sector;

• relevant professional associations and education providers increase the numbers of Aboriginal and Torres Strait Islander students undertaking mental health and related training and entering the mental health professions and workforce. Progress is benchmarked against standards developed by professional associations and education providers; and

• relevant professional associations and education providers develop specialist Aboriginal and Torres Strait Islander mental health courses based on Djirruwang Program (Charles Sturt University) and roll them out nationwide.

This approach to reform will require national Aboriginal and Torres Strait Islander mental health planning and service and programme design over the next 12 to 18 months prior to commencing implementation. Such could occur through the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-19 alongside with the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013 and the National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy.

The vehicle for this coordinated implementation process should be a dedicated, national Aboriginal and Torres Strait Islander mental health plan and the plan should be developed and implemented in partnership with Aboriginal and Torres Strait Islander leaders, experts and stakeholders in this area. While it is critical that the priority focus of each of the above strategies is maintained in implementation, a coordinated implementation process for all four is not to avoid duplication and be more efficient while also ensuring holistic and connected services.

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Thank you again for the opportunity to make this submission.

Mr Christopher Holland, NATSILMH’s Executive Officer, is the best point of contact for office-to-office communications, and if you have any questions. His contact details are cholland@internode.on.net or 0438 409 149.

Yours sincerely

Professor Pat Dudgeon

Chair NATSILMH – and on behalf of the members: Dr Tom Calma AO, Mr Tom Brideson, Ms Adele Cox, Ms Sandy Gillies, Ms Vickie Hovane, Professor Gracelyn Smallwood, Dr Robyn Shields, Ms Lisa Briggs and Mr Richard Weston.
Appendix 1 – the National Aboriginal and Torres Strait Islander Leadership in Mental Health

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 peoples.

NATSILMH’s priority work is to lead and provide advice in the above areas for the mental health commissions of Australia. That is the:

• National Mental Health Commission;
• Mental Health Commission of New South Wales;
• Queensland Mental Health Commission; and the
• Western Australian Mental Health Commission.

NATSILMH’s origins start with the Sydney Declaration made at the Sydney meeting of Australian and international mental health commissions on 11 and 12 March 2013. Here, the Australian mental health commissions agreed to support the international Wharerātā Declaration on Indigenous peoples’ mental health and its vision of healthy Indigenous individuals, families and communities.

Following six months of developmental activity, NATSILMH was established and first met on 14 November 2013 at a two-day ‘ Aboriginal and Torres Strait Islander Leaders in Mental Health Forum’ that was supported by the Mental Health Commission of New South Wales.

NATSILMH has coalesced around a core group of senior Aboriginal and Torres Strait Islander people working in social and emotional wellbeing, mental health and suicide prevention. Most are based in, or associated with, the Australian mental health commissions or other nationally important mental health bodies. Additionally, the National Aboriginal Community Controlled Health Organisation and the National Aboriginal and Torres Strait Islander Healing Foundations are members.

It is anticipated that NATSILMH’s membership will grow over time.

In March 2014, NATSILMH established a Secretariat that operates one day a week. This is administered from the Mental Health Commission of New South Wales with the financial support of the four Australian mental health commissions.

For further information see: www.natsilmh.org.au.

Our members

Professor Dudgeon is from the Bardi people of the Kimberley. She is well known for her leadership in Indigenous higher education and Indigenous mental health. Currently she is a research fellow and professor at the School of Indigenous Studies at the University of Western Australia. She is actively involved with the Aboriginal community, having an ongoing commitment to social justice for Indigenous people. Professor Dudgeon is a Commissioner with the National Mental Health Commission, the Chair of the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) and is currently Co-chair of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group. She is Project Director of the Aboriginal and Torres Strait Islander Suicide Prevention Project and the National Empowerment Project at University of Western Australia.
Mr Brideson is a Kamilaroi man and the NSW State-wide Coordinator of the *Aboriginal mental health workforce program*. The position is located at Bloomfield Hospital in Orange, NSW. He has a broad interest in health policy development, social and emotional wellbeing, clinical mental health care, suicide prevention and educational matters across these domains. He is member of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.

Ms Briggs is an Aboriginal Health Worker by trade and worked in the field of Aboriginal health for the last 25 years. She has been part of the National Coalition for the Close the Gap Campaign for Indigenous Health Equality. She is member of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.

Dr Calma is an Aboriginal elder from the Kungarakan tribal group and a member of the Iwaidja tribal group in the Northern Territory. He has been involved in Indigenous affairs at a local, community, state, national and international level for over 40 years. Dr Calma was the Aboriginal and Torres Strait Islander Social Justice Commissioner from 2004 – 2010 and the founding Chair of the Close the Gap Campaign for Indigenous Health Equality. He was also Chair of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group that oversaw the development of *the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, and is currently Co-chair of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, National Coordinator for the Closing the Gap Tackling Indigenous Smoking measures, Chancellor of the University of Canberra, Co-chair of Reconciliation Australia and an Ambassador for Suicide Prevention Australia.

Ms Cox is a Bunuba & Gija woman from the Kimberley region of Western Australia. She started her working life in media and in suicide prevention. Adele is a former member of the WA Ministerial Council for Suicide Prevention and currently a member of the Australian Suicide Prevention Advisory Council, the National Senior Consultant to the National Empowerment Project and a member of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.
Ms Gillies is a Gungarri woman from southwest Queensland. She is currently the Director, Engagement and Reporting for the Queensland Mental Health Commission and has over 25 years’ experience in senior management roles both within the government and Aboriginal Community Controlled Health care sectors across Queensland. She completed her Graduate Certificate in Health Management in 2009 at Griffith University, Queensland. Ms Gillies has been a strong advocate and leader in the provision of cultural awareness training over many years to both government and non-government organisations. She has co-authored a number of academic papers highlighting the need for the evaluation of cultural awareness training and its effectiveness in changing organisational culture and practice.

Ms Hovane is an Aboriginal woman from Broome in the Kimberley region of WA. She holds a First Class Honours Degree in Psychology. Ms Hovane is a Director on the board of the new National Centre for Excellence in Research for the prevention of violence against women and children. She is a former Co-chair of the Australian Indigenous Psychologists Association and a member of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.

Professor Smallwood is a prominent Aboriginal leader with 45 years’ experience, nationally and internationally, as a nurse, midwife and human rights activist. She has devoted her career to advocating for the empowerment of Indigenous communities through education, health and economic sustainability working in some of the most remote parts of Australia. Professor Smallwood has completed a certificate in Indigenous mental health, a Master of Science in Public Health and a PhD thesis Human rights and first Australians’ wellbeing. In 1975 Gracelyn was a graduate with four other Indigenous students in culturally appropriate mental health training. She anticipates doing a post doctorate in culturally appropriate mental health services next year. In 2007 she received the Deadly Award for Outstanding Achievement in Indigenous Health and an Australia Medal for 25 years’ service in public health. She has been an editorial board member for Health and Human Rights at Harvard University for the past 20 years and in 2013 received the United Nations Association of Queensland Award for her contribution to public health and education. She is currently an adjunct Professor at James Cook University and the first Elder in Residence in the Indigenous Health Unit.

Dr Shields as a proud Aboriginal person of the Bundjalung people. She has worked in the mental health sector for many years, and is now undertaking specialist training as a psychiatrist. She is a member of the NSW Mental Health Review Tribunal, member, Aboriginal Health & Medical Research Ethics Committee and has an Order of Australia (AM division) for development of Aboriginal mental health services, 2004. She has concentrated on raising the status of mental illness in the public consciousness, and developing new models of care for the mentally ill people in the most disadvantaged groups, particularly Aboriginal people and forensic patients.
Mr Weston is a descendant of the Meriam people of the Torres Strait. He has lived and worked for 27 years in urban, regional and remote settings where he gained a unique insight into grass roots Indigenous issues. He led the successful Maari Ma Health Aboriginal Corporation in Far West NSW as CEO from 2000-2009. He spent 12 months with the Indigenous Health Service in Brisbane from 2009-2010. His current role is as CEO of the Aboriginal and Torres Strait Islander Healing Foundation based in Canberra which commenced in September 2010.

Mr Weston sits on a number of committees in Indigenous Affairs representing the Healing Foundation – National Health Leadership Forum (NLHF), The Close the Gap Steering Committee, National Aboriginal and Torres Strait Islander Leaders In Mental Health (NATSILMH), National Empowerment Project (NEP) and ANU Medical School Aboriginal and Torres Strait Islander Advisory Group.

The work of the Healing Foundation in its short life has delivered 90 projects into Aboriginal and Torres Strait Islander Communities across Australia that have employed 738 Aboriginal and Torres Strait Islander people, delivered 1675 activities to 16,000 people and have improved Social And Emotional Wellbeing to 94% of participants.


xxxi Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander Health Organisations, Online Services Report – key results 2012-2013, AIHW cat. no. IHW 139, 2014, p 1.

xxii As above, p.5.

xxiii Panaretto et al, above note 46.

xxiv Panaretto et al, above note 46, p 650.

xxv Panaretto et al, above note 46, p 650.

