DIVERSITY PAPER

DIVERSITY

1. INTRODUCTION

Primary health care workers respond to people from many different circumstances and degrees of advantage or disadvantage. In addition to material conditions there are social factors that affect health and wellbeing. These issues include:

- The knowledge that your wishes, views and aspirations matter and can make a difference to what happens in life

- That you are socially connected to significant others – family, community, friendship group etc.

- That you are valued and 'known' within this group – what happens to you matters to them

- That you have access to resources, e.g. meaningful work, housing, education, health and social services, and protection of the law

- That there are social conventions and legal sanctions that ensure that this access is protected

- The assumption (and experience) that you will be treated respectfully as you go about your affairs

- That what you contribute to your society has meaning and is valued.

It is clear, even from such a brief account, that some people within our society have easier access to, and more experience of, these positive 'building blocks' than do others. Everyone of course, experiences difficulties, but some people also live with additional difficulties such as:

- Prejudice and stereotypical assumptions about their community and culture

- Not speaking English as a first language

- Homophobic responses to their perceived or actual sexual preferences

- A disability – and people's assumptions about what this means about them

- Poverty

- Health issues, physical and/or mental

- Geographical isolation

- Social isolation

- Homelessness

- A combination of the above.

It is important that these people are given effective and appropriate support in the community. Given the range of differences and needs, it is obviously not tenable to adopt a simple position that claims to treat everyone the same.

2. EIGHT KEY POINTS ABOUT DIVERSITY

2.1. DEVELOPING IDENTITIES

Identity is a term which is used in a variety of ways in the social sciences. Psychologists speak of identity as an individual's sense of self. In sociology and political science the notion of social identity is used to refer to the ways individuals label themselves as members of particular groups – such as nation, social class, gender or ethnicity. Contemporary cultural theory emphasises that the way in which identity is formed is constantly evolving, always incomplete and contingent on different contexts.

A person's sense of identity and ways of seeing the world are made up from a complex weave of factors, for example:

- Gender

- Age

- Sexual preference

- Learning experiences

- Geographical location

- Physical health and ability

- Formal education

- Employment or lack of it

- Interpersonal relationships with significant others

- Life events and experiences unique to the individual

- Number of siblings

- Gender of siblings

- Age position in family

- Expectations of family and community

- Social class

- Friendships

- Ethnicity

- Religion

- Parents' experiences and background.

In addition, none of these features necessarily has a fixed priority. Constellations of such factors come into the foreground in a person's experience at different times and in different contexts. For example, being Jewish might feel completely normal and 'just the way life is' for a child until s/he comes up against some experience of anti-Semitism. Similarly, for a child who is being brought up by same-sex parents.

A list such as the one above, could go on indefinitely, and to make things even more complicated, people are not static in who they are. Growth is a dynamic process and human beings grow and change throughout their lifetimes so that some of these factors could change over time. The point of spelling out these layers of complexity is to underscore the inadequacy of thinking and practices that either:

- Classify whole communities according to some observed characteristic (eg. non English speaking), or

- Seek to wash out differences between people with simplistic and doubtful assumptions such as: we treat everyone the same.

2.2. CULTURAL PRACTICES AND MEANINGS

Culture can be defined as 'the network of beliefs, attitudes, behaviours and histories that are prevalent among communities of people' (*CommunityMatters*, 2001, p.15). Culture is socially created, not genetic or biological. Everyone has 'culture'. It is learned from birth and continues to grow through a range of social and environmental experiences and relationships (and the meanings we make of them). Experiences of cultural practices in communities and smaller groups with which we affiliate, such as work teams, are so much a part of us, that what we do and think seems to be 'natural'. Culture becomes an integral part of how we think and behave; it is like a lens through which we see the world.

One of the consequences of regarding cultural practices and beliefs as 'natural' and 'normal' (the way things are), is that it is possible (perhaps unavoidable) to make some spurious assumptions about others – both in terms of their motivations and their behaviours. This is especially problematic when some groups hold more systemic power or influence than other groups.

Examples of spurious assumptions can include:

- That social/legal systems and arrangements in place are value-free and non discriminatory

- That some behaviour applies to whole categories of people (eg. In X culture wife beating is acceptable – as if individual differences do not occur)

- That some categories of people can be spoken of as if they are one homogenous group, e.g. people who do not speak English as their first language

- That some individuals are inherently bad

- That experts know best

- That some people and groups are by definition problematic (or can't help it)

- That some people/groups are, by definition, ignorant.

2.3. EVERYONE IS A CULTURAL PARTICIPANT

All of the factors mentioned above apply to everyone – they are not special features that apply to certain (other) cultural or ethnic groups.

2.4. THE IMPORTANCE OF CONNECTIONS

Being a part of a culture or community can offer feelings of belonging, mattering and connectedness. Developing a sense of personal identity is usually influenced by cultural or community connection (or lack of it).

2.5. CHANGES AND DEVELOPMENTS

Cultures and communities are not static. Practices, values and traditions are likely to change over time. Think for example, of 'dating behaviour' in your own cultural context of thirty or so years ago, or the food practices and styles that were in place when you were a child, to note how quickly things can move on. Such changes are likely to be the case for all communities, and so it is important not to carry fixed notions or stereotypical ideas about how things work in particular groups.

2.6. MULTIPLE REALITIES

Individuals usually operate in and between several groups and communities throughout their everyday lives. And so, aspects of cultural affiliations are 'in play' or highlighted, depending on the context. If, for example, someone is at a family wedding, it is quite likely that particular ethnic and cultural traditions are in the foreground of a person's responses, feelings and sense of community identity.

However, when that same individual is involved with another group – for instance a work group or a group of significant friends – the connections that are in the foreground of experience and response may well have absolutely nothing at all to do with ethnic origin.

In these different contexts 'cultures' are constructed which function to produce shared meanings, values and aspirations for the group. Such cultural constructions and meanings are rarely named or spoken of – but they are learnt and known by members of particular groups. Cultural constructions might involve for example:

- Attributes that give someone status

- Things that are regarded as funny

- Achievements that are seen as important

- Social values and attitudes that are regarded as important.

One of the features of group affiliation and operating within its frameworks, is that it then becomes a relatively easy step to define insiders and outsiders. Creating insiders and outsiders can operate as a hostile mechanism – as is sometimes seen in schoolyard behaviours where certain children are

excluded, or in racist behaviours and practices. However, it can also be a benign phenomenon – where groups can use a 'shorthand' with each other that others may not understand at all – but where no particular intent to exclude exists. Imagine, for instance, a discussion among a group of physicists, where concepts, questions and enthusiasms may well be incomprehensible to someone who is not in that culture. In a similar way, the conversations and preoccupations of a group of people in long-term custody may not make much sense if we are not familiar with the cultural assumptions and experiences of incarceration that are in play.

2.7. BALANCES AND CONTEXTS

There is a common phenomenon of naming (and therefore seeing) people through a highlighted aspect of their identity. In the popular press for example, tags are used such as 'paedophile magistrate, Joe Bloggs', or 'drug cheating athlete, Mary Smith'.

We are encouraged to think of particular aspects of a person as being their total identity – the definition of 'who they are' and all we need to know. For people with a disability, this is a commonly reported frustration – i.e being seen as disabled first and then as a person, second.

Perhaps there are some issues that prompt responses of not **wanting** to know any more about the person. This has certainly happened throughout history. For example, Oscar Wilde was gaoled and then banished from his own country, because of his homosexuality. His literary genius, his commitment to parenting his children, and his talents for being an exceptional friend, became totally irrelevant.

If we define someone totally by a particular aspect of their behaviour, we are deciding to close the door on any further possibilities or future insights. For service providers, this can be problematic and even counter-productive, especially in the area of suicide.

2.8. KNOWING BEST

There are some issues that all workers can take as given, for example, the priority of safety. There are some issues however, where holding an absolute assumption about what is best for someone, may not in fact be an assumption shared by the person or people in question.

Gay and lesbian people could be identified as a minority group, but it certainly could not be assumed that they would prefer to be 'straight', or that the communities and groups in which they live are less rich or diverse than in any other group.

Being 'marginal' is not always experienced as a negative. What **is** experienced painfully are some of the stereotypical attitudes and responses that are often directed towards marginalised groups.

What emerges from these points is that it is vital to think through our own responses (and what informs them) just as carefully as we think about groups to whom we offer services and responses. It just might be the case that a person's greatest burden is dealing with the assumptions that are being made about them!

3. ETHNICITY

Typically, approaches to promote cross-cultural awareness have involved majority group members either learning about 'other people's cultures', or employing workers who come from minority cultures. The presumption here is often that cultural diversity can be acknowledged within services, by simply 'adding on' (non-majority) cultural features.

This may take the form of:

- Information being made available in multiple languages

- Offering interpreter services to clients

- Practitioners engaging in cultural awareness training

- Promoting the visibility of non-white cultural groups (e.g. through posters).

These types of strategies represent important interventions into the often mono-cultural nature of the health system in Australia. However, they do not necessarily encourage health workers, policy makers and researchers to explore their own cultural location (and the implications of it) or to acknowledge and engage with the cultural specificity of the health system as it is currently configured.

Recent critiques of the rhetoric of multiculturalism in Australia (e.g. Stratton, 1999) have drawn attention to the fact that although there are many differing cultures within the Australian population, the majority of our political, legal and social institutions do not represent a genuine engagement with the multicultural nature of Australian society.

The beliefs and values of Anglo European heritage are most often imposed or assumed, in a top-down fashion, onto all cultural groups currently living within Australia This often results in a system where the experiences, values and opinions of minority group members are not heard, and are not afforded space in the formulation of policy guidelines.

The following points are adapted from Manderson (2005) in her introduction to a cultural diversity awareness package for health workers:

- It is important to respect the integrity of cultural beliefs. Individuals' explanations for their ill-health and their expectations of health care can affect their acceptance of treatments and the eventual outcome of health care

- People who may not share prevailing explanations of the causes of their ill-health, may nonetheless accept conventional treatments – it is not necessary to 'convert' them to your way of thinking to get a good result

- It is not necessary to agree with every aspect of another's culture just as the other person does not have to accept everything about yours. Effective and culturally-sensitive health care can still occur

- All of us are capable of identifying with our own culture and forming prejudiced views about other cultures and other belief systems – the skill is in being aware of this possibility and recognising when it is occurring.

These points emphasise the need both for respect and self reflection. They encourage primary health care workers to be mindful of the multiple, complex and dynamic ways in which individuals operate in relation to cultural identity.

In terms of responding effectively to a diverse range of people, an awareness of cultural issues and their potential impact on behaviour will assist service providers to respond – rather than to feel that they should always refer to culturally specific services.

In their work on service provision to South Asian women living in Manchester, UK, Burman *et al.* (2002) outline some of the problems that may arise if majority group members within health continue to simply refer minority clients on, rather than actually changing their own practices and engaging with such clients. Some of these problems include:

- The dearth of minority-group-specific services

- The failure of majority group practitioners to examine their own privilege

- The burden that arises for minority services that are often under-resourced

- The fact that some people from minority groups may not wish to consult with members of their own group, for fear of judgement or reprisal.

These issues do not negate the importance of continued funding for culturally specific programs. Nonetheless, there is also a need for practice that reflects an engagement with the cultural specificity of existing health services.

4. POPULATION GROUPS

The discussion of the following population groups is not intended to generalise about particular groups of people – but rather, to identify some of the factors that have been identified within the literature as increasing the suicide risk potential of these populations.

Obviously this increased risk will be further mediated by factors such as class, gender and ability. It is also important to keep in mind that some individuals may fall into a number of these categories. This should not suggest an additive model, whereby for example, being a refugee + identifying as same-sex attracted + living in a remote area would necessarily equal a set of insurmountable odds. As outlined in the overview paper, suicide behaviour results from the complex interactions between social and individual pressures and a person's resilience.

For some people, a multiple number of stressors may not result in suicide behaviour, while for another person one single event or stressful social situation may result in suicide behaviour. This suggests that we must listen to the subjective experiences of stress and suicide that are presented within the primary health care setting, rather than relying on a set of 'cultural prescriptions' to diagnose risk. The following discussions of at-risk populations are therefore simply a guide to increase awareness of cultural risk factors, which may be useful when assessing risk.

4.1 INDIGENOUS AUSTRALIANS

Acknowledging Australia's colonial history and its ongoing impact is an important starting point for understanding any health and wellbeing issue for Indigenous people. Similarly, valuing the cultural beliefs of Indigenous communities, and examining the cultural assumptions of the white majority are important when working in the area of suicide prevention.

It is also important to acknowledge that within Australia there are many differences between Indigenous peoples. Many Indigenous people no longer live on traditional lands or speak their language. In addition, Indigenous people will have a range of different cultural practices and beliefs that are specific to their particular Indigenous 'nation'. This suggests that primary health care workers need to engage with the specific and contextual values and needs of Indigenous people, rather than relying on generalised knowledge. As Professor Lowitja O'Donoghue commented, when consulted for this resource:

I'm an Aboriginal woman and I'd be pretty peeved if a health worker assumed that because of my cultural heritage I must have all sorts of problems!

There are, however, some important facts that are relatively representative of most Indigenous communities in Australia:

- Suicide rates in Indigenous communities are reported as being two to five times higher than in non-indigenous communities (Tatz, 2001)

- Because of the ongoing impact of dispossession, Indigenous communities face a greater number of life stressors, fewer resources and lower life expectancy, than do most non-indigenous people

- These factors continue to be exacerbated by the misrepresentations and prejudice that circulates in Australia about Indigenous people.

Addressing Indigenous suicide rates requires workers to acknowledge the cultural specificity of their own knowledge about suicide, and to engage with the knowledge and values surrounding suicide that Indigenous people may bring with them.

Tatz (2001) points out that responding to suicide in Indigenous communities may lie in addressing discrimination, providing access to services or simply listening to subjective meanings of suicide. Some of these subjective meanings are outlined in his suggestion that suicide in Indigenous communities results from the fact that many Indigenous people:

- Are tired, worn out and worn down – even young people

- Have little or no mental or physical stamina left

- Are tired of an oppressive life as a result of colonisation

- May look for a way out of these problems (p. 122).

Recognising these factors and acknowledging their impact will assist health workers in understanding the complex, institutional causes of high Indigenous suicide rates.

4.2 SEXUALITY ISSUES

There has been a great deal of research and public debate in recent decades about the intersections between sexuality and mental health/suicide (see Fergusson *et al.* 1999). These often adopt a set of judgements in which those who do not identify as heterosexual are presumed to automatically demonstrate some form of deviance, pathology or sickness.

This may appear in particular research questions (e.g. research that seeks to prove pathology), or in the ways that public policy or health is admiinistered (e.g. when a health provider assumes that an individual's mental health problems are a result of their sexual orientation). Such thinking can lead researchers and health workers to make associations where perhaps there are none, and to ignore some of the potentially important risk factors that warrant consideration.

What has been demonstrated within current research, however, is that those who do not identify as heterosexual are often at increased risk for stigmatisation and discrimination. Examples of this may include:

- Harassment in the workplace

- 'Gay bashing' and abuse in public places

- Rejection by family members and friends

- Stereotyped responses from health providers or educators

- Inability to access certain rights.

What makes discrimination based on sexuality so entrenched is that it is reinforced by a wide range of legislation and policy which privileges heterosexual people. Experiences of marginalisation are therefore widespread and produced in everyday ways such as:

- The assumption that a partner is of the opposite sex

- Questioning of a (non-heterosexual) person's sexual identity in order 'just to learn more'

- The assumption that everyone is heterosexual.

These less obvious examples of discrimination are no less powerful than the more explicit types of discrimination, and may occur on a regular basis, leading an individual to feel helpless (for more on such examples of 'mundane heterosexism' see Peel, 2001).

It is important that workers review their own contexts for the ways in which such everyday examples of discrimination may be played out. It is also important to recognise the ways in which the cumulative influence of discrimination may influence a person to consider suicide as an option.

The key point here is not about pathology in a same-sex attracted individual who may find social discrimination overwhelming. But rather, that the experience of discrimination is often the norm rather than the exception for same-sex attracted people. Addressing discrimination and providing access to support services and resources (where available) is therefore a central role that health workers can provide in supporting same-sex attracted individuals.

Similarly, it is important that workers ensure non discriminatory practices and interactions within their own contexts. Clients who find prejudice overwhelming and who contemplate suicide may come to them for assistance. It is crucial that in these circumstances, popular prejudice is not reproduced.

Therefore, people need to work towards creating a safe, supportive space within which same-sex attracted individuals can discuss the issues they face.

4.3 IMMIGRANTS

Research on suicide in immigrant communities in Australia highlights the conflicts that exist between the cultural values that immigrants may bring with them, and the cultural values of the white Australian majority (Burvill, 1995; Kennedy *et al.*, 2005).

The degree to which immigrants acculturate within their new location is not necessarily a useful tool for ascertaining risk. In addition, the promotion of acculturation to avoid risk may well promote strategies that deny the importance of maintaining cultural links and for those links to be respected and valued within the Australian community. With respect to suicide and self harm, it is still vital to assess individual risk.

One potential cause of suicide behaviour amongst recent immigrants is the notion of 'cultural clash' (Kennedy *et al.*, 2005). This occurs when there is a pressure on immigrants (often from family members) to maintain close cultural links, whilst at the same time there is pressure (often from government services, employers and new friends) to acculturate or give up traditional ties. This clash is often an intergenerational occurrence, and cannot be simply alleviated by either acculturation or resistance. People will need to pay particular attention to the ways in which they respond to this tension, if it is a factor.

Research has also demonstrated that suicide rates among communities of migrants tend to closely mirror those within their former country, although means to suicide often change to mirror those of their new country (Burvill, 1995). These contrasts between rates and means may demonstrate the inadequacy of acculturation for explaining how suicide in these circumstances occurs. Instead, it may be important to recognise the dynamic ways in which cultures are resisted, assimilated and conformed to, often by the same person.

This also suggests that workers must engage with the subjective meanings that clients from other countries bring with them. For some immigrants, culture of origin may hold significant meaning and value, and the disrespect or ignorance of this culture may result in serious outcomes, such as feelings of hopelessness, depression, and potentially suicide. For other people such feelings may result from an apparent inability to assimilate as desired by the individual, or as required by particular institutions.

Social responses toward immigrants therefore contribute to the ways in which they are likely to respond to, or engage with, a host culture. The denigration or dismissal of the value of non-white cultures is often evident in the mass media and other daily interactions. The fact that difference is often either written out, or stereotyped, within a nation that is comprised of so many different cultures, does not signal strong moves towards celebration of multiculturalism.

Awareness of the social impact of such dynamics can enrich understanding of what particular individuals and/or groups might be dealing with, in addition to the issues involved in creating a healthy life that might apply for everyone.

4.4 REMOTE AND RURAL COMMUNITIES

Those living in remote and rural communities often face many, compound problems that may lead to feelings of despair. Some of these include:

- Small community numbers may provide little buffer against social discrimination

- Changing socioeconomic situations may result in feelings of inadequacy or failure

- Unpredictability of ecological issues (e.g. drought, flood) may contribute to a person's feeling that they lack control

- Out-migration – young people often tend to move to larger towns and cities, thus reducing the available workforce

- Lack of public infrastructure may mean that those in crisis have little access to support and resources.

Constant experiences of hardship and lack of support may lead those living in remote or rural communities to contemplate suicide. Research (Rajkumar & Hoolahan, 2004) has shown that those living in these areas may not only be at increased risk of suicide, but may also:

- Use more violent means to suicide

- May engage in higher risk behaviours in general (e.g. drinking)

- Be more likely to actually complete suicide rather than self-harm

- Display less obvious warning signs of suicide risk

- Have greater access to means to suicide (e.g. guns)

All of these factors suggest that those living in remote and rural communities can be at increased risk if multiple stressors exist, when resilience levels are low and when help or support is unavailable.

The distribution of health services in remote and rural areas, and the relative closeness of interpersonal relationships may lead individuals to feel that support is not available, or that if it is, it will not be private or anonymous. Health workers in remote and rural areas need to be mindful of the possible conflicts that may exist between families of origin and individual stressors. Whilst anonymity may not be guaranteed in a small community, it is important that health workers attempt to provide clients with access to resources or support that meets their needs for privacy.

The increasing implementation of Internet technologies in some rural and remote areas may be one tool for providing such support. The use of e-health facilities may provide some people living in remote and rural communities with means to support and access to resources that are relatively private (Buckley *et al.*,1996; Mitchell, 1999). Obviously access will be mediated in many cases by socioeconomic status and family relations (Quinn, 2003), which suggests a great need for the health care sector to provide ongoing resources to remote and rural communities for online access. Online suicide prevention websites (see Resources paper) could be important resources for health workers to provide to clients.

4.5 WAR VETERANS

Research has long shown that the effects of being involved in war and other such forms of militarised violence increase an individual's risk of suicide. This is predominantly due to effects of:

- Post Traumatic Stress Disorder (PTSD)

- Amputation, spinal injury or other such impediment arising from fighting

- Being a prisoner of war

- 'Survivor guilt'

- Chronic pain or depression (Bullman & Kang, 1996).

There is also often a high degree of comorbidity of symptoms amongst war veterans, with many experiencing the effects of PTSD alongside depression or substance abuse. The severity of these symptoms, possibly combined with greater access to means or greater knowledge of means, often means that suicide amongst war veterans is both more lethal and violent than in the general population (Thoresen *et al.*, 2003).

While research has proposed that there may exist a 'Healthy veteran effect' (e.g. Bullman & Kang, 1996), whereby the high level of physical screening and ongoing health checks tend to create soldiers/veterans with higher levels of health than in the general population, this is countered by the increased likelihood of mental health problems amongst war veterans. This suggests that although war service may result in higher levels of physical health (precluding death or serious injury in battle), the emotional and mental health of soldiers and veterans may well be compromised.

Interestingly a study by Thoresen *et al.* (2003) found that suicide rates amongst peacekeepers were similarly higher than that of the general population. This suggests that while peacekeeping may be considered to be less dangerous or violent than frontline combat, the risks for mental health and emotional problems are just as high. This research suggests that, much like war veterans, peacekeepers are more likely to be:

- Not married, or to have been divorced

- To have little or poor social support

- To experience lower socioeconomic status.

All of these factors have been identified as stressors that may contribute to the increased likelihood of suicide (Hassan, 1995). This suggests that involvement in both war and peacekeeping may constitute a number of multiple stressors that may contribute to increased suicide risk.

A final important point about this particular population, is that suicide also appears to affect the children and families of war veterans who suicide, potentially over and above the effect it has on all who are bereaved by suicide. Research has suggested that there may be a potential for PTSD to be transferred as a learned behaviour across generations, thus increasing the risk of children of war veterans of being exposed to a major stressor for suicide (O'Brien, 2004).

Similar research has found that in addition to dramatically increased rates of poor health amongst children of Vietnam veterans in comparison with children within the general population, such children have a three times greater likelihood of suiciding (Australian Institute of Health and Welfare, 2000). This demonstrates the ongoing impact that war service may have upon the population within Australia, and that health workers must be mindful of the specificities of an individual's experiences of trauma and stress when assessing risk for suicide.

4.6 OLDER ADULTS

Research on suicide in Australia has recognised for some time now the growing numbers of older adults suiciding (Hassan, 1995). Some of the factors involved with suicide among older adults are:

- Loneliness

- Loss of a partner

- Chronic/terminal illness/pain

- Loss of mobility and freedom

- Men are at higher risk

The Australian government's LIFE suicide prevention programme suggests that:

While suicidal behaviour and thinking are strong risk factors for suicide at all ages, older people who die by suicide are less likely than younger people to have a history of suicidal behaviour and thinking. The act of suicide in older people is less impulsive, methods tend to be violent, and there is less opportunity for rescue. Suicidal thinking, when it does occur, indicates a high risk for suicide. These facts suggest that preventive strategies different from the ones used to target young people are needed (Life Framework, 2000, p. 23).

These differences in rates and means suggest that it is important that health workers are aware of the diverse meanings of ageing and suicide that may exist within differing communities. The cultural specificity of death and dying is also important to note in relation to suicide in older adults. Campbell *et al.* (2000) have noted that the meanings of death and dying are highly culturally specific, and the ways in which the bereaved engage with those who have died, or who are terminally ill, may be very dependent on particular cultural values.

Suicide rates amongst older adults of a wide range of cultural groups (and particularly amongst first generation immigrants) have been seen to be affected by the length of time living in Australia, and to relate to the degree to which an individual feels that their cultural values are respected (Burvill, 1995).

Respecting specific cultural values and beliefs around death and dying is therefore important, and may be a necessary topic of conversation for health workers dealing with older adults.

Feelings of hopelessness and despair, particularly due to lack of social support or cultural respect may be displayed within the clinical setting when levels of resilience are reduced by factors such as ongoing health problems, reduced mobility or other such impairments.

Although there are support systems for older adults (such as Meals on Wheels, community nurses etc.) these services are dependent upon a person's knowledge of their availability, a willingness to utilise the services, and the suitability of the service to a person's individual cultural needs. Health workers may be able to assist older adults in accessing these services, and in identifying the need for new services that do not currently exist.

There is also a need to provide support to older adults who are bereaved by suicide, particularly the suicide of a partner or loved one. Such suicide may result in the bereaved person being alone, perhaps with little likelihood of new relationships forming late in life. This combined with the difficultly in accessing resources for older adults, or the possible unwillingness of older adults to admit a need for support, may put those bereaved at a greater risk for suicide.

Health workers who are aware of deaths through suicide amongst older adults should therefore be mindful of the potential consequences for partners. This may particularly be the case for those involved in the palliative care sector, where access to the bereaved may provide an important site of intervention.

Finally, health workers should be aware of the ways in which social stereotypes about older adults circulate and may influence the consultation environment. The high social value placed upon independence and autonomy within Australian society often means that a loss of these factors impacts negatively upon people.

Older adults are particularly susceptible to this, though it should also be recognised that this risk may be increased by media and other representations of older adults as helpless, infirm or otherwise unable to cope. Positive representations of older adults as continuing to achieve, alongside the provision of public spaces and support systems within which this can be achieved, may help to alleviate some of the assumptions of hopelessness that currently circulate about older adults, and which may well be adopted by older adults themselves.

4.7 REFUGEES

Those seeking refuge in Australia may do so on the basis of:

- Religious persecution

- Political situations that involve ongoing warfare

- Fear for personal safety in times of great social upheaval

- Keeping children safe from conscription into the army

- Loss of citizenship (or statelessness).

Yet, in contrast to suicide prevention programmes such as LIFE, which promote recognition of cultural diversity, the policy of mandatory detention may be seen as one that actively ignores the increased likelihood of self-harm and suicide in detention centres. Suicide rates in mandatory detention centres are 41 times higher than the national rate for men and 26 times the national rate for women (Dudley, 2003). Such drastically high rates in detention centres (and less dramatically higher rates for refugees living within the community) are suggested to result from:

- The tightening of review processes, making it harder to gain a permanent visa

- The impact of temporary protection visas on the mental health of refugees

- The fact that family reunion requests are often ignored

- The ways in which access to work, education, health and social security are restricted for most refugees.

Self-harm within refugee communities (both within and outside detention centres) can be understood, in the words of Williams (1997, p. xiii), as 'a cry of pain first, and only then a cry for help'. In particular, self-harm in the context of mandatory detention may represent the voicing of political dissent against mistreatment, the practice of grieving for lost freedom or family members, and the only available response to extreme mental anguish and abuse. Self-harm in this context may take the form of:

- Hunger strikes

- Sewing lips shut

- Explicit drawings of self-harm

- Active attempts at highly visible self-harm (Dudley, 2003)

Practices of self-harm, which are common amongst all populations within mandatory detention, raises the issue of human rights at a systemic level. Although individual people may resist this or speak out against such mistreatment, the system at large has not responded effectively to the mental health issues that are clearly in evidence.

Suicide behaviour and feelings of extreme hopelessness are not limited to refugees in detention centres. There are many detrimental implications for refugees post-detention, and also for refugees who manage to avoid detention. These include:

- Grief and loss relating to missing family members

- Loss of previous status in regards to employment and education

- Breakdown of a supportive community and recognition of rights

- Mental health problems (such as PTSD) from observing severe forms of abuse

- The refutation and disrespect of religious and cultural practices

While support services and cultural awareness are increasing in response to the pressing needs of refugee communities, there continue to be alarmingly high rates of suicide and suicide behaviours within refugee communities.

Health workers must therefore be committed to understanding some of the social, political and individual factors that underpin suicide within refugee communities, and this must be accompanied by dedicated interventions to addressing these issues. Professional advocacy and promotion of the issues facing refugees is thus an important task for health workers to undertake.

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