Informing the direction of ACON's Online Suicide Prevention Hub: a review

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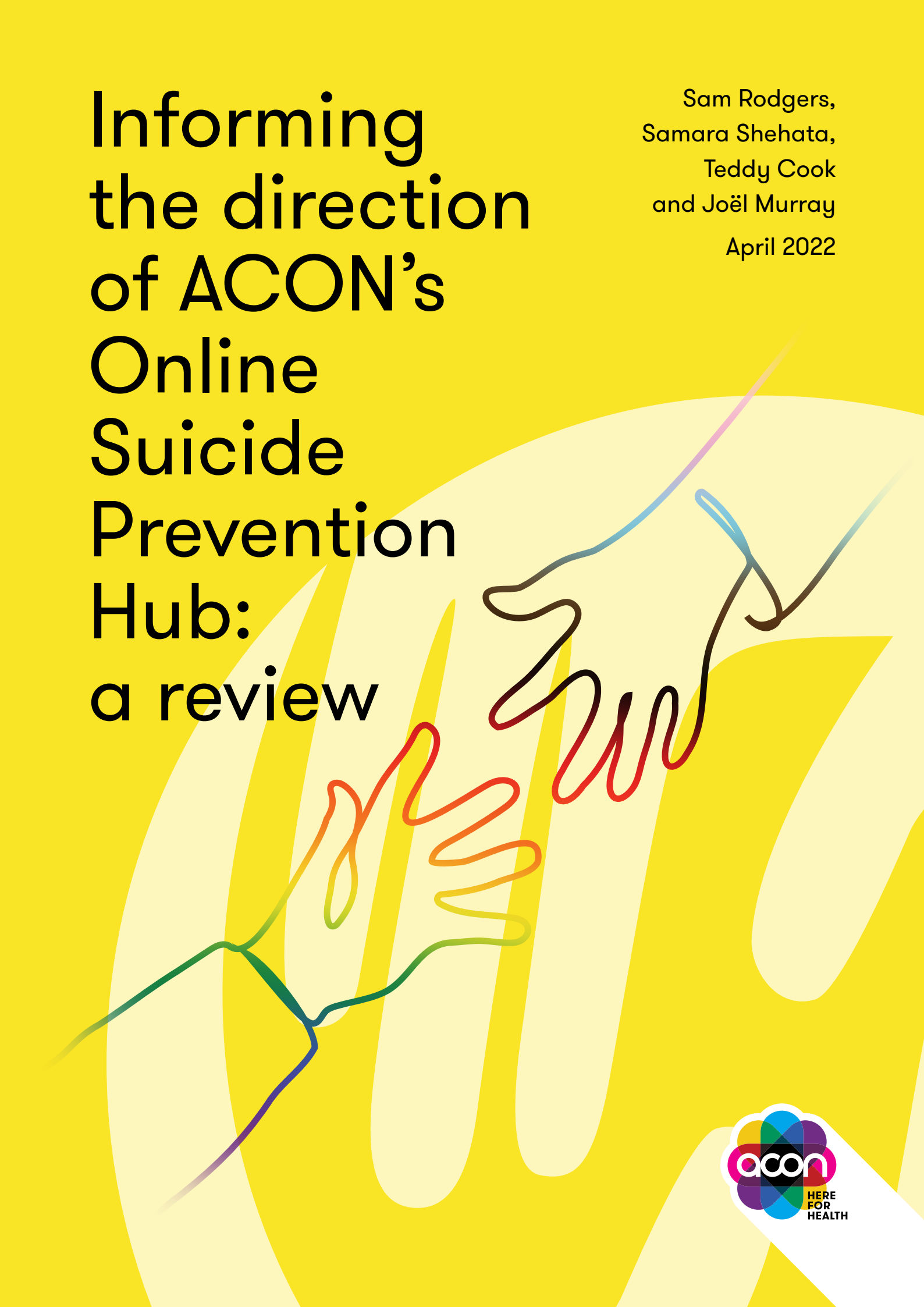

HERE FOR HEALTH

About ACON

ACON is NSW's leading health organisation specialising in community health, inclusion and HIV responses for people of diverse sexualities and genders. Established in 1985, ACON works to create opportunities for people in our communities to live their healthiest lives.

We are a fiercely proud community organisation, unique in our connection to our community and in our role as an authentic and respected voice.

Members of Australia's sexuality and gender diverse communities experience health disparities when compared to health and wellbeing outcomes experienced by the total population. They may also face significant barriers to accessing traditional healthcare pathways.

We recognise that members of our communities share their sexual and gender identity with other identities and experiences and work to ensure that these are reflected in our work. These can include people who are Aboriginal and Torres Strait Islander; people from culturally, linguistically and ethnically diverse, and migrant and refugee backgrounds; people of colour; people who use drugs; mature aged people; young adults; and people with disability.

Acknowledgement of Traditional Custodians

Contact details

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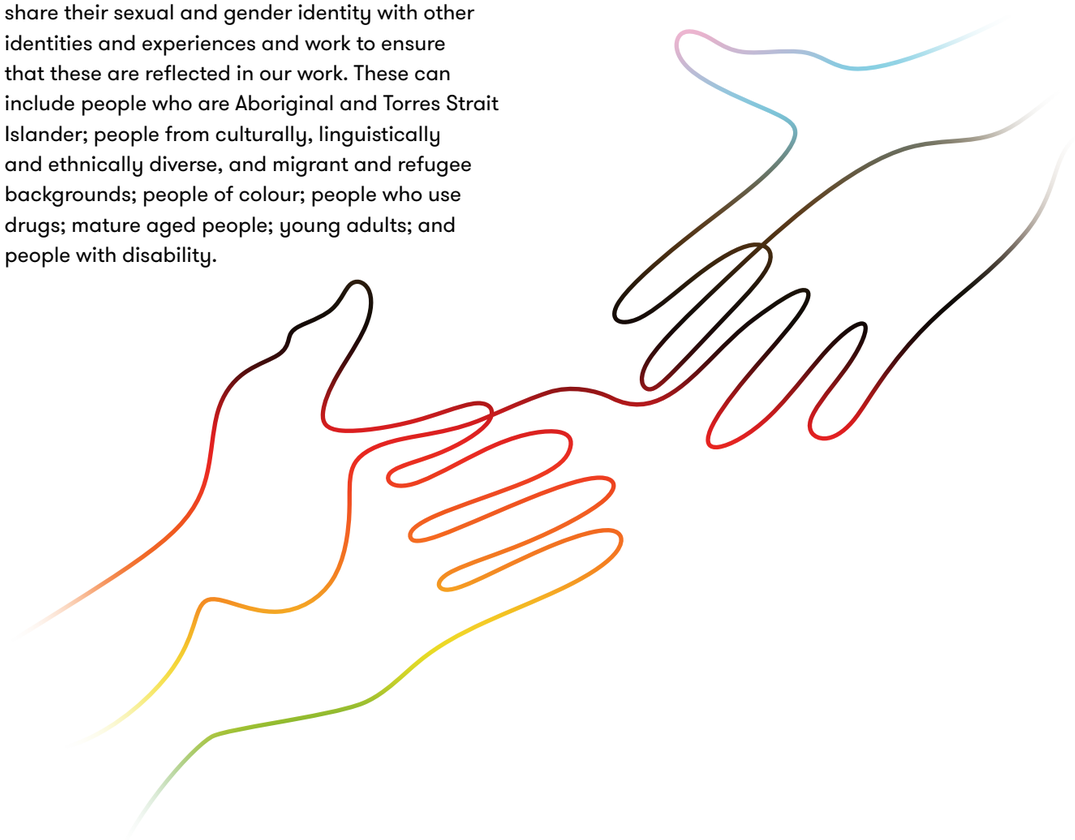

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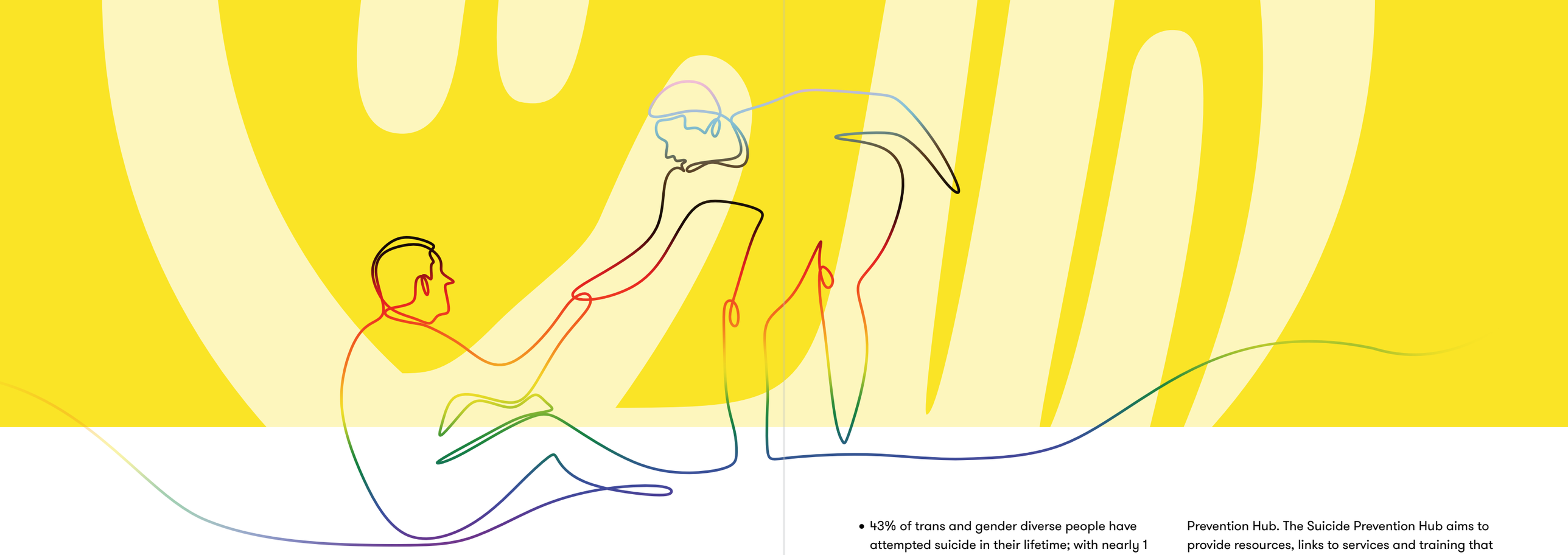


Executive summary

ACON has been funded by the NSW Government to support the Premier's Priority to reduce the suicide rate in NSW by 20 per cent by 2023. ACON will create a digital Suicide Prevention Hub to reduce suicidality and suicide attempts in sexuality and gender diverse communities in NSW.

This scoping review takes evidence from a range of sources: peer-reviewed literature, grey literature, program evaluations of existing programs, an environmental scan, consultations with people with lived and living experience of suicidality, and government frameworks. The evidence provided in this scoping review will inform the codesign and creation of the digital Suicide Prevention Hub for our communities.

The need for this project

LGBTQ+ people experience higher rates of mental illness, mental distress, suicidality, planning, and suicide attempts than the general Australian population

- around 1 in 20 LGBTQ+ people will have attempted suicide in the past 12 months
- around 1 in 3 LGBTQ+ people will have attempted suicide in their lifetime.

Risk factors look different for individuals with intersecting marginalised lived experiences.

- Aboriginal and Torres Strait Islanders experience suicidality at higher rates than the general Australian population, compounding minority stressors and risk factors for LGBTQ+ Indigenous people
- 43% of trans and gender diverse people have attempted suicide in their lifetime; with nearly 1 in 10 attempting suicide in the past 12-months.
- around 50% of LGBTQ+ people living with disability or long-term health conditions have attempted suicide in their lifetime.

Our communities also experience significant barriers and limitations to support. The complexity of navigating the healthcare system when in crisis can be overwhelming. Cultural safety and competency within suicide support services is another challenge for LGBTQ+ people. Adequate resources and training are needed for workers across suicide services (crisis, post support, and postvention) when working with LGBTQ+ individuals.

A sense of belonging, being accepted by community, and connection to culture are all common protective factors for LGBTQ+ people experiencing suicidality. Part of the second phase of this program of work will codesign and develop peer-led community workshops and activities that specifically aim to strengthen these protective factors for LGBTQ+ people.

ACON will address specific needs of the community in its co-design and delivery of the Suicide Prevention Hub. The Suicide Prevention Hub aims to provide resources, links to services and training that includes:

- Targeted resources for identifying mental health distress and risk of suicide in individuals or peers/ loved ones.
- Services listings for suicide support services – crisis, aftercare, and postvention.
- Peer/bystander guides for how to best support someone at risk.
- Tips for navigating inclusive health services as a LGBTQ+ community member.
- Videos and blogs of community's stories.
- Safety and self-management plans/skills.
- Supporting health professionals to have low-cost access to the RACGP Accredited 'LGBTQ Inclusive Practice Suicide Prevention' eLearning and the 'Trans Vitality Trans-Affirming Practice' eLearning.
- Link to other evidence-based training including 'Recognise and Respond', the Black Dog Institute's online gatekeeper training.

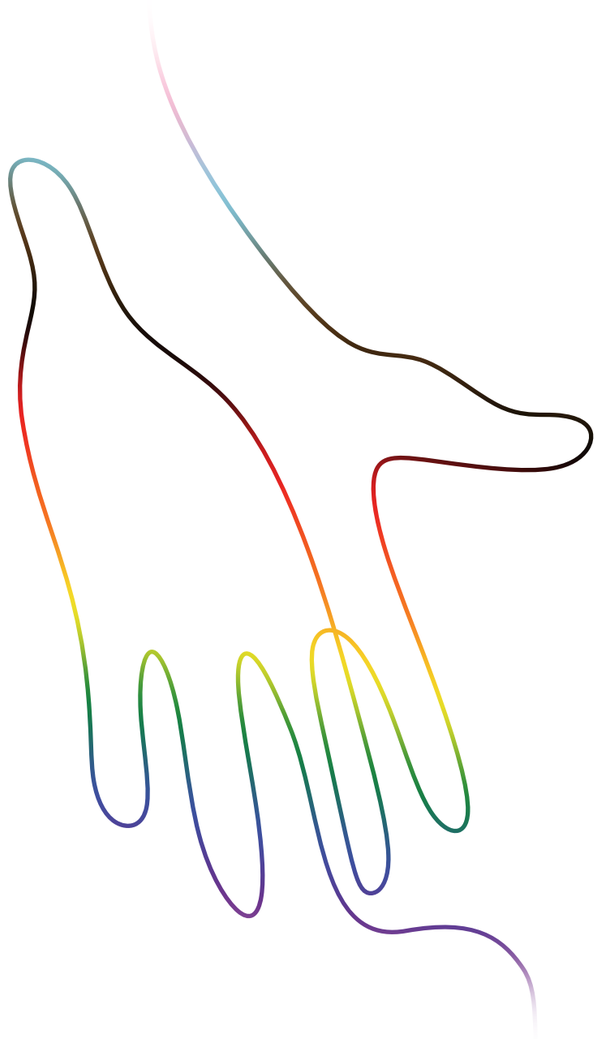
Introduction

In Australia, suicide is the leading cause of death for people aged 15-44, and in NSW deaths by suicide can be more than double the yearly road toll. In 2020, 876 people died by suicide in NSW alone (AIHW, 2022). LGBTQ+ people in Australia are between 3 to 19 times more likely to attempt suicide or self-injury than the general Australian population, and experience suicidal ideation at even higher rates (Melvin et al., 2020).

Suicide Prevention is a NSW Premier's Priority that aims to reduce the suicide rate by 20% by 2023. For LGBTQ+ people, having access to targeted and inclusive resources and services contributes to developing positive mental wellbeing and protection against suicide. To promote these resources, ACON will create a digital Suicide Prevention Hub, which will compile existing and emerging information about suicide and mental health for the LGBTQ+ community.

This scoping review will examine the current literature on mental health and suicidality and present the disparities of suicidality between LGBTQ+ individuals and the general population. The review will also consider the intersectional needs within the community, outlining the risk and protective factors for the broader LGBTQ+ community, and specific factors for Aboriginal and Torres Strait Islander communities, with focus on Sistergirls and Brotherboys and other trans mob, the trans and gender diverse communities, people living with disability or long-term health conditions, and people from culturally, ethnically, and linguistically diverse backgrounds.

The review will include a scoping of crisis support services already available and specific services available to the above communities, as well as a brief of preliminary findings from the first consultations and co-design plans with the Rainbow Mental Health Lived Experience Network. Finally, it will present the considerations for the Suicide Prevention Hub.



Mapping the landscape of language and approaches

Definitions

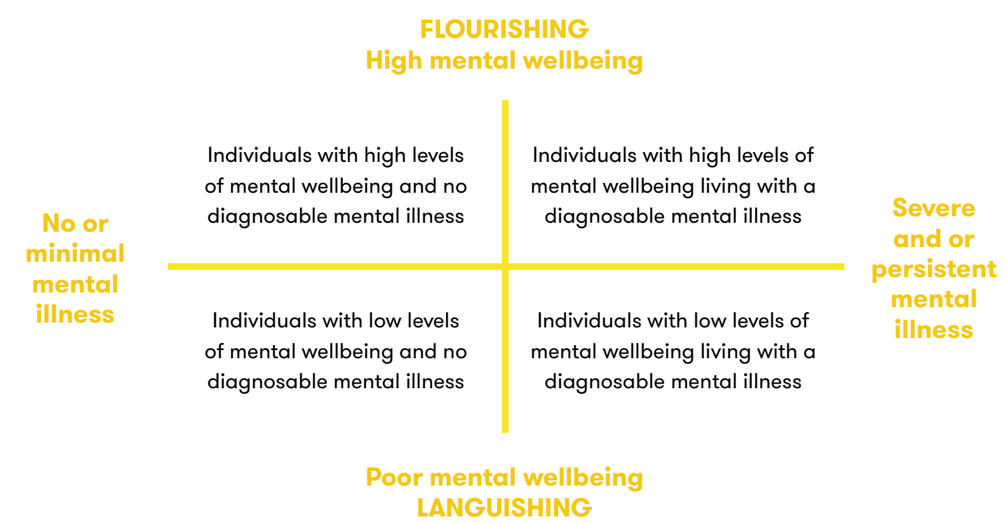
The World Health Organization defines mental health as a state of wellbeing that enables people to cope with stress, reach their potential, and live a meaningful, fulfilling life (World Health Organization and Calouste Gulbenkian Foundation, 2014). A mental health condition is commonly defined as a health problem that significantly affects how a person thinks, feels, or behaves (Manderscheid et al., 2009). Prevention and early help for signs of psychological distress aim to prevent progression, duration, and severity of mental health conditions.

Mental Wellbeing and Mental Illness

'Mental wellbeing' and 'mental illness' are not a part of the same continuum, but can be measured independently and in relation to each other (see Figure 1). A person's mental wellbeing is the extent to which they feel positive and hopeful about their own life, their ability to manage behaviours, feelings, and stress, and the development of critical self-reflection and autonomy (Manderscheid et al., 2009).

FIGURE 1

Dual-continuum model of mental health and wellbeing[1]



[1] Adapted from Tudor, 1996 in Jay et al., (2017) in Elmes, et al., (2021).

The dual continuum shows the distinct and separate concepts of mental health and mental illness (Elmes et al., 2021). Flourishing may also be known as spiritual, cultural, social, physical, psychological, or emotional wellbeing. Flourishing is not necessarily a constant state of being, but rather like a flower opening and closing with the patterns of the sun, people can move in and out of this experience. It is possible to experience high mental wellbeing but also experience the impacts of a diagnosable mental health illness (Elmes et al., 2021). For people from sexuality and gender diverse communities, feelings and experiences of pride and gender euphoria could be likened to flourishing.

Mental illnesses are physiological conditions that impact a person's cognition, emotion, and behaviour (Manderscheid et al., 2009). These are usually diagnosable (such as, depression, anxiety, ADHD) and can be managed with clinical treatments. Together, mental wellbeing and mental illness form a picture of a person's mental health and can influence physical health and body regulation. Mental health is also affected by social determinants of health, like income, housing, early childhood experiences, social exclusion, education level, sanitation, social support, discrimination, mental illness stigma, and access to resources (Manderscheid et al., 2009). Minority populations can often experience negative determinants putting them at greater risk of developing mental illnesses and low mental wellbeing, which, in turn, may lead to suicidality.

Suicidality

'Suicidality' refers not only to attempts and completion of suicide, but to suicidal ideation and planning, too (Johnston, Pirkis, & Burgess, 2009). Suicidal ideation is not always a measure of how likely a person is to attempt suicide, and there is no typical person prone to suicide, nor typical suicidal thoughts and ideations (Harmer et al., 2022).

While the majority of people who experience suicidal ideation will not attempt suicide, most who do will have had suicidal thoughts. These thoughts will vary in intensity over time, from a passive desire to fall asleep and never wake up to actively planning ways to end one's life.

People with poor mental wellbeing impacted by negative social determinants of health are more at risk of suicidality, however it is important to emphasise the heterogeneity of factors that lead to suicidality. The Interpersonal-Psychological Theory of Suicidal Behaviour (IPTS) was developed to uncouple suicidality from mental illness. It presents two key interpersonal factors that impact suicidal ideation: Thwarted Belongingness (TB) and Perceived Burdensomeness (PB) (Batterham et al., 2018, p97).

These are multidimensional constructs of feelings of social isolation and/or being a burden and are informed by barriers to interpersonal connection in a person's life. TB includes loneliness and an absence of reciprocally caring relationships, whether actual, or interpreted through a cognitive bias towards rejection (Van Orden et al., 2010, p582). PB can be developed through experiences of family conflict, unemployment, and physical illness, and can be observed as low self-esteem, self-blame and shame, and mental anguish that can manifest physiologically (Van Orden et al., 2010, pp583–584). These cognitive states fluctuate over time and during triggering life events, but when combined with feelings of hopelessness, the risk of serious thoughts of suicidal action increases.

Risk assessment of suicidality must therefore extend to individuals without any known mental illness – not just those with a history of suicidal ideation – as a way of promoting mental health and wellbeing overall, and a tool for prevention (Harmer et al., 2022).

Situational Distress

The term "situational distress" is a relatively recent addition to suicide prevention literature. A situational approach to suicide prevention acknowledges the contextual, systemic and socio-cultural determinants and risks present in a person's life that could impact their suicidality (Ashfield et al., 2017, p6). This approach de-emphasises mental illness in assessments of suicidality to broaden the lens in prevention and reduce the harm of deficit language in mental illness diagnoses. The hub will use "situational distress" in place of "social determinants" for clarity of meaning and to use suicide-specific terminology.

Reviewing the evidence

LGBTQ+ people experience higher rates of mental illness, mental distress, suicidal ideation, and suicide attempts than the general Australian population (Hill, et al, 2020). People from sexuality and gender diverse communities experience a range of diagnosed and treated mental health conditions, however, LGBTQ+ people are not homogenous in our experiences of mental wellbeing.

In the same study, trans people (binary and non-binary) experienced higher recent and lifetime experiences of suicidal ideation compared with their cisgender peers. Pansexual, bi+, queer, and asexual participants experienced higher recent and lifetime suicidal ideation when compared to lesbian and gay participants.

One in twenty participants reported having attempted suicide in the past 12 months, ten times higher than reported among the general Australian population. Over one in three reported having ever attempted suicide at some point during their lives, which is eight times higher than reported among the general Australian population (Johnston, Pirkis, & Burgess, 2009).

Suicidality in LGBTQ+ communities is correlated to poor mental wellbeing, however, not all people with poor mental wellbeing will experience suicidality. An individual's mental health can be impacted by social determinants such as an inherent predisposition to mental illness, homelessness and financial insecurity, minority stress based on race, culture, sexuality, or gender, a person's life stage, adverse life events, and more recently experiences of ill health and wellbeing due to COVID-19 (Melvin et al., 2020). For LGBTQ+ individuals, a prevalence of suicidality narratives in literature and on screen has also created a "*cultural logic of suicide*" as a solution to adversity (Cover, 2021, p366).

For trans communities, there are additional considerations for social determinants of mental health and wellbeing, such as discrimination and stigmatisation, and denial of healthcare (Drabish & Theeke, 2022). These have an effect on the higher rates of suicidality among these individuals. Access to gender affirming care and early adopting of gender affirming treatments have been found to reduce the psychological distress that can influence suicidality (Almazan & Keuroghlian, 2021, p612; Tordoff et al., 2022, p2; Turban et al., 2021, p2).

Aboriginal and Torres Strait Islander individuals who are LGBTQ+ have a similarly greater risk of suicidality, with Sistergirls, Brotherboys and trans mob especially at risk (Curtis et al., 2021, p4). Factors such as intergenerational trauma, family displacement, institutional and casual racism, and overrepresentation in custodial settings, are influenced by trauma and racism for these communities and contributes to poor mental wellbeing outcomes (Dudgeon & Holland, 2018, p167).

More than 90% of LGBTQ+ individuals living with severe disability or long-term health conditions reported ever experiencing suicidal ideation, while half of those individuals reported having attempted suicide (Hill et al, 2020). Individuals with mild to moderate disability or long-term health conditions still reported higher frequencies of ideation and action than LGBTQ+ individuals with no disability or long-term health conditions, and the general Australian population.

Due to the specific and intersecting needs of our communities, barriers to care from Crisis Support Services (CSSs) have been reported. Mainstream CSSs are limited in their familiarity with LGBTQ+ concepts and ability to provide support for issues specific to people from sexuality and gender diverse communities (Cronin et al., 2021). Even LGBTQ+ CSSs are limited in their ability to provide specific support for culturally, ethnically and linguistically diverse individuals, and those with religious needs (Waling et al., 2019).

Population data on suicide and mental health among LGBTQ+ people

The data in this section come from the Private Lives 3 study, Australia's largest national survey of the health and wellbeing of lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ) people to date. It was conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University and published in 2020. One of the benefits of using these data is the ability to make comparisons between different parts of our communities, and the cohort against the general Australian population.

Psychological stress (K10), diagnosed or treated mental health conditions, and suicidality

LGBTQ+ people experience higher rates of mental illness, mental health distress, suicidal ideation, and suicide attempts than the general Australian population (Private Lives 3).

Psychological distress

Participants in Private Lives 3 reported experiencing significantly higher rates of psychological distress (measured using a K10 score) when compared to the general Australian population, as seen in Figure 2.

Mental health conditions

People from sexuality and gender diverse communities experience a range of diagnosed and treated mental health conditions.

Depression and generalised anxiety disorder

LGBTQ+ people are not homogenous in our experiences of mental wellbeing. Below we show the differences between depression and anxiety of the Private Live 3 sample, by gender (figure 2), and by sexuality diversity (figure 3)

FIGURE 2

Proportion of participants experiencing low, moderate, high, or very high psychological distress (K10) (n=6,676)

TABLE 1

Ever diagnosed with one or more mental health conditions and diagnosed or treated in the past 12 months (n=6,554) by prevalence rates, and among the general Australian population in the past 12 months

	Private Lives 3		General Australian population
	Ever	Past 12 months	Past 12 months
Condition	%	%	%
Depression	60.5	39.1	4.1
Generalised anxiety disorder	47.2	33.4	2.7
Post-traumatic stress disorder	18.2	11.1	6.4
Eating disorder	10.5	3.3	–
Social phobia	7.9	4.0	4.7
Panic disorder	7.7	4.4	2.6
Obsessive-compulsive disorder	6.1	3.1	1.9
Bipolar disorder	5.7	3.7	1.8
Agoraphobia	2.2	1.0	2.8
Schizophrenia	0.9	0.5	nd
Other mental health challenge	13.3	9.3	nd
Any of the above	73.2	51.9	4.1

FIGURE 3

Diagnosed or treated for depression or generalised anxiety disorder in the past 12 months by gender (n=6,502)

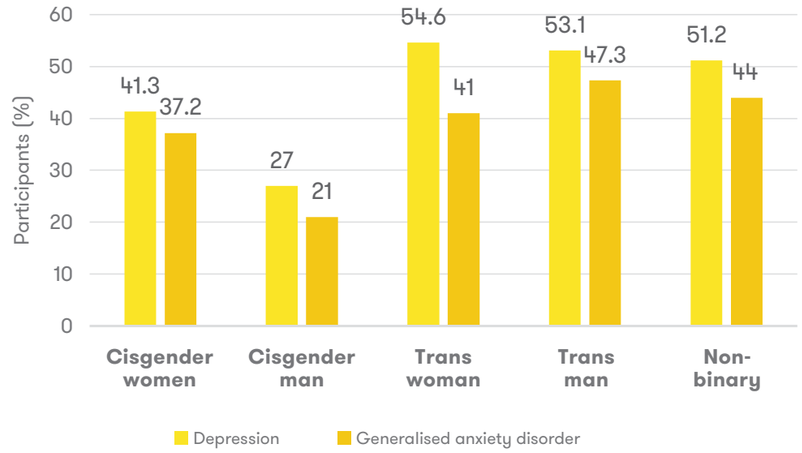


FIGURE 4

Diagnosed or treated depression or generalised anxiety disorder in the past 12 months by sexuality diversity (n=6,537)

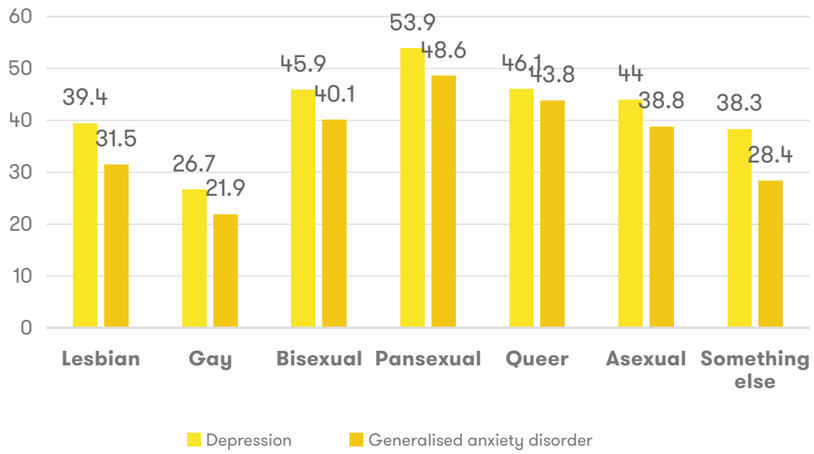
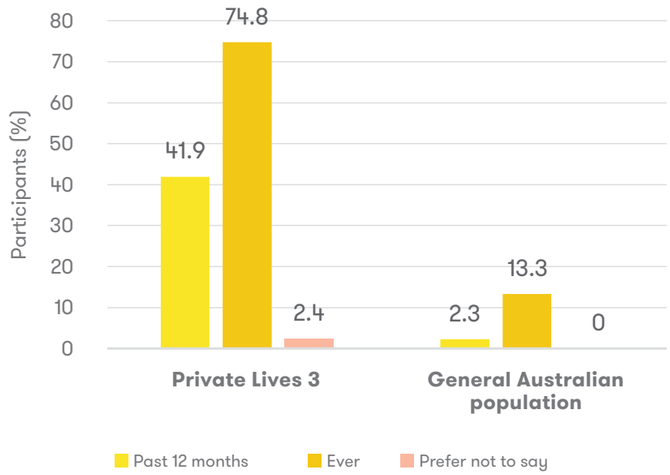


FIGURE 5

Suicidality(n=6,799) in the past 12 months and ever among PL3 participants and the general Australian population



Suicidality

Over one in four participants in Private Lives 3 reported that they had experienced suicidality in the previous 12 months, almost twenty times higher than the general Australian population (Hill, et al, 2020). Almost three-quarters reported having ever experienced suicidality at some point during their lives, which is more than five times higher than reported among the general Australian population (Johnson, Pirkis, & Burgess, 2009).

It is important to reiterate the critical distinction between suicidality and suicide attempt. We still do not know for whom or when suicidality will lead to an attempt – no single precedent for suicide attempts has been recognised in individuals who experience ideation (Klonsky, Dixon-Luinenburg, & May, 2021).

Figure 6 shows participants reported experiences of suicidality from Private Lives 3 (Hill, et al, 2020) by sexuality diversity. Pansexual, bi+, queer, and asexual participants experienced higher recent and lifetime suicidality when compared to lesbian and gay participants.

Suicide attempts

One in twenty reported having attempted suicide in the past 12 months, ten times higher than reported among the general Australian population (Johnson, Pirkis, & Burgess, 2009). Over one in three reported having ever attempted suicide at some point during their lives, which is eight times higher than reported among the general Australian population (Johnson, Pirkis, & Burgess, 2009).

Figure 8 shows participants reported experiences of suicide attempt from Private Lives 3 (Hill, et al, 2020) by sexuality diversity. Pansexual, bi+, queer, participants experienced higher recent and lifetime suicide attempt when compared to lesbian, gay, and asexual participants.

FIGURE 6

Suicidality in the past 12 months and ever by sexuality diversity (n=6,779)

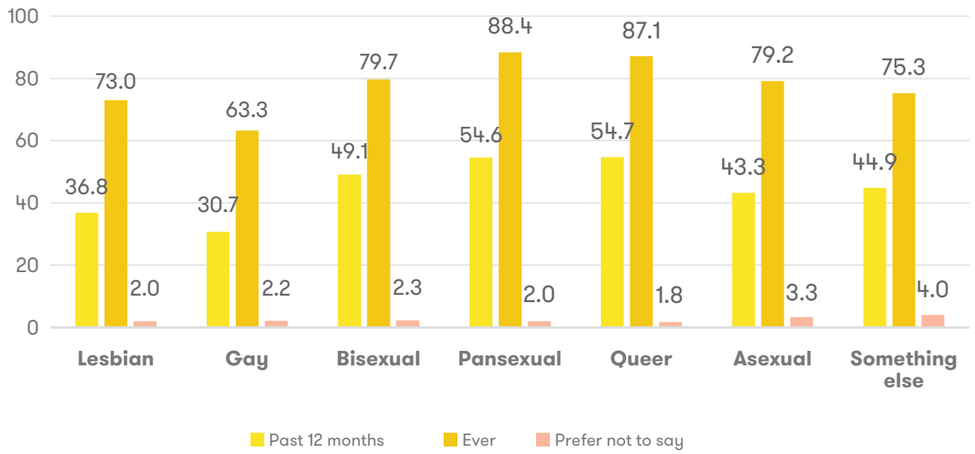


FIGURE 7

Suicide attempts (n=5,306) in the past 12 months and ever among PL3 participants and the general Australian population

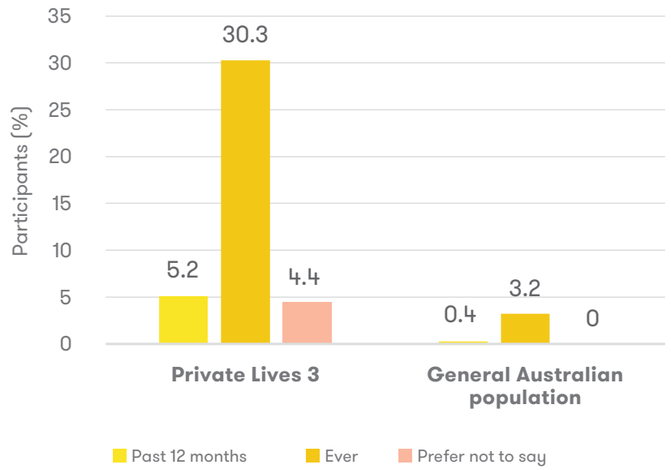
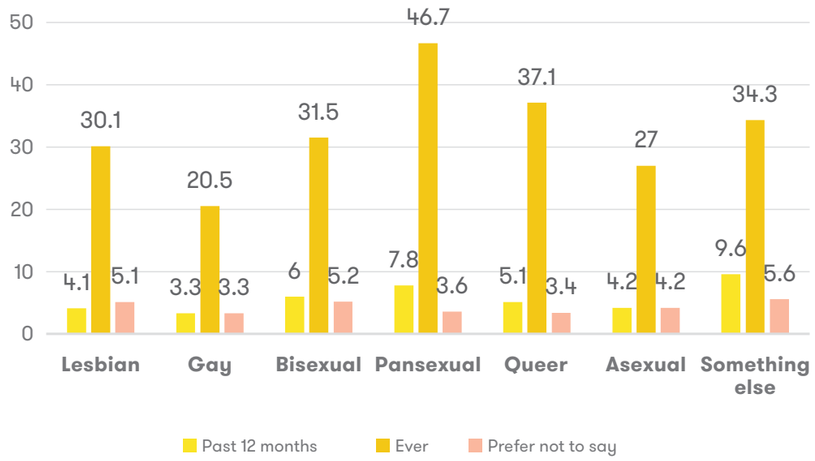


FIGURE8

Suicide attempts in the past 12 months and ever by sexuality diversity (n=5,291)



Risk and protective factors

There are a range of factors that may increase a person's risk of poor mental wellbeing, mental health illness, and/or experiencing suicidality. Conversely, evidence shows us there are a range of protective factors that may reduce or prevent poor mental wellbeing and suicidality. Some risk and protective factors are common across the general Australian population, while other risk and protective factors are specific to people from sexuality and gender diverse communities, the experience of intersecting identities, and belonging. Importantly, risk and protective factors focus on associations with mental health, rather than show a causal relationship (CPHAC, 2000). The tables below indicate the protective and risk factors of suicidality for the general population:

TABLE 3

Protective and risk factors (community and cultural) for mental health for the general Australian population

Community and cultural factors	
Protective factors	Risk factors
• sense of connectedness • attachment to and networks within the community • participation in community or religious/faith groups • strong cultural identity and ethnic pride • access to support services • community/cultural norms against violence	• socioeconomic disadvantage • social or cultural discrimination • isolation • neighbourhood violence and crime • population density and housing conditions • lack of support services including transport, shopping, recreational facilities

TABLE 4

Protective and risk factors (life events and situations) for mental health for the general Australian population

Life events and situations	
Protective factors	Risk factors
• involvement with a significant other person (partner/mentor) • availability of opportunities at critical turning points or major life transitions • economic security • good physical health	• physical, sexual, and emotional abuse • school and work transitions • divorce and family breakup • death of family member • physical illness / impairment • unemployment, underemployment, homelessness • incarceration • poverty / economic insecurity • unsatisfactory workplace relationships • workplace accident/injury • caring for someone with an illness/disability • living in a nursing home or aged care hostel • war or natural disasters

Characteristics associated with suicidality and suicide attempt among LGBTQ+ people

An analysis of Private Lives 3 participants was undertaken looking at the association between suicidal ideation and suicide attempt (recent and lifetime) and certain characteristics of the cohort (logistic regression analysis – univariate and multivariate). Trans (Hill, et all, submission under review) and cis (Lyons, et al, 2022) participants were disaggregated and analysed separately, recognising the higher rates of suicidal ideation and suicide attempt among trans people compared with their LGBQ+ cis peers.

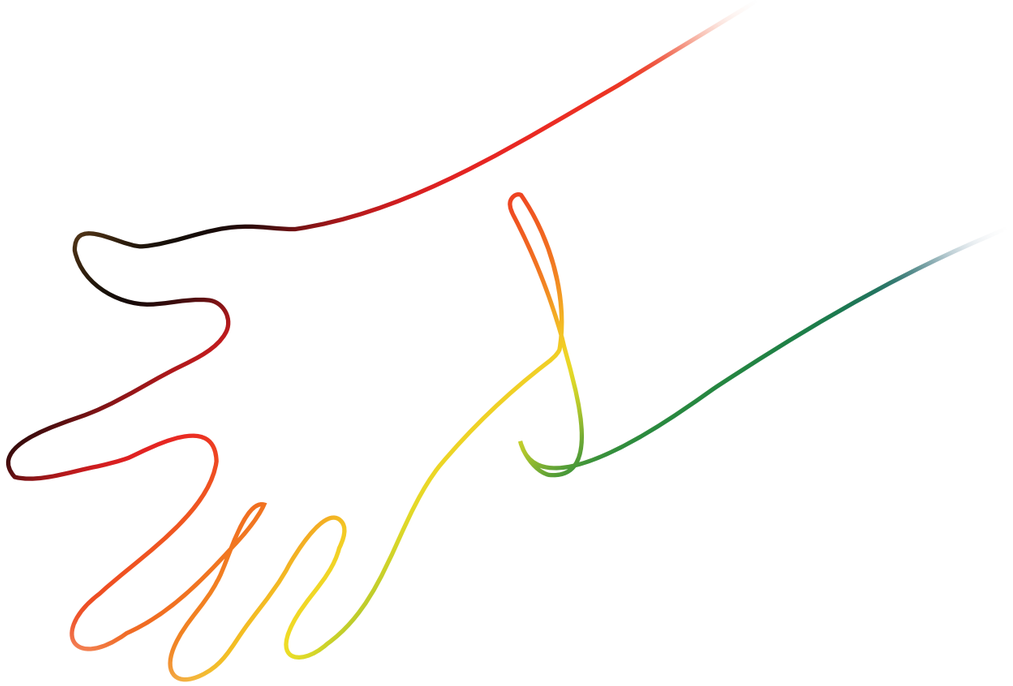
Trans people in Private Lives 3

For trans participants of all sexualities, reporting suicidality in the past 12-months, there were:

- Significantly higher adjusted odds of reporting recent suicide attempt for people who reported sexual harassment or assault based on their sexuality or gender in the past 12-months.
- Significantly lower adjusted odds of reporting recent suicide attempt for people who were older than 18-24 years, and for non-binary participants compared to trans men.

For trans participants of all sexualities, reporting suicide attempt in the past 12-months, there were:

- Significantly higher adjusted odds of reporting recent suicidality for people who felt they have been treated unfairly due to their gender in the past 12-months.
- Significantly lower adjusted odds of reporting recent suicidality for people who had a university degree, were older than 18-24 years, felt accepted at work, or with family members, or felt their gender was very/extremely respected when accessing a mainstream medical clinic in the past 12-months.



Cis LGBQ+ people in Private Lives 3

For cis LGBQ+ participants reporting suicidality in the past 12 months, there were:

- Significantly higher adjusted odds of reporting recent suicidality for queer and bisexual participants compared with gay participants and for participants who felt they had been treated unfairly or socially excluded due to their sexuality in the past 12 months.
- Significantly lower adjusted odds of reporting recent suicidality were found for participants who had a postgraduate degree, were born outside of Australia, were in committed romantic relationships, and who agreed/strongly agreed they felt a part of the Australian LGBTQ community. In addition, being aged 55 an older (compared to aged 18 to 24), and those who reported feeling accepted at work, with family members, or when accessing a health or support service had significantly lower odds of reporting suicidal ideation in the past 12 months.

For cis participants reporting suicide attempt in the past 12 months, there were:

- Statistical higher odds of reporting suicide attempt for participants who reported feeling socially excluded or had experienced verbal abuse due to their sexuality.
- Statistically lower odds of reporting suicide attempt among participants who were aged 24 years or older (compared to aged) 18 to 24, were in a committed romantic relationship, agreed/strongly agreed that they feel part of the Australian LGBTQ community, and who had not accessed a health or support service in the past 12 months.[2]
- While there was a significant higher odds of suicide attempt for those who reported living rurally on the univariate analysis, the significant effect was not found in the multivariate analysis. That said, other evidence suggests people living rurally experience greater stressors in relation to their sexuality when compared to their peers living in inner or suburban cities, with these stressors a potential risk factor for both mental health distress and suicidality (Morandini et al., 2015).

[2] The authors note this could be interpreted as people who have experienced suicide attempt access health services after the event or individuals are functioning at a high level who do not require access to health services or are highly engaged in alternative forms of help-seeking behaviour.

Aboriginal and Torres Strait Islander perspectives

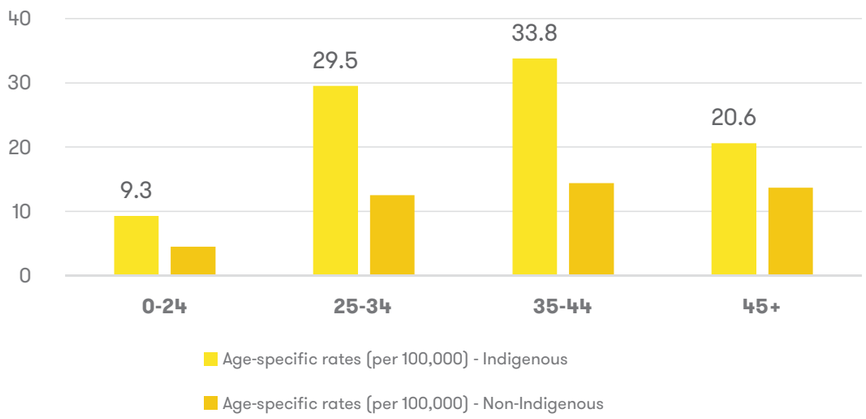
ACON acknowledges the ongoing high rates of suicidality and the impact of this on Aboriginal and Torres Strait Islander Peoples, communities and country. European invasion and the subsequent genocide of First Nations Peoples, as well as the ongoing impacts of colonialism contribute to suicidality among this population (Dudgeon et al., 2022). For LGBTQ+ Aboriginal and Torres Strait Islander Peoples, including Sistergirls, Brotherboys, and trans mob, the risks of suicidality are notably higher than for non-Indigenous LGBTQ+ people, and the general population.

ACON acknowledges that Aboriginal and Torres Strait Islander Peoples are the oldest living continuous cultures on Earth, sustaining those communities for tens of thousands of years, and remain a source of pride, strength, and wellbeing in the present, as outlined by the *Gayaa Dhuwi* (Proud Spirit) Declaration from the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) group (2015).

The concepts of this touchstone text are used throughout research and guidelines for Indigenous social and emotional wellbeing, mental health, and suicide prevention. We also acknowledge Outcome 14 in the National Agreement on Closing the Gap (2020, p38) that *"Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing"* and Target 14 for *"Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero"*.

FIGURE 11

Figure 11 Suicide deaths by Indigenous status & age groups in NSW, 2016-2020 (ABS Causes of Death, Australia, 2021)



Research into suicidality and suicide among LGBTQ+ Aboriginal and Torres Strait Islander Peoples is new and evolving. A recent report – *Breaking the Silence* – based on data from focus group sessions with Indigenous LGBTQ+ community members and health care professionals in Western Australia produced an insightful framework for approaching Indigenous LGBTQ+ peoples mental health (Hill et al., 2021).

While LGBTQ+ Indigenous people feel pride in their identities, participants in the study often experienced heteronormativity, as well as racism from both queer and non-queer non-Indigenous people. 73% reported experiencing discrimination in the past 12 months, while 13% had experienced homelessness or housing insecurity because of their sexuality and/or gender identity. More than half of the participants felt little or no sense of connection to the LGBTQ+ community as Indigenous people, while a third felt invisible to the Indigenous community because of their sexuality and/or gender identity. From the report, broad policy changes to health practices were recommended, including proactive welcoming of Indigenous LGBTQ+ people to health and support services, better data collection of Indigenous LGBTQ+ experiences with services, and professional development training at all levels within an organisation on Indigenous LGBTQ+ needs (Hill et al., 2021).

Sistergirls, Brotherboys, and trans mob

While many Sistergirls, Brotherboys, and trans mob live affirmed, happy, and healthy lives, growing up and planning for their futures they can face barriers to education, work, making friends, building community, and starting relationships. They are highly vulnerable when accessing healthcare services due to racial and gender-based discrimination, over-policing, and incarceration, and further minoritised when accessing medical and legal gender affirmation, including confirmation of Aboriginality (Kennedy, 2021; Uink et al., 2022).

At the intersection of the higher rates of suicidality for trans people and Indigenous people (twice the death rate of non-Indigenous), Sistergirls, Brotherboys, and trans mob face more marginalising factors than almost any other group in Australia. There are some risk factors unique to Sistergirls, Brotherboys, and trans mob but others that are a universal experience among Indigenous Australians. Isolation from family, culture and country can exacerbate these experiences, which impact the individual's perception of self and the safety of their relationships (Curtis et al., 2021). COVID-19 has also impacted community members' ability to have face-to-face yarning sessions, experiencing closed services and community centres (Follent et al., 2021). Lockdowns made it difficult to find personal space between work and home, as well as ongoing employment, managing mental ill-health and substance use, and accessing culturally safe services. Living in unsafe places during this time also made decision-making about housing and accommodation difficult, especially if they had been homeless before. (Curtis et al., 2021).

Yarn it Up

Yarn it Up is an ACON Trans Health Equity project delivered in 2021 and 2022, in collaboration with Sistergirls and Brotherboys Australia, ACON's Aboriginal Project and BlaQ Aboriginal Corporation. It enabled Sistergirls, Brotherboys and trans mob in NSW and across Australia to connect and come together for a series of four themed virtual yarning circles. These focussed on storytelling, strengthening kinship, cultural and spiritual connections, and supporting a resilient community.

Recommendations from the Yarn it Up report include ongoing consultation with Sistergirls, Brotherboys, and trans mob, collection and distribution of information and data about community experiences and identities in affirming ways, expanding yarns beyond NSW, virtually and in-person, expanding topics and functions of yarns to include families and allies, and establishing platforms, workshops, and training across services for Sistergirls, Brotherboys, and trans mob in NSW and Australia. Moreover, regional, and remote areas need more support to provide Sistergirls, Brotherboys, and trans mob with culturally competent care (Curtis et al., 2021).

TABLE 7

Protective and risk factors for LGBTQ+ Aboriginal and Torres Strait Islanders

Protective and risk factors	
Protective factors	Risk factors
• access to gender affirming care • regional and remote culturally competent services for Sistergirls, Brotherboys and Trans mob • peer support for Sistergirls, Brotherboys and Trans mob • connections to culture and Elders • connections to LGBTQ-friendly family and community • provision of skills programs • access to education and training • access to housing and transport	• effects of colonisation • forced assimilation practices • intergenerational trauma • family separation and negative experiences in out-of-home care • racism, discrimination, stigmatisation, marginalisation • alcohol and other drugs harms • exposure to deaths by suicide in community • experiences of homelessness • experiences of the justice and carceral systems • unemployment • bereavement including loss and grief

Risk and protective factors

To strengthen social and emotional wellbeing for Aboriginal and Torres Strait Islander Peoples as part of suicide prevention, the role of culture has been emphasised. Physical and mental health depends on positive connections of the self to body, mind and emotions, family and kin, community, culture, country, ancestors and the "spiritual dimension of existence" (Cox et al., 2014, p345). Connecting young people with Elders, possibly through ceremonies, is important, and for those living on country away from cities, remote living can be beneficial to practicing self-determination (Cox et al., 2014, p345).

Protective strategies summarised include:

- For individuals: restore and strengthen connections to culture, family, and community. There should be a focus on young people and on individual health, and provision of life skill programs, such as communication, self-esteem, mentors, and role models.
- For families: shared activities to restore a sense of community, access to education/training, life skills programs (communication, dealing with conflict, healthy lifestyle), and access to transport.
- For communities: focus on youth (provide activities, drop-in centres, camps, connect to elders, health promotion and education sessions, parenting programs, restore sporting competitions), shared activities (hosting community events, such as fun days, competitions, projects), self-determination, men's and women's groups, and provide access to employment, education, housing and transport

Trans lives

Trans people (binary and non-binary) experience suicidality at a much higher rate than cis members of the LGBQ+ communities. Some studies report that on most measures of mental health, trans people have poorer outcomes, more so for those trans people who are also LGBQ (Rosenberg et al., 2021). In the Private Lives 3 sample, trans people experienced higher recent and lifetime experiences of suicidality compared with their cis peers.

Trans people reported experiencing higher recent and lifetime suicide attempt compared with their cis peers. In this cohort, trans men and non-binary participants presumed female at birth had higher odds of lifetime suicide ideation, while trans women and non-binary participants presumed male at birth had lower odds of lifetime suicide ideation, but still higher than cis participants in the Private Lives 3 data (Hill et al., 2020; Zwickl et al., 2021).

FIGURE 9

Suicidality in the past 12 months and ever by gender (n=6,747)

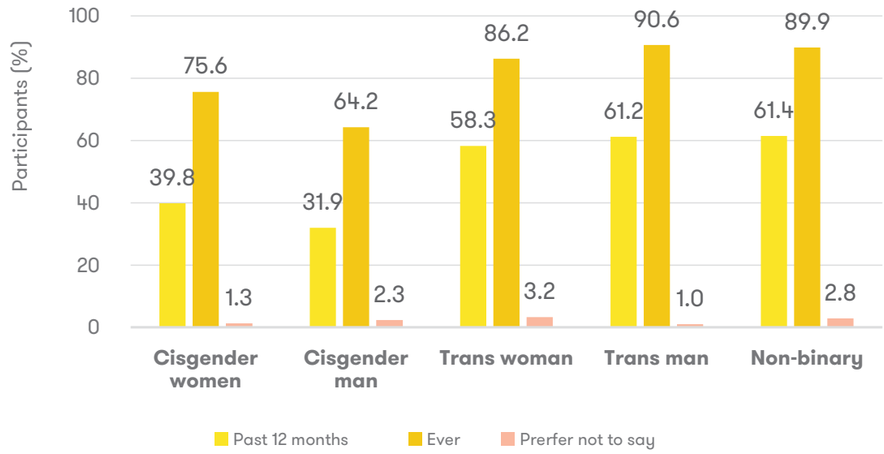
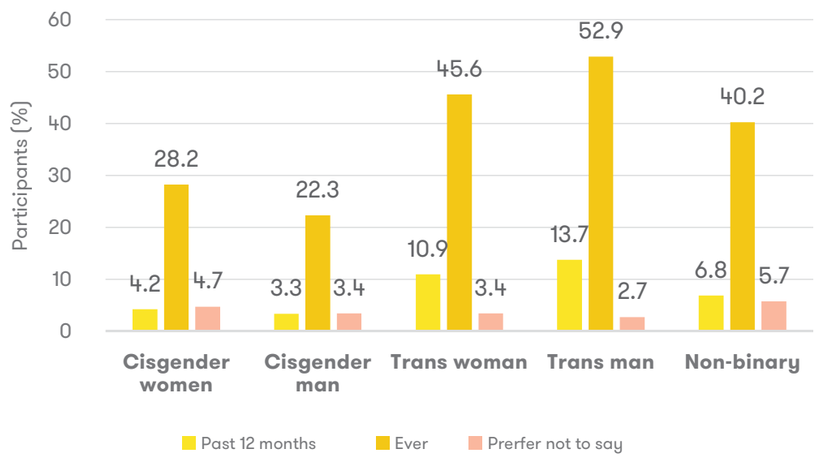


FIGURE 10

Suicide attempts in the past 12 months and ever by gender (n=5,263)



As with suicidality in the general population, : little is known about when and for whom suicidality becomes action. Trans people are a higher at risk of poorer mental health, and therefore suicidal ideation, due to quantifiable social determinants. These include minority stress, threats of violence and physical assault, gender-based violence (including verbal abuse), peer rejection, barriers to gender affirming healthcare, inability to get legal gender recognition without surgery, large gaps between the cost of gender affirming surgery and the Medicare reimbursement, and reduced access to housing, education, employment and healthcare due to cisgenderism (Zwickl et al., 2021; Rosenberg, et al, 2021a).

Institutional cisgenderism – the structural oppression that positions cisgender people as 'normal', 'natural' or 'superior', and enforces the 'correct' way to be a woman or a man – affects all aspects of the trans lived experience while also being a driver of the gender-based violence experienced by cis heterosexual women (Rainbow Health Victoria, 2020). Cisgenderism increasing the risk of violence, financial stress, and housing instability for trans people (Zwickl et al., 2021; Rosenberg, et al, 2021a). It can produce heightened feelings of shame, hopelessness, and isolation. It can also dehumanise, seen in the way in which trans people are spoken about in mainstream media, with news reports of trans suicides breaching guidelines to minimise imitative behaviour (Bolzern, Mnyama, & McMillan, 2019), a history of demonisation and under-representation in popular narratives (Feder, 2020), and by (Rainbow Health Victoria, 2020) misgendering and misnaming the trans person after they have died (Seely, 2021, p88).

Suicidality in the trans community occurs when structural, environmental, socio-political, and interpersonal risk factors interact. Ongoing dismantling of barriers to gender affirming healthcare and tackling institutionalised cisgenderism will reduce incidents of discrimination, stigmatisation, and violence. Shifting the discourse from inherent risks and deficits and applying a strengths-based approach to focus on trans strategies for resilience and trans-specific health needs will protect the community against suicidality (Zwickl et al., 2021, p8).

Gender affirmation and trans-affirming care

Recent studies have shown that trans people who have access to gender affirmation and are respected in health settings have lower risk of suicidality (Almazan & Keuroghlian, 2021, p612; Tordoff et al., 2022, p2; Turban et al., 2021, p2).

Gender affirming care relates to the personal process or processes a trans person determines is right for them in order to live as their defined gender and so that society recognises this. Gender affirmation may involve social, medical and/or legal steps (ACON, 2021).

Some gender affirming surgeries are available in Australia, and Medicare covers medical items to some degree. However, as these procedures are provided by a select number of private surgeons, largely due to state-based health system policies that ban access to public hospitals, the gap between the cost of the service and the Medicare rebate makes surgery unaffordable to most. The limited number of surgeons also influences accessibility and price (Rosenberg et al., 2021).

Studies show that trans people's psychological distress is reduced the sooner gender affirming treatments can be accessed. People who desired gender affirming surgery in the future, but could not access it in the past, had greater odds of reporting a lifetime history of suicide attempts (Zwickl et al., 2021, p5).

Trans-affirming practice relates to a culturally safe and informed provision of health services to trans people that is not directly related to gender affirmation. This includes the provision of affirming and non-judgmental allied and primary care, using chosen name and pronouns, using forms that reflect gender and delivering client-centred care.

Accessing Mainstream Services

Trans people report issues accessing healthcare services, stating stigmatising and discriminatory behaviour including transphobic language, incorrect pronouns, or deliberate misnaming and misgendering of service users (Rosenberg et al., 2021, p4). Other barriers to healthcare include a lack of trans-affirming services, cost of consultation and treatment, and mistrust of providers and health system in general. Trans people with a history of suicidality and self-harm are more likely to report feeling isolated from healthcare services (Rosenberg et al., 2021, p4).

While mainstream health services are the most frequently accessed by LGBTIQ people, they are the least accessed by trans people and are the least likely to respect service users' genders (Rosenberg et al., 2021, p6). While many trans people in distress seek help from any mental health service, they are more likely than their cis LGBQ peers to seek out LGBTQ+ specific mental health services, rather than mainstream services, this means all providers must be trained in trans-affirming practice, for linguistic and conceptual competency so that trans people can self-describe more accurately in healthcare contexts, such as the provision of trans-affirming intake forms (Hill et al., 2020; Zwickl et al., 2021).

Other community services, like those assisting in housing and homelessness, management of alcohol and other drug use, and intimate partner and family violence, all present barriers to accessibility as those described above. As these lived experiences contribute to the mental health and wellbeing of trans people, developing informed, affirming, and effective services will help reduce the risk of hopelessness, and therefore suicidality, in the community (Rosenberg et al., 2021, p5).

Risk and protective factors

The most up-to-date data on suicidality in trans communities revealed:

- In Australia, 43-44% of trans people self-reported lifetime suicide attempts (Zwickl et al., 2021, p5).
- In the last 12 months, 62.4% reported suicidal ideation and 9.5% reported suicide attempts (Hill et al., 2022, p2).
- Experiences of institutional cisgenderism increased risk of suicide (Zwickl et al., 2021, p2).
- Intersections with sexual identity, housing instability or homelessness, lower income or educational attainment, and living with a disability can compound suicidality in trans people (Hill et al., 2022, p4).
- Suicidal ideation higher for younger trans people due to social exclusion and unfair treatment because of their gender identity (Hill et al., 2022, p4).
- Young trans people who feel accepted among family and/or at work were one-third less likely to report suicidal ideation (Hill et al., 2022, p13).
- Higher education lowered suicidal ideation, possibly due to an environment more accepting of diverse genders (Hill et al., 2022, p13).
- Transphobic discourse related to gender affirmation and medical intervention in media and medical circles increases risk of distress, especially for young trans people (Hill et al., 2022, p13).
- Delayed or denied access to medical gender affirmation is linked to suicidality in trans people compared to those who receive timely and comprehensive treatment (Hill et al., 2022, p4).
- Greater likelihood of suicide attempts for young trans people who experience sexual harassment based on sexuality or gender identity (Hill et al., 2022, p2).
- Internalised transphobia, which correlates to perceived burdensomeness in the IPTS, is associated with higher lifetime suicide attempts (Snooks & McLaren, 2021, p1).
- Significantly higher odds of lifetime suicide attempt if diagnosed with depression (Zwickl et al, 2021, p7).
- Prejudiced physical assault increased odds of suicidality more than assault not linked to an individual's trans identity (Zwickl et al., 2021, p6).
- Unemployment in trans communities is 3 times higher than general population and increases the odds of lifetime suicide attempt by 55% (Zwickl et al., 2021, p6).
- Service denial in healthcare correlated with higher rates of attempted suicide (Zwickl et al., 2021, p6).

- Higher odds of lifetime attempted suicide for individuals desiring gender affirming surgery in the future (Zwickl et al., 2021, p5).
- Access to gender affirming hormone therapy (GAHT) in adulthood was associated with greater odds of lifetime suicidality (ideation and attempts), but not in the past year (Turban et al., 2022, p9).
- Access to puberty blockers and/or gender affirming hormones in adolescence significantly reduced suicide ideation (Tordoff et al., 2022, p2).
- Trans non-binary children who had socially affirmed their gender only did not have increased rates of depression but did have higher rates of anxiety symptoms (Tordoff et al., 2022, p9).
- Univariate analysis showed no significant difference in the proportion of suicide between states of residence, nor increased risks for those living in rural areas (Zwickl et al., 2021, p5).

TABLE 6

Protective and risk factors for trans and gender diverse Australians[3]

Protective and risk factors	
Protective factors	Risk factors
• access to gender affirming healthcare at a younger age • supportive environments for social affirmation • use of inclusive language at work • inclusive healthcare and other services, including trans- and nonbinary-informed intake forms • free, accessible, local, depathologising, and affirming community-led, strengths-based services • community outreach • education programs for families, workplaces, medical and allied health providers • education campaigns addressing transphobia and promoting affirmative representation in news and media • trans people are a distinct priority population across federal, state, and territory policy frameworks • family and peer support • pride in identity	• institutional cisgenderism • anxiety and depression risk from social determinants of health • discrimination and stigmatisation • minority stress • intersectional needs • social isolation • unemployment • barriers to gender affirming puberty blockers, hormones and surgery • service denial • untrained service providers • sexual violence • physical assault • internalised transphobia • disconnection from peers and community

[3] (Hill et al., 2022; Mental Health Commission of New South Wales, 2020; Perales et al., 2022; Snooks & McLaren, 2021; Tan et al., 2021; Tordoff et al., 2022; Turban et al., 2022)

LGBTQ+ people with a disability or long-term health condition

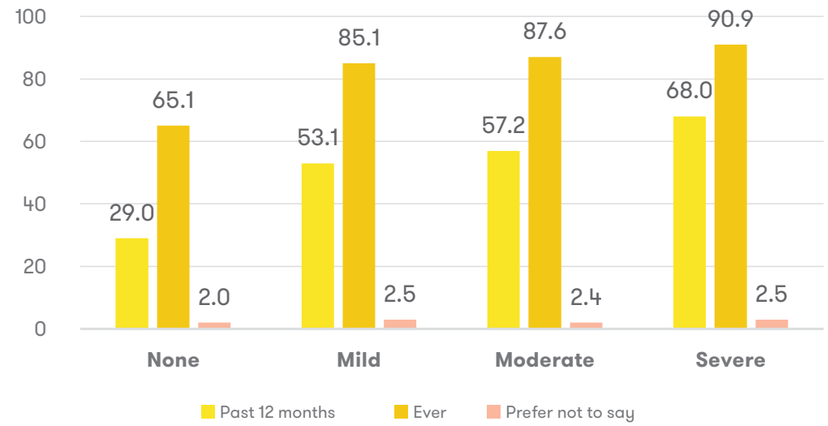
Fewer studies have been made on the LGBTQ+ people living with a disability or long-term health condition, let alone the connections between disability and suicide in Australia's LGBTQ+ populations (Leonard & Mann, 2018). Data gathered from Private Lives 3 gives the only available snapshot of suicidality among these populations, and it is important to indicate the intersections individuals living with disability have with race, gender diversity, and cultural background that are not quantified in the study. At a glance, mild to severe disability or long-term health conditions impact suicidality considerably.

According to Private Lives 3, almost four in ten LGBTQ+ participants claimed to live with a disability or long-term health condition, and one in ten reported a profound or severe disability (Hill et al., 2020). The data finds that just over half of the cohort felt a sense of belonging to the LGBTQ+ community, while fewer than half felt accepted on LGBTQ+ dating apps and using health and support services, and concerningly low numbers feel acceptance in mainstream institutions, events, and venues. Four in five people living with disability or long-term health condition reported high or very high psychological distress (Hill et al., 2020).

LGBTQ+ individuals living with mild to severe disability or long-term health conditions reported higher recent and lifetime suicidal ideation than those participants who reported no disability or long-term health condition.

FIGURE 12

Suicidal ideation by disability or long-term health condition (n=6,499)



LGBTQ+ individuals living with mild to severe disability or long-term health conditions also reported higher recent and lifetime suicide attempts than participants who reported no disability or long-term health condition.

Risk and protective factors

There are limited data on the risk and protective factors for disabled people from sexuality and gender diverse communities. Based on the risk factors of suicide ideation presented by the Interpersonal-Psychological Theory of Suicide, Thwarted Belongingness (TB) and Perceived Burdensomeness (PB), we can make our own correlations to suicidality among people living with disability and long-term health conditions.

FIGURE 13

Suicide attempt by disability or long-term health condition (n=5,043)

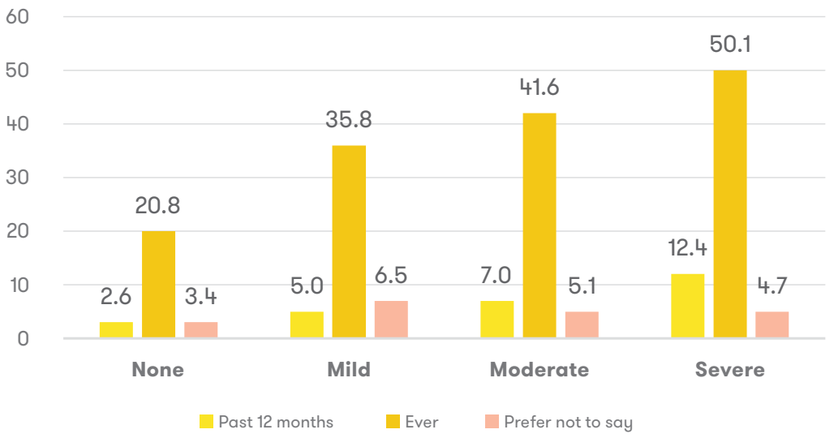


TABLE 8

Protective and risk factors for LGBTQ+ people living with disability or long-term health condition

Protective and risk factors	
Protective factors	Risk factors
• inclusive and affirming mainstream health services • accessible LGBTQ+ health services • targeted campaigns for community inclusion • inclusive and affirming support services for accessing the NDIS • inclusive and affirming support for carers	• ableism • isolation • lack of support services including transport, shopping, recreational facilities • physical, sexual, and emotional abuse • unemployment, underemployment, homelessness • poverty/economic insecurity • living in a nursing home or aged care hostel

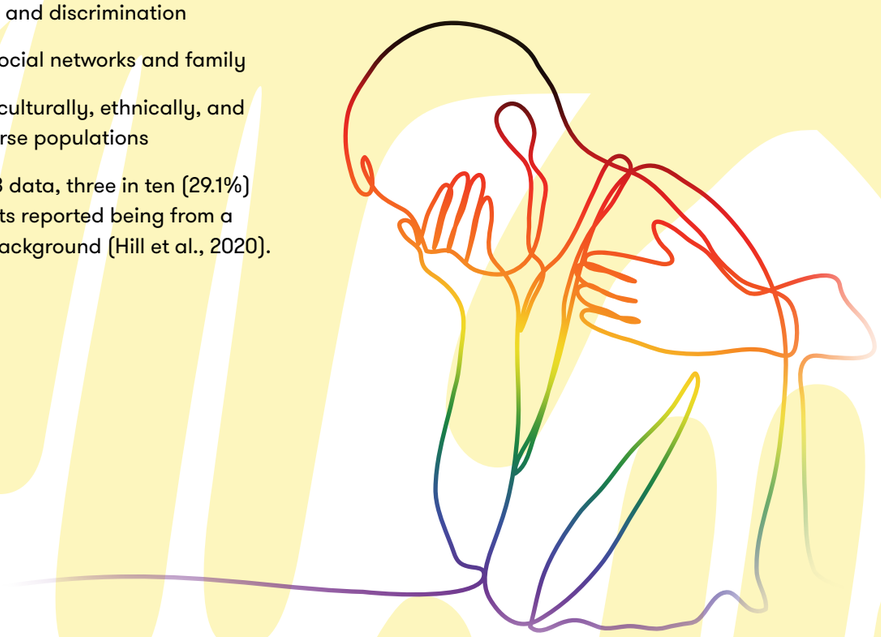
LGBTQ+ people from culturally, linguistically and ethnically diverse, migrant, and refugee backgrounds, and LGBTQ people of colour

Australia has one of the biggest multicultural populations in the world, with an estimated 7.3 million migrants in 2018 (Bowden et al., 2020). According to a systematic review of suicidality in the general population of culturally, ethnically, and linguistically diverse communities in Australia conducted by Beyond Blue, the key themes that indicated suicide risk were the following (Bowden et al., 2020):

- acculturation difficulties (the process of social, psychological, and cultural integration)
- culturally, ethnically, racially and religious motivated stigma and discrimination
- the influence of social networks and family
- heterogeneity of culturally, ethnically, and linguistically diverse populations

From Private Lives 3 data, three in ten (29.1%) LGBTQ+ participants reported being from a culturally diverse background (Hill et al., 2020).

Suicidality was marginally worse for culturally diverse participants (by 2%). The main outlier in the data was in response to 'unfair treatment as a result of ethnicity, cultural identity or heritage', where a third of participants reported they were treated unfairly in the past twelve months (Hill et al., 2020, p111).



LGBTQ people from culturally, linguistically and ethnically diverse, migrant, and refugee backgrounds, and LGBTQ people of colour often report having to navigate spaces that never fully embrace the complexities of their identities. They may experience racism or a lack of understanding of cultural diversity in LGBTQ spaces. At the same time, may also struggle to be fully accepted by their families or cultural communities of origin because of their sexuality or gender identity. This is especially important because connection to peers and the LGBTQ community is associated to greater health outcomes and access to Services (ACON, 2021a).

In terms of this population living in Greater Western Sydney, the largest and most diverse multicultural and multi-faith metropolitan area in Australia, specific minority stressors have been identified (Robinson et al., 2020). Just over half of those surveyed 'always' felt safe at home.

Study participants preferred to travel to neighbouring areas to access more inclusive services, benefiting from the perceived increase of safety, anonymity, and confidentiality.

Furthermore, sexuality and gender-based stigma and discrimination were often experienced in health care contexts and finding primary care where a GP was both multilingual and understanding of intersecting cultural, sexuality and gender issues was difficult (Robinson et al., 2020).

Finding adequate translation of LGBTQ+ terminology can also be a problem, with mainstream translators often using derogatory language (Stevens, 2022). To mitigate these risk factors, a focus on social inclusion and culturally competent health services is necessary.

TABLE 9

Protective and risk factors for LGBTQ+ people from culturally, ethnically & linguistically diverse backgrounds

Protective and risk factors	
Protective factors	Risk factors
• inclusive and affirming mainstream health services • accessible LGBTQ+ health services • targeted campaigns for community inclusion • LGBTQ+ sensitive translations	• acculturation difficulties • language barriers • cultural shock • mental health stigma • relational conflict • isolation • exclusion from LGBTQ+ community

Scoping of services

Current Crisis Support Services

Crisis support services (CSSs) are phone or text hotlines people in a mental health crisis can call to get immediate emergency counselling by a trained professional, peer or volunteer. Several in NSW operate 24/7, while others for specific demographics have restricted opening hours, mostly staffed by volunteer counsellors.

Currently, the list of CSSs operating in NSW, both mainstream and for LGBTQ+ communities, include:

Mainstream:

- Emergency 000
- 13YARN (24/7 phone)
- Beyond Blue (24/7 phone; 1pm-12am online chat)
- Youth Beyond Blue (24/7 phone; 1pm-12am online chat)
- Lifeline (24/7 phone and online chat)
- Kids Helpline (24/7 phone and online chat)
- NSW Mental Health Line (24/7 phone)
- Suicide Call Back Service (24/7 phone and online chat)
- MensLine Australia (24/7 phone)

LGBTQ+:

- Qlife (3pm-12am phone and online chat)

It is apparent that there is a disparity between the number of mainstream 24/7 hotlines and LGBTQ+ ones. For LGBTQ+ individuals experiencing mental health crises, there are considerable gaps in their knowledge about which CSSs are available, and barriers to receiving the right care when they do contact them. In the Understanding LGBTI+ Lives in Crisis Report, a survey was conducted with 472 LGBTI people (and follow-up interviews with 10) that sought to enhance the evidence base of why these gaps exist, and how CSSs can work to design, resource, or deliver services to meet the needs of LGBTI people in Australia (Waling et al., 2019, p21).

Barriers to care

Only 68% of survey participants could name 1 to 5 CSSs, and over 71% of participants chose not to use a CSS during their most recent crisis.

Key barriers cited were:

- Anticipation of discrimination
  - Assuming crisis support workers would use heteronormative, cisgenderist, homophobic or transphobic language and value cisgender, heterosexual people above all others, or be ignorant of LGBTQ+ needs.
- Lack of awareness of CSSs, both mainstream and LGBTQ+
  - Only 68% could name one or more CSS
- Physical access
  - i.e.: difficulty finding private space to speak therapeutically about their crisis, their gender and/or sexuality without being overheard by family, peers or work colleagues
- Technical barriers
  - Owning a phone, having internet connection in private place
- Financial barriers
  - Affording phone and internet data charges[4]

[4] This was the financial barrier for free crisis support services, however the authors note the financial barriers associated with private mental health services and waitlists for community services

- Feelings of burdensomeness
    - 29% did not think their experience warranted a crisis intervention. The belief that only immediate danger of self-harm or suicidal thoughts necessitates contacting a CSS
- The crisis wasn't "serious enough"
    - Similar to feeling like a burden, many participants thought that by using a CSS they would be diverting the attention of the crisis support worker away from someone who needed it more
- Fears of being "outed"
    - Concerns that the disclosure of their gender and/or sexuality could threaten their personal safety and/or professional lives
- Not being "queer enough"
    - Participants who do not perceive themselves as fully accepted by LGBTQ+ communities, may not be sure whether mainstream or LGBTQ+ services can accommodate their experiences and/or needs
- Concerns about confidentiality
    - Using LGBTQ+ services staffed by close-knit, local LGBTQ+ community members and peer networks could pose issues with confidentiality
- Concerns about police/medical involvement
    - Only done in extreme circumstances, however LGBTQ+ individuals may have negative experiences and/or connotations with police and the medical system, so calling police or ambulances may be triggering in a crisis situation
- Preferred familiarity with GP
    - Nearly half surveyed contacted their GP during their last crisis, even though most used them as intermediaries to access other services or medication

Limitations of care

In the Understanding LGBTI+ Lives in Crisis report (Waling et al., 2019), while crisis support workers showed some acceptance and familiarity with sexuality and gender diverse concepts, their actual ability was lacking. This was especially pronounced in their understanding of and capacity to work with gender diverse people.

- Acceptance shown towards people from sexuality and gender diverse communities
    - While 80% (n-76) of participants rated crisis support workers being 'Good' or 'Excellent' with accepting sexuality diverse individuals, only half rated their acceptance of gender diverse individuals that way
- Familiarity with concepts relating to sexuality and gender diversity
    - Just over half of participants rated crisis support workers as 'Good' or 'Excellent' with their familiarity with concepts of sexuality and gender diversity
- Ability to provide support for issues specific to sexuality and gender diverse individuals
    - Much fewer participants rated crisis support workers as having a 'Good' or 'Excellent' ability to provide specific support for sexually diverse (37.9%, n=36) and gender/sex diverse (20%, n=20) individuals
- Intersections with religion, ethnicity, culture
    - LGBTQ+ participants of faith shared experiences using mainstream services that did not meet their specific needs, while LGBTQ+ services were not well-equipped to support their religious needs.
- Language barriers
    - Crisis support workers may only be fluent in one language

(Waling et al., 2019, The reference Waling et al., 2019 would suffice here, for consistency across the report)

Mental Health Services & Safe Havens

For non-acute mental health crises, there are various mental health services that can provide support, information, resources, and referral. Safe havens provide non-clinical alternatives to hospital emergency departments.

Mainstream mental health services in NSW include:

- Head to Health
- Black Dog Institute
- Beyond Blue
- SANE Australia
- Blue Knot Foundation
- Everymind
- headspace
- Wellways
- STARTTS for refugees and Asylum Seekers

LGBTQ+ mental health services:

- ACON
- Qlife
- Twenty10
- The Gender Centre

Towards Zero Suicides services available to the public in NSW include:

- Towards Zero Suicides safe havens, located in local health districts
- Suicide Prevention Outreach Teams
- Rural Counsellors
- Building on Aboriginal Communities' Resilience

Post Suicide Services

Post suicide services are essential following a suicide attempt or death of someone close. Switchboard Victoria provides resources and LGBTIQA+ suicide bereavement groups for people in NSW. Roses in the Ocean provides resources for people with lived experience of suicide.

Free 24/7 support is available from StandBy post-suicide support service for anyone affected by suicide.

Aftercare Services

Aftercare support is for people who have recently attempted suicide and help with recovery plans and links to other support services.

Alternatives to Suicide (Alt2Su) peer support groups are non-clinical, peer-based, and led by a trained facilitator. Meetings are held around New South Wales in person and across Australia via Zoom links.

Mainstream aftercare services include Care Connect (by Social Futures), the Way Back Support Service (by Beyond Blue), and Life in Mind aftercare services (by HealthWISE).

Mind Australia offers LGBTIQ+ Aftercare and specific LGBTQ+ resources for safety planning and suicide prevention.

Suicide Prevention Apps

Along with crisis support services like Lifeline and Beyond Blue offering online chat facilities, there has been a proliferation of mental health and suicide prevention apps on the market. Systemic reviews identified between 14 and 49 suicide prevention apps available in Australia and the US. They vary in target users (mostly for at-risk users, some third party, some combined), and target populations (broad community, or specific groups, such as youth or military), as well as varying in content, features, and functions (Larson et al., 2016, p1). The access and anonymity of online and mobile apps for suicide prevention have been shown to reduce the risk of suicide in people with suicidal ideation (Franco-Martín et al., 2018, p2).

Several mental health and suicide prevention apps are used by ACON support workers, including the following:

- Beyond Blue: Beyond Now Suicide Safety Plan App
- Beyond Blue: The Check In App
- Suicide Safety Plan

An analysis of 16 suicide prevention training modules found that none used technology and only a quarter used social media. Wellways' UrHere is a youth suicide prevention campaign that builds awareness of supports available to young people in times of increased stress, suicide risk and isolation. As part of this campaign, Wellways are rolling out content over TikTok, Instagram, Youtube, and Facebook. TikTok, like the other social media platforms, has a large reach, particularly with the youth-targeted demographic as part of Wellways' campaign. While there is little research on suicide prevention on popular social media apps, TikTok's large reach and recently policies on suicide and self-harm prevention could make it a useful tool to educate LGBTQ+ users on risks and protective factors.

Services for Aboriginal and Torres Strait Islander people

13YARN

13 YARN [13 92 76] is a crisis support line designed, led and delivered by Aboriginal and Torres Strait Islander people across varying demographics. It is funded by the Commonwealth Government with the support of Lifeline and developed in collaboration with Gayaa Dhuwi (Proud Spirit) Australia.

Indigenous Suicide Prevention Apps

A qualitative study was created to investigate the efficacy of mobile apps for supporting Indigenous gatekeepers in suicide prevention for their communities. They used participatory design workshops with Indigenous health workers and community members to explore what knowledge, skills and support they would require. Gatekeepers in the community could be either health professionals or community members well positioned to assist at-risk people, such as teachers, service providers, family, friends, and peers. The participants noted that 'gatekeeper' was not a culturally appropriate term (hierarchical) and suggested renaming it to something like 'responder'. The action plan used was "Identify, support, refer" (Brown, et al., 2020).

One app tailored especially for Indigenous youth, iBobbly, has been trialled and evaluated to gauge its efficacy in a community in the Kimberley region of Western Australia (Tighe, et al., 2020). Overall, it was rated as effective, acceptable, and culturally appropriate by the young participants. Key findings include:

- Privacy was appreciated ("less worrying than actually talking to someone")
- Visually, the app appealed to users with dyslexia and other needs
- Helped participants improve mental health literacy and therefore could be used to communicate with mental health professionals
- App helped participants identify potentially harmful behaviour, changing their perspectives and demonstrating better coping strategies
- App helped improve self-awareness and interpersonal communication
- Mobility of app meant it could offer consistent and appropriate support on the move

Responder Training

The *Talking About Suicide* gatekeeper, or responder, training course was created based on a set of guidelines for providing mental health first aid to Aboriginal and Torres Strait Islander Peoples experiencing suicidal thoughts or behaviour. It was developed with 27 Aboriginal and Torres Strait Islander experts in Indigenous suicide prevention. In the advice to first aiders, yarning was emphasised, that is, not asking too many direct questions and not disrespecting the person by trying to take charge of the situation (Armstrong, et al., 2018; Armstrong, et al., 2020).

Another responder training program, 'We-Yarn', was recently set up for suicide prevention in rural New South Wales. It was similarly assessed to be culturally appropriate, and used the specific action plan, SCARF (suspect, connect, act, refer, follow-up), to help at-risk people (Davies, et al., 2020).

> “I look for the LGBTQIA+ services first.
> I was aware of Black Dog, BeyondBlue.
> The Conversations Matter one was really good.
> I think that lived experiences help
> in everything we do.”

> “I also look for the LGBTQIA+ information first.
> I look to see that they sign post,
> different signs at the bottom.
> I try to see that they are inclusive in different ways.
> Particularly the Black Dog info were overwhelming
> because there was so much information on there.
> If I was in a crisis and not sure what I was looking
> for I feel that it would be too much.
> A balance of words, images and lived
> experiences in a diverse manner helps.”

> “When I’m unwell, I don’t go anywhere
> because I think they won’t be able to help me,
> so I go more for direct service not resources
> or websites. I like the idea of peer workers,
> especially relationship stuff.”

Services for trans people

Peer Support

Peer support for trans people needing mental health support and suicide prevention can save lives, but often comes as a response to inadequate mental health services for LGBTQ+ communities (Worrell et al., 2021). Therefore, the hub will be promoting P41 and ACON’s peer mental health service with the client service team.

Trans Vitality

Trans Vitality is ACON’s resilience-building program for all trans adults in NSW and includes online peer education workshops, a Resilience Toolkit, an eLearning for mental health and crisis services to build their capacity for trans-affirming practice and access for community members to the Black Dog Institute’s Recognise and Respond online training.

DISCHARGED

DISCHARGED is an Australia-wide peer group for trans people who have experienced suicidality. The program utilises Alt2Su, which provides an alternative to risk assessments, and pathologising and controlled environments that can compound negative experiences for trans people navigating healthcare services. In the DISCHARGED program, peers with a lived experience of both suicidality and being trans create a safe space for people to build relationships and talk about their experiences without the fear of clinical interjection (Wishart & Martin, 2019, p9).

Services for people with disability or long-term health conditions

QueerAbility

The hub will provide external links to ACON’s QueerAbility, a toolkit that provides support for LGBTQ+ people wishing to access the NDIS. The hub can also link to SQuAD, a Sydney-based Queer and Disability Community group that raises awareness and organises social activities.

Otherwise, we recognise the lack of LGBTQ+ disability organisations, as well as the lack of mainstream disability services explicitly including and affirming LGBTQ+ clients and programs.

Services for people from culturally, ethnically & linguistically diverse backgrounds

Providing community connections and culturally safe healthcare services for LGBTQ+ people from culturally, ethnically and linguistically diverse backgrounds will be a key function of the hub. This will include the following:

- Asylum Seekers Centre – LGBTIQ Community Support
- ACON Asian Gay Men
- ANTRA – Australia and New Zealand Tongzhi Rainbow Alliance
- FOBGAYS+
- SheQu
- Trikone Australasia
- Selamat Datang Indonesia Community
- Qlife
- Dayenu
- Sydney Queer Muslims
- Advance Diversity Services
- Rainbow Cultures | LGBTQIA+ multicultural directory
- TransHub gender affirming doctors list
- Forcibly Displaced People Network
- Queer Sisterhood Project

Policy context

ACON's online Suicide Prevention Hub is an initiative funded by the NSW Ministry of Health as part of Towards Zero Suicides, which seeks to provide best practice crisis care and support, build on local community resilience and improve systems and practices to reduce the suicide rate in NSW by 20% by 2023. Towards Zero Suicides follows the Mental Health Commission of NSW's strategic plan, Living Well in Focus 2020-2024, and the Strategic Framework for Suicide Prevention in NSW 2018- 2023.

In the creation of ACON's online Suicide Prevention Hub the following models, frameworks and action areas will be considered, as well as consultation with the Rainbow Mental Health Lived Experience Network.

Suicidal ideation is understood to be distinct from suicidal action as outlined by Harmer et al. (2022) and the Interpersonal-Psychological Theory of Suicide (IPTS), used by the Black Dog Institute (Batterham et al., 2018). This theory, along with the ideation-to-action 3-step framework (Klonsky & May, 2015) and Minority Stress Theory (Meyer, 2003) will underpin ACON's understanding of suicidality.

To engage with intersecting communities, a series of consultations will take place for co- design to occur. For the trans and gender diverse community, the hub will adhere to the priorities in ACON's Blueprint for Improving the Health and Wellbeing of the Trans and Gender Diverse Community in NSW. For LGBTQ+ people from culturally, linguistically and ethnically diverse, migrant, and refugee backgrounds, and LGBTQ+ people of colour accessing the hub and promotion to those communities, ACON will be following the Multicultural Engagement Plan. In accordance with ACON's Reconciliation Action Plan, for Indigenous communities Blak Terms of Reference will be followed, as will the touchstone text of the Gayaa Dhuwi Declaration, the outcomes and targets of the Closing the Gap Agreement, and culturally relevant suicide prevention action plan frameworks. Finally, LGBTIQ+ Health Australia provides a Knowledge Hub for Disability Inclusion, which is guided by the principles of the Convention on the Rights of Persons with Disabilities and the social model of disability.

The hub will also acknowledge the existence of other online resources that use appropriate language and have sound familiarity with the specific communities they serve. The hub will provide external links to these websites, including Black Rainbow for LGBTQ+ Indigenous health and wellbeing resources, and P4T: Peer support by & for trans communities. Furthermore, the hub will include a page of all mainstream and LGBTQ+ CSSs in New South Wales and Australia, a direct link to a 24/7 service (such as Lifeline) on every page, and a quick exit button.

The ongoing aim of ACON's Suicide Prevention Hub is to provide an educational toolkit for both community and practitioners. For this reason, it will implement a recovery college approach to suicide prevention and aftercare service providers, whereby the information and resources available will seek to empower visitors to the site so that they can live meaningful and autonomous lives in the community, as well as training for professionals to build awareness of the particular social determinants of mental health for LGBTQ+ individuals and to build capacity for LGBTQ+ inclusive and affirming practice. This will include accessible insights into mental health experiences and new strategies for recovery and increased mental wellbeing.

Early-stage consultations with The Rainbow Mental Health Lived Experience Network

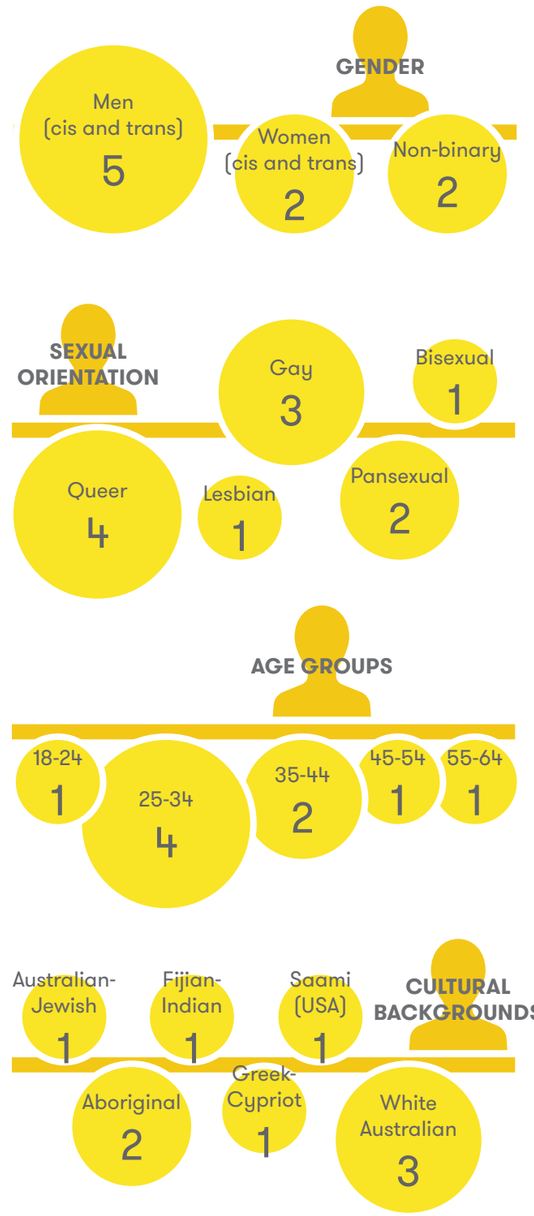
The Rainbow Mental Health Network is a group of sexuality and gender diverse individuals with lived experience of mental distress. The Network currently comprises of 29 people from across NSW, including Sydney, Western Sydney, Hunter, South Coast, Northern Rivers, and Murrumbidgee regions. ACON has facilitated two of five planned consultations to identify gaps, needs and experiences of suicide prevention and mental health resources. This includes surveying online sites and apps by members of the Rainbow Mental Health Lived Experience Network. We conducted an evaluation survey and nine people responded out of the thirteen attendees to the consultations. Their demographics were:

LOCATIONS OF PARTICIPANTS

Riverina region, Clarence Valley region, Sydney, Newcastle, Lismore, and Elland.

Participants identified services, language and content ACON should include in the development of an online hub for Suicide Prevention and Mental Health for LGBTQ communities.

Ongoing consultation will ensure the language used on the hub reflects that being used in the community, especially when linking resources/ services and when creating content for the hub. A language guide has been highlighted to be of significant need around destigmatising words and diagnosis/clinical language and highlighting intersectional health needs especially around harm reduction, including alcohol and drug use in LGBTQ+ communities across NSW.



Peer Support Models of Care

Peer education and peer support are formal, semi-structured or informal occasions where education, care and support are provided by and shared between people with shared lived experiences (Molyneux, Delhomme & Mackie, 2021). In the suicide prevention context, peer education and support can be highly valuable as the unique understanding of suicidality between peers can create a safe space for sharing experiences, providing emotional assistance and practical help (Pfeiffer et al., 2019; Worrell et al., 2021).

Peer education in any context is a process which attempts to build on existing information exchange, or where people with common backgrounds share information in social groups. As well as building on existing information, the process creates discourses and forms of knowledge that are specific to each peer group, making the information more relatable and easier to understand (Molyneux, Delhomme & Mackie, 2021).

Peers draw on shared personal experience often in a way that is mutually beneficial. Benefits can include forming collective strategies to manage health, developing resilience and self-esteem, and advocacy and collective action. While peer relationships can include friends sharing information or insights in an informal, unstructured way, structured peer support is delivered by trained, skilled volunteers or staff (Molyneux, Delhomme & Mackie, 2021).

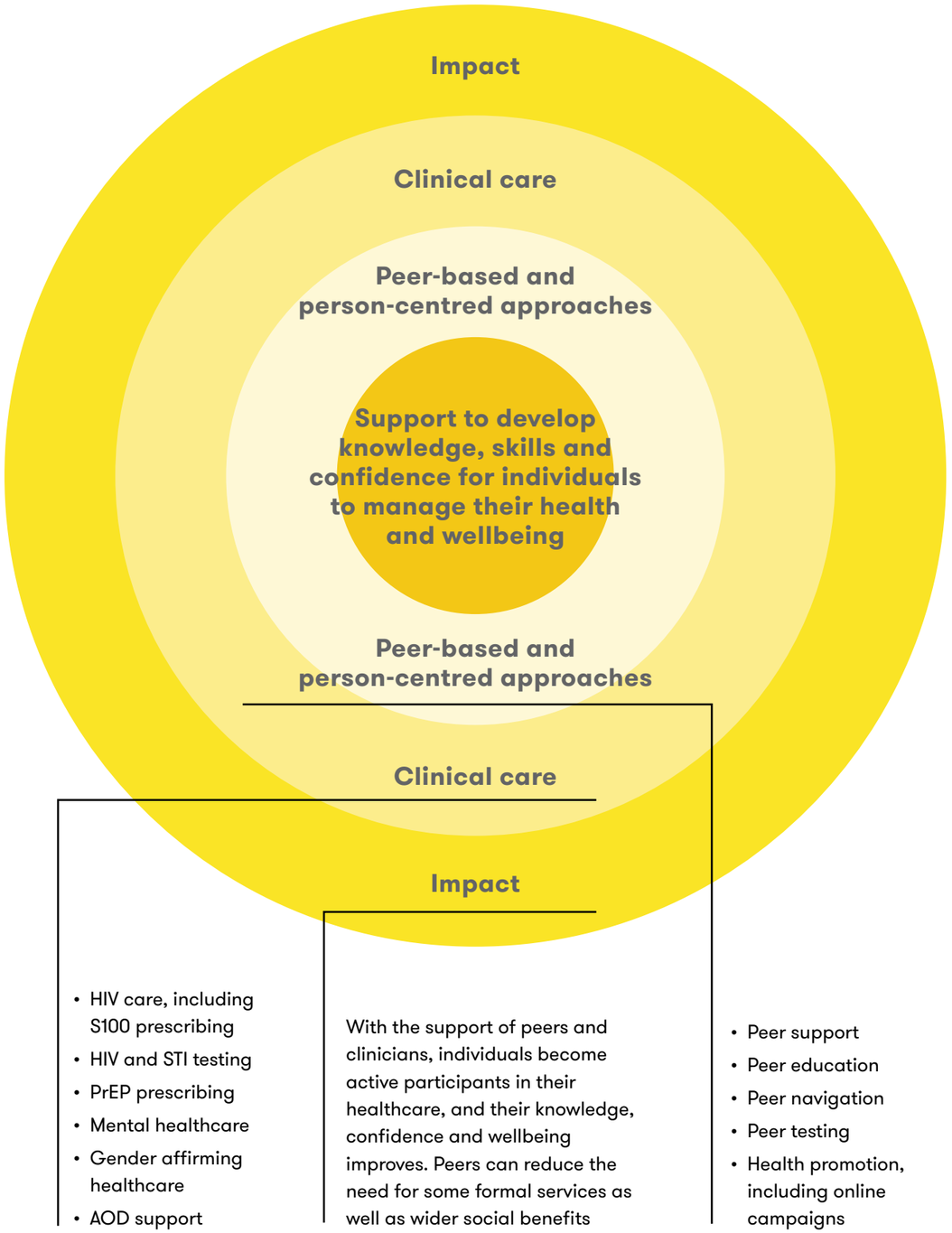
Peer education and support should be non-judgemental in its delivery. Empathy (being open to understanding a person's point of view), congruence (the ability to relate to others without a professional or personal façade) and acceptance (being non-judgemental) are vital elements to the success of peer work. These core elements can also be seen as important principles and values in the delivery of peer education and support (Molyneux, Delhomme & Mackie, 2021).

Peer work is at its heart person-centred and community oriented and is therefore also tied to the notions of social and cultural determinants of health. For peer work the notion of empowering people and communities more broadly to take control of their own health is key to its success. Peer work embodies the notion of people and communities working together to address their own health behaviours, concerns, and issues (Molyneux, Delhomme & Mackie, 2021).

In practical terms, peers may operate in many different roles, from providing informal advice and support through to trained peers providing some clinical services. ACON services for suicide prevention are run by and for peers, including Mental Health Peer Work, and P4T.

Evidence has shown that working with peers helps individuals feel more valued and empowered, builds self-esteem and confidence, and promotes a greater sense of identity. There is also evidence that behaviour change is more likely with support from a peer. Physical, mental, emotional, social, and spiritual wellbeing are all important factors in one's quality of life and these determinants cannot be achieved through clinical care alone. Peers play an important role in understanding the psychosocial needs of people living with suicidality and strengthening these quality-of-life determinants. Peers can also help navigate health systems, share information on mental health treatment and treatment access, and other issues to allow for the best quality of life (Molyneux, Delhomme & Mackie, 2021).

PEER WORK IN PRACTICE



ACON's Suicide Prevention Hub

Summary of considerations for the Suicide Prevention Hub

Specific considerations must be taken when planning a Suicide Prevention Hub for LGBTQ+ communities. These are:

- Social determinants of health impact mental illness and wellbeing
- LGBTQ+ communities experience unique marginalising social conditions that negatively impact our mental health
- Poor mental health can lead to suicidal ideation, but not always
- Suicidal ideation can lead to suicidal action (attempts), but not always
- Suicidal ideation is born from a combination of factors including 'thwarted belongingness', 'perceived burdensomeness' and 'hopelessness'
- A social determinant for poor mental health among LGBTQ+ individuals is a feeling of not being connected to or accepted by community
- Suicidal ideation among LGBTQ+ individuals is 5 times higher than in the general population
- Suicide attempts among LGBTQ+ individuals are 8 times higher than in the general population
- Suicidality is higher for queer, bi, pan, and asexual people by as much as 25% more than lesbian and gay identifying individuals
- 43% of trans people report suicide attempts in their lifetime
- Prejudiced physical assault, unemployment, and service denial increase suicidality risk among trans and gender diverse individuals
- Gender-affirmation significantly reduces odds of suicidality among trans and gender diverse individuals
- Suicidality risk is compounded among LGBTQ+ Aboriginal and Torres Strait Islanders
- Connection to culture reduces risk among LGBTQ+ Aboriginal and Torres Strait Islanders
- Mitigating experiences relating to displacement, racism, and disadvantage reduces risk among LGBTQ+ Aboriginal and Torres Strait Islanders
- LGBTQ+ people with a severe disability or long-term health condition were 2.5 times more likely to have attempted suicide than those without
- 90% of LGBTQ+ people with a severe disability or long-term health condition report having suicidal ideation in their lifetime
- LGBTQ+ individuals from culturally, ethnically and linguistically diverse backgrounds experience isolation and exclusion from multiple communities
- LGBTQ+ individuals from culturally, ethnically and linguistically diverse backgrounds require culturally competent health services and access to LGBTQ+ inclusive concepts in their first language
- Crisis Support Services (CSSs) are not widely known
- LGBTQ+ specific CSSs have limited hours of operation
- LGBTQ+ people are hesitant to use CSSs due to anticipation of discrimination, fears of being 'outed', physical, financial, and technical barriers, concerns about medical or police interventions, concerns about CSS workers not having enough training to support LGBTQ+ needs
- Those interviewed in the Rainbow Mental Health Lived Experience Network emphasise the importance of LGBTQ+ targeted services
- Peer support networks can offer therapeutic care outside the clinical model

Evidence-based outcomes

The Understanding LGBTI+ Lives in Crisis report (Waling et al., 2019, pp44-47) outlines the following recommendations for suicide prevention, which relate to the desired outcomes of the ACON Suicide Prevention Hub:

- LGBTQ+ culturally competent and safety training for mental health practitioners and service providers
- Crisis intervention and bystander guides
- Promotion and awareness
  - Awareness of availability of varying service modalities
  - Awareness of which services are LGBTQ+ inclusive and affirming
  - Encouragement to use crisis support services
- Addressing intersecting needs
- Primary prevention, focussing on resiliency, hope, community and kinship, gender affirmation, and other social determinants
- Further research
  - Supporting the training of crisis support workers
  - Health and crisis support needs of Aboriginal and Torres Strait Islander LGBTQ+ people
  - Health and crisis support needs of LGBTQ+ from culturally, ethnically, and linguistically diverse backgrounds

Recommendations to address

ACON's Suicide Prevention Hub will address the following needs for community:

- Provide immediate contact details of Crisis Support Services and their operational times
- Provide a detailed list of CSSs and a short description of what each can offer, including which ones are LGBTQ+ inclusive
- Provide links to internal ACON sites and external organisations that specialise in specific communities
- Provide explanations of mental health and wellbeing, and how suicidal action is separate from suicidal ideation, including risk and protective factors
- Explanation of how any experience of poor mental health or suicidal ideation is "serious enough" to use CSSs
- Encouragement to use CSSs and/or suicide prevention apps
- Give information about how suicidality affects LGBTQ+ communities
- Give information about intersectional needs for trans and gender diverse, Indigenous, culturally, ethnically, linguistically diverse, and people living with a disability or long-term health condition
- Provide links to training materials and support for crisis support workers
- Provide personal stories of survivors and people who have experienced suicidal ideation in a blog format
- Give information about LGBTQ+ suicide narratives in literature and on screen with the explanation of these tropes and the importance of representation

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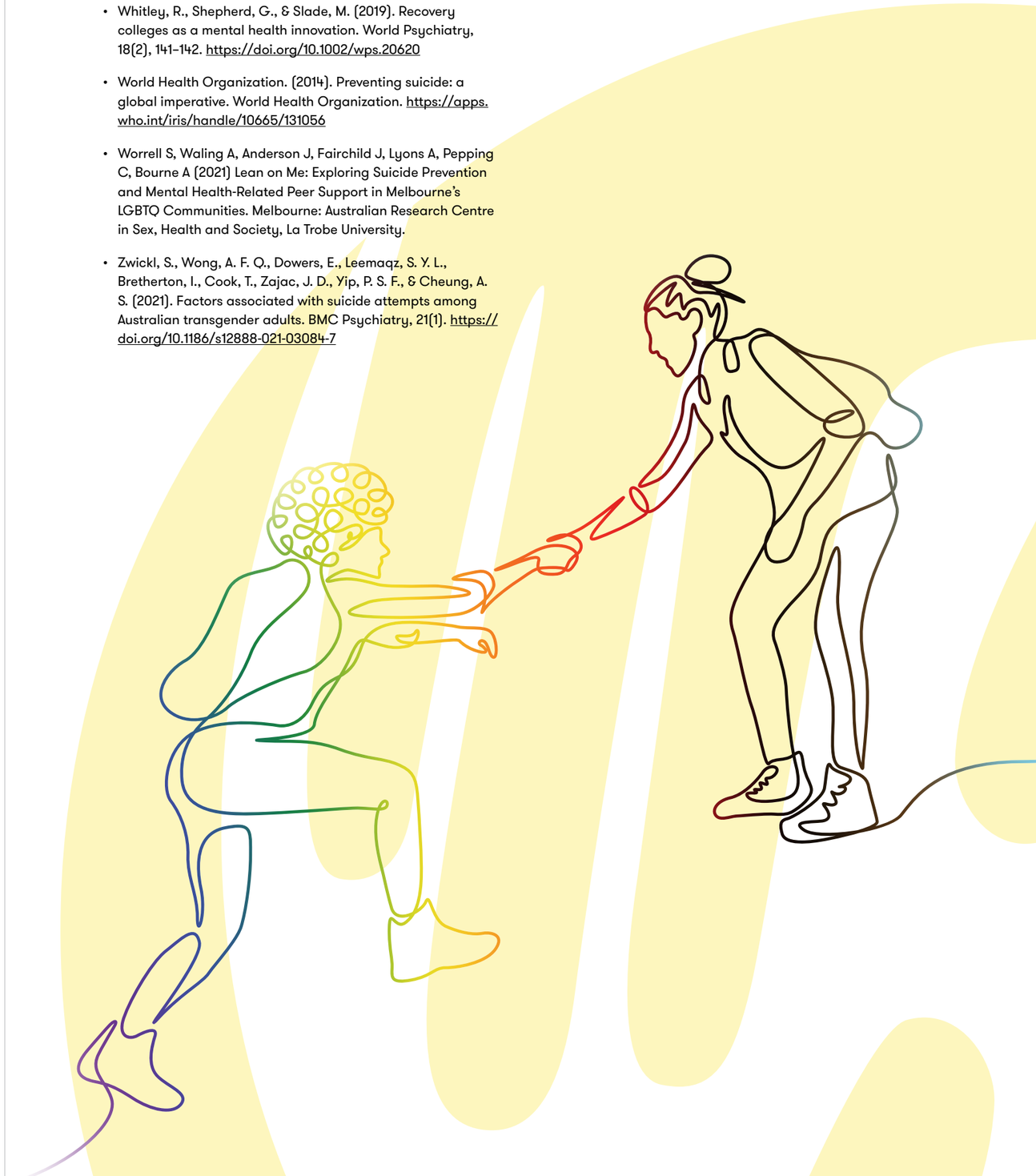

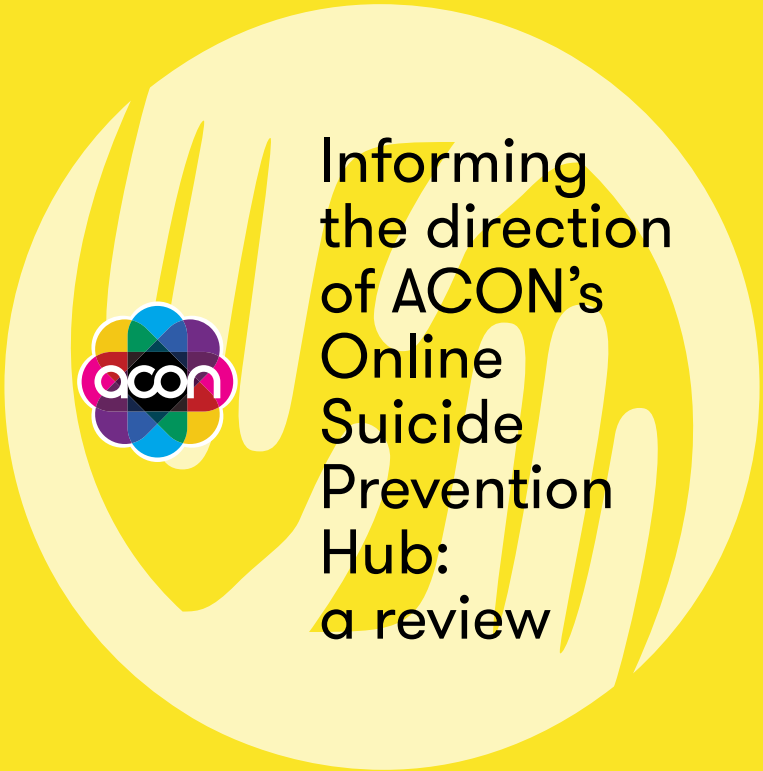

Informing the direction of ACON's Online Suicide Prevention Hub: a review