WHEN RAINBOWS AREN'T ENOUGH

A brief report into the lived experience of suicidal crisis for LGBTQ+ people in Australia

Interviews and Report conducted by Dragan Zan Wright www.draganwright.com on behalf of National LGBTI Health Alliance.

"One professional said 'I've never met a bisexual person before'"

"Professionals need to be willing to educate themselves

rather than the burden being on the person

who's suicidal to educate them"

"The structures and systems are against me,

I'm consistently hitting brick walls"

"The hospital was draconian,

like 'One Flew Over the Cuckoo's Nest'"

"All you get is diluted CBT and some pamphlets"

"Holding the intersectionality of faith, colour

and sexuality is exhausting"

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ACKNOWLEDGEMENT

We would sincerely like to thank all the participants who helped bring this report to life.

Without the willingness to have personal and courageous conversations, this project would, quite literally, never have got off the ground. The generosity of spirit displayed in sharing times of loneliness and deep distress, trusting that those stories would be well represented and treated with respect, is humbling to say the least.

We never cease to be amazed by the resilience of LGBTQ+ people and by the willingness to step forward and share experiences, often in the hope that it will make a difference for others, and that the path, which was rocky for many, can be eased for those that follow.

We hope these personal stories contribute to real change for access to appropriate services, and inclusivity in service delivery, for LGBTQ+ people who experience suicidal crisis.

EXECUTIVE SUMMARY

This report was commissioned by the Australian Department of Health for the National Suicide Prevention Adviser. The aim of the research is to build a better understanding about LGBTQ+ peoples lived experience of suicide and suicidal crisis in Australia.

The National LGBTI Health Alliance (The Alliance) was commissioned in October 2020 to undertake the research. This research was conducted through a series of interviews with LGBTQ+ people who have a lived experience of suicidal crisis and were willing to be interviewed.

Between October – November 2020 the Project Consultant interviewed six LGBTQ+ people about their experiences of suicidal crisis, including their experiences of the health system, responses by health professionals and broader social and community experiences.

The initial research focus is on people who have attempted suicide or experienced a suicidal crisis, rather than on chronic suicidality over long periods of time or other broader experiences of suicidal ideation. However, all participants had experienced chronic suicidality, often over many years and for large periods of their life.

Although the cohort of six interviewees for this report limits the generalizability of the results, the findings from this project are aligned with Australian and international research.

Talking with LGBTQ+ people who have a lived experience of suicidal crisis provides a unique viewpoint into conditions that have contributed to reaching that crisis point. This includes personal stressors as well as the systemic stressors of discrimination, stigma, minority stress and daily micro aggressions that many LGBTQ+ people experience.

This report is a starting point into the breadth of research required to fully understand the lived experience of suicidal crisis for LGBTQ+ people in Australia. There is currently a paucity of literature domestically and internationally on the topic[1].

It is clear from the statistical data acquired in other research projects mentioned in this report that these populations are amongst the most at risk within our diverse Australian society.

A limitation of this research, is that no expression of interest was received from intersex people and in the short timeframe it was not possible to find somebody from this under-represented population. As such, when referring to the participant cohort, the report applies the acronyms LGBTQ+ as opposed to LGBTIQ+.

[1] Delaney M. Skerrett Kairi Ko˜lves Diego De Leo (2017). Pathways to Suicide in Lesbian and Gay Populations in Australia: A Life Chart Analysis. Archives of Sexual Behavior, Vol.46 (5), pp.1481-1489

SUMMARY OF KEY FINDINGS

Topic 1: What do LGBTQ+ people who have attempted suicide and/or who have experienced a suicidal crisis believe were the most significant contributing factors to their suicide attempt or crisis?

Consistent with research findings of LGBTQ+ mental health, participants had a significant exposure to risk factors for poor mental health leading up to their suicide crisis. These factors intersected with experiences of isolation and negative social and family attitudes and responses to their sexuality and identity.

Isolation, 'felt difference' and suppressed sexuality were the most frequently cited contributing factors leading up to participants' suicidal crisis.

Participants also disclosed significant experiences of Adverse Childhood Experiences such as physical and sexual abuse, domestic violence, and neglect.

Childhood adversity, exacerbated by the systemic adversity of being an LGBTQ+ person i.e., experiencing isolation, feeling 'other,' and suppressing one's identity, have been major factors in the conditions leading up to these individuals experiencing suicidal crisis. Trauma informed responses are required to address the significant experiences of trauma amongst LGBTQ+ people presenting with suicide crises or suicide attempts.

- sexual abuse 83%
- emotional neglect 83%
- emotional abuse 67%
- domestic and family violence 67%
- severe mental illness in the home 50%
- physical abuse 33%
- alcoholism in the home 33%
- death of a parent 10%.

From this information the conclusion can be drawn that childhood adversity, exacerbated by the systemic adversity of being an LGBTQ+ person i.e., experiencing isolation, feeling 'other,' and suppressing one's identity, have been major factors in the conditions leading up to these individuals experiencing suicidal crisis.

Topic 2: What were their experiences with a range of services in the lead up to, during and following their suicide attempt?

Interviewees described a health system response that was inconsistent and unpredictable. Participants' descriptions of their experience with the health system suggested that the system was at times psychologically unsafe and may have added to their distress and mirrored contributing factors for their suicide crisis or attempt.

Some health professionals were described as sensitive, caring, and responsive (for example emergency services personnel such as paramedics were supportive, some participants described Police as unexpectedly supportive), but this was not consistent. Others, generally in hospital settings and in professional interactions such as with psychiatrists and psychologists were experienced as judgmental, ignorant, or uninformed in responding to a person who is LGBTQ+.

The lack of consistency in responses and the poor experience in some aspects of the health system highlighted the need for better education and training of health professionals, particularly in hospital and clinical settings. There is a risk that the experience of these settings increases feelings of isolation and 'felt difference' and as a result may create further risks to the person's mental health.

Services delivered by NGOs and particularly services designed specifically to support people who are LGBTQ+ were viewed as being more responsive and were generally (though not always) seen as more appropriate and supportive. However, participants identified that these were often under resourced and particularly for LGBTQ+ services, had long wait lists and were not always able to provide ongoing therapeutic care.

Participants spoke about a range of services and professionals they consulted including:

- Clinicians: psychiatrists, psychologists, counsellors
- Educational staff: high school, university
- Emergency services: police, paramedics, crisis response teams
- General Practitioners
- Hospitals: public and private
- Individual support: home visit nurses, peer workers, caseworker
- Mental Health Support services: youth, generic
- Mental Health Support services: LGBTQ+
- Phone lines, chat services

It was evident that there was a lack of consistency in some fundamental service provision due to a lack of training and utilisation of useful frameworks like Trauma Informed Care and Practice and Cultural Competency when working with LGBTQ+ people.

When services were not only uninformed but discriminatory, this added to the adversity for the participants and contributed to the distress they experienced when in suicidal crisis.

Topic 3: What services or which people were especially unhelpful or helpful with regard to the suicidal state that they experienced?

Out of the nine categories of service provision identified in topic 2, hospitals were the most talked about service provision with participants' experiences ranging from unhelpful (20.4 %) to helpful (7.4%). Unhelpful experiences included being misdiagnosed, treated pathologically and triggering environments, while helpful ones included a consistency of care and connecting with peers.

There was little difference between whether clinicians were helpful (11.5 %) or unhelpful (12.8 %), with unhelpful themes related to not being listened to, an authoritarian focus on diagnosis and medication, and a lack of therapeutic approaches being utilised. Helpful themes spoke of individually tailored and comprehensive therapeutic interventions with clinicians who knew about complex trauma and were comfortable talking about suicide.

There was a clear distinction of positive impact when working with LGBTQ+ practitioners (6.1%) and when provided with consistent one on one individual support with someone who was kind, non-judgmental and had some understanding about suicidal crisis, as well as some cultural competency related to working with LGBTQ+ people (2%).

Participants identified that having consistent one on one individual support from someone who was kind, non-judgemental and had some understanding about suicidal crisis, as well as some cultural competency related to working with LGBTQ+ people, was extremely helpful.

Practical support to help address issues such as finance and housing was very helpful when the person was overwhelmed by the crisis and connections with mental health nurses who either visited at home or called to check in were valued. It was the consistency of an understanding and connection that was key. Peer workers were cited as being very helpful in this context.

Despite being in the midst of a mental health and suicide crisis, interviewees described having to 'educate' health professionals about their sexuality and identity in order to get their needs met or get access to appropriate treatment.

They also described attitudes toward their sexuality/gender identity that suggested they were 'difficult', not 'normal'. These experiences left participants feeling isolated, unseen and unheard.

HISTORY

Although many lesbian, gay, bisexual, transgender and queer (LGBTQ) Australians live healthy and happy lives, research has demonstrated that a disproportionate number experience poorer mental health outcomes and have higher risk of suicidal behaviours than their peers. These health outcomes are directly related to experiences of stigma, prejudice, discrimination and abuse on the basis of being LGBTI[2].

The findings of the above study correlate with the lived experience of the people who have contributed to this report. While knowledge about the lived experience of suicidal crisis for LGBTQ+ people in Australia is limited, it is a growing area of research. Studies like this are essential for developing an accurate understanding of the challenge LGBTQ+ people face within a society where they are often still marginalised and maligned.

'Bring the marginalised people out from the shadows, they must be visible, and they must be listened to, let them lead and take leadership, let them create their own solutions.'

Compared to the general population, LGBTI people are more likely to attempt suicide in their lifetime, specifically:

- LGBTI young people aged 16 to 27 are five times more likely
- People with an intersex variation aged 16 and over are nearly six times more likely
- LGBT young people who experience abuse and harassment are more likely to attempt suicide
- Transgender people aged 18 and over are nearly eleven times more likely[3]

[2] National LGBTI Health Alliance. (2020). Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People. Sydney, Australia: National LGBTI Health Alliance.

[3] Ibid

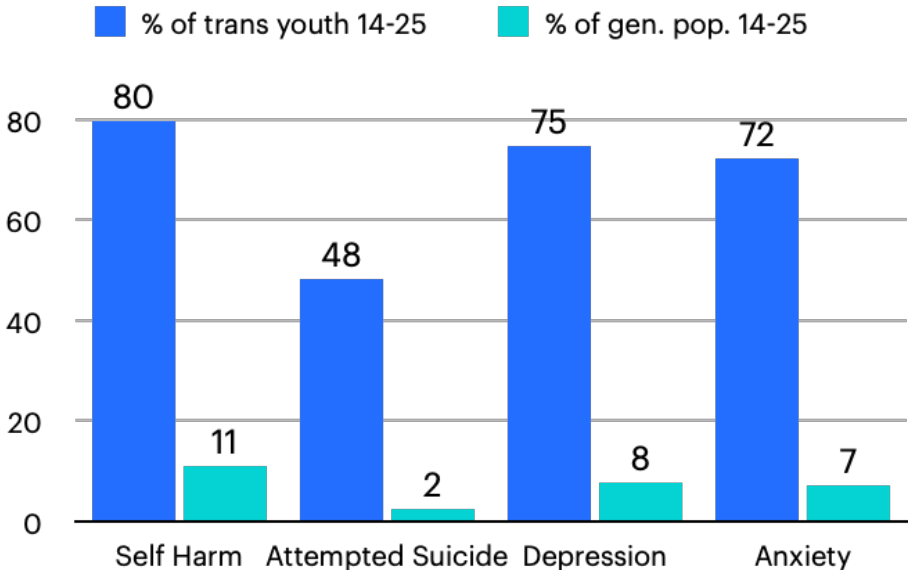

Figure 1: Table collated from Trans Pathways. (2017)[4]

This report is a starting point into the breadth of research required to fully understand the lived experience of suicidal crisis for LGBTQ+ people in Australia. There is currently a paucity of literature domestically and internationally on the topic[5].

It is clear from the statistical data acquired in other research projects mentioned in this report that these populations are amongst the most at risk within our diverse Australian society.

Although the cohort of six interviewees for this report means its scope is limited, the findings are aligned with other larger bodies of research, both domestically and internationally[6].

Talking with LGBTQ+ people who have a lived experience of suicidal crisis provides a unique viewpoint into conditions that have contributed to reaching that crisis point. This includes personal stressors as well as the systemic stressors of discrimination, stigma, minority stress and daily micro aggressions that many LGBTQ+ people experience.

It is abundantly clear that changes need to be made in key areas, including:

[4] Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., Lin, A. (2017). Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results. Telethon Kids Institute, Perth, Australia

[5] Delaney M. Skerrett Kairi Ko˜lves Diego De Leo (2017). Pathways to Suicide in Lesbian and Gay Populations in Australia: A Life Chart Analysis. Archives of Sexual Behavior, Vol.46 (5), pp.1481-1489

[6] Delaney M. Skerrett, Kairi Kõlves & Diego De Leo (2015) Are LGBT Populations at a Higher Risk for Suicidal Behaviors in Australia? Research Findings and Implications, Journal of Homosexuality, 62:7, 883-901

- All personnel in support services, government / non-government organisations and health settings that LGBTQ+ people in mental distress and/or suicidal crisis frequent are educated in utilising inclusive and trauma informed practices
- LGBTQ+ people who have a lived experience of suicidal crisis are consulted in the design of service provision
- Increased availability and access to services for LGBTQ+ people who are in suicidal crisis
- Increased availability of long-term therapeutic connection and a range of trauma informed therapeutic approaches
- Suicidality brought into the same realm as other mental health conditions to promote conversations and reduce shame

LANGUAGE

To support inclusivity, the LGBTIQ+ acronym has expanded over the years to include other demographics who also sit underneath the umbrella of sexuality and gender diversity.

In this report the + at the end of the acronym is intended to include other identities beyond Lesbian, Gay, Bisexual, Transgender or Queer, for example, Agender, Asexual, Non-binary, Gender Non-Conforming etc.

For some community members these words designate identity, for others they refer to political ideology or other explorations outside the 'normative.'

In this report LGBTQ+ will be used when referring to generic issues or statements about wider communities.

When referring to the National LGBTI Health Alliance, 'the Alliance' is used.

When referring to participants and the data pertaining exclusively to this report LGBTQ will be used as the interviewees have identified themselves as belonging to those demographics.

'They' is used where appropriate in the non-gendered singular.

INTERVIEW PROCESS

Recruitment

To source interviewees with a lived experience of suicidal crisis the Alliance sent an Expression of Interest (EOI) invitation to all of their member organisations nationally. These members are a mix of LGBTQ+ organisations. An EOI was also placed on the Alliance's website.

A total of seventeen people responded with an EOI and from those seventeen, six participants were selected. The selection criteria represented a diversity of culture, sexuality, gender identity and geographical location.

Participants needed to:

- Identify as LGBTIQ+
- Have a lived experience of suicidal crisis
- Be willing to be interviewed about their lived experience of suicidal crisis and have the interview recorded
- Be willing and able to use Zoom videoconferencing (it was decided by the interviewer to use videoconferencing rather than a telephone interview due to the belief that it is easier to read cues of safety, or lack of safety, face to face)
- Provide the interviewer with answers to a series of questions related to potential ways to support them during and after the interview (These questions were emailed prior to the interview and enabled the interviewer to assess that the interviewee had enough support for the interview process to be a safe enough option for them, see appendix A)

Confidentiality

Participants were notified that they would be de-identified in the report, that interviews would be voice recorded only and that the recordings would be destroyed once the information had been collated. Participants were asked to give verbal consent to being recorded prior to the interview commencing.

Participants were advised that de-identified quotes may be used in the report, which they personally may be able to identify, but that these quotes would be anonymous to anyone else but the author.

Reimbursement

All participants were reimbursed financially for their contribution to this report, the remuneration being $90 for a 1hr interview. They were also provided access to funds for a post interview counselling session with a therapist of their choice should they desire this.

Process

The interview process was undertaken utilising the principles of Trauma Informed Care and Practice[7]. The interviewer (Dragan Zan Wright) is a professional complex trauma therapist with fourteen years of experience and for eight years has been a national educator in the field of Trauma Informed Care and Practice, both for the Blue Knot Foundation and privately running workshops on Trauma Informed Diversity Awareness: Gender, Sexuality and Relationship Diversity.

As a member of LGBTQ+ communities for thirty-nine years and with a lived experience of complex trauma and suicidal crisis, the interviewer was uniquely placed to conduct these interviews in a respectful and safe manner befitting the seriousness of the subject matter.

The interviews took place between November 2nd and 9th, 2020 and the report was completed on November 30th.

[7] Blue Knot Foundation (2012). The Last Frontier. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.

DEMOGRAPHICS

The six participants had a diversity of sexuality and gender identities with some individuals having multiple identities:

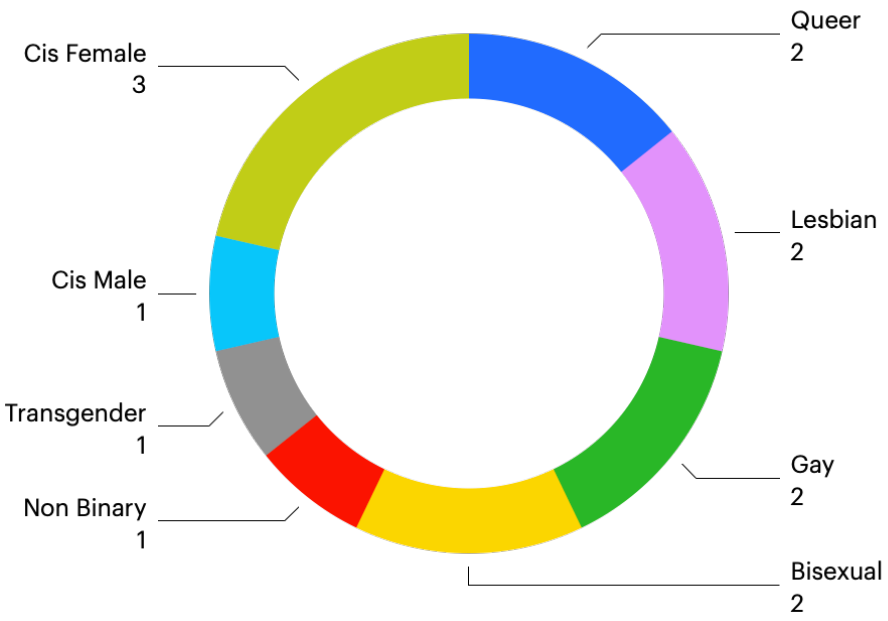

Figure 2: Sexuality and gender identity of participants

Age – participants age representation was 24, 26, 29,31, 35 and 40.

Ethnicity – the ethnicity demographic was predominantly Caucasian with one interviewee identifying as a person of colour.

Geographic representation - ensuring that a diverse range of sexuality and gender was represented meant that some geographical diversity was sacrificed with three participants from Victoria, one from Queensland, one from the Australian Capital Territory and one from New South Wales.

Unfortunately, due to the time constraints, the majority of participants were from metropolitan areas as regional, rural and remote representation was unable to be sourced.

INTERVIEW QUESTIONS

Three topics were explored in the interviews. These topics were delivered to the interviewer via the Alliance on behalf of The National Suicide Prevention Taskforce. The interviewer then ascertained the best way to present these topics and what specific questions would be asked.

Interviews were conducted in a conversational manner, both to allow for an ease of communication and so that interviewees didn't feel 'interrogated.' This style of interviewing was chosen with the intent of creating connection and equalising the power differential. It enabled the researcher to be a part of the conversation, having disclosed in the introductory email that they too had a lived experience of suicidal crisis, rather than being a 'spectator' to a person's periods of suicidal distress.

Topic 1: What do people who have attempted suicide and/or people who have experienced a suicidal crisis believe were the most significant contributing factors to their suicide attempt or crisis?

- What was going on for you in the lead up to your suicidal crisis? I.e., looking back, what do you think were significant events or conditions that contributed to how you were thinking and feeling at the time?

These could be adverse childhood or adult experiences e.g., abuse and neglect, abandonment, bullying, rejection, isolation, experiencing or witnessing violence, overwhelming stress caused by study, employment, relationship struggles, finances, challenges with physical and/or mental health etc.

- Did being an LGBTQ+ person contribute to this experience in any way?

Topic 2: What were their experiences with a range of services in the lead up to, during and following their suicide attempt?

- Did you have contact with any services or organisations:
  - When you began to feel suicidal?
  - When you were in the midst of a suicidal crisis?
  - After the suicidal crisis?

- As an LGBTQ+ person what was your experience of any services, organisations, environments or groups?

This could include phone support lines, government agencies like Centrelink, housing services, mental health services, hospital services, the police, a GP, school environment, workplace environment, university environment, community support…

Topic 3: What services or which people were especially unhelpful or helpful with regard to the suicidal state that they experienced?

- Were there any services, organisations or people who were particularly unhelpful at that time? What made them unhelpful?

- Were there any services, organisations or people who were particularly helpful? What was it about them that was helpful?

- Was there anything else that helped you through those suicidal experiences and/or that helped in your recovery journey?

FINDINGS

Topic 1: What do people who have attempted suicide and/or people who have experienced a suicidal crisis believe were the most significant contributing factors to their suicide attempt or crisis?

Although this report is focused on a suicidal crisis, all participants communicated that they had experienced chronic suicidality, often over many years and for large periods of their life.

This meant that identifying factors specific to a particular suicidal crisis was complicated by the fact that the suicidal crisis may have been one of many, and that it may have been something that built up from many factors over time, including experiences like early childhood trauma.

Previous research into risk factors has named various experiences that may increase the risk of suicide e.g., a family member or someone close to the person suiciding. While this is a factor that is named in this report, it is clear that it is further down the list than broader factors like isolation, suppressing one's sexuality within a dominant heterosexual culture and violence, abuse and neglect; particularly sexual abuse and neglect and/or abuse in the home.

Figure 3 shows by far the most significant contributing factors for participants were isolation 100%, felt difference 100% and suppressed sexuality 100%. These figures represent the percentage of respondents who experienced each factor.

Other factors relate closely to the findings of the Adverse Childhood Experience (ACE) study[8] in that elevated childhood adversity can have a direct correlation to elevated levels of suicidality.

8 Thompson MP, Kingree JB, Lamis D. Associations of adverse childhood experiences and suicidal behaviors in adulthood in a U.S. nationally representative sample. Child Care Health Dev. 2019 Jan;45(1):121-128

Out of the ten categories of childhood adversity named in the original ACE study of 1998[9] eight have been named in this report (Figure 3) as contributing factors: sexual abuse 83%, emotional neglect 83%, emotional abuse 67%, domestic and family violence 67%, severe mental illness in the home 50%, physical abuse 33%, alcoholism in the home 33%, and death of a parent 10%.

From this information the conclusion can be drawn that childhood adversity, exacerbated by the systemic adversity of being an LGBTQ+ person i.e., experiencing isolation, feeling 'other,' and suppressing one's identity, have been major factors in the conditions leading up to these individuals experiencing suicidal crisis

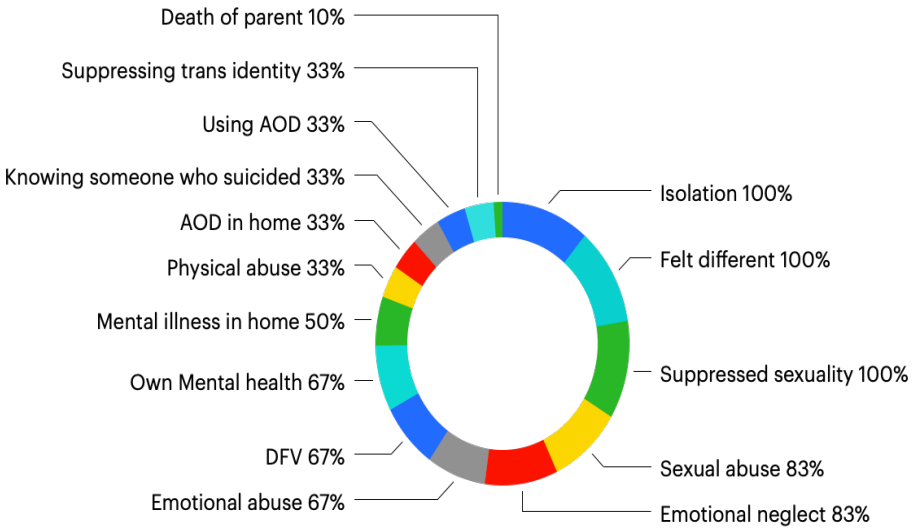

Figure 3: The most common cumulative and contributing factors to suicidal crisis

"No one noticed me as a kid, I self-harmed

and had suicidal ideation nearly every day"

[9] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245–258.

Topic 2: What were their experiences with a range of services in the lead up to, during and following their suicide attempt?

Participants spoke about a range of services and professionals which included:

- Clinicians: psychiatrist, psychologist, counsellor
- Educational staff: high school, university
- Emergency services: police, paramedics, crisis response teams
- General Practitioners
- Hospitals: public and private
- Individual support: home visit nurses, peer workers
- Mental Health Support services: youth, generic
- Mental Health Support services: LGBTQ+
- Phone lines, chat services

Other stressors that were mentioned by individuals included:

- The stress of studying
- Relationship breakup
- Loss of a job
- Shame: that suicidality and mental health were not talked about

As expected, some experiences of the same service were variable, but some were consistent across participants. For example, a phone service was cited as being helpful in the midst of a crisis but its chat component as being unhelpful, due to the utilisation of a rote approach to reflective listening. Experiences with emergency services were expressed as being generally good, with LGBTIQ+ organisations being identified as very helpful but under resourced.

While subjective experiences can account for some variability it was also evident that there was a lack of consistency in some fundamental service provision due to a lack of training and utilisation of useful frameworks like trauma informed care and practice and cultural competency in working with LGBTQ+ people.

When services were at times not only uninformed but discriminatory, this added to the adversity that the participants experienced and contributed to the distress they were experiencing when in suicidal crisis, such as, unhelpful experiences in the hospital system included heteronormative assumptions about sexuality, with one participant citing she felt pressure to pass as heterosexual in order to receive non-judgemental care. There was also the example of encountering transphobic staff.

"You're not trans, you're crazy"

Unhelpful clinical treatment was either entirely inappropriate, such as, a psychiatrist performing gay conversion therapy in secret, or lacked cultural competency in working with LGBTQ+ people being in suicidal crisis and educating professionals about ones' sexuality.

"I was told by professionals I would grow out of it."

Topic 3: What services or which people were especially unhelpful or helpful with regard to the suicidal state that they experienced?

This report identifies nine categories of service provision and examines whether participants had a helpful or unhelpful experience of support when in suicidal crisis. Figure 4 displays the percentage of helpful or unhelpful experiences across the nine service categories identified in Topic 2 during a suicidal crisis. During the interviews these services were mentioned a total of 147 times in different contexts and related to separate issues brought by each participant - if one participant brought up the same issue more than once it was counted as one issue, but if another participant brought it up, it was counted as a separate issue. The percentages, and whether each category was mentioned in a helpful or unhelpful context, was then calculated.

Other factors that were identified as helping in the recovery journey from suicidal crisis can be seen in Appendix B.

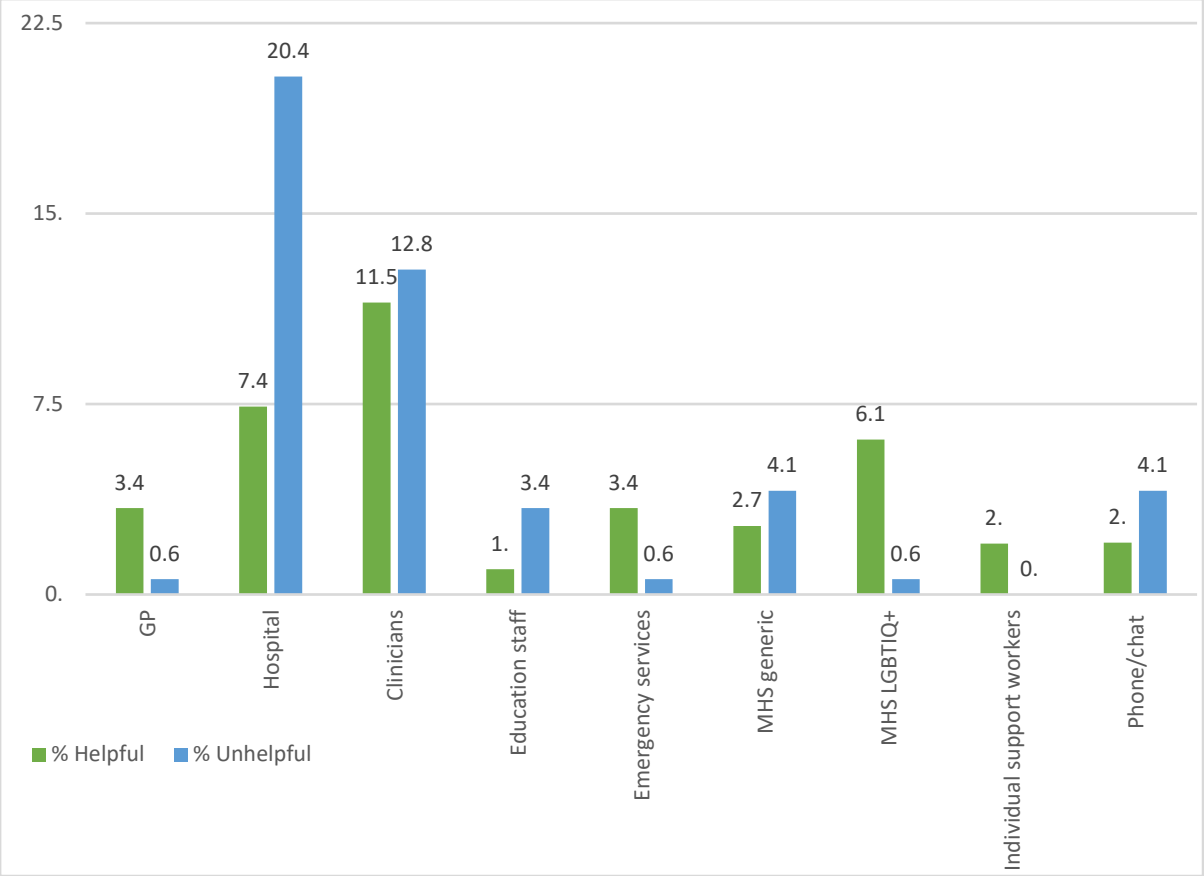

Figure 4: Percentage of helpful or unhelpful experiences with services during a suicidal crisis

Hospitals

Figure 4 indicates that there are a lot of gaps in service provision within both public and private hospital settings and therefore great opportunities for change. Hospitals were the most talked about service provision with participants' experiences ranging from unhelpful (20.4 %) to helpful (7.4%).

"Worst experience of my life"

Unhelpful experiences (20.4 %) with hospitals included being treated pathologically, misdiagnosed, a lack of care and privacy, a lack of therapeutic options for CBT and group therapy. Additionally, participants reported not being listened to or taken seriously, inconsistent care, changes in rosters and improper handover meaning care could feel ad hoc and triggering environments that felt unsafe.

A common theme was that participants felt they were not taken seriously because they presented well or were able to mask their distress. It was felt that professionals sometimes did not understand the complexity of suicide. Participants in suicidal crisis sometimes felt that they had to escalate their behaviour in order to get the support they needed, with one

younger participant stating that she often reached out but was not deemed to be acutely unwell enough for inpatient admission.

"I had to tell professionals I'm presenting better than I feel, you can't trust what you're seeing"

In a hospital setting participants reported helpful experiences (7.4%) as having a sense of connection and not feeling alone; this included a psychosocial group, talking with peers and 'kind' nurses. The experience of going into hospital was expressed as giving legitimacy to one's distress, it made their distress more visible and meant others took it more seriously. It was also mentioned that having one's basic needs met and structure, when life felt chaotic, was useful. Having one doctor overseeing a person's case was cited as providing a consistency of care and having more programs and activities was helpful.

"First time I was taken seriously... I didn't feel like I had the insane stamp there"

Clinicians

"I can't tell you how many times I told a professional a red flag and they wouldn't ask about it or follow it up"

Clinicians were also cited many times with an interesting point of note being that there was little difference between participants helpful (11.5 %) or unhelpful (12.8 %) experiences with clinicians. Common themes in relation to unhelpful (12.8%) experiences of clinicians, such as psychiatrists, included not being listened to or engaged with when in suicidal crisis, finding the psychiatrist authoritarian and dismissive, and the focus being on diagnosis and medication rather than enquiring about what was really going on.

"I needed more help than I was getting"

It was clearly stated that ten sessions on a Mental Health Care Plan was not enough and led to inconsistent care with long periods in between. One participant described the effort to find a clinician who would work for them:

"Find a psych, try them out for 2-3 sessions, try another one for 2-3 sessions, half your sessions are gone - you're ripping off the bandage again and again"

Helpful experiences (11.5%) of clinicians included practitioners who knew about Complex PTSD, were authentic and honest, used a variety of modalities and not a 'one size fits all' approach, were comfortable talking about suicide, open to reviewing diagnosis and medication and available for consistent ongoing connection. The structure of seeing a good

clinician every week, particularly when in suicidal crisis, was cited as something that could help 'hold' someone so that they could get through that period.
Additionally, it was helpful when psychiatrists were willing to admit they didn't have all the answers and worked collaboratively with the patient to find useful strategies (including medication) to suppress suicidal urges and stabilise the person.

"I got respite from suicidality for first time, it proved to my mind it was possible"

LGBTQ+ Mental Health Services

Helpful clinical treatment was expressed most often as being with culturally aware clinicians or with an LGBTQ+ practitioner (6.1%). Connecting with an LGBTQ+ non-government organisations that provided mental health services meant that there was an availability of knowledgeable clinicians. It was also highlighted that there weren't enough LGBTQ+ mental health services, waitlists could be long, and these services weren't generally funded to do long term therapeutic work.

"Finding a trans psychologist was great"

The experience of attending an LGBTQ+ mental health program was seen as very positive with the opportunity to meet other LGBTQ+ people, connect with peer support and be in an environment that could understand the complexity of diverse identities. However, it was also noted that an unhelpful experience (0.6%) was that LGBTQ+ practitioners could be culturally incompetent in other areas of diversity, such as, a person in suicidal crisis who was gay, Christian and a person of colour.

"Being in a group with people like me... now I have people I can call who get it"

*"Being a gay organisation, I didn't have to explain why I was there,
why I should exist, it was a known factor"*

Individual Support

Individual support (helpful, 2% and unhelpful, 0% experiences) lends itself well to future recommendations. In discussions it was clear that having consistent one on one individual support from someone who was kind, non-judgemental and had some understanding about suicidal crisis, as well as some cultural competency related to working with LGBTQ+ people, was extremely helpful.

When overwhelmed and feeling unable to cope it was expressed that having a caseworker to help deal with practicalities like finance and housing was very helpful, as was connection with

mental health nurses who either visited at home or called to check in. It was the consistency of an understanding connection that was key and peer workers were cited as being very helpful in this context.

"She asked the good questions"

Educational staff

High school teachers and university staff are in a unique position to notice students who are struggling and to either provide support or direct the person towards someone who can possibly help. Participants reported both helpful (1%) and unhelpful (3.4%) responses ranging from teachers in year 12 who were supportive, to university staff who were experienced as judgemental.

"There was no flexibility, I felt blamed,
that it was my fault, there was no empathy"

Emergency services

The experience of emergency services, such as police, paramedics, crisis assessment and response teams was generally positive (3.4%) with participants either calling these services themselves after a suicide attempt, or family and friends calling them. Paramedics were seen as generally compassionate and there was an overall positive experience of the police from two participants. In one example the Crisis and Assessment Treatment Team were seen as less helpful.

"They came and did an assessment, I had a suicide plan,
they took it and nothing else happened"

General Practitioners (GP)

GP's are arguably some of the best people placed to pick up suicidal crisis and to resource a person appropriately. Getting GP's trained in utilising Trauma Informed Care and Practice and the Adverse Childhood Experiences Questionnaire or some other framework to assess for adversity, seems a sensible option, as they are often the first service a person will go to.

Common themes relating to what was helpful (3.4%) were GP's who listened, were non-judgemental and kind and who were appropriate in their management of a person's suicidal crisis, taking time to assess the best way forward and giving good referrals.

Phone/chat services

These services were identified as being useful for short term support (2%), when in the midst of a suicidal crisis, but unhelpful responses were also identified (4.1%) with one participant citing that staff needed to be well trained across the board. Responses to participants in suicidal crisis were found to be variable, with not enough understanding of the complexities involved. One phone line was credited with asking a simple, yet helpful, question:

"Is there anything we need to know to best support you?"

RECOMMENDATIONS

The recommendations from participants are grouped into four sections: clinical, communication, connection, and service provision.

Clinical

The recommendations here speak to a perceived gap in the education of clinicians and practitioners.

It was deemed important to ensure clinicians and practitioners are skilled in working with and understanding diverse sexualities, gender expression and gender identity, as well as how to work effectively with complex trauma, of which mental distress and suicidal crisis can often be symptoms. Participants identified that exposure to different kinds of trauma informed therapeutic approaches would be helpful.

The suggestion was that where possible clinicians be educated by LGBTQ+ people who have a lived experience of mental distress and suicidal crisis, and that all practitioners learn how to apply the principles of Trauma Informed Care, which would lead to a more authentic, collaborative and transparent engagement.

Communication

This section is about changing the culture of service provision as it pertains to suicidal crisis and speaks to the fact that conversations about suicide and mental distress need to be 'on the table.' Participants expressed wanting it to not be taboo to talk about these issues, and that suicidality be brought into the same realm as other mental health conditions to reduce stigma and shame.

It was also seen as important to have the opportunity to be able to learn language around feelings, how to grade emotions, how to talk about feelings safely, and to have that role modelled by others.

"Ask the deeper questions, don't be taken in by appearances"

"Things have changed for me since I've been able to talk about it… the biggest risk factor is if I stop talking about how I feel"

Connection

This section refers to both formal and informal connections.

Formal connections refer to availability and access to clinicians and other practitioners, with the option for long term therapeutic engagement. LGBTQ+ services and peer lead services, programs and networks were assessed as being particularly useful.

Informal connections refer to friends, family, 'logical' or 'chosen' family and connection to LGBTQ+ communities and activities. It was suggested that providing safe spaces, like drop- in centres, for LGBTQ+ people to connect, relax and have some respite, would be useful. The observation was also made that there are some services now available for young LGBTQ+ people but that there need to be more programs and services available for when people transition out of youth services into adult services, as well as services and support for aged LGBTQ+ people.

Service provision

A primary recommendation in this section was that all personnel in services, organisations and settings that LGBTQ+ people who are in mental distress and/or suicidal crisis frequent, need to be educated in utilising inclusive and trauma informed practices.

Consulting and collaborating with LGBTQ+ people who have a lived experience of suicidal crisis to design supportive service provision was identified as an important step. Suggestions from participants include more responsive programs, exposure to a wider array of therapeutic approaches, and individualised safety plans that are collaborative, flexible, creative and realistic.

The availability of long-term connection with a therapeutic service was a key recommendation, along with Mental Health Care Plans being more than ten sessions.

The need was identified to have visible LGBTQ+ teachers and lecturers in educational settings and visible LGBTQ+ practitioners in a variety of services in order to provide a safe and visible presence for LGBTQ+ people in mental distress and/or suicidal crisis. An example of this could be more LGBTQ+ liaison officers in the police.

"One positive experience of accessing care can make a huge difference"

"Listen to people, let them lead, let them create their own solutions"

CONCLUSION

When in suicidal distress people need to be able to see a way out and a hope for a future that can be different. A system that often does not see or acknowledge sexuality and gender diversity can be a barrier to the journey of recovery.

The interviews conducted in this project highlight that LGBTQ+ people experience isolation when they seek help and have varied and inconsistent responses with the health system.

Participants identified a high level of previous trauma experiences and as a result required a trauma-informed approach, which was not always available.

Overall, there is a clear opportunity for health services to be more inclusive and respond more effectively and appropriately to LGBTQ+ people experiencing a suicide crisis.

Access to, or availability of specific LGBTQ+ mental health services is a challenge due to high demand and long waiting lists and is an area where investment in increased services could deliver improved outcomes for a community that is currently underserved by the health system.

LGBTQ+ people have often felt betrayed by the system that aims to support people in crisis, which can make it hard to trust and reach out again. It is evident there needs to be more inclusion and visibility of LGBTQ+ people within broader service system and additional LGBTIQ+ practitioners.

"The system failed me, I had 3 years of distress in services,
now I'm having to work through that''

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APPENDIX A

Introduction Email

Hi (name)

Thank you for expressing an interest at being involved in the National Suicide Prevention Taskforce's research into the lived experience of suicide in Australia.

My name is Dragan Zan Wright and I have been asked by the LGBTI Health Alliance to conduct interviews with members of LGBTQ+ communities who have experienced an acute suicidal crisis. While its' clear that many people in our communities experience chronic suicidality over their lifespan, this project is focusing on times of acute suicidal crisis. From the information gathered I will compile a report from the perspective of LGBTQ+ participants.

This report is intended to build a better understanding of issues that are particularly relevant to LGBTQ+ people in this context, in order that these views can be integrated into the wider research, which is intended to inform recommendations to government.

I am transgender, a psychotherapist and identify as queer. My therapeutic and educational work is in complex trauma, trauma informed practice, minority stress for LGBTQ+ people and gender affirmation. If you'd like to check out my website to get a sense of where I'm coming from, you can do this at www.draganzanwright.com

As someone who has lived experience of complex trauma and suicidal crisis, I know how important it is to feel 'safe enough' to have these conversations, so I'm wondering if you'd feel comfortable to answer the 'Keeping Oneself Safe' pre-interview questions below. This is so that I can be as prepared for you as possible.

We will have a one-hour interview together and this will be conducted via Zoom. The reason for using Zoom is so that we can have some face - face connection and see each other, during a conversation which is personal. It also enables me to get more of a sense of how you might feel during the interview, which is important for me, so that I can make it as safe a process as possible.

I will record the interview to compile the final report for the National Suicide Prevention Taskforce, but I will not record the visual video, only the sound. The recording will be deleted when I have the information and you will be de-identified in the report i.e. no names or identification will be used. When it is completed you will be able to have a copy of the report if you wish.

You will be paid $90 for the hour and after our interview I' will give you a 'Sitting Fee' form to fill in and send to the LGBTI Health Alliance. This form will need your name and bank account details so that the LGBTI Health Alliance can pay you. I can go through the form at the end of our meeting if you would like that.

During our interview we can stop at any time and take a break, slow it down, change topics, get up and stretch… whatever you need in the moment to feel ok.

Keeping oneself safe

Pre-interview questions

- Is there a day of the week or time of day that would work best for you to have this interview?

    - Is there someone who can support you during or after this process? It's totally possible to have a support person with you for the interview, or to have a pet with you if that would help.

- What kinds of things do you do to keep yourself ok when talking about topics which might be challenging and/or which might bring up emotions? Examples - using breathing techniques, thinking about somewhere you love to be, using grounding techniques, taking a break and re-orienting to things that feel good… which specific techniques work well for you?

- Are there any specific words/topics/potential scenarios that may arise in our interview that you know might be triggering for you?

- Is there anything else I can do to support you feeling safe enough throughout this process?

If you are able to email me the answers to these questions early next week that would be great, so that we can set up the interview time. This project needs to be finished and written up by the end of November so we don't have as much time as I would like.

Before we begin, we can check in and make sure we are on the same page regarding what you need and what will work best for you.

Post interview

After our interview it would be good to schedule some time to connect with someone you feel safe with and/or to do something in the realm of 'self-care.' Such as, doing something nourishing, relaxing or soothing, gardening, getting out into nature, doing something fun, and/or you may also want to do something that gets your body moving like a walk, swim, exercise or yoga/stretching. Physical activities can help move and release any emotion that may have arisen.

There is also the option to have a counselling session paid for by the LGBTI Health Alliance after our interview if you feel it would benefit you to talk about, or process, any feelings that come up.

During the interview

The questions we will discuss are below, you may or may not want to read them or think about them in a lot of depth now, but it's important that you know what we are intending to talk about, so having a look through them at some point before our interview would be beneficial.

You don't have to answer them now, just in the interview. Even reading these questions may bring up feelings, so it might be wise not to read them on the fly, but to give yourself some time and space to read them.

Please make sure you're well supported through this process. It really is a good idea to have someone that can support you if you should need that. This could be a therapist, friend, partner, peer worker, support worker, sponsor, phone support line e.g., Qlife, Beyond Blue, Lifeline, the Blue Knot Helpline, even a colleague you have a good relationship with. It's important not to be alone when doing something like this.

Interview Questions

- What was going on for you in the lead up to your suicidal crisis? I.e. looking back, what do you think were significant events or conditions that contributed to how you were thinking and feeling at the time?

These could be adverse childhood or adult experiences e.g. abuse and neglect, abandonment, bullying, rejection, isolation, experiencing or witnessing violence, overwhelming stress caused by study, employment, relationship struggles, finances…, challenges with physical health or mental health etc.

- Did being an LGBTQ+ person contribute to this experience in any way?
- Did you have contact with any services or organisations:
  - when you began to feel suicidal?

- when you were in the midst of a suicidal crisis?
- after the suicidal crisis?

- As an LGBTQ+ person what was your experience of any services, organisations, environments or groups?

  This could include phone support lines, government agencies like Centrelink, housing services, mental health services, hospital services, the police, a GP, school environment, workplace environment, university environment, community support.

3. Were there any services, organisations or people who were particularly unhelpful at that time? What made them unhelpful?

- Were there any services, organisations or people who were particularly helpful? What was it about them that was helpful?

- Was there anything else that helped you through those suicidal experiences and/or that helped in your recovery journey?

APPENDIX B

Other factors that helped in the recovery journey from suicidal crisis

Programs/skills/tools
• Connecting with and moving the body • Opportunities to connect with others • Trauma informed places of acceptance and kindness • Learning how to use breath and regulation/self-soothing skills • Creation of a good life maintenance plan e.g., therapist, GP, utilising own skills, catching distress early, having some good connections • Structuring time when in overwhelm • Positive beliefs • Different therapies e.g., EMDR, trauma informed therapies, music therapy

Empowerment
• Finding autonomy • Moving out of home • Getting a licence • Exploring identity • Coming out (as LGBTQ+) • Positive representations of LGBTQ+ people in the media and in various educational and service environments • Volunteering • Study • Connection with faith • Finding purpose • Stable housing

- Stable finances
- Work and study environments that are understanding and supportive

Connection
• Biological family • Chosen family • Friends • Internet community • Partner • Peers • LGBTQ+ community • Being able to talk about suicide