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SARAA Suicide Prevention Plan consultation

11/4/2021

Background

The South Australian Rainbow Advocacy Alliance is the main advocacy body for the rights, health, and wellbeing of LGBTIQA+ South Australians. We work by holding community events, lobbying through the media and in partnership with other advocacy organisations, and working with Parliamentarians and state authorities to change legislation and policies and to improve the wellbeing of our community. At the time of writing, we are a volunteer organisation except for one paid staff member, our Policy and Project Officer, Mx Kelly Vincent, who assisted our Chairperson, Mr Matthew Morris, to compile this document.

Efforts to improve the mental health of the LGBTIQA+ community remain a key priority for SARAA. We are particularly concerned by the disproportionate rates at which LGBTIQA+ people experience mental health issues, suicidal ideation, or attempt suicide, as demonstrated in research such as *Private Lives 3* and *Writing Themselves In 4* from La Trobe University. As highlighted in this research, we recognise that factors such as bullying, discrimination, a lack of LGBTIQA+ inclusive support services, and other factors external to the individual are the leading reasons for this increased risk, and that by addressing these issues positive change is possible.

Historically, strategies and plans to address issues such as mental health or suicidality have far too often taken a “one size fits all” approach that ignores the needs of diverse communities. We believe that engaging with, listening to, and developing plans and services in conjunction with these diverse communities will ensure that meaningful improvements transpire. We thank Wellbeing SA for the opportunity to provide this feedback on behalf of LGBTIQA+ community members who we have consulted with, and we welcome the opportunity to remain involved in the development of the Suicide Prevention Plan to ensure the needs of our community are met and that suicide rates in South Australia can decrease.

Participants

SARAA invited members of the LGBTIQA+ community and their allies to provide their insights about what the new South Australian Suicide Prevention Plan should look like. Consultation occurred on 11/4/21, with attendees sharing their thoughts about guiding questions provided by Wellbeing SA, together with questions asked by the facilitators.

The consultation was advertised via SARAA's Facebook page and shared in various LGBTIQA+ Facebook groups in the 1-2 weeks before the consultation. Roughly half a dozen LGBTIQA+ people and allies attended the consultation. Of this group, most had lived experience of suicidal ideation and/or suicide attempts.

Several other people had registered but provided their apologies for being unable to attend on the day. Many disclosed that they were not attending because they felt like they didn't have the mental resilience to participate on the day. This is seen as an indication that while the topic of suicide prevention is important for people with lived experience, it can also be difficult to talk openly about this topic. People who sent an apology were encouraged to share their thoughts via the YourSay website instead or to provide SARAA with their feedback via email, and they were provided with information about support services they could contact if required.

Where possible, additional feedback provided by email after the consultation has been incorporated into this document as well.

Methodology

The consultation was facilitated by SARAA's Policy & Project Officer (Kelly Vincent) and SARAA's Chair (Matthew Morris) during a 2.5-hour session. Participants were advised at the beginning of the consultation that Matthew, a qualified counsellor, was available to provide counselling support if required. Participants also agreed to guidelines that encouraged open, respectful and confidential conversations, with information about support services provided as well.

Wellbeing SA provided six guiding questions to aid facilitators in the consultation, however, it was agreed in advance that the conversation would be led by participants wherever possible, so not all of these questions were explicitly asked. Instead, some alternate questions were asked to help the conversation flow naturally.

Results

Responses to specific questions posed by facilitators during the consultation

The following questions were asked, with a summary of participant responses provided:

Question 1: Suicide can be hard to talk about. What could we do to shift this? What would make it easier for you/your communities to talk about it?

- Normalising conversations about suicide is important. As a society, we need to get better at talking openly about it
- We need safe places for people to be able to open up about things that lead to suicidality. For example, places they can go to talk safely with friends
- “Suicide” tends to cause more anxiety than “self-harm” when people hear these terms. This anxiety makes it harder for people to listen when someone talks openly about feeling suicidal
- We need to equip people with the knowledge of how to respond when someone talks about feeling suicidal. Providing people with the right language to use and the comfort to start the conversation makes a big difference
- People also need to know what language to avoid using (ie “You’re not thinking of doing anything silly, are you?”). Even doctors and psychologists make these sorts of comments which pass a value judgement on clients’ actions, and it makes people less likely to seek support again in the future
- Knowing how to connect someone with support when they’re experiencing a crisis is important. Often it’s friends/family who are approached when someone is feeling suicidal, so these types of people need to know where they can direct their loved one in times of need
- Helping people to naturally feel comfortable talking about suicide rather than “imposing that they must” talk about suicide is important
- Making it easier for LGBTIQA+ people to talk about who they are is important (for example having more accepting schools where people can be open about their sexuality/gender identity)
- Helping more “traditional” parts of society (ie churches or sporting clubs) to be more supportive of LGBTIQA+ people will lead to this community feeling more included and being able to talk openly when thinking of suicide
- It’s hard to talk openly about the reasons for feeling suicidal if you feel like you can’t be open about your sexuality or gender identity with the person you’re talking to
- More intersectionality is important. Even queer spaces are sometimes unwelcoming to more diverse orientations (e.g. bi/pansexual and asexual people) and diverse groups such as people of colour and disabled people. Attendees suggest an ad campaign to tackle this
- We need to talk directly about suicide. Speaking directly doesn’t mean someone will suicide as a result. Perhaps we need to develop cultural programs, e.g., writing poetry and short story workshops for people with lived experience who have an opportunity to voice their experiences and discuss them
- Have more forums during FEAST about addressing suicide

- How about an exhibition at UniSA or Migration museum about bereavement and loss to recognise the loss in the LGBTIQA+ community through suicide?

Question 2 If the goal of the suicide prevention plan is to prevent suffering and loss of life, how might we do that? What things might we need? What could make a difference?

- We need to move beyond the mental health framework and talk about context, which is social, cultural and so on. This means understanding that LGBTIQA+ issues will intersect with ability, age, class, ethnicity and so on. These things are not separate dimensions
- We need to create forums for the bereaved/attempt survivors just to come and talk without being pathologised (ie MOSH). Of course, this will require the presence of counsellors who can provide support and help
- We need better access to inclusive services such as surgery or mental health for LGBTIQA+ people. More psychologists, psychiatrists and doctors specialising in LGBTIQA+ issues, who are sensitive and professional
- Easy access to information about where you can find inclusive services
- Co-designing different services and initiatives with communities rather than going to them with something already designed. Communities, regardless of what they are, need to have a sense of ownership about suicide prevention. It would be amazing to co-design something for the LGBTIQA+ community by community
- Have more support for drop-in centres, or more of them (ie the Feast Queer Youth Drop-in). Some young people literally survived because of these drop-in spaces. Drop-in places emphasise the importance of safe spaces for LGBTIQ people.

Additional question: What stopped, or made it difficult for, you or someone you know to seek help in the past?

- Waiting times for support hotlines are too long. When you're in a crisis, waiting on hold for 30 minutes or more is unrealistic. It's also not feasible if you're at school/work and have a limited break where you can make the call
- Internalised homophobia and transphobia makes it difficult to reach out for help, often because you feel a great sense of shame
- Feeling shame or embarrassment for thinking about suicide, in general, makes it really hard to seek help

Question 3: Resilience and compassion are often described as helpful responses and protective in responding to suicidal distress. Do you agree? Please tell us.

- Compassion and resilience are great in theory, but how are we doing this in practice? We need to build on these practical traits so they are more common in our communities
- Equipping community members with tools to foster resilience and wellbeing is important, even from a young age

- There is perhaps too much focus on suicide and self-harm as the result of a spectrum of issues. We need to move away from only talking about mental health once it becomes poor, and toward focusing more on individual strength and wellbeing
- One participant said very eloquently: “Compassion is everything, which means keeping company to someone’s struggle and not making them feel like a freak, ashamed and like a failure. Sometimes this means not speaking. Eating together, hanging out together. Not panicking. Not judging. People don’t reach out because they are scared of being judged, because they are scared of moralised views of suicide, which are damaging. Shame kills.”

Additional question: What can professionals do to show compassion, or what do they do that doesn’t help?

- Avoid statements around shame
- Show effort to understand the person you’re supporting. For example, ensuring you use the right name or pronouns when supporting a transgender person
- Providing clearer language guidelines around mental health, mental illness and suicide. Not instructive, however, if provided in strength, as the next plan comes out, it will help media groups eg commercial news, radio to get a better picture, and faster, about what is healthy reference vs not.

Additional question: Has anyone experienced resilience as a barrier to seeking help?

- Resilience can sometimes be paradoxical because sometimes we can believe that “resilience” means being able to take care of yourself independently. We need to be wary that instilling resilience in people doesn’t reduce their likelihood of seeking help by instead ensuring they know that true resilience is reaching out for help when you need it

Additional question: How do we support people better before they reach a crisis point?

- More services you can access with low to moderate needs. So often it feels like you need to be in the midst of a crisis before you’re taken seriously or receive meaningful support

Question 4: How will we know the suicide prevention plan is working?

Note: For question 4, participants were prompted to write down how we will know if the plan *is* working and how we will know if the plan *isn’t* working

Working:

- There are more places out there that can help people/more government funding (raised by two people)
- Suicide rates reduce (raised by two people)
- Increase in use of services (raised by two people)
- Changes of attitude about suicide; less judgement, more understanding
- Community education/awareness about support systems
- As a flow-on effect, rates of substance misuse and domestic violence will decrease
- Politicians and the media stop using mental health issues for political game-playing
- Fewer people are needing emergency mental health services
- There is more research about suicide/suicide prevention being conducted
- The language society uses about suicide improves
- Empathy and true compassion being taught and demonstrated
- More community discussions about suicide are taking place
- We are gathering and recording statistics about suicide in a better way (which leads to better research)
- By talking directly to the people who used the services. By talking directly to the service providers to understand their experiences with support. All of this requires qualitative research like interviewing and focus groups. Counting how many services are on offer and how often they were used does not describe quality and experience with services

Not working:

- Suicide rates stay the same or increase (raised by three people)
- We see more people thinking about/completing suicide for reasons not related to mental health issues
- Politicians continue to hijack mental health issues for political game-playing
- Bigoted and ignorant values around suicide and mental health continue to occur

Question 5: What don't we know? How could we find out?

- We need to recognise the diversity of the LGBTIQA+ community. Even within our community, we're very different and it's inappropriate to take a "one size fits all" approach when responding to our needs
- Having specific support services for different communities is important, but there should also be a central body or network to oversee these services and ensure they're working properly
- More research outside of psych/medical sciences. It's out there, but no one taps into it, because it either challenges the status quo, or people assume that psych/med professions are the only sources of knowledge and research

Additional question: How can the LGBTIQA+ community help its own members?

- Being there as someone to listen who understands when people are needing support
- Looking out for one another

Question 6: What is the most important thing you want us to know?

- Teach and show tolerance/respect (note: others felt showing “acceptance” was more appropriate than “tolerance”)
- We need more resources/funding for suicide prevention
- The importance of context. We need to move beyond the mental health model without forgetting that mental health is really important. It’s important to consider other aspects in culture/society, such as the impacts of homo/transphobia, social isolation, economic insecurity, etc. upon LGBTIQA+ people
- Being LGBTIQA+ doesn’t make you suicidal - it’s the things you experience that are harmful

Additional feedback shared via email after the consultation

- **Person-centred approach**

The person-centred approach is outdated by research standards and limiting. While framed as a game-changer in the Suicide Prevention Plan document (SPP) (because it pays attention to the person), it differs very little from the individualised approach of medical sciences and psychiatry, which govern much of the plan. Carl Rogers, an American psychologist, pioneered person-centred therapy in the 1950s. Person-centred therapy is a humanistic approach which says that human beings tend to develop themselves, but this can become distorted. Empathy, congruence and unconditional positive regard are key to responding to a distressed person. While this approach has its merits, it does not consider the context. For instance, would a transgender person be suicidal if during their transitioning they had access to surgery and good health care professionals, and did not experience transphobia on a daily basis? A lot of these aspects are part of context, which include society and culture, rather than the individual only.

An example of the importance of context is the MIC program (page 18) – mates looking after mates isn’t just about mental health and individual men reaching out (in what is probably a very hetero industry). It’s also about the culture of masculinity, working-class masculinity in particular in blue-collar industries. We need to talk about context of gender here – straight men don’t easily talk to other men about struggling. It’s seen as a weakness. What about trans men and gay men in those industries?

- **Suicide is not solely a mental health issue**

On page 6, it's great to see SPP acknowledge that suicide is not solely a mental health issue, and it often includes a complex set of factors. SPP also acknowledges the importance of a holistic approach. While the holistic approach is discussed throughout the document, suicide is continually framed as a mental health issue or arising from distress. While there are lots of services listed, giving the impression of being holistic, most of them appear psych/med oriented, or the police.

The use of language throughout the document demonstrates the point above. The language describing people struggling with suicide is still very clinical/mental health framed. It also dips into legal language by focusing on suicide mitigation. By this, I do not mean that suicidal people, including LGBTIQ people, do not struggle with mental health issues, or that risk should not be assessed. Rather, if we are going to understand suicide as multi-faceted, then we need to describe it through social and cultural terms for it is there that protective factors can often be found. Mitigation will involve risk assessment (page 12) – so how can we shift away from risk assessment to something more comprehensive?

- **LGBTIQ specific acknowledgements**

It's acknowledged that LGBTIQ people are at greater risk of suicide on pages 7 and 9. Page 11 also states that care must be sensitive to the needs of the LGBTIQ community. Other than those 3 statements, nothing else is said. Who will determine whether care is appropriate? What will it look like? What will be their basis or expertise for doing so? Will the different services be able to deal with LGBTIQ issues? The plan is too generic – a one fits all model despite attempts to not be like that.

Language is very binary – he or she. Assumptions are made about pronouns. Where is "they/them"?

- **Other issues**

A lot of the document is about training and more training. Raising awareness and reducing stigma. These things are important, but they also sound very 1997. I worked in suicide prevention and education in 1997 and 1998 in Adelaide (educating GPs, mental health professionals, health care and community workers).

Success will be measured? I'm assuming this will involve surveys or some other quantitative instrument. How about interviewing survivors or doing focus groups to assess the impact of the SPP?

Page 16 – how will raising awareness and breaking down stigma occur? Will this involve co-designing with communities that need services/help the most?

Lots of very useful services mentioned and where they will be provided, but what is their sustainability?

Discussion

The above summary captures the key points that were raised during the consultation. Participants also shared some personal stories, however, it was agreed that these would remain confidential so they have not been included in this document.

The majority of answers to the questions asked during the consultation did not relate specifically to gender, sexuality or sex characteristics. Gender and sexuality were instead raised in the context of the stories that participants shared, with themes often revolving around experiences of abuse, discrimination, or homophobia/transphobia (either from other people or internalised) and how these hardships had contributed to thoughts of suicide.

Throughout the consultation, a key theme was noticed amongst people with lived experience of suicidality. Participants wanted to contribute to making a difference and to helping other people, but they often felt unsure about how to do this. Their motive for attending the consultation was to make such a contribution, and feedback received from these participants after the consultation confirmed that they felt like their participation had been meaningful for them and had actually improved their own mental health and resilience. They still wanted to do more though and wanted to remain in contact with SARAA to hear about ways they might be able to volunteer to support the LGBTIQA+ community either in regards to suicide prevention or in other ways. Information about volunteer opportunities with other LGBTIQA+ organisations was also provided in some instances.

Based on these observations, it is suggested that LGBTIQA+ people are interested in supporting their peers who are experiencing suicidality or emotional distress, but that there aren't enough opportunities for this to occur. It is also suggested that creating spaces where personal stories can be discussed and shared has benefits for this community, and that this most easily occurs in the presence of peers who understand your experiences and will listen without judgement. In efforts to establish services and systems that can support everyone, we instead create systems that exclude diverse communities because members of these communities feel like they can't openly discuss the nuance of their experiences in these spaces. In developing the Suicide Prevention Plan, it is thus suggested that alternative models of care that are designed for, by, and with the LGBTIQA+ community (and other diverse communities) are considered, as well as preventative actions that can be taken to meet the needs of these communities before a crisis occurs in the first place.

Conclusion

In addition to the comments made on the previous pages, these additional comments are made by the facilitators based on their observations from the consultation:

- Current approaches to suicide prevention in South Australia fail to adequately recognise the needs of the LGBTIQA+ community, or the barriers that prevent members of this community from seeking support in times of need

- Ensuring that support services are inclusive and understanding of the diversity of the LGBTIQA+ community - including diversity around age, gender, cultural identity and ability status - is essential if we are to make sure that LGBTIQA+ people seek support when they need it
- Feeling connected to the community, and feeling that you are able to contribute to the community in a meaningful way, is seen as a key protective factor based on comments made by participants on the day. It's noted though that this isn't always an option when someone is in the midst of a crisis, and may only become feasible after they have had time to recover
- Having supportive friends, families and communities is a key protective factor for LGBTIQA+ people
- The reasons for LGBTIQA+ people feeling suicidal will often be similar to the reasons experienced by other members of society, however, discrimination based on gender, sexuality or sex characteristics exacerbates what might otherwise be manageable life challenges
- Equipping the community (both the LGBTIQA+ community and society more broadly) with the language and confidence to talk about suicide, and knowledge of where to refer people who are thinking about suicide is crucial. Building empathetic, supportive communities can also serve as an alternative to accessing professional services
- Creating more inclusive, respectful communities free from homophobia and transphobia is a crucial step to addressing LGBTIQA+ suicidality, and these changes need to occur throughout society

SARAA encourages Wellbeing SA to ensure that the needs of the LGBTIQA+ community are carefully considered in the development of the Suicide Prevention Plan, with particular attention paid to research and initiatives from abroad. By association, we believe it is also important to ensure the needs of other diverse communities are addressed, so no one is left behind in the important goal of reducing suicidality in our state.

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