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

Discussion Paper On The Adaptation Of The *Wharerata Declaration* For Use By Aboriginal And Torres Strait Islander Peoples In Australia

Part 1: Introduction

The National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH – See Appendix 1) are working to progress the adaptation of the international *Wharerata Declaration* to contextualize it for use by Aboriginal and Torres Strait Islander peoples in Australia. This Discussion Paper:

- introduces the *Wharerata Declaration*;
- proposes a draft adapted *Wharerata Declaration* for use by Aboriginal and Torres Strait Islander peoples; and
- requests your comments and feedback.

NATSILMH intend that this Discussion Paper begins a consultation process on the adaptation of the *Wharerata Declaration* with leaders, leadership groups and other stakeholders working in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing and suicide prevention areas. However, NATSILMH have only limited available resources, so much of the consultation process will necessarily be paper-based and limited in scope.

(a) Background

The Wharerata Group of Indigenous mental health leaders from Canada, the US, Australia, Samoa and New Zealand developed the *Wharerata Declaration* (Declaration) in 2010. The Declaration is about 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 Declaration in 2010 and now promote it as a key part of their work. (See Appendix 2 for further information.)

Through the March 2013 *Sydney Declaration*, the *Wharerata Declaration* was endorsed in Australia by key government mental health agencies including the:

- National Mental Health Commission;
- New South Wales Mental Health Commission;
- Western Australian Government Mental Health Commission;
- Australian Capital Territory Health Directorate; and the
- mental health/substance abuse divisions of the health departments of South Australia, Victoria, Northern Territory and Tasmania.

(See Appendix 3 for the *Sydney Declaration*.)

Further, since its establishment on 1 July 2013, the Queensland Mental Health Commission has supported the development of Aboriginal and Torres Strait Islander leadership capacity in partnership with other commissions.

This endorsement underpinned the formation of NATSILMH in 2013-2014. Guided by the *Wharerata 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, and to advise the commissions in these areas.

A priority task of NATSILMH is to adapt the *Wharerata Declaration* for use by Aboriginal and Torres Strait Islander peoples.

(b) Overview of the *Wharerata Declaration*

The Wharerata Group recognised that a common set of mental health challenges face Indigenous peoples in post-colonial country settings. Further, that Indigenous peoples are also able to draw on similar sources of resilience and support for their mental health (for example, culture, family and community).

Nonetheless, the Wharerata Group also recognised that a 'universal declaration' would be of limited value to the degree it could not accommodate the differences between each country's Indigenous peoples. As such, they agreed that each country's Indigenous peoples should adapt the international *Wharerata Declaration* to their particular circumstance.

The Wharerata Group based their Declaration on a vision of a world in which Indigenous mental health is achieved. This vision is that:

- The negative effects of colonisation on mental health are reversed, and Indigenous peoples have renewed pride in their culture and their ability to succeed in wider society, and have visibility as contributing members in their countries.

- Mental health and addictions services and training programmes purposefully make space for Indigenous cultural approaches to mental health, collaborate towards dual competency of clinical and cultural approaches and successfully build relationship with Indigenous individuals and communities.

- Indigenous mental health leaders take their place alongside non-indigenous leaders, and together contribute to both Indigenous and mainstream mental health systems.

- Indigenous people achieve mental wellness similar to their non-Indigenous counterparts, and given the historical strengths of culture and social cohesion, achieve more than parity.

NATSILMH believe that adapting the *Wharerata Declaration* for use by Aboriginal and Torres Strait Islander peoples is timely. Recent data suggests an entrenched and possibly worsening mental health crisis for Aboriginal and Torres Strait Islander peoples, and a growing 'mental health gap' with the non-Indigenous population. For example,

- 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.[i] That is nearly 3 times the non-Indigenous rate.[ii] 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.[iii]

- 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.[iv] Rates of psychiatric disability (including conditions like schizophrenia) are double that of non-Indigenous people.[v]

- Suicide: The overall Aboriginal and Torres Strait Islander suicide rate was twice the non-Indigenous rate over 2001-10.[vi] Around 100 Aboriginal and Torres Strait Islander deaths by suicide per year took place over that decade. In 2012, 117 suicides were reported.[vii] The Overcoming Indigenous Disadvantage 2014 report finds that hospitalisations for intentional self-harm increased by 48 percent since 2004-2005.[viii]

As such, improving Aboriginal and Torres Strait Islander people's social and emotional wellbeing and mental health and reducing the rates of suicide should be a priority focus of Australian governments. Further, this should be a foundation response to addressing Aboriginal and Torres Strait Islander disadvantage.

NATSILMH agrees with the Wharerata Group about the importance of Indigenous mental health leadership to effect necessary change. We believe that Aboriginal and Torres Strait Islander leadership is critical in Australia to overseeing these improvements because without such leadership the mental health needs of Aboriginal and Torres Strait Islander peoples are likely to remain invisible and unaddressed by the mental health system.

By adapting the Declaration, NATSILMH aims to align domestic mental health policy, services and programs with human rights principles (particularly the right of Indigenous peoples to self-determination as set out in the UN *Declaration on the Rights of Indigenous Peoples*,[ix] and to the highest attainable standard of mental health by the right to health[x]) and an internationally agreed way of developing best practice and improving the mental health of Indigenous peoples.

NATSILMH believes the *Wharerata Declaration* to be a succinct guide to governments to assist them in supporting Indigenous leadership in mental health. We hope you and/or your organisation will support NATSILMH with your comments and feedback as we work to adapt this important document for wider use in Australian mental health, suicide prevention and related policy, service and program settings.

Part 2: The *Wharerata Declaration*: Five Themes

The *Wharerata Declaration* is a framework of five themes to guide States' responses to Indigenous peoples' mental health needs. As noted, critically, the Declaration focuses on Indigenous leadership as key to healing and better mental health outcomes.

Theme 1: Indigeneity must be recognised as a point of difference that mental health systems must recognise and take action to include in policy, services and programs.

Aboriginal and Torres Strait Islander mental health is a specialised area of practice within the mental health system, despite areas of overlap with non-Indigenous mental health.

Aboriginal and Torres Strait Islander peoples understand that culture cannot be separated from mental and physical health and wellbeing. In particular, social and emotional wellbeing (SEWB) is a culturally determined concept of physical and mental health, which includes the health of family and community, culture, relationships to land, spirituality and ancestors. Important considerations that influence SEWB include a history of colonisation and ongoing adverse social determinants. SEWB is also a collective concept that includes the SEWB of individuals, families and whole communities.

Aboriginal and Torres Strait Islander concepts of SEWB are thus broader than non-Indigenous concepts. It is a 'whole of life' perspective on wellbeing that includes mental health, but is not limited to it and includes all dimensions of wellbeing. It also acknowledges the history of colonisation and the continuing effects of oppression. The Guiding Principles of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009*[xi] shed further light on the Aboriginal and Torres Strait Islander SEWB concept, and are included as Appendix 4 to this Discussion Paper.

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

- First, as a source of resilience.[xii] Resilience is important because Aboriginal and Torres Strait Islander people experience adverse 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.[xiii] For Aboriginal and Torres Strait Islander peoples, mental health promotion and prevention needs to include strengthening SEWB to provide the resilience needed to cope with the unique and greater rates of stressful life events that they face.

- Second, because as with Aboriginal and Torres Strait Islander health in general, a holistic 'whole of person' approach that includes working with the cultural needs of individuals, families and communities 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 are culturally competent, and services and programs are culturally safe.

Theme 2: Best practice in Aboriginal and Torres Strait Islander mental health will combine Aboriginal and Torres Strait Islander holistic concepts of mental health, wellbeing and healing with the best non-Indigenous mental health practice.

Theme 2 builds on in Theme 1 with its recognition of Indigeneity as difference. It considers how mental professionals, services and the mental health system as a whole should respond based on that recognition.

The Declaration asserts a combination of cultural and clinical approaches as the best practice. What this means in Australia is that Aboriginal and Torres Strait Islander and clinical perspectives working together will make the greatest contribution to healing and ensuring better mental health outcomes for Aboriginal and Torres Strait Islander peoples.

The Declaration also asserts that this combined approach – that includes locating the mental health of the individual within the context of family, community and society - is an Indigenous contribution to best practice in mental health that could benefit of all humankind.

Theme 3: Aboriginal and Torres Strait Islander perspectives should contribute to the evidence base for best practice in Aboriginal and Torres Strait Islander mental health, SEWB and suicide prevention services and programs.

Theme 3 also builds on in Theme 1 with its recognition of Indigeneity as difference. It considers how policy-makers should measure positive mental health outcomes from Indigenous perspectives. Further, it acknowledges that such outcomes may not be not measurable in the same way clinical interventions are.

The Wharerata Group argue that the strict adherence to clinical assessments as the basis for developing an evidence base for Indigenous mental health is not effective for Indigenous peoples. Further, that this works against the development of such an evidence base led by Indigenous people and, subsequently, the inclusion of this evidence base and Indigenous knowledge in peer-reviewed journals.

Instead, they propose the recognition and development of <u>Indigenous values-based mental health outcome measures</u> (and, for the purposes of this paper, Aboriginal and Torres Strait Islander-values based outcome measures) to assess mental health outcomes. For example, the following questions that reflect Aboriginal and Torres Strait Islander-values based outcome measures could be asked to help measure success:

- How has the intervention enhanced the individual’s relationship with their family?
- To what extent has it enhanced their capacity to function as part of their community?
- How have their spiritual beliefs been considered as part of the outcome assessment process?
- To what extent has the relationship between their physical health and mental well-being been considered?
- How has the intervention considered their cultural needs?

In this way, the *Wharerata Declaration’s* vision of best practice in Indigenous (and for our purposes Aboriginal and Torres Strait Islander) mental health (as discussed in Theme 2) can be supported and upheld by an evidence base that includes Aboriginal and Torres Strait Islander perspectives on healing and wellbeing and measures of success.

Theme 4: Aboriginal and Torres Strait Islander leadership is required if best practice in Aboriginal and Torres Strait Islander mental health is to be realised. This requires the mental health system to take action to accommodate Aboriginal and Torres Strait Islander models of leadership.

Theme 1 explored the points of difference between Indigenous and non-indigenous concepts of mental health and wellbeing. The logical outcomes of this were explored in Themes 2 and 3.

Theme 4 asserts that Indigenous leadership is required if Themes 2 and 3 are to be realised. However, Indigenous models of leadership will also have points of difference when compared to non-Indigenous leadership models.

These differences are largely the result of Indigenous concepts of community and the collective dimension of life. Leadership in this context is not distant, but is ‘hands on’, connected to and embedded in Indigenous community life and a network of community-relationships. It is more fluid and consensus-

oriented than dictatorial. Further, it understands and respects diverse, culturally shaped notions of leadership operating within different communities.

The Declaration asserts that the optimal leadership model in Indigenous mental health will include the best elements of both Indigenous and non-Indigenous leadership models. Nonetheless, this will result in a different model of leadership that the mental health system must take action to accommodate.

The *Wharerata Declaration* asserts five areas of Indigenous leadership that capture this 'best of both worlds' approach to mental health leadership. In the table below, these are adapted for use by Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander leadership quality	**Description**
Informed	• Informed by Aboriginal and Torres Strait Islander perspectives, particularly social and emotional wellbeing and holistic concepts of physical and mental health. • Able to work across disciplines – to understand the connections between Aboriginal and Torres Strait Islander mental health problems and social determinants, drugs and alcohol and so on. • Able to work with non-Indigenous and clinical perspectives on mental health. • Using appropriate language styles to communicate effectively to Aboriginal and Torres Strait Islander community members as well as Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system, in the mental health professions, and among mental health policy-makers and politicians.
Credible	• Credible with Aboriginal and Torres Strait Islander community members. • Credible among Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system, in the mental health professions, and among mental health policy-makers and politicians. • Personally credible: with values such as integrity, capacity to self-reflect, empathy, vision and care for others.
Strategic	• Raises awareness. • Future oriented. • Embrace new paradigms. • Able to bring Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system, in the mental health professions, and among mental health policy-makers and politicians with them. • Promotes consensus.
Connected	• Extensively networked, including with other Aboriginal and Torres Strait Islander leaders. • 'Tribal' and community connections. • Connected to Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system, in the mental health professions, and among mental health policy-makers and

	politicians.
Sustainable	• Practices self-care. • Supportive family, friends, community and work peers • Plans for succession. • Contributes to the betterment of Aboriginal and Torres Strait Islander peoples in many areas of life.

Theme 5: Aboriginal and Torres Strait Islander leaders must be supported to be proactively visible in order to challenge the historical and contemporary invisibility of Aboriginal and Torres Strait Islander leadership and exert influence for change.

While Theme 4 set out the unique qualities required of Indigenous mental health leaders, Theme 5 explores how leadership should be exercised to exert influence and bring about necessary change.

As with the previous four themes of the Declaration, Theme 5 is aimed at addressing the unique experience of Indigenous peoples: in particular, the historical and contemporary 'invisibility' of Indigenous leadership that is a part of wider social exclusion, discrimination and a failure of governments to recognise Indigenous peoples' right to self-determination and leadership in that context.

In part, the influence of Aboriginal and Torres Strait Islander leaders will be exercised through their networks including with:

- communities;
- other Aboriginal and Torres Strait Islander leaders;
- Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system;
- mental health professions; and
- mental health policy-makers and politicians.

For Aboriginal and Torres Strait Islander leaders, being comfortable with advocacy in Aboriginal and Torres Strait Islander-specific and non-indigenous media and undertaking promotional and other advocacy-related activities is also important.

Part 3: Towards An Adapted Wharerata Declaration For Use By Aboriginal And Torres Strait Islander Peoples

NATSILMH propose the following as the basis of an adapted Declaration:

Draft Adapted *Wharerata Declaration* for Use By Aboriginal and Torres Strait Islander Peoples In Australia

Preamble

- In common with Indigenous peoples in many countries, Aboriginal and Torres Strait Islander peoples in Australia are subject to the profound impacts of colonisation, racism, social exclusion and negative social determinants on their mental health and wellbeing.

- Aboriginal and Torres Strait Islander peoples experience significantly higher rates of mental health problems and suicide than non-Indigenous people. Impacts are felt in all areas of life: physical health, employment, education, family life, community life, and cultural life.

- The high rates of Aboriginal and Torres Strait Islander mental health problems and suicide are a social justice and human rights issue that must be addressed. Aboriginal and Torres Strait Islander peoples require healing and restoration to mental health and wellbeing both individually and on collective levels.

- The Australian mental health system should be accountable to Aboriginal and Torres Strait Islander peoples for improved mental health and suicide prevention outcomes that will contribute to the healing and restoration of Aboriginal and Torres Strait Islander peoples.

- Aboriginal and Torres Strait Islander peoples with mental health problems are largely subject to the dominance of imposed non-indigenous mental health paradigms, and the lack of cultural competence of mainstream mental health professionals, and lack of cultural safety in services and programs. Such professionals, services and programs are often ineffective.

- Aboriginal and Torres Strait Islander peoples are under-represented in the mental health professions, services and programs that should be accountable to them. Historically, these have excluded Aboriginal and Torres Strait Islander people.

- In common with Indigenous peoples in many countries, Aboriginal and Torres Strait Islander peoples in Australia connect their mental health to strong Indigenous identities, to participation in their cultures, families and communities, and to their relationship to their lands, ancestors and the spiritual dimension of existence. This holistic concept of health that includes mental health is referred to as social and emotional wellbeing.

- Aboriginal and Torres Strait Islander peoples have maintained their own systems of traditional healers and healing methods that address mental health and wellbeing problems.

- Human rights, including the rights of Indigenous peoples, provide a framework for restoring the mental health and wellbeing of Aboriginal and Torres Strait Islander peoples. This includes rights:

    - to the highest attainable standard of mental health;

    - to self-determination and to lead in partnership in decision-making that affects their mental health and wellbeing in addition to all other areas of their lives;

    - to access traditional healers and healing methods for mental health problems; and

    - to access mental health services and programs, without direct or indirect discrimination.

Acknowledging this, and in order for the Australian mental health system to adapt and be accountable to Aboriginal and Torres Strait Islander peoples for better mental health outcomes and lower suicide rates, we make the following Declaration:

1: Aboriginal and Torres Strait Islander mental health should be recognised by the mental health system as a specialised area of practice

- The holistic concept of social and emotional wellbeing should guide all Aboriginal and Torres Strait islander mental health and suicide prevention policy development and service and program delivery.

- Aboriginal people and Torres Strait Islander people with mental health conditions must[xiv] have access to traditional healers and healing methods (including their contemporary forms).

2: Aboriginal and Torres Strait Islander and clinical perspectives working together will make the greatest contribution to the mental health and wellbeing of Aboriginal and Torres Strait Islander peoples.

- Led by Aboriginal and Torres Strait Islander peoples, the mental health system should incorporate Aboriginal and Torres Strait islander concepts of mental health and social and emotional wellbeing, traditional healers and methods, as well as clinical perspectives when working with Aboriginal and Torres Strait Islander people.

3: Aboriginal and Torres Strait Islander values-based mental health outcome measures should contribute to the assessment of mental health services and programs for Aboriginal and Torres Strait Islander peoples.

- Led by Aboriginal and Torres Strait Islander peoples, the mental health system should incorporate established and agreed upon Aboriginal and Torres Strait Islander values-based mental health outcome measures, as well as clinical measures, in evaluation frameworks for Aboriginal and Torres Strait Islander mental health services and programs as well as the evidence base for Aboriginal and Torres Strait Islander mental health.

- Further to the above, Aboriginal and Torres Strait Islander values-based mental health targets should be adopted by the mental health system.

4: Aboriginal and Torres Strait Islander leadership is required for the mental health system to adapt and be accountable to Aboriginal and Torres Strait Islander peoples.

- Aboriginal and Torres Strait Islander people should be employed to work at all levels of the mental health system and among the professions that work in the mental health system.

- Aboriginal and Torres Strait Islander people should be employed and empowered to lead in those part of the mental health system that are dedicated to improving Aboriginal and Torres Strait Islander mental health and wellbeing, and in all parts of the mental health system used by Aboriginal and Torres Strait Islander people.

- Aboriginal and Torres Strait Islander people should be employed and empowered to lead in all areas of government activity that affect the mental health and wellbeing of Aboriginal and Torres Strait Islander people.

5: Aboriginal and Torres Strait Islander leaders should be supported to be visible and influential in the mental health system.

- The mental health system should support different concepts of Aboriginal and Torres Strait Islander leadership to that of non-Indigenous people. In particular, Aboriginal and Torres Strait Islander leaders are directly accountable to their communities and the wider Aboriginal and Torres Strait Islander population and this should be accommodated.

- The mental health system should support the presence and visibility of Aboriginal leaders across of

the mental health system, and support them to be influential in all parts of it.

Part 4: Next Steps

NATSILMH aim to meet the following schedule for the adaptation of the *Wharerata Declaration*:

Time	Task
4 December 2014	• NATSILMH seeks endorsement of the process from the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.
February - March 2014	• Draft is sent to selected stakeholders for comment and feedback.
April 2015	• Extraordinary meeting of NATSILMH to consider feedback and to develop a final draft.
First half of 2015	• Final draft to be presented at a national event (i.e. the Social and Emotional Wellbeing National Conference/ National Aboriginal Community Controlled Health Organisation Summit) for endorsement; AND • Final draft is sent to selected stakeholders for endorsement.
After endorsement	• Final Declaration launched at a dedicated event with a media release and media attention (alternately, this might piggy-back on another event). • NATSILMH uploads the final Declaration to website / ongoing media, etc.
Aim for September 2015	• NATSILMH aims to present the final Declaration at the IIHML meeting in Vancouver.

To fit with this schedule, could you please provide us with your or your organisations feedback, comments and/or proposed changes by 31 March 2015.

Please send this feedback to our Executive Officer, Mr Christopher Holland, at cholland@internode.on.net.

On behalf of the members, I look forward to hearing from you and please do not hesitate to contact Mr Holland if you have any questions.

Best wishes,

Professor Pat Dudgeon
Chair, NATSILMH

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.natsiilmh.org.au.

The Wharerata Declaration – the development of indigenous leaders in mental health

Rose Sones
First Nations, Canada

Carol Hopkins
First Nations, Executive Director of the National Native Addictions Partnership Foundation, Canada

Spero Manson
Native American, Director of the Centers for American Indian and Alaska Native Health, USA

Ray Watson
Maori, Commissioner at the Mental Health Commission, New Zealand

Sir Mason Durie
Maori, Professor at Massey University, New Zealand

Valerie Naquin
Consultant at Cook Inlet Tribal Council, USA

This article has been written on behalf of the International Initiative for Mental Health Leadership (IIMHL). The IIMHL is a 'virtual' membership agency that works to improve mental health services by supporting innovative leadership processes: www.iimhl.com. The IIMHL contributes an article to every issue of *The International Journal of Leadership in Public Services.*

Abstract

Indigenous populations and communities around the world confront historical, cultural, socioeconomic and forced geographic limitations that have profound impacts on mental wellness. The impacts of colonialism and, for some indigenous populations, forced residential schooling and the resulting loss of culture and family ties, have contributed to higher risks of mental illness in these groups. In addition, there are barriers to healing and mental wellness, including inconsistent cultural competence of mainstream mental health professionals, coupled with the limited numbers of indigenous mental health professionals. The Wharerata Declaration is a proposed framework to improve indigenous mental health through state-supported development of indigenous mental health leaders, based on a new indigenous leadership framework. Developed by the Wharerata Group (original membership noted in the acknowledgements section at the end of this article), the framework will be presented for support to the member countries of the International Initiative for Mental Health Leadership (IIMHL) in 2010.

Key words

Indigenous; aboriginal; First Nations; Inuit; Maori; mental health; leadership; cultural competence.

10.5042/ijlps.2010.0275

Introduction

Almost 400 million indigenous people reside across the inhabited continents of Earth. Some are easily identified, such as the First Nations and Inuit in Canada, the American Indians and Alaska Natives in the United States, the Maori in New Zealand, and the Aboriginals in Australia. Some indigenous peoples are less visible, and some are not officially recognised by the governments of their countries. Indigenous people come from thousands of cultures and are over-represented among the poor and disadvantaged. Overall, their health compares unfavourably with their non-indigenous counterparts (Gracey & King, 2009). A generally agreed upon definition of indigenous peoples has been set by the United Nations:

> *'communities, peoples and nations… …which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or part of them. At present they form non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as a basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system.'* (United Nations Permanent Forum on Indigenous Issues, 2004)

Indigeneity encompasses the diversity of indigenous groups and cultures, as well as their similarities.

* Indigenous peoples share a longstanding and enduring relationship with the natural environment, such as the 14,000 years of history for First Nations in the northwest of Canada, and 50,000 years for Aboriginal Australians.
* Indigenous peoples have distinctive languages, such as Inuktitut for the Inuit in Canada's north, and nine large language families in the United States plus a number of smaller distinctive languages.
* Indigenous peoples share a worldview that is derived from ecological associations and are spiritually-based. Indigenous peoples commonly have sacred stories and traditions that have been passed down for generations and which tie their culture to the land.
* Indigenous peoples share experiences that threaten their language, land, customs and social organisation. Colonialist governments have sometimes ignored indigenous peoples' rights, including the right to practice their own culture or raise their children within their culture.
* Indigenous peoples share a determination to survive and prosper as indigenous peoples – and as global citizens.
* Indigenous peoples share an aspiration that indigenous families and communities should have optimal health and well-being.

Indigenous perspectives and definitions of health are often different than the mainstream or Western definitions.

> *'Western definitions are exemplified through the disciplines of psychology, social work and psychiatry, and which tend to focus on pathology, dysfunction or coping behaviours that are rooted in the individual person. Aboriginal mental health is relational; strength and security are derived from family and community. Aboriginal traditions, laws and customs are the practical application of the philosophy and values of the group. The value of wholeness speaks to the totality of creation – the group as opposed to the individual.'* (Little Bear, 2000)

Unfortunately, indigenous peoples continue to face the challenge of retaining their indigeneity in the face of racism in the current day. Yet the resiliency of indigenous peoples, rooted in culture and community, has carried them through tremendous challenges throughout history. This strength continues to form the basis of community wellness and well-being (Durie, 2001). Despite this history, Indigenous culture and community cohesion are commonly overlooked health determinants in mental health practice, research, and policy development.

Mental wellness challenges

Data regarding the mental health and well-being of indigenous peoples is lacking, partly

because of challenges in the identification of indigenous clients, mistrust of mainstream mental health, frequent absence of culturally competent care, and lack of access to indigenous healing options and services. Despite an absence of large-scale data, such as found in census or surveys, indigenous peoples indisputably face higher risks of mental illness.

According to the Te Rau Hinengaro (New Zealand Mental Health Survey), Pacific peoples in New Zealand (NZ) experience mental illness at higher levels than the general population: 25% compared with 21% of the overall NZ population, and close to half had experienced a mental illness at some stage during their lifetime (Oakley & Wells, 2006). Research has found that First Nations people living on reserve face higher rates of depression by 1.5 times, and suicide rates of five to six times higher (Mood Disorders Society of Canada, 2009). Surveys suggest that Aboriginal people are more likely than other Canadians to seek help for mental health problems: whereas eight per cent of all Canadians had consulted a mental health professional in the previous year, in some First Nations groups the proportion seeking help was as high as 17% and would probably have been even higher if more mental health professionals were available in northern and isolated areas (Government of Canada, 2006). Data on mental health challenges has also been collected for American Indians and Alaskan Natives, and driven by extraordinarily high levels of exposure to trauma, the rates of post-traumatic stress disorder are three to four times higher than that of national comparators (Manson *et al*, 2005). It is not surprising, then, that in many tribes alcohol abuse and/or dependence and suicide risk far exceed national norms (Beals *et al*, 2003; LeMaster *et al*, 2004).

Culturally adapted approaches to mental health and wellness are based in cultural identity and spirituality as the primary framework for treatment approaches, aimed at restoring balance of the individual with family and community. Because this framework emphasises indigenous values (spirituality, cultural identity as a source of strength, family and community), many believe the ensuing therapeutic work to be more effective than conventional approaches, which typically emphasise 'illness' and 'individuality' without regard for the broader social and cultural determinants of health.

While there are instances where indigenous peoples may choose to rely solely on indigenous mental wellness interventions and support, there are also instances where indigenous peoples choose to access mainstream mental health services (Gurley *et al*, 2001; Novins *et al*, 2004). This experience is not always positive for the indigenous client. The most significant mental health challenge is the potential conflict between indigenous worldviews and western worldviews. The legacy of colonialism, such as forced residential schools, is a heavy burden. But indigenous peoples may continue to face intentional or unintentional racism in everyday life, and may also encounter a lack of cultural competence in the mental health system. Indigenous peoples may still face inequitable response from the mental health system, ranging from a lack of respect for the client's culture, to lower rate of referrals, to disproportionately higher rates of diagnoses for more severe mental illness. The conflict between indigenous cultures and mainstream cultures continue to play out in the field of mental health, to the detriment of indigenous clients. The Wharerata Declaration sets out two complementary approaches to address this: supportive learning environments for mainstream mental health practitioners and leaders to strengthen indigenous cultural competency, and state supports for the development of indigenous mental health leaders and policy-makers.

The holistic nature of indigenous approaches is fundamental to practice and theory. The concept of holism would appear on the surface to be similar to other mainstream constructs. But indigenous languages offer a unique vehicle for communicating an understanding of indigenous worldviews on concepts of health and mental health. As we attempt to link indigenous concepts of health with western paradigms, there is always a risk of parsing or breaking down the indigenous construct into manageable parts, which better aligns to a western paradigm. In retaining the holism intrinsic to indigenous perspectives, we hope to communicate the points of compatibility between indigenous knowledge and western thought. For example, 'Le Va' is an indigenous Pacific Island term

that articulates an understanding of the 'space that relates' or often referred to as the negotiated space that exists between relationships (Mila-Schaff, 2009), and is used in treatment and support as a fundamental way to reconnect those suffering mental distress to relationships with others. This example is one of many that unveils the differences between cultural views on individualism and collectivism.

Wharerata is not about a minority approach to cultural safety. The Wharerata Declaration defines best practice for mental health practice and leadership as the strategic use of both indigenous cultural and clinical approaches in structure, process and outcome. We advocate that it is time that the mental health system meets indigenous clients on indigenous ground, and makes intentional space for indigeneity.

The Wharerata Declaration

The Wharerata Declaration was prepared by the Indigenous Leadership Group, assembled and supported by the International Initiative for Mental Health Leadership (IIMHL) in February 2009; the authors are referred to as the Wharerata Group. The Group met in the Wharerata building at Massey University in New Zealand, and included indigenous mental health practitioners and leaders from Canada, the US, Australia, Samoa, and New Zealand.

As presentations were given and discussions unfolded, four common challenges emerged. First, the mental health status of indigenous peoples lags behind non-indigenous populations. Second, indigenous perspectives and ways of healing are not always afforded equity in mainstream mental health systems of care. Third, indigenous mental health human resources are greatly under-represented throughout these systems (from practitioners to policy development). Finally, the influence of indigenous peoples with their representative countries' governments is inconsistent. The emerging consensus was that the development of indigenous mental health leadership naturally offers a foundation by which to address these four challenges (Durie, 2001).

The result was the Wharerata Declaration, a model to frame and advance indigenous mental health leadership in the IIMHL countries. While the Declaration specifies mental health, the Group believes that the principles also apply to the broader field of health.

> The word ***Wharerata*** is Maori in origin and was used as a name for one of the University's original buildings. *Whare* translates to 'house', and Rata translates to 'a tree with bright red flowers and a large canopy'. *Whare rata* is 'a house of wisdom and understanding, a house of shelter and protection'.

In health and mental health, indigenous perspectives are worthy not only of inclusion, but they also add value to western and medical perspectives. Indigenous perspectives on health are properly conveyed by indigenous practitioners and leaders. The creation of a cadre of indigenous health leaders is essential for inclusive conversations on health as well as culturally competent health indicators, and is essential to closing the gap in indigenous mental health (Durie, 2001; 1999).

Developing indigenous leaders necessarily differs from more conventional approaches to preparing mainstream health leaders. Business models are plentiful in leadership development theory, but none enshrine culture and community as essential components to build and sustain the indigenous leader.

The Wharerata Declaration articulates five themes for balancing indigenous and mainstream approaches to develop indigenous mental health leaders. These themes revolve around the following:

1. Indigeneity
2. Best practice
3. Best evidence
4. Informed, credible, strategic, connected, sustainable leadership
5. Influential and networked leadership.

Theme 1 – Indigeneity

Certain values and perspectives about life and health are shared by all indigenous peoples. Indigenous cultures retain sophisticated systems of healing and well-being developed prior to contact with colonising bodies.

> *'Aboriginal ideas about the body, disease, and medicine, then, were not just remnants of some pre-contact past but were living ways of viewing the world, ways of viewing that contested the colonizing discourse of Western medicine as it came to be articulated… …during the first half of the twentieth century. Through their very presence,*

Aboriginal conceptions of the body disrupted the intended medical dialogue of non-Native doctors and missionaries and forced, instead, a terse, discordant dialogue.' (Kelm, 1998)

Indigenous health and mental health are specialised areas of practice. Indigenous peoples understand that culture is inherently bound to complex social and community relationships, which include health and well-being. Given differences in health definitions, one incorporating culture and one not, it is not unreasonable to expect practitioners to include cultural competence and safety among the services provided to indigenous clients. There is a growing understanding that cultural competence takes us far beyond a simple awareness or acknowledgement of differences of 'other' cultures, even beyond recognising the importance of respecting differences. The concept has evolved to include the skills, knowledge and attitudes of practitioners (Indigenous Physicians Association of Canada & Association of Faculties of Medicine in Canada, 2009). Cultural safety is an intentional construct that acknowledges the experience of the patient as the evaluator of the degree of safety provided by the practitioner.

The development of culturally safe or culturally competent mental health practice is a lifelong journey. There are standards of cultural competence, one being Canada's First Nations, Inuit and Métis Cultural Competence Standards for Physicians and Psychiatrists by the Indigenous Physicians Association of Canada. Opportunities for learning more about cultures and how they relate to mental health are encouraged at community, academic, programme development and policy levels.

Theme 2 – Best practice

Mainstream or clinical practice has a major focus on the change within the individual, with a focus on psychological and biological dimensions, so treatment and care are primarily structured around individual patients, often on the premise that bio-medical perspectives are sufficient for the process of recovery. Yet there is growing recognition that culture and cultural approaches are achieving results, so the question then becomes: how do we combine clinical and cultural approaches in a meaningful and respectful manner?

If mental health systems are to improve the well-being of indigenous peoples, then we must strengthen understanding of indigenous perspectives as equally relevant as clinical perspectives, and recognise both the similarities and differences. For example, when using an indigenous values-based health outcomes perspective, it would be important to measure outcomes such as:

- has the intervention enhanced the individual's *relationship with their family?*
- has it enhanced their capacity to function as *part of their community?*
- have their *spiritual beliefs been considered* as part of the outcome assessment process?
- has the relationship between their *physical health and mental well-being* been considered?
- has the intervention considered their *cultural needs?*
- has the intervention process and outcome increased a *well-ness* orientation?

The Wharerata Declaration asserts the combination of cultural and clinical approaches as the best practice. Indigenous and clinical perspectives together have cumulative benefits that outweigh those deriving from a single track. A combined approach that explores the biological and psychological functioning of an individual, and at the same time locates the individual within the broader landscape, is the heart of an indigenous contribution to best practice. There is responsibility for both indigenous and mainstream practitioners to come together to find common ground and best practice.

Theme 3 – Best evidence

Evidence in mainstream health and mental health tends to be based in a positivistic approach, which sets out that '*phenomena are separate, self-contained, simple, and homogeneous*' (Ratner, 2006). Many factors restrict the inclusion of indigenous knowledge into the accepted body of knowledge in mental health. The holistic nature of indigenous knowledge almost defies a positivistic approach, and therefore is less likely to be published in peer-reviewed journals. Indigenous world views emphasise an ecological perspective that locates wellness and

Table 1: Comparison of indigenous and mainstream assessments of intervention (Kelm, 1998)

Inclusive of indigenous perspective	Clinical/mainstream
As a result of the intervention do you feel:	As a result of the intervention are you:
a) more valued as a person	a) more able to set goals for yourself
b) stronger in yourself as a Maori	b) more able to think, feel and act in a positive manner
c) more content within yourself	c) more able to manage unwelcome thoughts and feelings
d) healthier from a spiritual point of view	d) more able to understand how to deal with your health problem

illness within a broad landscape of spiritual, social, economic, customary and environmental dimensions. Following the point that best practice combines both cultural and clinical approaches, then how is evidence collected that upholds a culturally competent approach?

The Wharerata asserts that best evidence is based within the intervention – if the intervention is clinical, then the assessment or evidence should also be based in clinical perspectives. If the intervention is cultural, then the evidence of success should also be based in cultural perspectives. The sourcing of evidence from one epistemology to assess the other does not follow cultural competence standards. Determining outcomes is not solely about resolving the symptoms of an individual – there are broader changes based on the holistic health definition that should also accrue from programmes and services:

* functional outcomes: family functioning, a capacity to work, involvement in tribal or community life, and a sense of contentment are relevant to health gain
* clinical outcomes: personal insight, the absence of psychopathology, and sound reality testing are also markers of health gain
* indigenous research increasingly points to advantages accruing from traditional healing and cultural affirmation.

The combination of evidence and measures of success from clinical and cultural perspectives opens the door to an inclusive perspective on the inputs and products of change for the individual and community. A holistic approach to evidence is inclusive of the wider array of societal variables, including the supports or systems that surround an individual and community (see ***Figure 1,*** opposite). If 'it takes a village to raise a child', then it possibly takes the village to measure a child's success.

Theme 4 – Indigenous leadership

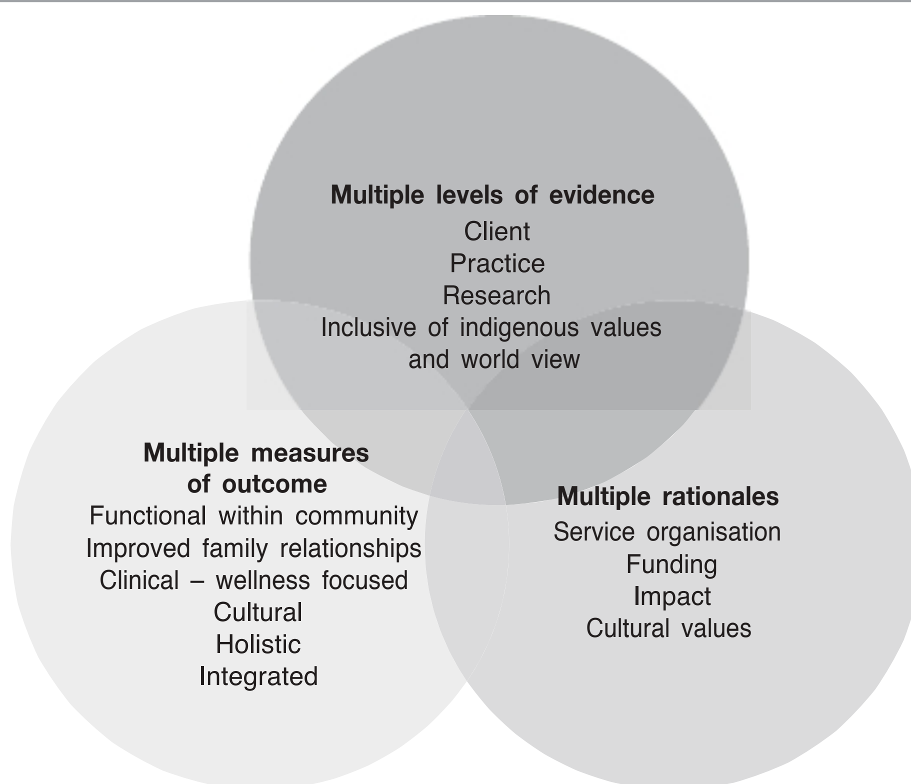
The Wharerata Group discussed possible reasons why there are so few indigenous leaders in mental health, and considered that the training programmes for leadership and mental health may not be inclusive of indigenous perspectives. Currently, most literature and discussions on leadership within health are based on corporate business models. There are few, if any, that examine this issue from an indigenous framework. However, most Maori organisations would agree that the following saying is one of the better indications of the core values of tribal leadership.

> *'Taku ate hoki ra,taku rata tutahi, taku whakamarumaru, taku whare kii tonu, taku tiketike ka riro, unuhia noatia te taniwha i te rua.'*
>
> *'You were my heart, my solitary rata tree, my sheltering place, my house of plenty, my elevated one now departed, withdrawn now is the dragon from its lair.'*

In this chant a leader is compared to a large tree in a forest that provides protection and sustenance for the community.

The practical application of best practice requires representation of, and participation

Figure 1: Best practice and best evidence



by, indigenous mental health practitioners and leaders throughout the mental health system, especially within policy areas. It is equally important that indigenous peoples share their world views and perspectives on mental health and culture, as this role cannot be given over to non-indigenous people.

The World Health Organization asserts that

> *'community empowerment is a major structural driver of health inequities when talking about indigenous communities. Health equity depends vitally on the empowerment of individuals and groups to represent their needs and interests strongly and effectively and, in so doing, to challenge and change the unfair and steeply graded distribution of social resources. Inequity in power interacts across four main dimensions – political, economic, social, and cultural – together constituting a continuum along which groups are, to varying degrees, excluded or included'* (World Health Organization & Commission on Social Determinants of Health, 2009).

The Wharerata is a strong declaration that the development of indigenous leaders must be supported by states as one of the five ways in which to address positive change for indigenous mental health. This needs to be accomplished by respecting unique indigenous leadership theories and perspectives.

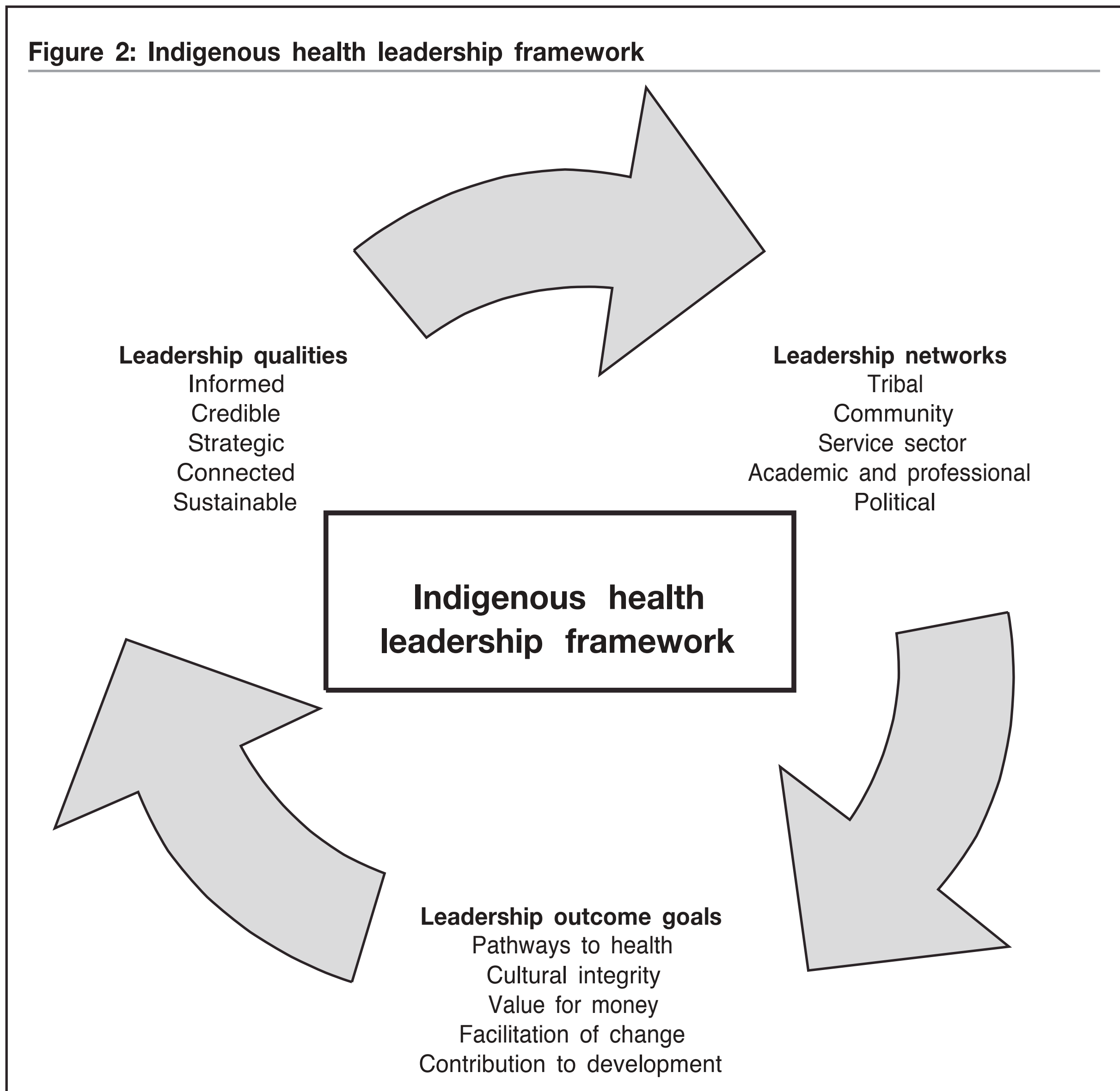
Indigenous mental health leaders must develop and maintain credibility from indigenous community; from mainstream peers; and are expected to advocate and effect change on a systems level.

The three domains of indigenous leadership are each characterised by five qualities, some of which are similar to mainstream leadership development theory, however some qualities are uniquely indigenous (see ***Figure 2***, overleaf).

Leadership qualities

1. **Informed** by both conventional wisdom and new knowledge
   * able to move between disciplines to uphold the principle of holistic health (such as addictions and mental

Figure 2: Indigenous health leadership framework



health, qualitative and quantitative data, etc)

* able to work at the interface between indigenous and mainstream worldviews
* comfortable with ambiguity and the unknown
* able to use and select appropriate language and vocabulary for the audience in order to build bridges, without risking integrity or reputation – an indigenous leader chooses the appropriate communication style to talk to his or her own community, mainstream funders, and the country's elected officials.

2. **Credible** leadership that enhances the leader's influence
* credibility within indigenous circles
* credibility within peers in the mainstream mental health system and health sector
* personal credibility – values such as integrity, creativity, self-reflection, humour, empathy, vision, capacity to care for others.

3. **Strategic** leadership is future-oriented
* creative leadership is able to move beyond convention and status quo in order to advance the cause, and is able to bring others with them

- able to facilitate and empower others
- able to promote consensus through skilled negotiation, for immediate and longer-term goals.

4. **Connected** leaders maintain their network, 'He toa takitini'

- tribal and community connections
- sector connections in health and professional peers
- policy and government connections
- part of a leadership network.

5. **Sustainable** leaders maintain work–life balance in order to protect their own contribution and relevance

- maintenance of supportive operating environment – social, work, family
- intentional planning for career succession pathways
- access opportunities for ongoing training
- awareness of, and contributing to, wider development goals of tribes, of communities.

Effective leadership encompasses all of the above, yet without influence there will be little impact on the mental health system and outcomes for indigenous clients and communities. Therefore, the Wharerata Declaration places unique value on the next dimension of 'influence'.

Theme 5 – Influence

Leadership is about the ability to influence change, and to raise awareness of indigenous health perspectives in such areas as: mental health development, political purchase, contracting for outcomes, population health, primary mental health care, relationships and boundaries, and workforce development initiatives. Indigenous leaders have visible and active networks, through which change can be influenced: tribal and indigenous communities, service sector, professional peers, and the political realm.

Influence is particularly important for indigenous mental health to overcome the historic invisibility of indigenous peoples, perspectives and holistic health. Mental health systems themselves are sometimes the barrier to mental wellness for indigenous peoples, so the ability to influence a wide variety of government policy-makers and service providers is a critical skillset.

Conclusion

Mason Durie (2001) wrote that

> *'often Maori [and indigenous] health is best understood, and improved, by targeting the lifestyles and dilemmas that face people in the course of their day-to-day encounters. The task then is to build strong foundations so that the demands of an unfriendly environment and the scars of unkind relationships can be softened, and the opportunities to be well can be enhanced'.*

The challenge facing us all is the reality that indigenous peoples continue to suffer from higher rates of mental illness than non-indigenous populations, and for some indigenous populations the rates are still increasing. The Wharerata Declaration, along with national initiatives to support mental wellness in indigenous communities, could contribute to a shift in momentum. The Wharerata Group envisions a world in which indigenous mental health is achieved.

- The negative effects of colonialism and residential schools are reversed, and indigenous people have renewed pride in their culture and their ability to succeed in wider society, and have visibility as contributing members in their countries.
- Mental health and addictions services and training programmes purposefully make space for cultural approaches to mental health, collaborate towards dual competency of clinical and cultural approaches and successfully build relationship with indigenous individuals and communities.
- Indigenous mental health leaders take their place alongside non-indigenous leaders, and together contribute to both indigenous and mainstream mental health systems.
- Indigenous people achieve mental wellness similar to their non-indigenous counterparts, and given the historical strengths of culture and social cohesion, may actually achieve more than parity.

This is a collective vision, one that requires a collaborative approach involving a number of partners, including community, providers and

government. But, like all collective action, it starts with individuals, and this vision starts with mental health leaders using their influence and networks to contribute to positive indigenous mental health, locally, regionally and nationally.

What are the next steps?

The Wharerata Group is currently building support for the Declaration in their respective IIMHL countries and indigenous peoples. The Declaration will be presented for support by all IIMHL countries at the IIMHL 2010 conference in Ireland. After that, IIMHL countries will be encouraged to find ways to resource and support implementation of the Declaration, specifically around the development of cultural competence in mainstream mental health systems, and to increase indigenous mental health leadership in policy and practice. We recommend that each country negotiate the target numbers of indigenous leaders to develop within a set time period with its respective indigenous groups.

> *The Wharerata Declaration is an organic document, and intended to be as inclusive as possible of indigenous perspectives. The Wharerata Declaration represents an additional tool to be used by indigenous groups in building their influence in their local mental health systems. Nothing in this plan should be interpreted as binding on indigenous groups, or restricting indigenous groups' work within their respective countries.*

Implications for leadership in practice

- The Wharerata Declaration is intended to spark discussion on the real-world application of the principle of best practice within the mainstream mental health field. Please join in the discussions on the Wharerata online home at www.indigenous-mental-health.ca, and share your thoughts on the Declaration.
- Develop your own knowledge of indigenous cultures, and your country's mental health system, and consider how to build bridges between the two.
- Share the vision of mental health in indigenous communities, and for indigenous peoples around the world.
- Consider how you can use your networks to build support for the Wharerata Declaration.

Acknowledgements

The original membership of the Wharerata Group is listed below.

Sir Mason Durie – Maori, Professor at Massey University, New Zealand
Ray Watson – Maori, Commissioner at the Mental Health Commission, New Zealand
Carole Maraku – Maori, Te Upoko o Te Rae, New Zealand
Dr Rees Tapsell – Maori, Director of Midland Forensic Mental Health Services, New Zealand
Dr Te Kani Kingi – Maori, Director of Academy of Maori Research, New Zealand
Nani McCloskey – Maori, Te Upoko o Te Rae, New Zealand
Kimini Anderson – Aboriginal, Queensland Health, Australia
Dr Helen Milroy – Aboriginal, University of Western Australia
Sailau Sualii-Sauni – Samoan, Otago University, Samoa
Dr Spero Manson – Native American, Cook Inlet Tribal Council, United States
Carol Hopkins – First Nations, Youth Solvent Abuse, Canada
Rose Sones – First Nations, Canada

Addresses for correspondence

Rose Sones
Communication Co-ordinator for the Wharerata Group, Canada
Email: webmaster@indigenous-mental-health.ca
Web: www.indigenous-mental-health.ca

Carol Hopkins
Executive Director, National Native Addictions Partnership Foundation, Canada
Email: chopkins@nnapf.org
Web: www.nnapf.org

Spero Manson
Distinguished Professor and Director
Centers for American Indian and Alaska Native Health, University of Colorado, US
Email: spero.manson@ucdenver.edu
Web: http://www.ucdenver.edu/aianp

Ray Watson
Commissioner, Mental Health Commission
New Zealand
Email: rwatson@mhc.gout.nz
Web: http://www.mhc.govt.nz/

Sir Mason Durie
Professor, Assistant Vice-Chancellor Te Mata o Te Tau, Massey University, New Zealand
Email: m.h.durie@massey.ac.nz
Web: http://www.massey.ac.nz

Valerie Naquin
Consultant, Cook Inlet Tribal Council, Alaska USA
Email: vnaquin@gmail.com

References

Beals J & Spicer *et al* (2003) Disparities in alcohol use: comparisons of two American Indian reservation populations with national data. *American Journal of Public Health* **93** (10) 1683–1685.

Durie M (1999) Mental health and Maori development. *Australian and New Zealand Journal of Psychiatry* **33** (10) 5–12.

Durie M (2001) *Mauri Ora: The dynamics of Maori health*. Australia: Oxford University Press.

Government of Canada (2006) *The Human Face of Mental Health and Mental Illness in Canada*. Ottawa: Minister of Public Works and Government Services Canada.

Gracey M & King M (2009) Indigenous health part 1: determinants and disease patterns. *Lancet* **374** (9683) 63–75.

Gurley D, Novins DK, Jones MC, Beals J, Shore JH & Manson SP (2001) Comparative use of biomedical services and traditional healing options by American Indian veterans. *Psychiatric Services* **52** (1) 68–74.

Indigenous Physicians Association of Canada & Association of Faculties of Medicine in Canada (2009) *First Nations, Inuit, Métis Health Core Competencies: A curriculum framework for undergraduate medical education*. Ottawa: IPAC & AFMC.

Kelm M (1998) *Colonizing Bodies: Aboriginal health and healing in British Columbia, 1900–50*. Vancouver, BC: UBC Press.

LeMaster PL, Beals J, Novins DK & Manson SM (2004) The prevalence of suicidal behaviors among Northern Plains American Indians. *Suicide and Life-threatening Behavior* **34** (3) 242–254.

Little Bear L (2000) Jagged world views colliding. In: Battiste M (Ed) Reclaiming Indigenous Voice and Vision. Vancouver, BC: UBC Press.

Manson SM, Beals J, Klein S, Croy C & AI-SUPERPFP Team (2005) The social epidemiology of trauma in two American Indian reservation populations. *American Journal of Public Health* **95** (5) 851–859.

Mila-Schaaf H (2009) *Negotiating Space for Indigenous Theorising in Pacific Mental Health and Addictions*. New Zealand: LeVa.

Mood Disorders Society of Canada (2009) *Quick Facts: Mental illness and addictions in Canada*. Ottawa: MDSC.

Novins DK, Beals J, Moore L, Spicer P, Manson SM & AI-SUPERPFP Team (2004) Use of biomedical services and traditional healing options among American Indians: sociodemographic correlates, spirituality, and ethnic identity. *Medical Care* **42** (7) 670–679.

Oakley B & Wells S (2006) *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

Ratner C (2006) Contextualism versus positivism in cross-cultural psychology. In: G Zheng, K Leung, & J Adair (Eds) *Perspectives and Progress in Contemporary Cross-cultural Psychology*. Beijing: China Light Industry Press.

United Nations Permanent Forum on Indigenous Issues (2004) *The Concept of Indigenous Peoples: Background paper prepared by the Secretariat of the Permanent Forum on Indigenous Issues*. New York: UN.

World Health Organization & Commission on Social Determinants of Health (2009) *Closing the Gap in a Generation: Health equity through action on the social determinants of health*. Geneva: WHO.

Appendix 3 – The Sydney Declaration

**Meeting of State and National Mental Health Commissions
and International Mental Health Leaders**

11 and 12 March 2013 Sydney, Australia

**Hosted by the National Mental Health Commission of Australia
in partnership with the New South Wales Mental Health Commission
and the Mental Health Commission of Canada**

Meeting Communique - The Sydney Declaration

International, National and State guests assembled in Sydney for two days to discuss ways to bring about change for the benefit of people living with and recovering from mental health difficulties, their families and supporters and the wider community.

Two days were spent in a spirit of joint purpose to share experiences, learn from each other, create connections and explore opportunities for future partnerships and collaborations at national and international levels. People with lived experience of mental health issues and family members were present throughout the discussions, which enhanced the sharing of experiences and learning, and the identification of opportunities and partnerships.

The discussions focused on five areas:

1. Indigenous mental health
2. Seclusion and restraint
3. Work and mental health
4. Knowledge exchange
5. International benchmarking

These five areas were chosen following a number of suggestions made before the meeting. The areas selected are not exhaustive, rather they represent issues that were of significant interest to the participating organisations and leaders, and they align with a number of the key priority areas of focus for the National Mental Health Commission of Australia.

The participants agreed to issue this declaration setting out their commitment and dedication to pursuing actions on these five areas. This declaration acknowledges that people's lived experiences inform the focus of this future work and that makes improvements towards a fully contributing life for people living with mental health difficulties, their families and supporters is the goal. The declaration is issued recognising

that actions to be taken forward will be determined locally.

The declaration has been produced to help underline the participants shared and common commitment to advocating for, supporting and driving change. This commitment will be further served by continuing collaboration and partnership and by creating opportunities for further dialogue and learning.

1. Indigenous Mental Health

We recognise Indigenous peoples as the first or original peoples of our countries, who have a longstanding and enduring relationship to the land. We recognise that colonisation negatively impacted on Indigenous cultures, communities and peoples, and that its legacy continues to affect their mental health and wellbeing today. We recognise and value the strength and resilience of Indigenous peoples and communities. Indigenous peoples share similar values regarding the importance of family and community as protective factors for social and emotional well-being. These values need to be inherent in mental health systems to help underpin holistic approaches to health, mental health and well-being for the benefit of all in our communities.

Together we commit to adopt the Wharerātā Declaration with its vision of *Healthy Indigenous individuals, families and communities.*
http://www.fnhma.ca/conference/2011/FNHMA%20English/Workshop%20L.pdf

We commit to the principles of partnership with Indigenous peoples and mental health leaders to achieve the vision of culturally accessible and competent mainstream mental health services for Indigenous individuals, families and communities, and to the development of Indigenous leaders in mental health to influence future systems change.

We uphold the principle of genuine partnership with Indigenous peoples to develop mental health programs, interventions and policy together, to increase the effectiveness for Indigenous peoples and as Indigenous leaders request, "nothing for us, without us".

We will advocate for cultural competence across all mental health professions as well as higher education curricula as a key quality improvement approach. In the development of cultural competence standards and future learning opportunities it is crucial to ensure Indigenous peoples play significant leadership roles.

We recognise the vital role of Indigenous leaders to advocate for holistic, cultural and community-based approaches in mental health. We support the on-going development of Indigenous leaders in mental health, so that they are able to influence change in systems which will benefit us all. As evidence of our commitment to Indigenous peoples mental health and well-being, we commit to:

1. Include and value Indigenous perspectives and practice in our respective programmes of work.
2. Advocate for and promote trauma-informed care approaches to strengthen mental health practice across all our communities.
3. Contribute to the on-going development of Indigenous leaders in mental health by supporting Indigenous peoples to collaborate and learn from each other domestically and internationally (for example with and through the International

Initiative for Mental Health Leadership, IIMHL
4. Impart knowledge from Indigenous communities on holistic approaches to health, mental health, social and emotional wellbeing.

2. Seclusion and Restraint

We recognise that seclusion and restraint has been formed in part as a cultural practice across services and systems and is not based on evidence of effectiveness in caring for and supporting people with mental health difficulties and their families and supporters. We acknowledge the views of people with lived experience and recognise that seclusion and restraint can and does damage people, especially those who have experienced trauma. Seclusion and restraint practices can lead to further re-traumatisation and fear of accessing care, treatment and support.

We also recognise that families, supporters and service providers are extremely concerned about the use of seclusion and restraint and the lack of information and response following the use of these practices. This underlines the need for reflective practice and continuing practice improvement. The use of involuntary practices and specifically seclusion and restraint is a complex area and together we will work to bring an end to the practices of seclusion and restraint across our mental health systems. To help this, we commit to:

1. Sharing knowledge and experience, including how to implement models of good practice in ending seclusion and restraint practices.
2. Advocating for the engagement of people using services, their families and communities in the on-going development of services, particularly around working together to bring an end to seclusion and restraint.
3. Finding common definitions to facilitate improved data collection and indicators to report on seclusion and restraint to help measure the extent to which these practices are ending.
4. Supporting one another to bring about the changes needed to get evidence regarding improving patient safety and occupational health and safety issues that help underpin this work.
5. Consider the need for possible legislative mechanisms to support bringing an end to seclusion and restraint practices.

As evidence of our commitment to helping to bring an end to the practices of seclusion and restraint, we agree to:

1. Show leadership in bringing an end to seclusion and restraint and raise this agenda as one for immediate change.
2. Identify and share practices, improvements and lessons learned.
3. Meet within the next three years on an international basis to review progress.

3. Work and Mental Health

We recognise that addressing the relationship between work and mental health has benefits for people with mental health difficulties, broader communities and economies. The participation of people in meaningful work is a matter for governments, public services agencies, businesses large and small, NGO's and communities. The workplace can contribute to mental well-being and play an essential part in helping people and families attain their full potential in living a contributing and meaningful life.

It is also important to highlight that the health or harm created in workplaces can migrate into families, communities and society as a whole, and vice versa. Meaningful employment is a key component of recovery from significant mental health difficulties and challenges. It is acknowledged that participation in the workplace by some people with lived experience may require additional support for both the person and their employer and we will advocate for appropriate funding and support to help make this a reality. Where participation in work is not the most appropriate course for people, we will advocate for and promote full participation within education and training, and full inclusion in community life, helping to bring an end to stigma and discrimination in our workplaces and communities. We also recognise the importance of supporting employers to be able to create and support more mentally healthy workplaces, sustainable employment opportunities for people living with mental health difficulties and support for those in a family or caring role.

Together we will not only focus on prevention of mental illness and promotion of good mental wellbeing but also on early intervention and ensuring that those with lived experience are able to participate in skilled, meaningful work, where appropriate adjustments are made and individualised support provided to enable people to aspire to and achieve valued work. We are also committed to exploring and continuing to develop peer employment opportunities.

In advocating for and promoting initiatives addressing mental health issues in the work place, we commit to:

1. Involving a broad stakeholder group – comprising labour organisations, government, corporations, unions, the mental health community, providers, employees and employers and others in bringing about sustainable change.
2. Leading by example - as mental health organisations and departments, we need to be leaders and champions for this agenda and ensure our own workplaces are psychologically healthy and safe. We should also model a workplace that includes people with lived experience and one that supports those who have a caring role.
3. Being inclusive – by including small and medium organisations in what we do and acknowledging that they are often the most impacted by economic, workplace and social pressures.
4. Supporting employers to create mentally healthy workplaces, adopt family and carer friendly employment practices, and improve opportunities for employing and

sustaining the employment of people living with mental health difficulties and challenges[1].
5. Supporting evaluation and the sharing of outcomes to facilitate employment and workplace initiatives.

As evidence of our commitment to work and mental health, over the next three years, we will move this issue forward in our programs and:

1. Work collaboratively with employers to create and sustain a psychologically and physically healthy and safe work environment.
2. Develop a parallel and linked agenda on access to work and maintenance in work for those with severe mental illness.
3. Promote the collection of qualitative and quantitative data to demonstrate which programs, interventions and tools are effective and why.
4. Share best practices and evidence on what works and what doesn't.
5. Help develop clear expectations of the benefits of standards for psychological health and safety in the workplace through regulatory frameworks and guidance for employers.
6. Share and advocate the use of the voluntary *Standard for Psychological Health and Safety in the Workplace* developed by the Mental Health Commission of Canada.

4. Exchanging Knowledge

We recognise the value of exchanging knowledge and learning with and from others who are working hard to improve the lives and opportunities of people living with mental health difficulties, their families and supporters. We are committed to finding creative and innovative ways of furthering the exchange of knowledge and the translation of knowledge into practice and for sharing this knowledge across systems, jurisdictions and international borders.

We will continue to explore the exchange of knowledge and commit to developing further ways of sharing what we are learning together. We will aim to meet again in 2014 along with others to continue to pursue this.

5. International Benchmarking

We also appreciate the value of finding ways to compare and contrast what we and others are doing and the importance of finding measures and indicators that help benchmark the differences we are making towards achieving a contributing life for people living with and recovering from mental health difficulties. We commit to sharing our work and practices in the development of indicators, data and benchmarking and to working to identify and develop 'whole of life' benchmark indicators across jurisdictions and

---

[1] The Mental Health Commission of Ireland has no mandate for developing employment services.

international borders by building on work under way to help creatively achieve our aspirations.

As a first step towards this, we are aware of the interest shown by a number of national and state governments in data and indicators. In Australia this is a current live issue that the National Mental Health Commission is supporting. Participants agreed to share their views and developing work on indicators; this will be of value to many participants, but will be of especial value to helping influence the work already underway in Australia.

In Conclusion

We all feel we have benefited from these two days of discussions, and we will endeavour to find ways of continuing these and other collaborations. The next opportunities are in Perth in July 2013 for Australian based organisations and then in the UK in June 2014 during the next International Initiative for Mental Health Leadership's international exchange programme and network event.

Declaration endorsed by:

Participants in the Sydney meeting are listed below. Each of the people listed has endorsed the declaration on behalf of the agencies they represent and / or as individual participants.

National Mental Health Commissions

Australian National Mental Health Commission: Chair, Professor Allan Fels
Commissioners: Peter Bicknell, Professor Pat Dudgeon, Sam Mostyn, Professor Ian Hickie, Professor Ian Webster, Jackie Crowe, Janet Meagher, Rob Knowles
Robyn Kruk Chief Executive Officer, Georgie Harman Deputy Chief Executive Officer, Catherine Lourey Director Report Card, Jane Moxon Director Policy, Strategy and Projects

Mental Health Commission of Canada – Louise Bradley President and Chief Executive Officer, Sapna Mahajan, Director Prevention and Promotion Initiatives, Nicholas Watters, Director Knowledge and Innovation

Mental Health Commission of Ireland – Martin Rogan, Commission Member and Dr Patrick Devitt, Inspector of Mental Health Services

New Zealand Mental Health Commissioner – Dr Lynne Lane

Australian Mental Health Commissions

New South Wales Mental Health Commission – John Feneley Commissioner, Professor Alan Rosen Deputy Commissioner

Mental Health Commission of Western Australia – Eddie Bartnik Commissioner, Barry

McKinnon Chair of the Mental Health Advisory Council

Queensland (Mental Health Commission in development) – Liz Powell, Director Queensland Mental Health Commission Transition Unit

Australian States and Territories

Australian Capital Territory – Dr Peggy Brown, Director General, Health Department

Northern Territory – Mike Melino, A/Executive Director, Health Services Division Department of Health, Bronwyn Hendry, Director Mental Health Services

South Australia – David Davies, Executive Director, Mental Health and Substance Abuse

Tasmania – Nick Goddard, CEO Mental Health Services, Department of Health

Victoria – Paul Smith, Executive Director, Mental Health, Drugs and Regions, Department of Health

International guests

Rose Sones-Lemay, Chair Wharerata Group and Strategic Policy, Planning and Information, First Nations and Inuit Health, Health Canada

Geoff Huggins, Deputy Director of Health and Social Care Integration, Scottish Government, Edinburgh, Scotland, UK

Professor Harold Pincus, Director of Quality and Outcomes Research, New York Presbyterian Hospital and Columbia University, New York, USA

Dr Ken Thompson, Chief Medical Officer Recovery Innovations and Pennsylvania Psychiatric Leadership Council, Pittsburgh, USA

Facilitator

Gregor Henderson, UK

Also in attendance:

Australian Institute of Health and Welfare – David Kalisch, Director, Gary Hanson, Unit Head Mental Health Services and Palliative Care Unit

Australian Bureau of Statistics - Paul Jelfs, Assistant Statistician leading the Social Analysis and Reporting Branch

Comcare – Paul O'Connor, Chief Executive Officer

Acknowledgements

With thanks and acknowledgements to all participants and particularly to:

- Commissioner John Feneley and his team at the Mental Health Commission of New South Wales
- President and CEO Louise Bradley and her team from the Mental Health Commission of Canada
- Rose Sones-LeMay, International Coordinator at the Wharerātā Group and Health Canada Community Development and Capacity Building (First Nations & Inuit)
- Dr Lynne Lane, New Zealand Mental Health Commissioner
- All the Australian organisations who gave their time, input and support.
- All those who contributed to the meeting papers and discussions
- Australian National Mental Health Commission staff, especially Joan Reeves
- Special thanks to Gregor Henderson, UK, Facilitator of the Meeting

Appendix 4: Guiding Principles of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009*[xv]

This Framework's Guiding Principles are:

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.

2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.

3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally, and mental health problems, in particular.

4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.

5. The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health, (versus mental ill health). Human rights relevant to mental illness must be specifically addressed.

6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and well being.

7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.

8. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.

9. It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

Aboriginal and Torres Strait Islander peoples have different cultures and histories and in many instances different needs. Nevertheless, both groups are affected by the problems that face them as Indigenous peoples of Australia. The differences must be acknowledged and may need to be addressed by locally developed, specific strategies.

[i] Australian Bureau of Statistics, 'Psychological Distress' *Australian Aboriginal and Torres Strait Islander Health Survey, First Results, 2012*, ABS cat. no. 4727.0.55.001, 2013 (Webpage) <www.abs.gov.au/ausstats/abs@.nsf/Lookup/9F3C9BDE98B3C5F1CA257C2F00145721?opendocument>. [Verified 19 December 2014.]

[ii] Australian Bureau of Statistics, 'Psychological Distress' *Australian Aboriginal and Torres Strait Islander Health Survey, First Results, 2012*, ABS cat. no. 4727.0.55.001, 2013, (Webpage) <www.abs.gov.au/ausstats/abs@.nsf/Lookup/9F3C9BDE98B3C5F1CA257C2F00145721?opendocument>. [Verified 19 December 2014.]

[iii] Australian Bureau of Statistics, *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13,* ABS cat. no. 4727.0.55.001 2013, (Webpage) <www.abs.gov.au/ausstats/abs@.nsf/Lookup/9F3C9BDE98B3C5F1CA257C2F00145721?opendocument>. [Verified 19 December 2014.]

[iv] Based on combined data from New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory. Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework 2012: detailed analyses*, Cat. no. IHW 94. Canberra, 2013, p.639.

[v] Australian Institute of Health and Welfare, 'Psychiatric Disability Support Services', Mental Health Services in Australia, May 2014, (Webpage) <http://mhsa.aihw.gov.au/services/disability-support/>. [Verified 14 August 2014].

[vi] Australian Bureau of Statistics, *Suicides, Australia, 2010*, ABS cat. no. 3309.0, 2012, <www.abs.gov.au/ausstats/abs@.nsf/Products/3309.0~2010~Chapter~Aboriginal+and+Torres+Strait+Islander+suicide+deaths?OpenDocument>. [Verified 19 December 2014.].

[vii] Australian Bureau of Statistics, *Causes of Death 2012*, ABS cat. no. 3303.0, 25/3/12, (Webpage) <www.abs.gov.au/ausstats/abs@.nsf/Lookup/by per cent 20Subject/3303.0~2012~Main per cent 20Features~External per cent 20Causes per cent 20(V01-Y98)~10021>. [Verified 19 December 2014.]

[viii] Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2014*, Productivity Commission, Canberra, 2014.

[ix] See: UN General Assembly, United Nations Declaration on the Rights of Indigenous Peoples: resolution / adopted by the General Assembly, 2 October 2007, A/RES/61/295, Article 1, available at: http://www.unhcr.org/refworld/docid/471355a82.html

[x] See: Article 12(1) of the UN International Covenant on Economic, Social and Cultural Rights (1966). UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: www.unhcr.org/refworld/docid/3ae6b36c0.html. Also: UN General Assembly, United Nations Declaration on the Rights of Indigenous Peoples: resolution / adopted by the General Assembly, 2 October 2007, A/RES/61/295, Article 24, available at: http://www.unhcr.org/refworld/docid/471355a82.html

[xi] Social Health Reference Group, *Social and Emotional Well Being Framework: A National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004-2009*, Australian Government Printing Service, Canberra, 2004, p.6.

xii Sun J, Buys N, Tatow D, Johnson L, Ongoing Health Inequality in Aboriginal and Torres Strait Islander Population in Australia:Stressful Event, Resilience, and Mental Health and Emotional Well-Being Difficulties
International Journal of Psychology and Behavioral Sciences, 2012 2(1): 38-45.

xiii Gee G, Dudgeon P, Schultz C, Hart A, and Kelly K, 'Social and Emotional Wellbeing and Mental Health: An Aboriginal Perspective'. Chapter 4, In Dudgeon, Milroy and Walker (eds) Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles *and Practice – Revised Edition*, Commonwealth of Australia, Canberra, 2013, p.62.

[xiv] The use of the word 'must' in this context aligns the Declaration with the wording in ss.50, 81, 189 of the *Mental Health Act 2014* (WA). For example, s50: Assessment of person of Aboriginal or Torres Strait Islander descent To the extent that it is practicable and appropriate to do so, the assessment of a person who is of Aboriginal or Torres Strait Islander descent must be conducted in collaboration with —

(a) Aboriginal or Torres Strait Islander mental health workers; and
(b) significant members of the person's community, including elders and traditional healers.

[xv] Social Health Reference Group, *Social and Emotional Well Being Framework: A National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004-2009*, Australian Government Printing Service, Canberra, 2004, p.6.