# The Colonising Effect of Western Mental Health Discourses

**Lila Rhodes**

**University of Sydney (Bachelor of Social Work)**

**Abstract**

Aboriginal and Torres Strait Islander peoples are three times more likely to experience high to very high levels of psychological distress than non-Indigenous Australians. However, mental health services are ill-equipped to work with First Nation's Australians in culturally appropriate ways. The continuing effects of colonisation have resulted in systemic racism, intergenerational trauma, dispossession of land and loss of culture. These have all contributed to lower experiences of social and emotional wellbeing. Through exploring current policies that aim to improve mental health and social and emotional wellbeing for Aboriginal and Torres Strait Islander peoples; distinguishing the difference between cultural competence and cultural humility and the need for cultural humility; breaking down the construction of mental illness; and drawing on the Uti Kulintjaku project, the need for a new way of thinking about mental health service provision for Indigenous peoples in Australian will be explored.

## Introduction

> "If you have come here to help me you are wasting your time, but if you have come because your liberation is bound up with mine, then let us work together."
>
> Lilla Watson (2011).

This quote by Aunty Lilla Watson feels an apt way of opening. When considering the subject matter of this paper I was conflicted with my positionality and whether or not I, as a White, middle-class university student had any business writing a paper on mental health provision for First Nation's peoples in Australia. This quote resonated with me as it allowed me to envision a way in which these issues can be spoken about, while still giving voice and agency to those who have been subjugated since Australia's invasion and ongoing colonisation.

The systemic oppression of First Nations People's in Australia has been characteristic of Australian social policy and society more broadly since the inception of colonisation. Western mental health systems play a key role in the continuance of colonisation through mechanisms of power and control (White, 2017) that serve to problematise behaviours based on racialised presumptions. This paper will explore how mainstream mental health services continue to reinforce colonialism. In response, it will investigate how we can create services that champion the voices and worldviews of their Aboriginal clients, while challenging the systemic racism that exists within these services. Taking the Uti Kulintjaku project in Central Australia as an example to inform practice, an alternative framework for practice will be explored. It will argue that mental health (and illness) is a Western construction designed to oppress populations, and work towards a framework that focusses on Aboriginal-led community initiatives.

## Overview

According to the Australian Bureau of Statistics (ABS), *National Aboriginal and Torres Strait Islander Social Survey, 2014-15*, 33 per cent of respondents had experienced high to very high levels of psychological distress, 2.6 times the rate for the non-Indigenous population (ABS, 2016; Department of the Prime Minister and Cabinet, 2017). Additionally, it has been found that Australian Aboriginals are two to three times more likely to receive a mental illness diagnosis than non-Aboriginal Australians (White, 2017). From 2011-2015, suicide was the leading cause of death for Aboriginal and Torres Strait Islander persons between 15 and 34 years of age and

the second leading cause of death for those between the ages of 35-44, putting suicide rates for Indigenous peoples in Australia at two to four times the rate of non-indigenous people (Department of the Prime Minister and Cabinet, 2017). These statistics demonstrate the gap in mental health and wellbeing between Indigenous peoples and non-Indigenous people and indicate that change must take place both on a systemic level as well as a community level. It has been clear that efforts to close the mental health gap have not made significant progress (Murrup-Stewart, Searle, Jobson & Adams, 2019; Tongi, 2017). This existing health inequality can be attributed to the (continuing) effects of colonisation. The impact of ongoing colonising practices can be identified within mental health systems in Australia, as well as wider social and economic policies that have negatively targeted First Nation's peoples.

## Policy background

Since the invasion of Australia, Aboriginal and Torres Strait Islander peoples have been systemically dispossessed of land and culture. Policies that enabled dispossession of land, forced removal of children, social inequity, poverty, racism, grief and loss, intergenerational trauma and the loss of culture and identity have all contributed to the higher levels of distress Aboriginal and Torres Strait Islander peoples experience, as well as the fear surrounding Western mental health services and practice (Dudgeon et al., 2014; Tongi, 2017). A number of reports and inquiries, such as the 1991 *Royal Commission into Aboriginal Deaths in Custody* report (Johnson, 1991), the *Burdekin Inquiry* 1993 (Burdekin et al., 1993) , the 1995 *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report* (Swan et al., 1995) and the 1997 *Bringing Them Home: Report on the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (HREOC, 1997), highlighted the need for mental health policies and strategies that target Aboriginal and Torres Strait Islander peoples specifically. These reports and inquiries demonstrated that mental health policies and strategies need to be Indigenous-led, holistic and take into consideration Indigenous conceptions of social and emotional wellbeing and help to inform strategic

plans (Dudgeon et al., 2014); the latest of which being the *National strategic framework for Aboriginal and Torres Strait Islander peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* (Prime Minister and Cabinet, 2017).

Connection to land, spirituality, ancestry and community have been identified as crucial to the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples (Drew, 2015; Dudgeon et al., 2014; Tongi, 2017; Murrup-Stewart et al., 2019; Vass, Mitchell & Dhurrkay, 2011). This makes connection a multifaceted concept that needs to be addressed within mental health policies. The *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004-2009* (SHRG, 2004) set out nine guiding principles for mental health practice with Indigenous peoples. These are:

1. Health as holistic, encompassing mental, physical, cultural and spiritual health
2. The right to self-determination
3. The need for cultural understanding
4. Recognition that the experiences of trauma and loss have intergenerational effects
5. Recognition and respect of human rights
6. Racism, stigma, environmental adversity and social disadvantage have negative impacts
7. Recognition of the centrality of family and kinship and the bonds of reciprocal affection, responsibility and sharing
8. Recognitions of individual and community cultural diversity
9. Recognition of indigenous strengths.

(SHRG, 2004, p. 14)

These nine principles have been cited in many of the proceeding mental health policies as essential elements for mental health practice in order to close the gap between Indigenous and non-Indigenous Australians (Dudgeon et al., 2014). The most recent framework draws on these nine guiding principles (Department of the Prime Minister and Cabinet, 2017). It recognises the need for culture to be considered when designing

mental health programs, with the needs of Aboriginal and Torres Strait Islander peoples in mind. It focuses on a stepped, care approach in order to address the mental health needs of people at different stages, such as the "well population, at risk groups, mild mental illness, moderate mental illness and severe mental illness" (Department of the Prime Minister and Cabinet, 2017, p. 11). By addressing mental health concerns in compliance with the nine guiding principles this framework seeks to improve mental health care access, promote wellness and challenge the impact of racism and intergenerational trauma (Department of the Prime Minister and Cabinet, 2017; Murrup-Stewart et al., 2019). While it is clear that policy is moving towards improving mental health access to services that are culturally appropriate, there are still some challenges that need to be addressed. Many mental health and wellbeing policies tend to be universal in approach, and therefore do not reflect the diverse needs and cultures of First Nation's peoples in Australia. Implementation of programs and service delivery often focusses mainly on the individual with limited regard for family and community contexts; thus failing to recognise systemic inequalities. Policies also often focus on risk and protective factors which do not take into account broader processes contributing to experiencing mental illness (Dudgeon et al., 2014). This can be seen as a result of the lack of recognition of Aboriginal representative bodies, the stalling of self-determination efforts and little acknowledgement of the community call for actionable change (Murrup-Stewart et al., 2019).

## Cultural humility: a new framework for practice

Cultural humility has been championed as a new framework for practice, to address the shortfalls of cultural competence. Cultural competence has been drawn on heavily as a key social work theory for practice settings including mental health settings (Fisher-Borne, Cain & Martin, 2015). Criticism of the use of cultural competence as a framework for practice focuses on its emphasis on 'getting comfortable with others', while negating self-reflection surrounding the power and bias professionals bring. The focus on obtaining knowledge and 'competence' about culture or cultures, without recognising the inherent diversity within cultural groups, positions culture as

something that is static and obtainable, and applicable to multiple contexts (Fisher-Borne et al., 2015). This frames White, English-speaking heterosexuals as normative, and all other identities as the 'other', creating inherent power imbalances (Moodley, Mujtaba, Kleiman, 2017). The cultural competence framework sees clients on an individual level and fails to challenge systemic inequalities (Fisher-Borne et al., 2015).

Cultural humility is built on accountability, self-reflection, and challenging power on both a one-one and a systemic level. By acknowledging that culture is dynamic and different people come with different world views and experiences, this framework for practice facilitates a shift of power to the client to allow them to direct meaningful practice. Cultural humility calls practitioners to be self-aware of their attitudes towards diverse clients and challenge their assumptions (Drew, 2016). This informs the three core components of cultural humility: "reflection, institutional and individual accountability, and the mitigation of systemic power imbalances" (Fisher-Borne et al., 2015, p. 173). By employing these three components the practitioner is held accountable on both an individual and a systemic level to work towards creating practice that brings both awareness of cultural differences and challenges the systems that continue to oppress people form diverse backgrounds (Fisher-Borne et al., 2015; Moodley et al., 2017). This framework aligns closely with Critical Race Theory, which has evolved to critically analyse power relations in a multicultural space (Moodley et al., 2017). This is particularly important when working in a mental health space, as societal structures have historically operated on racism and White privilege with Western mental health professions possessing the power to systemically discriminate and draw on historically racist philosophies of the states of mental illness (Moodley et al., 2017). It is clear then that cultural humility is needed when working with First Nation's peoples in mental health settings due to the impacts of colonisation, compounded by the oppressive nature of mental health systems. Dumbrill & Green (2008) argue that when incorporating indigenous knowledge into practice:

> it is the responsibility of White people to restore that which has been taken away by their colonizing processes… this requires moving beyond a critique of Eurocentrism and addressing restoration. Moving beyond critique is crucial because simply critiquing European dominance is by its nature another exercise in Eurocentrism. Furthermore, failure to move beyond critique simply induces guilt in the dominant and hopelessness in the oppressed. (p. 499)

## Mental Health: A Construct

Critical mental health theorists have argued that mental illness is a social construct. Thomas Szasz, a prominent figure in the anti-psychiatry movement contended that mental illness is better understood as a metaphor due to the biomedical way in which it is characterised. In this way, Szasz critiques the conflation of illness – something that is a "condition of the body or one of its organs" – to the mind (Burstow, 2017, p. 32; Szasz, 2011). The 'mind' or 'thinking' is not an organ; it is an activity. Therefore, characterising an activity as an illness should fall outside the biomedical model (Burstow, 2017; Szasz, 2011). Critical mental health theorists suggest that characterising a person's behaviour as a mental illness has been argued to be a form or power and control (Szasz, 2011;Tietze, 2015; White, 2017). Following a Foucauldian perspective, mental illness exists as a classification to medicalise "deviant" behaviour (Tietze, 2015; White, 2017). The power of language in creating labels within such classificatory systems is argued by White, citing Laing, as having real consequences, as these labels accordingly become social facts (White, 2017). Therefore, when thinking about mental illness in a general sense it is clear that the behaviours of people are not constructed; it is the labels.

When looking at the history of the construction of mental illness, it is clear that diagnoses are heavily racialised. Following the (European) Enlightenment of the 18$^{th}$ century, Western psychology and psychiatry emerged, and in the 19$^{th}$ century, strongly influenced by Darwinism, Western psychology became increasingly biologically based (Moodley et al., 2017). The Darwinist notion of survival and dominance of the 'fittest' assisted in the justification of colonial capitalism, in which

Europe successfully dehumanised, enslaved and exploited non-European peoples and their lands. It is within this context that discourses on mental illness continued to develop.

Ethnic stratification and social disadvantage are significantly linked with mental illness and theorised as a contributing factor. However, importantly ethnicity always precedes the onset of mental illness. Therefore, it cannot be characterised as a contributing factor to the onset of a mental illness as it one of the only things that remains constant throughout a person's life, and mental illness has been identified to exist among all ethnic groups. Thus the argument that ethnicity may be a contributing factor toward mental illness is nullified (Moodley et al., 2017; White, 2017). Therefore, it is more important to consider the social determinants that may mean that a person will experience various kinds of psychological distress (Murrup-Stewart et al., 2019; White, 2017). Research has demonstrated that highly stressful experiences throughout life contribute to the onset of a 'mental illness'. These include economic stress, uncertain employment, and witnessing family members being incarcerated (Dudgeon et al., 2014; White, 2017). These are all common experiences of Aboriginal and Torres Strait Islander people (Dudgeon et al., 2014). Therefore, it can be argued that the continued subjugation of First Nation's peoples contributes to high levels of ongoing psychological and social distress. Thus, those working with Aboriginal and Torres Strait Islander people need to closely consider and understand the historical background of colonisation and its current manifestations in higher rates of incarceration, experiences of racism and social, political and economic marginalisation in its many forms.

Section 18 of the Act provides health professionals, mental health professions and others described in the legislation with the power to detain someone in a mental health facility on the basis of their judgement that they are reasonable grounds that the person appears to be mentally ill or mentally disturbed and that it would be beneficial to the person's welfare to be dealt with in accordance with this Act. (Mental Health Act 2007 (NSW), Part 2, S.18)

Treatment under the Mental Health Act can then also be administered against a person's wishes (*Mental Health Act 2007*, NSW). This makes mental health 'treatment', the only medical treatment that people do not have the right to decline in certain contexts (*Mental Health Act 2007*, NSW). Szasz suggests this is a violation of human rights (2011). When considering the ways in which Indigenous Australians have been controlled by the state through institutionalised racism such as by overwhelming rates of incarnation and deaths in custody, there is no denying that mental health systems effectively continue colonisation. Therefore, the *Mental Health Act 2007* (NSW) s. 18 can be treated as a tool of colonisation, providing police and other health professionals the power to detain First Nation's people against their will, leaving them vulnerable to the realities of institutional racism. While critiquing the construction of mental illness, it is important to clarify that this construction does not mean people do not experience high levels of distress and merit care and support. Therefore, frameworks for practice need to take these considerations and look for ways to combat this Ahistorical, colonial construction while simultaneously providing care and services to First Nation's peoples in order to increase social and emotional wellbeing. The Ut Kulintjaku Project is a clear example of how to be cognisant of the drawbacks of operating within a Western mental health framework, while still promoting and facilitating culturally appropriate and safe practice.

## Uti Kulintjaku Project

> "We are looking for a new way of using the old way in the new world"
> NPYWC, 2018.

In Central Australia, the Uti Kulintjaku (UK) Project was started in 2012. It seeks to strengthen understanding between Anangu peoples (living in Central Australia) and non-Indigenous, mental health practitioners surrounding mental health and effective interventions, with long term goals of increasing cultural understanding between these two worldviews (Tongi, 2017). This is reflected in the meaning Uti Kulintjaku, which can be translated to "to think and understand clearly" (NPYWC, 2018; Tongi, 2017). The project was started in the Northern Territory in 2012 by the Ngaanyatjarra

Pitjantjara Yankunytjatjara Women's Council (NPYWC) and is an Aṉangu-led project that "sits within the sphere of social innovation to address complex issues" (NPYWC, 2018, p. 10). Leaders of the project concede that its successes in influencing mental health systems change can be attributed to its existence as a community-driven project and not a single program or service (NPYWC, 2018).

Emancipatory practice seeks to undermine oppressive structures to create practice that is holistic and beneficial (Phillips, 2018). The UK Project takes an emancipatory approach while considering the possibility of going back to the 'old world'. In effect, it takes elements of the 'old world' and brings them into the 'new world' (NPYWC, 2018). In other words, the UK Project aims to draw on Aṉangu knowledge systems and embed them back into their communities with an understanding of, and sensitivity to, the fact that colonisation brought with it a complete re-structuring of their lives (NPYWC, 2018). By bringing this knowledge to the forefront, the community, as well as health professionals, are able to incorporate both knowledge systems and establish practice that is holistic and culturally appropriate (Tongi, 2017). The UK Project was established to address the high rates of psychological distress, mental illness and suicide in the community, in the hope to increase help-seeking, and create more understanding of the worldviews and experiences of Aṉangu on Ngaanyatjarra Pitjantjara Yankunytjatjara (NPY) Lands in mental health practice settings (NPYWC, 2018). The project brings together 20 Aṉangu women from across NPY Lands and non-Aboriginal mental health professionals with over 20 years of experience working in Central Australia for regular workshops, forming the core activity of the Project. A key mental health topic informs the focus of each workshop. Here cross-cultural learning and knowledge exchange is promoted in order to find creative responses to the issue and craft resources for distribution (NPYWC, 2018). This has resulted in very real and tangible resources for use by both mental health practitioners and Aṉangu. These come in the form of printed materials (*Figure. 1*), conversation cards and books and a range of digital resources such as animations, as well as an app (NPYCW, 2018).

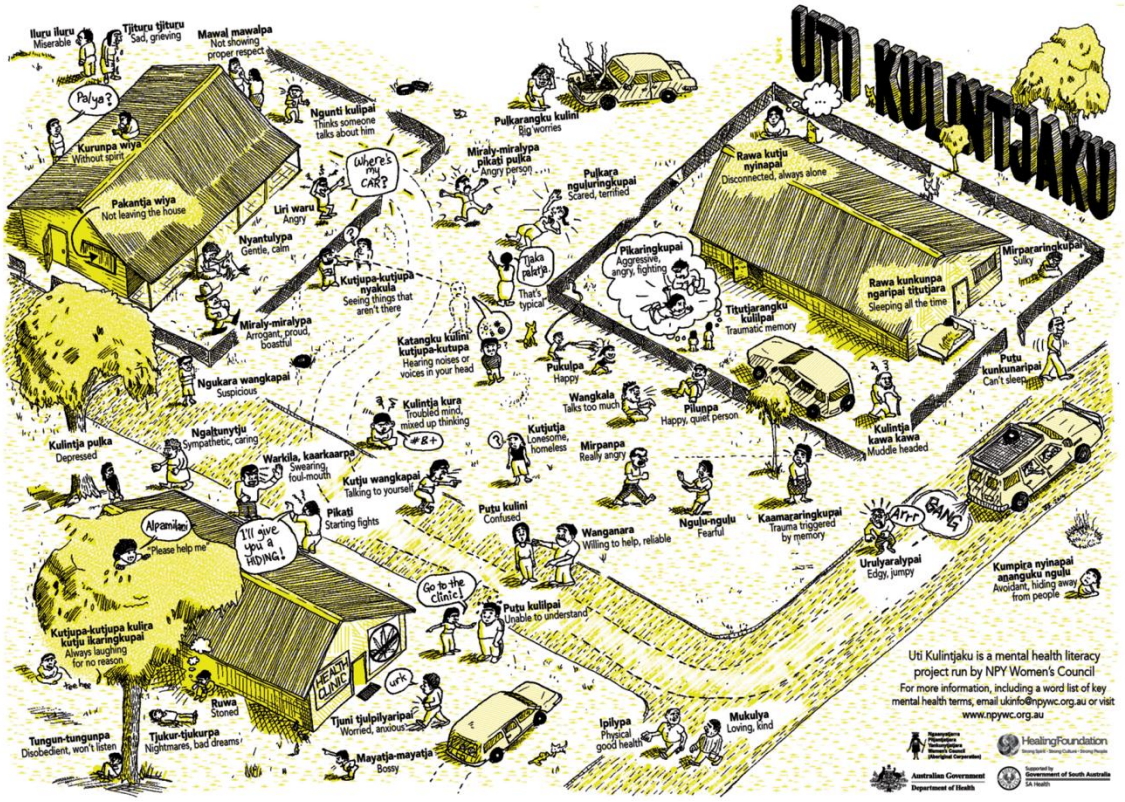


***Figure 1 Words for Feelings Map***

The *Words for Feelings Map* (*Figure 1*) is an example of a locally designed resource that came out of a UK Project workshop. It illustrates key words for common feelings, emotional states and behaviours in both Pitjantjatjara and Ngaanyatjarra, with English translations. The intended use of the poster is twofold: for the use of mental health and other professionals in Central Australia as well as for Anangu community member use. Its purpose is to increase understanding of Pitjantjara and Ngaanyatjarra language relating to mental health terminology and potentially assist with communication with clients (NPYWC, 2018).

The UK Project also draws heavily on storytelling to approach issues faced by Anangu communities (NPYWC, 2018). This has been identified as a valuable practice for improving social and emotional wellbeing for Aboriginal and Torres Strait Islander peoples (Murrup-Stewart et al., 2019). Moodley et al. (2017) argued that narrative and incorporating the lived stories of the oppressed are critical tools for undermining dominant discourses. Therefore, using the UK Project as an example, dominant

Western mental health discourses can be challenged, as well as systemic racism towards Indigenous Australians more generally. Leaders of the UK Project have attested that the project should be drawn on outside of NPY Lands. However responses cannot be standardised across different communities; instead they must reflect local needs (NPYWC, 2018).

## Where do we go from here?

With reference to the UK Project and consideration of the current policies pertaining to Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing ,a framework for practice will be put forward. It is clear that the nine guiding principles outlined in The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009* (SHRG, 2004) remain practice-focussed and do not adequately address the needs of First Nation's peoples. The UK project demonstrates that Aboriginal-led community involvement at all levels is the way forward. By putting forward Aboriginal knowledge and preferencing this over Western mental health paradigms, the colonial structures that inform these paradigms can begin to be broken down (Moodley et al., 2017; NPYWC, 2018; Tongi, 2017). It is clear that these programs need to be initiated on all levels of community with a focus on increasing help-seeking early on (Drew, 2015; NPYWC, 2018).

Social work practice in this arena must also look outside mental health service delivery alone and seek to challenge and dismantle the structures that continue to contribute to the higher levels of psychological distress experienced by Aboriginal and Torres Strait Islander peoples. This includes challenging institutional racism, such as police brutality, the pathologisation of spirituality and/or 'deviant' behaviours, higher economic distress, and detachment from land and culture (Dudgeon, 2014; Dumbrill & Green, 2008; Moodley et al., 2017; Tongi, 2017; White, 2017). Mental health practice should also seek to be critical of, and reflexive about, Western discourses of medicine, question the validity of diagnoses and interventions, and actively work with Aboriginal communities to build alternatives. This entails serious

reflection of what is considered to be absolute truth and allows a consideration and dismantling of the power of Western biomedical discourses and models of treatment.

## Conclusion

This article has explored the colonising effects of Western mental health discourses. Through an understanding of the ways in which mental illness is constructed and used as a mechanism of power, combined with the ways in which Aboriginal and Torres Strait Islander people are subjugated everyday as a result of systemic racism, this article has demonstrated that mental health service delivery needs far reaching reconsideration. While there is still a long way to go, it has argued that employing cultural humility as a framework for practice and promoting Aboriginal-led community initiatives, progress can be made in closing the mental health gap. The Uti Kulintjaku project was drawn on to demonstrate how community action can foster bi-cultural understanding between Anangu community members and non-Aboriginal mental health professionals. This facilitated barriers to be broken down on both sides and allowed for a dialogue of understanding to be created. The UK Project demonstrates the need for more community approaches rather than the establishment of specific programs and services, to allow Aboriginal and Torres Strait Islander knowledge and cultures to become integrated into mainstream services and society.

## References

Australian Bureau of Statistics (ABS). (2016). *National Aboriginal and Torres Strait Islander Social Survey, 2014-15*. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4714.0/

Burdekin B., Guilfoyle M., & Hall D. (1993). *Human rights and mental illness: Report of the National Inquiry into the Human Rights of People with Mental Illness Canberra*. Australian Government Printing Service.

Burstow, B. (2017). ‘Mental health’ praxis – not the answer: A constructive antipsychiatry position. In B. Cohen, *Routledge international handbook of critical mental health.* Routledge.

Department of the Prime Minister and Cabinet. (2017). *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017-2023*. Canberra: Commonwealth of Australia.

Drew, N. (2015). Social and emotional wellbeing, natural helpers, critical health literacy and translational research: connecting the dots for positive health outcomes. *Australasian Psychiatry*, *23*(6), 620-622.

Dudgeon, P., Walker, R., Scrine, C., Shepherd, C., Calma, T., & Ring, I. (2014). Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people.

Dumbrill, G. C., & Green, J. (2008). Indigenous knowledge in the social work academy. *Social Work Education*, *27*(5), 489-503.

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, 34(2), 165-181.

Human Rights and Equal Opportunity Commission (HREOC). (1997). *Bringing Them Home: Report on the National Inquiry into the Separation of Aboriginal Torres Strait Islander Children from Their Families*. Sydney: Spinney.

Johnson E. (1991). *Royal Commission into Aboriginal Deaths in Custody*. National Report, 5 volumes. Canberra: AGPS.

Mental Health Act 2007 (NSW) 8. (Austl.).

Moodley, R., Mujtaba, F., & Kleiman, S. (2017). Critical race theory and mental health. In B. Cohen, *Routledge international handbook of critical mental health.* Routledge.

Murrup-Stewart, C., Searle, A. K., Jobson, L., & Adams, K. (2019). Aboriginal perceptions of social and emotional wellbeing programs: A systematic review of literature assessing social and emotional wellbeing programs for Aboriginal and Torres Strait Islander Australians perspectives. *Australian Psychologist*, *54*(3), 171-186.

NPYWC (Ngaanyatjarra Pitjantjara Yankunytjatjara Women's Council). (2018). Uti Kulintjaku Project| Summary Report 2018 Evaluation.

Phillips, R. (2018). Emancipatory social work with older people: challenging students to overcome the limitations of ageism and institutional oppression. *Social Work and Policy Studies: Social Justice, Practice and Theory*, *1*(001).

SHRG (Social Health Reference Group). (2004). *A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional requires 2004–2009. Prepared for the National Aboriginal and Torres Strait Islander Health Council & National Mental Health Working Group*. Canberra: Australian Government Department of Health and Ageing.

Swan, P., & Raphael, B. 1995). *Ways Forward-National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report*. Canberra: Australian Government Publishing Service.

Szasz, T. (2011). The myth of mental illness: 50 years later. *The Psychiatrist*, *35*(5), 179-182.

Tietze, T. (2015). Peter Sedgwick: mental health as radical politics. *Critical and Radical Social Work*, *3*(1), 103-117.

Togni, S. J. (2017). The Uti Kulintjaku Project: The path to clear thinking. An evaluation of an innovative, Aboriginal-led approach to developing bi-cultural understanding of mental health and wellbeing. *Australian Psychologist*, *52*(4), 268-279.

Vass, A., Mitchell, A., & Dhurrkay, Y. (2011). Health literacy and Australian Indigenous peoples: an analysis of the role of language and worldview. *Health Promotion Journal of Australia*, *22*(1), 33-37

Watson, L. (2011). 'Liberation' and 'You Are On Aboriginal Land' | Sovereign Union – First Nations Asserting Sovereignty. Retrieved from http://nationalunitygovernment.org/ content/liberation-and-you-are-aboriginal-land

White, K. (2017). The Social Construction of Mental Illness. In B. Cohen, *Routledge international handbook of critical mental health*. Routledge.

*Words for Feelings Map*. (2019). [Image]. Retrieved from https://www.npywc.org.au/wordsfor-feelings-map/