The Causes of the Causes: Oppression and Suicide – Beyond an Individualistic Mental Illness Perspective

A Submission to the Senate Community Affairs Committee

Inquiry into Suicide in Australia

"To overcome discrimination and to promote inclusion, interventions need to occur at multiple levels of analysis" **– Nelson & Prilleltensky**

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Table of Contents

Acknowledgements

This submission has been prepared by Catherine Keating, Hanna Rosenthal, Jacinta Wainwright and Kate Bennett, students of the Masters of Applied Psychology (Community) at Victoria University, Melbourne. Whilst we have chosen several specific groups to illustrate our core argument, it is not our intention to speak for or indeed on behalf of those groups. Further to this, whilst we have all experienced disadvantage at some level as individuals, as a collective we wish to acknowledge our position of relative privilege with regard to the issues discussed - a concept that is at the heart of our submission.

We wish to thank the Senate Community Affairs Reference Committee for the opportunity to make a submission to the Inquiry into Suicide in Australia.

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Position Statement

Community psychology provides an alternative lens to understand and address suicide in Australia. It is the study of people in context, and is concerned with the impact of the social, cultural and political environment on the health and wellbeing of individuals, groups and communities. We believe our knowledge of both traditional psychology practice and community psychology approaches allows us to identify the limitations of interventions that are focused primarily on individuals. Community psychology adopts a strong social change orientation with an emphasis on identifying and eliminating oppression, and promoting social justice and human rights.

Our aim in this submission is to provide a summary of theory and research related to several vulnerable groups that have been identified in the literature, namely Aboriginal and Torres Strait Islander people; Women; and Lesbian, Gay, Bisexual and Transgender people (LGBT). In doing so, we present a perspective that highlights the links between oppression, marginalisation and suicide, and emphasise the need for current research and practice to look beyond 'traditional' models of suicide to incorporate the 'causes of the causes'. We propose that adopting an ecological approach to suicide prevention and engaging in both ameliorative and transformative practice will provide a more comprehensive program of suicide prevention aimed at addressing social injustice and promoting wellbeing.

Relevance of the Submission to the Committee's Terms of Reference

Our submission on the impact of suicide on the Australian community is relevant to the following terms of reference:

c. the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide

d. the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide

f. the role of targeted programs and services that address the particular circumstances of high risk groups

g. the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy

Recommendations

01. Addressing the negative mental health outcomes, including suicide, for women affected by violence should be part of larger efforts to prevent and eliminate men's violence against women.

02. Health practitioners such as G.P's and mental health workers should have training in understanding the dynamics of male family violence and appropriate practice responses to women who are affected. In addition, health services and family violence services require collaborative working relationships to support the safety of women and reduce the harmful impacts of violence.

03. Adequate service system responses and resources must seek to ameliorate the social, economic and health impacts of family violence given these areas interact and affect an individual's overall wellbeing.

04. Addressing the higher risk of suicide for LGBT people in the community should be part of larger efforts to eliminate discrimination based on sexual orientation. The legitimacy of diverse sexual orientation must be recognised and upheld across all levels of society reducing the heterosexism and homophobia that currently exists.

05. Such efforts should target both broader public education as well as target settings where discrimination and abuse based on sexual orientation is experienced in everyday settings such as family schools and workplaces.

06. LGBT sensitive health setting and practice must be available as well as LGBT specific services. Appropriately trained health practitioners may also be well placed to support and educate families coming to terms with a family member's sexual orientation particularly where mental health concerns are also present.

07. Comprehensive research is required in order to develop targeted and culturally appropriate strategies to improve the social and emotional wellbeing of ATSI people.

08. Suicide intervention/prevention strategies targeted at ATSI people must address the broader systemic issues that impact on risk and protective factors and recognise that suicide is often a consequence of contemporary disadvantage which has resulted from various forms of past and present social injustices.

09. Policy, legislation and practice must demonstrate a critical awareness and acknowledge the impact colonialism has had on the physical and mental health outcomes of ATSI people, including the impact of past and present racism on individuals and communities.

10. The policy landscape should reflect multiple views and not favour an Anglo-Australian perspective that reinforces dominant ideologies, theory and practice.

11. Suicide strategies should develop mechanisms for liberation rather than social control.
12. There needs to be a shift from a problem-focused clinical perspective of suicide to one that centres on empowerment and more general emotional and social wellbeing.
13. Adopt a decolonising approach to practice in which healthcare professionals recognise their race privilege, validate Indigenous wisdom, acknowledge Indigenous rights and discard the power they may exert in the name of professionalism.
14. Recognise the value of extended family, Elders and the community and incorporate indigenous notions of spirituality and healing into practice.
15. Develop collaborative approaches that emphasise community empowerment and build on traditions and cultural identity as a means to build resilience and promote mental health.
16. Suicide prevention needs to be developed within an ecological framework, which strives towards transformative as well as ameliorative change.
17. Policy and program initiatives such as the National Suicide Prevention Strategy should ensure that sufficient funding and support be afforded to groups and organisations in order to implement ecological frameworks within their research and practice of suicide prevention, and that time frames for evaluation are adequate to measure success.
18. Both ameliorative and transformative approaches are required in order to enhance the current programs of suicide prevention. Identifying and addressing the 'causes of the causes' of suicide and adopting a social justice and human rights approach to prevention is essential to address oppressive contexts, such as violence, poverty, racism and power imbalances which can lead to psychological distress and suicide.
19. Suicide prevention programs should simultaneously aim to reduce risk factors as well as enhance wellbeing, in order to address a range of health and social issues more broadly.
20. More research is required in order to identify further the 'causes of the causes' of suicide, in order to enhance suicide prevention strategies.

A Brief Overview of Suicide Theory

A brief overview of the seminal work of Emile Durkheim is presented in order to position the proceeding discussion illustrating the links between oppression and suicide for Aboriginal and Torres Strait Islanders; women; and lesbian, gay, bisexual and transgender people.

Developing cohesive societies

Part of the knowledge that community psychologists refer to for their understanding of society stems from the work of sociologist Emile Durkheim. Although a number of other models have extended on his ideas (Coser, 1971), Durkheim offered the first comprehensive theory of suicide. His study was based on the notion that social facts, such as suicide, cannot be explained by *individual* psychology alone and argued that collective phenomena exert strong pressures on individuals to act in certain normative ways. As such, we can expect to see suicides increase under conditions of: poverty; oppression; environmental disasters; social isolation; great social change and mobility; unemployment; drug and alcohol abuse; and in particular, in societies lacking social cohesion (Durkheim, 1897/1968).

Screening critical breaks in social ties

Halbwachs (1971) extended on part of Durkheim's understanding of suicide, stating that it is important to acknowledge and examine suicide in terms of *social isolation*. Halbwachs' theory suggests that it is not simply the fact that one *is* alone that produces suicide, but rather, that for suicide to be produced by social isolation, one must actually *feel* alone. Halbwach argued that suicides will always be preceded by specific changes in consciousness that follow from breaks in social ties.

Understanding and applying Halbwachs' theory allows us to screen for risk by directing our efforts to those areas in which particular fractures in social relationships occur, for instance: divorce, death of a loved one, jail, family breakdown and homicides. In this regard, it allows for individual assessment of risk because if changes to consciousness follow damage to social relationships, the resultant distress and chaos can therefore be determined. Accordingly, it is on a sense of sudden aloneness that Halbwach believes suicide depends. The individual feels detachment and loss to society without remedy and hence, has no reason for living.

Recognising the social persona and threats to mastery

This consciousness, angst and despair are the psychological counterpart of the social conditions of disorganisation and sudden breakdown in social membership. Travis (1990) explains this *consciousness* in anomic suicide as that which "entails a lack of legitimate control, where individuals realize they are being used, deceived, oppressed and persecuted… and in a form of rebellion…he stands ashamed and defeated" (p. 241). Thus, it is crucial to understand the changes that follow aloneness, that is, the changes to the *social persona* that follow the sudden recognition that one is alone and that impels individuals to commit suicide. When the social structures are absent and fail to support an individual's

ego-ideal and consciousness, the individual is at risk of suicide - having failed to master and control their social conditions.

Remedies to aloneness

Durkheim's theory and those that followed highlight the importance of examining forces of social cohesion and division. In traditional societies based on strong community ties, individuals will be expected to gain a sense of membership and purpose by belonging to that community. However, in modern rational forms of social organisation such as bureaucratic structures and impersonal forms of management, individuals may feel alienated from meaningful participation and social status. Social phenomena, such as suicide, cannot be understood separately from the social contexts in which they take place. An awareness of the importance of community ties and extended relationship networks is a powerful means by which to build the social capital of those groups most vulnerable to the sometimes fatal impact of competing social forces.

Oppression, Power & Suicide: Women; & Lesbian, Gay, Bisexual & Transgender (LGBT) People

Summary of key points

- Understanding and addressing suicide requires attending to the causes of psychological distress that are often found within the social and political context which advantages some people and groups while disadvantaging others.
- Research evidence demonstrates that intimate partner violence significantly increases the likelihood of psychological distress and suicidality of women who are abused.
- Failure to recognise and appropriately respond to women who are abused when presenting with a range of negative psychological symptoms may inadvertently reinforce a context of abuse and exacerbate a woman's psychological distress.
- Addressing the psychological distress experienced by women who are abused requires interventions that seek to change the social norms that support violence against women. This also includes ensuring that the broader community and service system responses to women are supportive and adequate.
- Research evidence demonstrates that the discrimination, rejection and abuse experienced by LGBT people has a negative impact on their health and wellbeing and significantly increases the risk of suicide.
- Addressing the higher risk of suicide for LGBT communities requires changing the social and institutional norms that support discrimination and prejudice due to sexual orientation. Interventions should also target family, school and workplace settings given the high prevalence of rejection, abuse and prejudice in these contexts.

Effective action to address suicide in Australia requires attending to what Joffe (1996) coined as the "causes of the causes". In this submission, we contend that underlying the psychological distress that leads an individual to suicide are factors that are found within the social, economic, political and cultural context. The social determinants of health are well recognised. There is strong evidence that health and ill health are linked to the social context, pointing to the need to create healthy societies if we want healthy individuals. As identified by the World Health Organisation (WHO), strategies to overcome poverty, violence, unemployment, homelessness and discrimination, require addressing social disadvantage and social injustice (Wilkinson & Marmot, 2003). While a relationship clearly exists between individual psychological distress and suicide, addressing suicide should expand beyond an individual focus and include broader efforts to understand and change the conditions that create such distress and ill health. These complex socio-political conditions are the 'causes of the causes'.

Violence against women is a striking example. The prevalence of violence against women is staggering with estimates of 1 in 3 women in Australia experiencing violence from a male partner (Mouzos & Makkai, 2004). Intimate partner violence has a devastating impact on women's social and economic status as well as physical and mental health. For example, VicHealth (2004) found that it was the leading contributor to death, disease and disability in Victorian women aged 15-44 years. Depression, anxiety and other forms of psychological distress including suicide are where this impact on women's health was most evident. The WHO (Astbury & Cabral 2000) has reported similar findings around the world and suggests that the relationship between violence, depression and anxiety is causal. They describe that "the psychological impact of violence may be understood from an experience of personal oppression (generally) within an intimate relationship which is reinforced and informed by a broader social context, where the unequal treatment of women remains normative" (p.77). Of relevance to this submission, they also suggest that suicidal behaviour in this context may be viewed as a woman's only escape from a situation of increasing violent victimisation and entrapment. This is supported by studies that suggest women who are abused are three and a half times more likely to be suicidal than non-abused women (Taft, 2003).

While men's violence against women arises out of the broader social context, this same context is also critical in ameliorating or exacerbating a woman's distress and disadvantage. A UK study (Bostock et al, 2009) found that inadequate societal responses such as limited options for support and protection and a lack of public acknowledgement of the unacceptability of violence prolonged and reinforced the abusive context. Further, women who were forced to leave their home due to inadequate protection being available were significantly disadvantaged. Inadequate service system responses have also been recognised in Australia, where policies and support options requiring women to leave the family home to escape violence have led to significant economic and social disadvantage, including homelessness, which many women and their children never recover from (Mcferran, 2007).

Historical and current mental health explanations for women's psychological distress has failed to recognise this social context and previously viewed women either as the inferior sex, prone to hysterics or in more contemporary times, as an individual with deficits or

flawed characteristics and/or skills requiring treatment. Such responses, as pointed out by Taft (2003), are experienced as victim blaming, have a negative impact on self-esteem and exacerbate negative mental health outcomes rather than support recovery and safety. Taft points out that when women experience supportive responses to disclosure (such as placing responsibility for violence on the offender and recognising her agency in responding) from family, friends, health practitioners and so forth, adverse mental health outcomes are less likely to occur.

Social norms and institutions that significantly advantage some people or groups and disadvantage others are evident across society. Increasingly, research has highlighted that the discrimination and prejudice experienced by lesbian, gay, bisexual and transgender (LGBT) people in their everyday life is linked with depression; alcohol and drug use; and suicide (Diaz et al., 2001; Harper & Schneider, 2003; Hillier et al., 2005; Johnson et al., 2007; McNair et al., 2001; Pitts et al., 2006; Rogers, 2007). Of interest to this submission, one British study (Johnson et al., 2007) identified that an incident of discrimination often preceded suicide attempts, suggesting that suicidal distress is not simply the result of individualised problems but the response by some LGBT people to institutionalised discriminatory practices perpetrated through education, health services, religion, media and the family.

As a result of heterosexism and homophobia in the broader social and political context, LGBT people experience feelings of guilt, shame, and fear of their sexual orientation being identified, and often modify their daily activities and behaviour due to fear of prejudice, discrimination and abuse (Diaz et al., 2001; McNair et al., 2001; Pitts et al., 2006). The capacity to develop a positive self identity and self worth is hindered under such conditions, (Johnson et al., 2007) and negative beliefs and feelings related to gender stereotypes and homophobia experienced in the broader social context is often internalised (Harper & Schneider, 2003; Oritz-Hernandez, 2005).

Those who experience discrimination and prejudice across a number of areas are even further disadvantaged. For example, a US study (Diaz et al., 2001) found that Latino gay and bisexual men experienced greater psychological distress and risk of suicide as a result of discrimination experienced due to sexual orientation, race and poverty, while Johnson and colleagues (2006) highlighted the double stigma faced by LGBT young people who also had a diagnosed mental illness.

Unlike the experience of other marginalised groups, LGBT people often experience rejection and abuse from family and friends due to their sexual orientation (Brown, 2002; Harper & Schneider, 2003). The threat and everyday experience of harassment, violence and abuse particularly for young LGBT people in their home, school and their workplaces is alarming Many same sex attracted young people hide their sexual orientation or lead a double life to protect themselves from abuse and rejection adding a significant burden of personal stress (Harper & Schneider, 2003). It is evident that if we are to address the increased psychological distress experienced by LGBT people, we must remove discrimination, positively recognise same sex relationships and increase the legitimacy and acceptance of diverse sexual orientation within the social and political context (Pitts et al., 2006). Such

action requires public education, a human rights agenda and addressing heterosexism found in social institutions and the law. Further, training and education must target mental health services to ensure they are LGBT sensitive and are able to support family members to understand and respond appropriately (Brown, 2002; Johnson et al., 2007).

Recommendations

01. Addressing the negative mental health outcomes, including suicide, for women affected by violence should be part of larger efforts to prevent and eliminate men's violence against women.

02. Health practitioners such as G.P's and mental health workers should have training in understanding the dynamics of male family violence and appropriate practice responses to women who are affected. In addition, health services and family violence services require collaborative working relationships to support the safety of women and reduce the harmful impacts of violence.

03. Adequate service system responses and resources must seek to ameliorate the social, economic and health impacts of family violence given these areas interact and affect an individual's overall wellbeing.

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05. Such efforts should target both broader public education as well as target settings where discrimination and abuse based on sexual orientation is experienced in everyday settings such as family schools and workplaces.

06. LGBT sensitive health setting and practice must be available as well as LGBT specific services. Appropriately trained health practitioners may also be well placed to support and educate families coming to terms with a family member's sexual orientation particularly where mental health concerns are also present.

Oppression, Power & Suicide: Aboriginal & Torres Strait Islander People

Summary of key points

- Targeted programs and services that address the particular circumstances of Aboriginal and Torres Strait Islander people are essential. Their efficacy and effectiveness will ultimately depend on a thorough understanding and acknowledgment of the colonial impact on contemporary disadvantage and more specifically, the physical and mental health outcomes of Indigenous people (terms of reference f).
- The historical relationship between the medico-legal system, and oppressive legislation and social policy presents specific challenges with regard to the appropriate role and effectiveness of agencies in the provision of care and in assisting Aboriginal and Torres Strait Islander people at risk of suicide (terms of reference c). "The system" remains a symbol of contemporary oppression in many Indigenous communities, which has ultimately resulted in a reluctance to engage with mainstream services.
- Systemic racism is evident in a number of government policies and in the practices of various helping professions which are historically Eurocentric and continue to be informed by a predominantly white-Australian perspective. The control of knowledge and maintenance of dominant scientific paradigms will not only determine how research findings are disseminated to practitioners and incorporated into government policy (terms of reference g), but will also affect the perceived importance and overall impact of public awareness programs (terms of reference d) in Indigenous communities.

The relationship between oppression and suicide is particularly evident when we consider the historical context and collective experience of various Aboriginal peoples. It is irrefutable that Aboriginal and Torres Strait Islander (ATSI) people continue to be overrepresented in the suicide data and remain particularly vulnerable to multiple social, economic, political and cultural risk factors that impact on their wellbeing - causes that may otherwise be referred to as the litany of "tragic indices" that characterise life for Aboriginal populations (Cassidy, 2003). The following provides a brief overview of three key areas of discourse present in the literature that we argue should be considered when addressing suicide and suicide prevention in Indigenous communities. They include: the relationship between colonisation and contemporary disadvantage; the historical ties between the health system and oppressive legislation and social policy; and systemic racism and the continued control of knowledge.

Colonisation & indigenous disadvantage

Whilst a dearth in the literature makes it difficult to determine any direct casual relationship, there is certainly a growing body of evidence across a number of disciplines to suggest that oppression and marginalisation contribute to higher suicide rates in the Indigenous population of Australia (e.g., Proctor, 2005; Kirmayer, Simpson & Cargo, 2003; Hunter, 2002). Furthermore, numerous studies have also shown that the Aboriginal people

of Australia, Canada, New Zealand (Kirmayer, Simpson & Cargo, 2003; Cassidy, 2003), Alaska (Sullivan & Brems, 1997) and the Caribbean Nations (Lester, 1995) have all shared similar socio-historical fates in which disproportionately higher levels of mental illness still exist in many Indigenous, as compared to non-Indigenous communities. Similarly, the study of black suicides in the United States has demonstrated that whilst comparable socio-cultural risk factors are associated with blacks and whites, the risk factors for blacks correspond more directly with contextual factors such as oppression and domination (e.g., Teasley & McCarley, 2007; Washington & Barnes, 2007). These studies alone give one pause to consider the social origins and political context in which mental illness and more specifically suicide occurs.

It is not difficult to discern that the common historical experience of many Indigenous peoples is that of European colonisation, which is intrinsically tied to oppression and the gross abuse of human rights. The emergence of European capitalism from the 1500s onwards depended on the systematic exploitation of environmental and human resources in other lands (Glover, Dudgeon & Huygens, 1995). Before colonisation, "Aboriginal and Torres Strait Islander peoples lived healthy, vital and meaningful lives" (Adams, 2006, p.70) in which men, women and children alike had clearly defined roles, rights and responsibilities; strong kinship and religious systems; and access to varied language and allied social groups (Adams, 2006). Not surprisingly, it has been suggested that prior to colonisation - a process which ultimately stripped people of their rights, responsibilities, spirituality and land - suicide was a relatively uncommon occurrence in Aboriginal culture (Cantor & Neulinger, 2000; Eastwell, 1988; Hunter, 1991; Cassidy, 2003). The processes of colonialism, in which all aspects of Aboriginal peoples lives were controlled, has ultimately resulted in negative outcomes for today's Indigenous population, including: poor health and nutrition; higher rates of substance abuse; low educational achievement; suppression of culture, language and spirituality; overrepresentation in the child protection, juvenile justice and criminal justice system; inadequate housing; and reduced employment opportunities (e.g., Briskman, 2008; Cassidy, 2003; Parker, 2010; Adams, 2006).

There is little doubt that the legacy of colonialism and its policies of oppression (the most enduring being protectionism and assimilation), has resulted in Indigenous people remaining at the lowest rung of the socio-economic ladder, having yet to experience the same gains evident in some other fourth world settler nations, particularly in the spheres of health, education and economic status (Briskman, 2008). There is a wealth of data available to support the argument that Indigenous people have poorer health outcomes than their non-indigenous counterparts and as such the issue of Indigenous disadvantage hardly requires further emphasis for the purposes of this discussion. Relatively less attention however has been afforded to our understanding of how they have come to be in a position of disadvantage in the first place. It is our contention that the process of colonisation and indeed its oppressive practices provides one valid explanation for this phenomenon. Given that there has not been a concurrent increase in mental illness rates with those of suicide (Taylor, 1996), the data certainly suggests that suicide cannot be totally explained by the mental illness view and that for groups who have been marginalised and oppressed in some way, suicide may in fact be the likely result of an increase in various social pressures.

The health system and oppressive legislation & social policy

"The building blocks of racism in Australia were derived from Social Darwinist ideologies that in earlier times were enacted through official legislative and policy instruments" (Briskman, 2008, p.86). An early example of this can be seen in the medical literature of the late 1880s to early 1920s in which science was used as evidence of an explicit demarcation between black and white madness. The reason versus madness paradigm aligned the white madman as the 'other' however, because Indigenous people were already situated as the 'other' with regard to white civilisation, the whiteness of the Anglo-madman was thus threatened. As a consequence, the insanity of Indigenous people was interpreted as the most exaggerated expression of their innate primitiveness, simplicity and savagery. This attempt to remedy the potential threat to white superiority lead to the elevation of white madness which came to be thought of as a highly complex, multifaceted and sophisticated illness by comparison because the white mind was considered to be significantly more evolved. This so-called science was filtered through the discourse of racial classification and ranking and ultimately served to maintain a social hierarchy based on race (Murray, 2007). It has been argued that a legislative history based on such racial constructs continues to inform the attitudes and actions of many mainstream healthcare professionals, who still express dominant value systems in Indigenous community health services (Cox, 2007).

This is an important point to consider when addressing the appropriate role and effectiveness of social services and agencies in assisting ATSI people at risk of suicide. We cannot ignore the fact that medicine and the healthcare system more specifically, have been historically tied to oppressive legislation and social policy. The health system was complicit in legitimising the extermination and segregation of ATSI people through numerous policies and legislation and is often still associated with various forms of punishment, degradation, humiliation and intimidation (Cox, 2007). Further to this, the mistrust of hospitals and health services is said to continue today as a direct consequence of the past and present relationship between the law and the health care system, raising questions as to whether current government policies and legislation serve the interests and needs of ATSI people or in fact continue to act as a mechanism of control. Social control and state power of the past has undoubtedly resulted in present-day resistance to health programs (Cox, 2007) and for many Aboriginal communities, agencies such as hospitals, jails, courthouses and the police have all become symbols of contemporary oppression (Hunter, 2002). We must also consider the point that the overall increase in ATSI suicides may in part be attributed to the dramatic increase of suicides in police custody, the majority of which is by hanging (Cantour & Neulinger, 2000). Even if the increase of suicide by hanging in police custody is more a reflection of opportunity and means rather than a conscious act of protest, the symbolic relationship to oppression and the social injustices practiced by such agencies in not lost, in fact, it has even been suggested that the black man hanging from a tree has become a central motif of social injustice for many Indigenous people (Hunter, 2002).

The current burden of health cannot be addressed without also carefully considering the burden of history. In the past, the medicalisation of intergenerational trauma has diminished the social injustice experienced by ATSI people by reducing such trauma to

psychological pathology and biological dysfunction (Adams, 2006, p. 69). The colonial impact on Indigenous societies however can no longer be explained in simple biological terms. Rather, the study of Indigenous wellbeing has begun to and must continue to systematically address the lasting effects of racial discrimination, dispossession, family disruption, poverty, social marginalisation and limited access to health care (Anderson, 2007) in order to gain a more holistic understanding of the issue. If the health system continues to lay down moral programs that prescribe how people should live their lives, it runs the risk of alienating individuals and negating their social realities and history by equating health with moral worth (Cox, 2007). Prevention programs that act under the auspices of established social institutions where people are forced to consume our goods and services (thereby providing the more advantaged with certain privileges) can easily become a new arena for colonialism (Rappaport, 1981). For public awareness campaigns and prevention strategies to be successful in Indigenous communities, governments must consider the cumulative impact of past and present medico-legal regimes and also address the view of many ATSI people that the health and criminal justice systems are interrelated.

Contemporary colonialism – systemic racism & the control of knowledge

As a standard part of colonisation, the European scientific paradigm was introduced as the only valid system of knowledge (Glover, Dudgeon & Huygens, 2005). Eurocentric paradigms continue to inform our practice and position other ways of knowing as inferior. According to Briskman (2008) there has been very little movement in Australia in the way of affirming Indigenous knowledge, with the dominance of Western knowledge causing great harm to ATSI people. Furthermore, Briskman also suggests that whilst most helping professionals would deny that they operate within colonial structures, colonialist practice is often not overtly visible and is therefore difficult to challenge.

Whilst racism occurs at a number of levels, the control of knowledge is of particular relevance for this submission as it speaks to issues of systemic or “invisible” forms of racism. This concept refers to the requirements, conditions, practices or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (Paradis, Harris & Anderson, 2008) and is considered by some to act as a contemporary form of colonialism (e.g., Hunter, 2002; Briskman, 2008; Kirmayer, Simpson & Cargo, 2003; Paradis, Harris & Anderson, 2008). Systemic racism is still evident in an array of governmental policy documents where the construction of practice remains largely within an Anglo-Australian lens. The values, beliefs, meanings and practices from the dominant culture are the benchmarks against which other values and meanings are measured and those outside of the mainstream are considered inferior (Briskman, 2008), subsequently privileging the knowledge and resources of some groups over others. It has also led to a raft of legislation, both historical and contemporary, that exist for the purposes of controlling the lives of Indigenous people (Cassidy, 2003).

Systemic racism can be difficult to establish and assess however, as Paradis, Harris & Anderson (2008) have pointed out, several studies have highlighted the widespread nature of such racism in the domains of national politics, the media, education, the welfare system,

the provision of public housing and in the legal/criminal justice systems. In order to address colonial injustice and the political and cultural oppression of indigenous people, there has been a strong focus placed on structural and institutional racism (Glover, et al., 2005; Paradis, Harris & Anderson, 2008). Making structural racism visible involves a number of key actions, including: laws and policies that generate social norms against discrimination and in support of diversity; social policy platforms to address systemic discrimination; initiatives to build cross-cultural networks and cohesion within communities; resources to raise awareness of and address discrimination and promote cultural diversity; and programs that increase contact and cooperation among groups between whom there is a social distance.

The disadvantage experienced by ATSI people in Australia is associated with both historical and contemporary racism, colonisation and oppression and it has been recognised that systemic racism in particular, acts as a threat to public health (Paradis, Harris & Anderson, 2008). Mental health promotion with Aboriginal peoples must go beyond focussing on the individual and strive to actively engage and empower communities (Cox, 2009). *Aboriginal identity* can be a unique resource for mental health promotion and intervention. Knowledge of living on the land, community, connectedness and historical consciousness all provide sources of resilience. Collaborative approaches that focus on the transfer of knowledge, skills, power and authority can hope to transcend current limitations in practice (Kirmayer, Simpson & Cargo, 2003).

Whilst a discourse that focuses on human rights and moves beyond the seemingly idealistic rhetoric of social justice may seem like an insurmountable challenge, it is imperative that we begin to challenge dominant paradigms in the theory and policy domains. Whilst it could be argued that we risk re-traumatising and disempowering individuals by denying their immediate personal psychological states and needs (Hunter, 2002), this is not to say that the wider social issues should not also be a priority, simply that they are beyond the capacity of the mental health sector alone. In fact, for human rights abuses and injustices of the past are to be addressed effectively, it is imperative that we adopt a whole of government approach. Ultimately, there is a need to find a balance between addressing what Noel Pearson (2000) identifies as two different types of traumatisation, the personal traumas of contemporary life and the collective healing of those traumatised by the past.

Recommendations

07. Comprehensive research is required in order to develop targeted and culturally appropriate strategies to improve the social and emotional wellbeing of ATSI people.

08. Suicide intervention/prevention strategies targeted at ATSI people must address the broader systemic issues that impact on risk and protective factors and recognise that suicide is often a consequence of contemporary disadvantage which has resulted from various forms of past and present social injustices.

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14. Recognise the value of extended family, Elders and the community and incorporate indigenous notions of spirituality and healing into practice.
15. Develop collaborative approaches that emphasise community empowerment and build on traditions and cultural identity as a means to build resilience and promote mental health.

Ecological & Transformative Approaches to Suicide Prevention

Summary of key points

- We believe that current programs of research and practice focus too heavily on individual explanations of suicide and treatment approaches (e.g., counselling, increasing suicide awareness, promoting coping skills (terms of reference g).
- Suicide prevention programs which are reduced to a limited number of risk and protective factors across a single level of analysis (i.e., individual/personal) do not adequately address the complexity of suicide. Developing interventions within the ecological framework, which recognise and target the multiple levels of society such as individual, family, community and broader historical, social, economic, cultural and political structures, is one approach to providing a more comprehensive, responsive and sustainable program of research on suicide (terms of reference g).
- There is a paucity of research and practice examples of ecological approaches to suicide prevention. This may be due in part to the complex and time-consuming nature of these interventions, the difficulty in measuring and analysing results, and the tradition within psychology to reject or avoid studies which advocate for social change (terms of reference g).
- Suicide prevention programs should include a mix of ameliorative and transformative strategies across multiple ecological levels. Ameliorative programs treat 'problems' by addressing proximal risk factors and increasing protective factors, in order to enhance wellbeing for individuals. Transformative programs aim to change *systems* rather than *people*, in order to promote collective wellbeing and to address the underlying causes of suicide, such as oppression and disadvantage. Activities for transformative interventions include advocacy, community empowerment and policy change (terms of reference g).
- Community- and population-level approaches that aim to broadly promote wellbeing, have the potential to address a range of health and social issues, including suicide, therefore may be more time and cost effective. These approaches require consideration that the measure of success of a program should include a range of outcomes that go beyond suicide-specific factors, such as increased social cohesion, implementation of policies to address systemic discrimination, or reduction in violence against women, to name a few (terms of reference g).

The following section of the submission aims to provide a future direction for the current program of research into suicide and suicide prevention. Based on the evidence presented above we propose that in order to achieve a more comprehensive examination of suicide, programs need to consider the broader social, cultural and political contexts of individuals and groups who experience various forms of oppression, particularly Indigenous people, women and LGBT people.

The ecological framework

Suicide prevention strategies often involve providing support to individuals, such as counselling services or education to increase suicide awareness and promote coping strategies. When programs are focused on intrapsychic causes of distress such as 'pathology' due to intellectual, emotional or spiritual deficits (Greenleaf & Williams, 2009), they result in person-centred treatment that holds individuals responsible for their problems (Nelson & Prilleltensky, 2005), thereby failing to change social settings which may be significant contributors to distress. While counselling, support and education for individuals are an essential part of suicide prevention, we believe that current programs of research and practice focus too heavily on this individual approach. Alternatively, we believe that suicide prevention needs to be developed within an ecological framework, which strives towards transformative as well as ameliorative change.

The ecological framework provides an understanding of the human experience as the "interaction between individuals and the multiple social systems in which they are embedded" (Nelson & Prilleltensky, 2005, p. 71). It proposes that wellbeing is influenced by multiple and interacting ecological levels, including *personal*, i.e., individual and psychological factors, interpersonal relationships; *relational,* i.e., groups, local organisations, networks, voluntary associations; and *collective* (i.e., communities, institutions and social, cultural, economic and political factors (Nelson & Prilleltensky, 2005; Christens & Perkins, 2008). Change in one system affects change in another as each level is interconnected. The ecological framework redirects the focus of interventions beyond the individual, to incorporate community, social and policy-level factors for change (Reppucci, Woolard & Fried, 1999). To ensure programs are effective and comprehensive, 'multi-level' interventions should be developed to address the personal, relational and collective systems either simultaneously or sequentially (Schensul & Trickett, 2009). For example, a suicide prevention program based on an ecological framework would typically develop strategies to address multiple risk and protective factors across the three ecological levels: *personal* (e.g., counselling to address cognitive distortions and emotional distress, and increase coping strategies), *relational* (e.g., school-based programs to increase suicide awareness and information about support services) and *collective* (e.g., responsible media reporting) (Ayyah-Abdo, 2002).

The ecological framework has a number of guiding principles. Emphasis is placed on collaborative practice, including multi-disciplinary and whole of government approaches. Participation of community members who are the target of the intervention is also emphasised by this approach (Trickett, 1986) and is particularly relevant for oppressed groups as a process of empowerment (Bess et al., 2009). Moreover, an ecological approach is not solely focused on outcomes for individuals within a particular intervention being delivered, but aims to build the capacity of a particular setting to create benefits in the future, thereby taking a long-term approach to achieving change (Kelly, 2006). Therefore, it may be argued that programs based on the ecological framework would provide a more holistic and comprehensive approach to suicide prevention.

Complex social problems, such as suicide, affect multiple contexts (Trickett, 2009). When a person suicides, the personal, social and economic impact is felt by family, peers, school, communities, health professionals, organisations and governments. 'Multi-level' prevention strategies which address these different layers of context in a coordinated manner have been found to be more responsive to overall needs and more sustainable (Trickett, 2009). Research evidence shows that individual change is difficult to sustain in the absence of environmental change (e.g., Campbell, 2000; DiClemente, Salazar & Crosby, 2007), therefore interventions need to include creating a supportive environment for individual behaviour change (Trickett, 2009).

Research evidence supports the use of the ecological perspective to examine a number of social issues, such as adolescent drug use (e.g., Ellis, 1998) and violence against women (e.g., Reppucci, Woolard & Fried, 1999). However, while there is strong evidence of multiple levels of risk factors for suicide (e.g., *personal*: depression, drug use; *relational*: abuse, social isolation; *collective*: poverty, discrimination, homelessness (Commonwealth of Australia, 2008)), there remains a paucity of research on ecological approaches to suicide prevention (e.g., Ayyah-Abdo, 2002; Baber & Bean, 2009; Judd, Cooper, Fraser & Davis, 2006). This may be due in part to the complex and time-consuming nature of these interventions, the difficulty in measuring and analysing results, and the tradition within psychology to reject or avoid studies which advocate for social change (Prilleltensky, 1999; Reppucci, Woolard & Fried, 1999; Trickett, 2009). Therefore, policy and program initiatives such as the National Suicide Prevention Strategy should consider that sufficient funding and support be afforded to groups and organisations in order to implement ecological frameworks within their research and practice in suicide prevention, and that time frames for evaluation are adequate to measure success.

Blending ecological, ameliorative and transformative approaches

Recognising and targeting interacting levels of society including the individual, family, community and broader historical, social, economic, cultural and political structures is one approach to providing a more comprehensive, responsive and sustainable program of research on suicide. Another component we see as important to suicide prevention programs is adding value to ameliorative interventions by incorporating strategies that strive for transformative change.

Much of the literature on suicide prevention strategies can be described as ameliorative, that is, programs aimed at treating 'problems' and increasing protective factors in order to enhance wellbeing for individuals (Nelson & Prilleltensky, 2005). The content of interventions is typically skill-building, self-help and therapy, which address proximal or immediate causes of the problem. While it is not the intention of this submission to criticise ameliorative approaches to suicide prevention, as highlighted in the above discussion of vulnerable groups, adopting a social justice and human rights approach to prevention work is essential to address systemic oppression and disadvantage which can often lead to psychological distress and suicide. Hence, in order to enhance the current programs of suicide research, which acknowledge and include high-risk groups such as those identified above, both ameliorative and transformative approaches are required.

Transformative interventions aim to change *systems* rather than *people* in order to promote collective wellbeing, as well as to address the root causes of problems that exist within different oppressive contexts, such as violence, poverty, racism and power imbalances (Evans, Hanlin & Prilleltensky, 2007). Rather than merely identifying these contexts as a way to compare and categorise suicidality (e.g., Evans, Hawton & Rodham, 2004), truly transformative interventions see these contexts as targets for change in their own right and engage in activities such as advocacy, community empowerment and policy change. While ameliorative interventions typically focus on risk reduction, transformative interventions aim to enhance health and wellbeing, which we believe should be an essential part of any suicide prevention program. Community-level and population-level approaches that aim to promote personal, relational and collective wellbeing broadly have the potential to address a range of health and social issues, including suicide and therefore may be more time and cost effective (Reppucci, Woolard & Fried, 1999). As such, adopting these approaches requires consideration that the measure of success of a program should include a range of outcomes that go beyond suicide-specific factors, such as increased social cohesion, implementation of policies to address systemic discrimination, or reduction in violence against women, to name a few.

It is now widely recognised that prevention and health promotion should look 'upstream' to identify the root causes of health and social issues (Berkman & Kowachi, 2000; Pearce, 1996; Susser & Susser, 1996). It may be argued that the efficacy of suicide prevention programs is dependent on ensuring that the range of causal factors, both distal and proximal, be addressed. While psychology and the social sciences have proposed a number of potential 'causes of the causes' of suicide, more research is required to identify these factors in order to enhance suicide prevention activities.

Recommendations

16. Suicide prevention needs to be developed within an ecological framework, which strives towards transformative as well as ameliorative change.

17. Policy and program initiatives such as the National Suicide Prevention Strategy should ensure that sufficient funding and support be afforded to groups and organisations in order to implement ecological frameworks within their research and practice of suicide prevention, and that time frames for evaluation are adequate to measure success.

18. Both ameliorative and transformative approaches are required in order to enhance the current programs of suicide prevention. Identifying and addressing the 'causes of the causes' of suicide and adopting a social justice and human rights approach to prevention is essential to address oppressive contexts, such as violence, poverty, racism and power imbalances which can lead to psychological distress and suicide.

19. Suicide prevention programs should simultaneously aim to reduce risk factors as well as enhance wellbeing, in order to address a range of health and social issues more broadly.
20. More research is required in order to identify further the 'causes of the causes' of suicide, in order to enhance suicide prevention strategies.

Conclusion

Understanding and intervening in the social causes of ill health is no easy feat and as students and practitioners we are only beginning to learn the complexities of such action. Nonetheless, as we have suggested in this submission, attention must be given to the distribution of power and resources embedded in the structures of society and its result of advantaging some groups and disadvantaging others, thereby creating conditions of oppression and marginalisation. Intervening in oppressive social and political conditions requires that the power relations between individuals, groups and communities inherent in oppressive contexts be made visible and for interventions to target social justice and social change, rather than assist individuals to adjust to unjust social conditions. As highlighted above, efforts in this direction require an ecological approach that blends both ameliorative and transformative action for change and targets the multiple levels of society including the individual; family; community; and broader historical, social, economic, cultural and political structures in a coordinated manner. Given the evidence of the links between oppression, psychological distress and suicide experienced by ATSI people, women and LGBT groups, there is an urgent need for well-planned and comprehensive programs of research and practice which go beyond immediate causes of suicide and begin to acknowledge and incorporate the 'causes of the causes'.

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