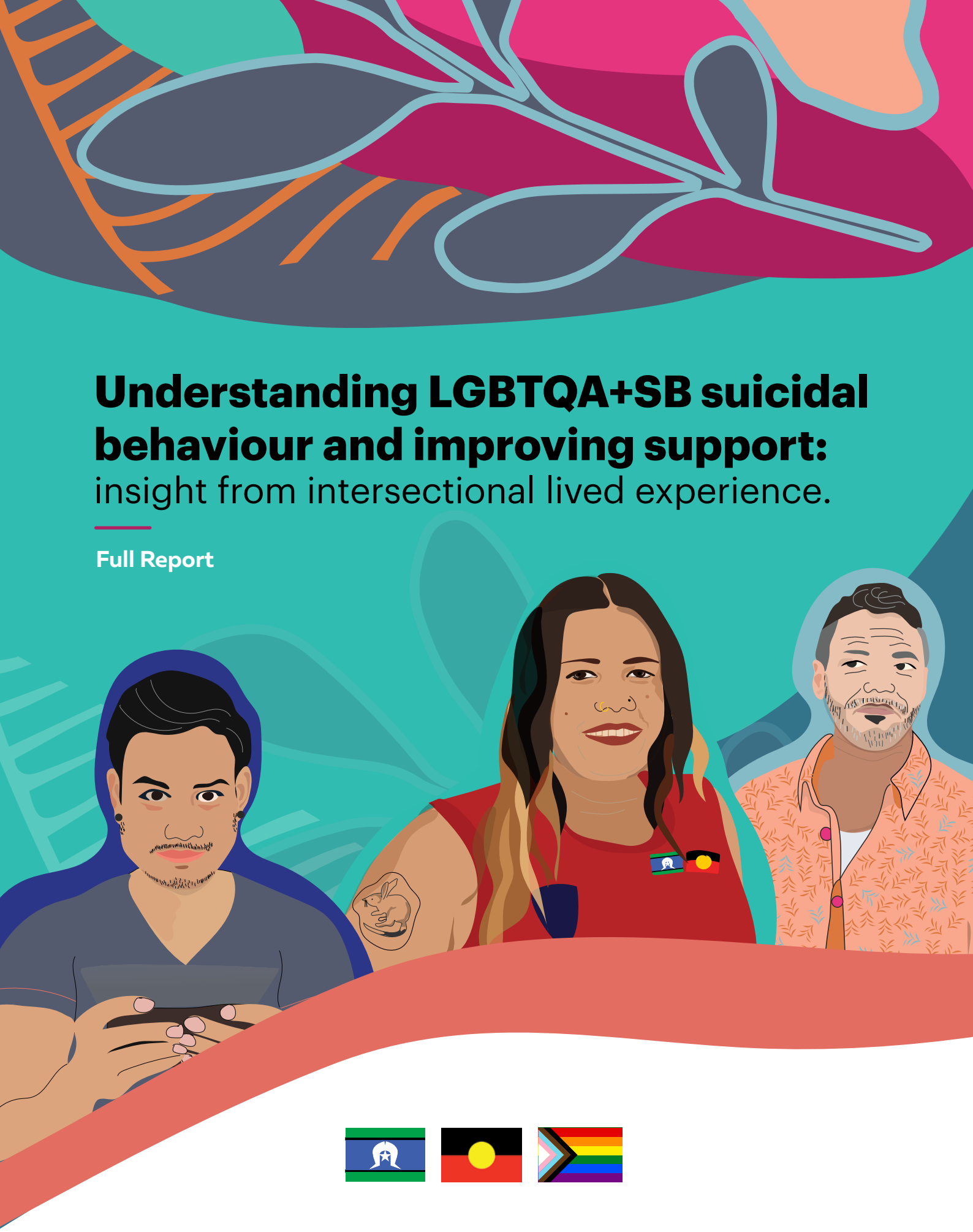
Understanding LGBTQA+SB suicidal behaviour and improving support:
insight from intersectional lived experience.

Full Report



RMIT UNIVERSITY

THE UNIVERSITY OF SYDNEY

Roses in the Ocean

Suicide Prevention Australia

switchboard

Acknowledgement to Country

We acknowledge the traditional lands of all the Nation, Clan and Tribal groups where the authors live and work and where the contributors live and work. We pay respect to Traditional Custodians, youth and Elders both past, present, future and emerging across all our lands. We are grateful for their histories, knowledge and culture and acknowledge that the land where we are learning and sharing stories today, always was and always will be, Aboriginal land.

About this research

This research was funded by a Suicide Prevention Australia Innovation Grant. The research is a collaboration between researchers at RMIT University (Katherine Johnson and Nicholas Hill), the University of Sydney (Vanessa Lee-Ah Mat) and partners specialising in LGBTQIA+ community support (Switchboard) and lived experience of suicide (Roses in the Ocean). We are grateful for the funding and institutional support that has enabled this research.

We have also received funding from the Social Change Enabling Impact Platform at RMIT University to support the translation of this research into training materials. We are grateful to them, and to Crosswalk Media and Jacq Moon for their input into the design and production of the report and related training materials.

As part of the research translation process, we have used composite narratives to develop an indicative character for each of our three cohorts of participants. Composite narratives draw on data from several interviews to create one narrative. The benefit is that the narrative is informed by lived experience but maintains the anonymity and confidentiality of participants who have shared their stories. These characters and their narratives are visually depicted in the graphics embedded in the report and the training materials.

If you are interested in finding out more about the research, please contact katherine.e.johnson@rmit.edu.au

If you are interested in finding out more about the training, please contact suicideprevention@switchboard.org.au

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Thank you to our participants for sharing their stories of suicidal distress with the research team. These stories will contribute to the collective understanding of Lesbian, Gay, Bisexual, Transgender, Asexual plus Sistergirl and Brotherboy (LGBTQA+SB) suicidal distress and provide policy makers, organisations, and service providers with a clearer understanding of how to create policies, programs and supportive environments people from all LGBTQA+SB communities (First Nations Peoples, People of colour (PoC), disabilities, and rainbow families).

We are extremely grateful to the advisory group listed below, whose expertise and contributions helped to shape the project and guided the development of culturally safe research procedures, and all outputs:

Joe Ball (CEO, Switchboard Victoria)

Bronwen Edwards (CEO, Roses in the Ocean)

Todd Fernando (The Victorian Commissioner for LGBTIQ+ Communities)

Samina Hassan (former Suicide Prevention Program Officer, Switchboard)

Eliza Hovey (Beyondblue, Research, Evaluation and Monitoring Adviser, Suicide Prevention)

Manu Kailom (Peer Support and Community Development Officer, Many Coloured Sky)

Abdurahman Katamish (QTIPOC community advocate)

Kenton Miller (Principal Advisor to the Victorian Commissioner for LGBTIQ+ Communities)

Esther Montgomery (Freelance Consultant)

ORGANISATIONS YOU MAY LIKE TO CONTACT FOR FURTHER SUPPORT OR INFORMATION

Helplines

Switchboard Victoria
www.switchboard.org.au or 1800 184 527

Switchboard Victoria provides peer-driven support services for the lesbian, gay, bisexual, transgender and gender diverse, intersex, queer and asexual (LGBTIQA+) people, their families, allies and communities.

Rainbow Door
www.rainbowdoor.org.au or 1800 729 367

Rainbow Door is a free specialist LGBTIQA+ (Lesbian, Gay , Bisexual, Transgender and Gender Diverse, Intersex, Queer, Asexual, BrotherBoys, SisterGirls) helpline providing information, support, and referral to all LGBTIQA+ Victorians, their friends and family.

QLife
www.qlife.org.au or 1800 184 527

QLife provides Australia-wide anonymous, LGBTI peer support and referral for people wanting to talk about a range of issues including sexuality, identity, gender, bodies, feelings or relationships.

Suicide Helpline Victoria
www.suicideline.org.au or 1300 651 251

Suicide Helpline Victoria is a free 24/7 telephone, video and online counselling service offering professional support to people at risk of suicide, people concerned about someone else's risk of suicide, and people bereaved by suicide.

13YARN / 13 92 76

13Yarn is run by Aboriginal and Torres Strait Islander people 24 hours, 7 days a week. Callers can talk to an Aboriginal or Torres Strait Islander Crisis Supporter

beyondblue: the national depression initiative
www.beyondblue.org.au or 1300 224 636

Beyond Blue provides information and support to help everyone in Australia achieve their best possible mental health, whatever their age and wherever they live.

Lifeline
13 11 14 (24 hrs)

A telephone counselling service that provides access to crisis support, suicide prevention and mental health support services.

Support services

queerspace
03 9663 6733 or www.queerspace.org.au

Queerspace provide counselling (including individual, relationship and family counselling), case management, individual advocacy and other support services to help people with a range of issues. queerspace also provide family education, group support programs, and can help people access LGBTIQ+ friendly healthcare options and services.

Contents

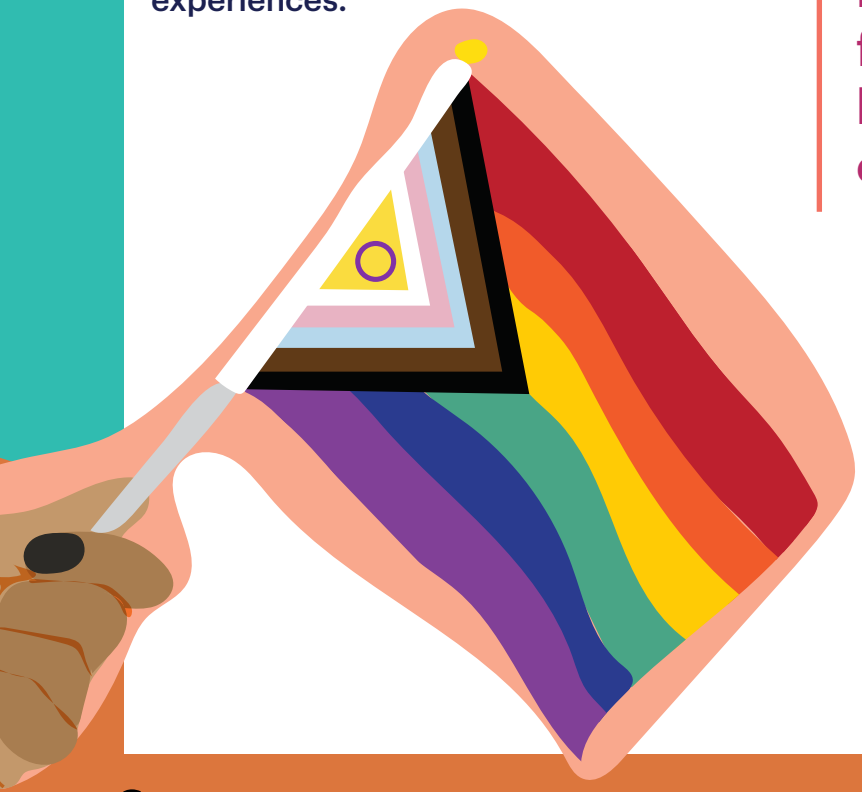
Executive Summary

Background

Within health and social care policies and service provision, the acronym LGBTIQA+ is often used to refer to lesbian, gay, bisexual, transgender, intersex variation/s, asexual, and other identifications. International research consistently identifies high rates of suicidal behaviour, including thoughts, feelings, and actions, amongst LGBTIQA+ populations. The need for tailored services and supports for suicidal behaviour for LGBTIQA+ individuals has begun to be recognised in social policy but there is little evidence about the form in which support should be delivered or the effectiveness of formal support and interventions. There is also a need for deeper insight into how experiences of suicidality and support vary across the breadth and diversity of LGBTIQA+ communities, with a particular focus on intersectionality and intersectional experiences.

Intersectionality draws attention to how people embody multiple identities, creating overlapping and interdependent systems of discrimination or disadvantage. This includes, but is not limited to First Nations Peoples, people of colour (POC), cultural and linguistic diversity, faith background, age, abilities, alongside diverse genders and sexualities. LGBTIQA+ lived experience accounts of suicidality can also generate insights into how individuals manage their suicidal feelings and move beyond moments of suicidal distress. Collating this insight can be used to inform policy makers and service providers about what support approaches might work best and why, and to develop approaches to service delivery that are accessible and inclusive for LGBTIQA+ people from diverse social and cultural backgrounds.

LGBTIQA+ lived experience accounts of suicidality can also generate insights into how individuals manage their suicidal feelings and move beyond moments of suicidal distress.



Project aims:

To facilitate better policy and service responses to LGBTIQA+ suicidal behaviour in Australia, this project has two aims:

1. To generate new insights into lived experiences of suicidal behaviour within LGBTIQA+ communities, including First Nations LGBTIQA+SB people and LGBTIQA+POC in Australia.

2. To better understand the factors that influence and protect against suicidal behaviour in LGBTIQA+SB communities, and the practices and services experienced as helpful and supportive to prevent or manage it.

Methodology and Method:

The methodology centred lived experience within an intersectional approach. This was informed by community psychology's commitment to progressive and generative collaborative practice which has been used to work effectively with LGBTIQA+ groups and First Nations Peoples of Australia. We use the acronym LGBTQA+SB throughout this report to recognise the diverse genders and sexualities of our participants and acknowledge that, despite attempts, we were unable to recruit participants who identified with intersex variations.

The research design adopted an intersectional lens with an explicit focus on understanding how LGBTQA+ identification intersected with First Nations status and racial and ethnic difference. In the presentation of the data, we use the acronyms First Nations LGBTQA+SB, LGBTQA+ POC, and LGBTQA+ to represent the three cohorts whose accounts comprise this research. First Nations LGBTQA+SB refers to Aboriginal and / or Torres Strait Islander participants including those who use the term sistergirl or brotherboy (SB). LGBTQA+POC is used to identify participants who identified as a person of colour (POC). We use LGBTQA+ to refer to participants who did not identify as either First Nations or POC.

Twenty LGBTQA+SB adults were recruited from across Australia with participants located in Queensland, Victoria, NSW, Western Australia and South Australia. Sampling sought to capture a range of experiences of suicidality and social supports and reflect the diversity of the LGBTQA+ community in terms of gender identity, sexuality and age, with particular emphasis on recruitment of First Nations LGBTQA+SB participants and LGBTQA+POC. In total, 3 First Nations LGBTQA+SB people, 7 LGBTQA+ POC and 10 LGBTQA+ people were interviewed as part of the study. Thematic analysis was applied to identify similarities and differences between each of the 3 groups (First Nations LGBTQA+SB people, LGBTQA+POC, and LGBTQA+ individuals).

Findings

Participant experiences are organised into five thematic areas which are summarised here.

1. Understanding LGBTQA+SB lives: Intersectional insights

We identify the strengths and challenges of LGBTQA+SB identification and highlight the sources of acceptance, affirmation and connection that helped our participants to live affirmatively. These stories are often missing from accounts of LGBTQA+SB experiences of suicidal distress. We also highlight the challenges that LGBTQA+SB people experience as they recognise and embrace their LGBTQA+SB identity and attempt to live affirmatively. Family life, friendships, and various social spaces can be significant sources of acceptance and affirmation but may also be drivers of distress and shame that shape help-seeking behaviours and influence what informal and formal support may be accessible and appropriate.

2. Experiences of suicidal distress

To better understand LGBTQA+SB experiences of suicidal distress we explored how our participants talked about navigating and responding to suicidal thoughts, feelings, and attempts within the context of their daily lives. Suicidal distress was described in relation to temporal rhythms with varying levels of intensity. Some participants reported discrete and acute episodes of suicidal distress, whereas others described more regular and pervasive experiences that fluctuated in intensity.

What is evident from people's accounts is that suicidal distress can begin at an incredibly young age, and participants often found ways of living with suicidal thoughts and feelings throughout their lives. Gender identity and / or sexuality featured in accounts of suicidal distress but were rarely the sole cause. Rather it is feelings of isolation, fear of rejection, and experiences of social and cultural rejection associated with homophobia, transphobia and racism. Social and cultural isolation was a strong contributor to suicidal distress among LGBTQA+ POC and First Nations LGBTQA+SB. More appropriate social and community supports are required for LGBTQA+SB people living with intersectional identities.

3. Help-seeking and informal support for LGBTQA+SB suicidal behaviour

Help-seeking plays a significant role in the provision of timely and appropriate informal and formal support for LGBTQA+SB people experiencing suicidal distress. Seeking support was identified as a challenge by many of our participants, although their accounts indicate help-seeking behaviour often changes over time, with people becoming more adept at managing their suicidal distress. Most of our participants pointed to numerous occasions where they concealed what they were feeling from others or did not access support. This was particularly prominent in participant accounts of suicidality when they were younger and experiencing suicidal distress for the first time.

Family support is vital for some people, particularly First Nations LGBTQA+SB people, but it is not always available or positive. LGBTQA+POC people may be more likely to seek support through friends, particularly when their family is located overseas. This can be due to cultural sensitivities around LGBTQA+ identities, not knowing where to get support, and wanting to protect family. Help-seeking does not only need to focus on talking about suicidal distress and can be more subtle (e.g., seeking company). Online communities can provide instant feedback and support, as well as widen networks of people experiencing similar things, particularly in relation to intersectional experiences. Many people liked the support gained from LGBTQA+ groups, but they can be exclusive or limited (especially re: intersectional or diverse experiences).

Findings

4. The role of formal mental health support for LGBTQA+SB suicidal behaviour

All but one of our participants had accessed a form of mental health and / or formal peer-based support at some point. Many participants had experience with talking therapies, predominately with psychiatrists and psychologists, but some had utilised counselling services available through their church, school, or via a phone-based service. Identifying and accessing appropriate support was a key challenge, with accessibility issues related to participants' own lack of knowledge about where and how to access services. These challenges were often compounded by barriers encountered within the healthcare system, which include limited knowledge and awareness about gender, sexuality and cultural diversity, a lack of appropriate services in rural and regional areas, and out of pocket expenses.

Increasing healthcare and support workers' knowledge about LGBTQA+SB issues, cultural diversity and the impact of intersectional experiences on First Nations LGBTQA+SB people and LGBTQA+POC is key to improving experiences of support. Discrete service providers that provide anonymity, particularly for First Nations LGBTQA+SB people, living in community was also seen as important.

5. The role of LGBTIQA+ specialist support in responding to LGBTQA+SB suicidal distress

We considered participants' lived experience and preferences for where support for LGBTQA+SB suicidal distress should be provided and explored how it can best meet the needs of First Nations LGBTQA+SB people and LGBTQA+POC. As with other forms of support, key items identified within participants' accounts related to issues of accessibility, trust and affirmation of all aspects of identity, not just gender identity and / or sexuality. Many participants found LGBTIQA+ services to be more affirmative than mainstream formal support, but there are still challenges to be met to improve accessibility and inclusion for those located at the intersections. This includes First Nations LGBTQA+SB and LGBTQA+POC, but also less visible gender identities, sexualities and geographical location.

There is also a need for greater visibility of LGBTQA+POC within services and the leadership of LGBTIQA+ services. For First Nations groups it may be better to have LGBTQA+SB members more visible and supportive within Aboriginal Community-Controlled Health Organisations, rather than First Nations LGBTQA+SB people being more visible within LGBTIQA+ community-led services.

Recommendations

Setting the policy context

- Policy interventions can improve the socio-cultural environment for First Nations LGBTQA+SB, LGBTQA+POC and LGBTQA+ people, help them feel affirmed in their gender, sexuality, racial, and cultural identities, and reduce feelings of shame, fear and stigma implicated in suicidal distress.
- Targeted early intervention will help to reduce suicidality over an LGBTQA+SB person's lifetime.
- All policies must be developed and evaluated with LGBTQA+SB people who have lived experience of suicide (including First Nations LGBTQA+SB) to ensure interventions are responsive to the heterogeneity of LGBTQA+SB communities and reflect intersectional experiences.
- When commissioning suicide prevention, postvention, and mental health services, policy makers must include LGBTQA+SB lived experience within service design and ensure services will attend to intersectional LGBTQA+SB experiences, including First Nation LGBTQA+SB people and LGBTQA+POC.
- LGBTQA+SB affirmative and safe support must be available and accessible regardless of who someone is, where they are living, their financial position, or cultural background.

Developing appropriate and affirmative support

- LGBTIQA+ community-led services, Aboriginal Community Controlled Health Services, mainstream mental health services, must work harder to foster trust, safety, and perceptions of confidentiality for LGBTQA+SB people accessing support.
- LGBTIQA+ community led organisations are best placed to deliver appropriate and affirmative support for LGBTQA+SB people experiencing suicidal distress.
- Aboriginal Community Controlled Health Organisations need to actively work with First Nations LGBTQA+SB people to develop services for Aboriginal and Torres Strait Islander LGBTQA+SB people experiencing suicidal distress.
- LGBTQA+SB people need to feel confident when accessing a service that all parts of their identity will be recognised and affirmed, particularly First Nations LGBTQA+SB people and LGBTQA+POC
- Increasing the visibility of services for LGBTQA+SB people experiencing suicidal distress, strengthening referral pathways between mainstream mental health services and LGBTIQA+ community-led services, and ensuring timely access will improve outcomes.
- Health and social care providers should undertake mandatory training provided by LGBTIQA+ organisations to improve knowledge and awareness of LGBTQA+SB lived experiences of suicidal distress, with particular emphasis on trans and gender diverse issues, intersectional identities, and the socio-cultural context of LGBTQA+SB lives.
- When allocating resources and developing support, prevention and postvention services for First Nations LGBTQA+SB, LGBTQA+POC and LGBTQA+ people, providers must have demonstrable understandings of and affiliations with those communities.

Recommendations

Improving community responses to suicidal distress

- Access to positive information about First Nations LGBTQA+ SB, LGBTQA+POC, and LGBTQA+ people and communities will promote understanding amongst families and friends and improve their ability to respond affirmatively.
- Targeted campaigns to address racism and reduce cultural isolation may help to improve the wellbeing of First Nations LGBTQA+SB people and LGBTQA+POC.
- Developing resources, awareness campaigns, and providing a platform for community role models can improve the literacy of LGBTQA+SB suicidal distress within queer communities, normalise help-seeking, facilitate conversations, and reduce associated stigma and feelings of shame.
- Training should be made available outside of service provision settings to resource people in broader communities to support LGBTQA+SB people who experience pervasive, on-going, or repeated experiences of suicidal distress.

Knowledge and training

- LGBTIQA+ community-led services need training to better address issues of race, disability, and gender diversity, including training to improve understanding about suicidal behaviour and appropriate forms of support for First Nations LGBTQA+SB people and LGBTQA+POC.
- LGBTQA+SB focused training and education of Aboriginal health workers is required to keep First Nations LGBTQA+SB population safe. Extra training should focus on improving the social and emotional wellbeing services offered by Aboriginal Community Controlled Health Services by training and supporting Aboriginal health workers to better understand and support LGBTQA+SB people.
- Making LGBTQA+SB lived experience of suicide training accessible to health and social care organisations, LGBTQA+SB communities, family and friends will facilitate awareness and increase confidence to talk about LGBTQA+SB suicidal distress, improve available support and facilitate help-seeking.
- Resources are needed to promote understanding of LGBTQA+SB suicidal distress and improve the ability of policy makers, service providers, LGBTIQA+ communities, First Nations communities, culturally diverse communities, families, and friends to respond appropriately and effectively.
- Specific LGBTQA+SB suicide prevention training should be developed for workplaces and education settings to support managers to respond affirmatively and effectively to LGBTQA+SB students and employees experiencing suicidal distress.

Recommendations

Further Research

- Further research is required to evaluate the effectiveness of suicide intervention approaches aimed at LGBTQA+SB people, including LGBTQA+SB lived experience of suicide initiatives, and LGBTQA+SB peer-led support.
- All research for, on or about LGBTQA+SB must have a First Nations LGBTQA+SB researcher as part of the chief investigator team, in the advisory group and available for debriefing First Nations LGBTQA+SB participants.
- More research is needed about how and where to provide confidential and appropriate supportive services for First Nation LGBTQA+SB people.
- Further research is needed to explore how maintaining connection to culture can reduce suicidal distress and promote wellbeing for First Nations LGBTQA+SB and LGBTQA+POC.
- To develop appropriate services for people with intersex variation, further research is needed to understand the experiences of suicidal distress for this population group.
- To develop resources to improve the ability of LGBTQA+SB communities, family, extended families of choice, households, and friends to respond to suicidal distress, research is needed to understand the lived experience of providing informal support.

Background

1

International research consistently identifies high rates of suicidal behaviour, including thoughts, feelings, and actions, amongst Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual plus (LGBTIQA+) populations [1-3]. Despite recognised limitations in the way information is collected and concerns about data integrity [4, 5], elevated rates of suicidal behaviour amongst LGBTIQA+ groups are also evident in Australia [5-7]

Appropriate supports, interventions and prevention strategies are clearly needed to reduce the burden of suicidal distress on LGBTIQA+ communities and individuals.

- LGBTIQA+ people in Australia 20 times more likely to have considered suicide than general population.
- 41.9% of LGBTIQA+ people in Australia have actively considered suicide in past 12 months.
- 61.2% of trans men, 58.3% of trans women, and 61.4% of non-binary participants actively considered suicide in past 12 months.
- More pansexual (54.6%), queer (54.7%) and bisexual (49.1%) people have seriously considered suicide in the previous 12 months than asexual (43.4%), lesbian (36.8%) and gay (30.7%) people.

Data taken from Private Lives 3 [6].

In Australia, there is a demonstrated gap in service provision and awareness about the support needs of LGBTIQA+ people. The 2021 LGBTIQ+ Health Australia update reported that only 38.1% of LGBTIQA+ people aged 14 to 21 who identified as experiencing some form of suicidal distress in the last 12 months had accessed professional supports, while 71% of LGBTIQA+ people aged 16 to 27 had not accessed mental health supports [8]. Of the LGBTIQA+ group aged between 14 and 21 who had accessed a support service, 59.3% felt their situation had improved afterwards.

Reasons for not accessing support amongst LGBTIQA+ people aged 16–27 included not feeling they needed support (29%), anticipated discrimination (32.6%), and not being aware of crisis support services or LGBTIQA+ specialist services (28.8%) [8]. Reports examining suicidal distress within LGBTIQA+ communities highlight increased rates of suicidal thoughts, feelings and actions for First Nations LGBTIQA+ people and LGBTIQA+ people from diverse cultural and linguistic communities [6, 7], but less is known about the unique experiences and support needs of these groups.

With significant levels of emotional and mental distress identified within LGBTIQA+ communities, and complex relationships with health and social care services reported, queer individuals often turn to peers for informal support because of ineffective mental health services and concerns about the ability of providers to provide appropriate and affirmative support. The recent *Lean on Me* report indicates that peer support is often reciprocal and beneficial to both provider and recipient, but a reliance on this type of support because of systemic limitations risks fatigue and burn out within LGBTIQA+ communities [9].

Understanding the role of protective factors in reducing LGBTIQA+ suicidal distress, including formal and informal support can improve policy development and service responses, facilitate referral pathways, and promote better outcomes for those individuals seeking support. National action plans, published reports, and LGBTIQA+ community organisations consistently call for evidence-based strategies drawn from lived experience [7, 10, 11].

Designing inclusive policy and services that reflect the diverse needs and breadth of experiences within LGBTIQA+ communities require careful attention to the way experiences of suicidality and support vary across intersecting identities, with a particular focus on age, First Nations status, cultural and linguistic background, faith background, abilities, and geographical location [12, 13].

Only 38.1% of LGBTIQA+ people aged 14 to 21 who identified as experiencing some form of suicidal distress in the last 12 months had accessed professional supports. Of those that did access support 59.3% felt their situation had improved afterwards

Attending to intersectionality

LGBTIQA+ populations are a designated priority group within national suicide prevention plans [11, 14], alongside Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse populations. Despite this emphasis, there is little work highlighting the experiences of groups living at the intersections. First Nations Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, and Asexual plus Sistergirl and Brotherboy (LGBTIQA+SB) people are under-represented in health/wellbeing research with much work focused on sexual health [15]. In addition, First Nations LGBTIQA+SB people may feel uncomfortable sharing either one or more aspects of their identity because of historical experiences of racism, discrimination, and a silenced 'queer' history [16].

This gap in knowledge limits our understanding of the issues impacting First Nations LGBTIQA+SB and inhibits the development of appropriate and effective support. Recent reports highlight the additional challenges that LGBTIQA+ people from culturally diverse backgrounds experience, including navigating spaces that do not fully recognise or value the complexity of their identities, limited representation, a lack of cultural understanding and instances of racism in queer spaces [10, 17]. A better understanding of approaches that support the integration of cultural and gender identities, and sexualities is essential to the development of effective strategies to support First Nations LGBTIQA+SB individuals and LGBTIQA+ people from culturally diverse backgrounds who experience suicidal distress.

An intersectional lens attends to the breadth and diversity within LGBTIQA+ communities and generates insights into the way diverse cultural and social positions intersect and contribute to suicidal distress and influence support needs [13]. Such a framework challenges the 'one-size-fits-all' approach evident within much LGBTIQA+ research, policy development and service responses, and invites more complex and nuanced approaches. Policy and services informed by intersectionality are better able to address entrenched health disparities and systemic barriers to mental health supports by tailoring interventions to the unique cultural and social locations that individuals occupy [18].

An intersectional lens attends to the breadth and diversity within LGBTIQA+ communities and generates insights into the way diverse cultural and social positions intersect and contribute to suicidal distress and influence support needs [13]

What are protective factors for LGBTQA+ suicidal behaviour?

Research on LGBTIQA+ suicidal behaviours often focuses on identifying risk factors that increase the chance of individuals or groups experiencing suicidal distress. Recently there has been a shift towards identifying factors that can act in a protective way, by reducing the effect of risk factors on LGBTIQA+ individuals and communities. Multiple protective factors have been shown to reduce suicidality and buffer the effects of particular risk factors for LGBTIQA+ people.

Distinctive protective factors are identified at the levels of the personal, interpersonal and social. Dispositional and individual traits shown to moderate identified suicide risk factors include, good health, high self-esteem, positive coping styles, resilience, and the individual ability to foster and extend positive emotions such as gratitude, optimism, and hope [19-21]. Intimate and familial relationships alongside friendship, social acceptance and LGBTIQA+ community connectedness also offer some protection against suicidality [22-24]. Other social factors also play a significant role, with socio-economic status and level of education providing protection [25]. The historical and cultural significance of two-spirit identity is important for First Nations people [26].

Protective factors can vary in strength and effectiveness between LGBTIQA+ groups [22, 27], and cultural and racial identities [28]. Personal, interpersonal, and social protective factors are important for all LGBTIQA+ people, but little is known about their relationship to risk factors within the white

settler colonial context of Australia and how these might vary for LGBTIQA+ people who might also have multiple intersecting identities. This has particular importance for understanding suicidal behaviour amongst First Nation LGBTIQA+SB people and LGBTIQA+ people from culturally diverse backgrounds with distinctive and sometimes traumatic experiences that have led to their migration to Australia.

The role of support in LGBTIQA+ suicide prevention

Despite the need for a better understanding of the support and intervention needs of culturally diverse LGBTIQA+ populations and First Nations LGBTIQA+SB people, few studies exist, with the majority focus on youth populations. Help-seeking behaviour studies show many young LGBTIQA+ people do not seek support for suicidal behaviour, may find it difficult when they ask do ask for help and only do so when in crisis [29]. A preference for informal support provided by partners, family, peers and significant others is highlighted across studies [24, 30], with help-seeking also occurring within online spaces [31]. Evidence from the US suggests some differences in help-seeking behaviour with White LGB individuals more likely to seek medical and mental health support following a suicide attempt, whereas Black LGB people are more likely to turn to religious and spiritual support [32]. More research is required to understand these crucial differences in LGBTIQA+ help-seeking behaviours within the Australian context.

A range of informal and formal support has been shown to be effective for reducing suicidal distress for many LGBTIQA+ groups. Studies consistently demonstrate the benefits of informal support provided by parents, with particularly strong effects found for LGBTIQA+ youth, and gender- and sexually diverse youth from distinct cultural backgrounds. Support provided by significant others is more beneficial than support received from parents for non-White and ethnically diverse sexual minority adults [33]. While not as strong in its benefits as parental support, friend and peer-based support is also found to reduce suicidal behaviour [21, 34].

Support received from significant others and mental health services is viewed as lifesaving and contributing to individual wellbeing [35], particularly by those people living in rural areas [26]. For gender and sexual minority refugees, religious faith can also be a source of strength [36]. Online spaces are also viewed as safe spaces where support can be found, and helpful information and advice exchanged by LGBTIQA+ individuals [37, 38]. These spaces can reduce experiences of geographical and social isolation for LGBTIQA+ youth, particularly those living in regional and rural areas, by opening new avenues for connection with others [26, 39].

While LGBTQA+ groups tend to express a strong preference for peer-based supports, a complex picture is emerging. Perceived social support and support provided by friends has been shown to reduce types of suicidal distress for men who have sex with men [21] and transgender adults [40]. However, caution may be needed because one study found an association between peer support and increased suicidal ideation for transgender veterans [41].

It is important to note that the effects of social support are not uniformly experienced across LGBTIQA+ populations with variation in efficacy for different types of suicidal distress identified within LGBTIQA+ populations [42-44]. Who provides support can contribute to the efficacy of informal support for transgender adults [45], with significant variations among different racial and ethnic groups identified [44]. Racial and ethnic differences are also evident in the way social support interacts with suicidal distress [33]. Further research in the Australian context is needed because available evidence suggests that the effects of social supports vary between LGBTIQA+ identifications and across racial and ethnic difference [43, 46].

Turning to lived experience

Complementing quantitative explorations of risk and protective factors, LGBTIQA+ lived experience research has several benefits. It problematises any conflation of LGBTIQA+ identification with suicidality and points to the complex interaction between individual, social and cultural factors in explanations for elevated prevalence rates. This includes experiences of abuse, bullying and discrimination associated with diverse genders and sexualities, alongside experiences of colonisation, racism, child abuse, sexual violence, and relationship breakdown [26, 36, 47-51].

Lived experience research provides insights into the embodied and temporal aspects of LGBTIQA+ suicidal distress and locates suicidal distress within important social and emotional relationships [49, 52, 53]. For example, studies highlight how early experiences of feeling like an outsider, misalignment of gender identity with the physical body, and early experiences of violence and discrimination can result in self-blame, shame, and self-destructive behaviour [52, 54]. Age, geographic location, faith background and the ongoing effects of colonisation for First Nations LGBTIQA+SB people are also found to intersect and contribute to suicidal distress [55].

LGBTIQA+ accounts of suicidality offer insights into the ways individuals begin to manage suicidal feelings and sometimes move beyond suicidal distress. These accounts situate protective factors, life events and social supports within LGBTIQA+ lives as they are lived in practice. They demonstrate how various factors, including social connection and support, positive life events, affirming family reactions, familial support, and stories of resilience, function together to reduce suicidal distress [26, 47, 56]. Lived experience research assists in the development of timely interventions and appropriate supports through the identification of key turning points within narratives of suicidal behaviour [57], and better understanding of the movement from suicidal ideation to attempt [52]. This report centres LGBTIQA+ lived experience of suicidal distress and provides a suite of recommendations to reduce the burden of suicidal distress across LGBTIQA+ communities and inform the development of appropriate and inclusive services and effective supports.

Lived experience research assists in the development of timely interventions and appropriate supports through the identification of key turning points within narratives of suicidal behaviour [57], and better understanding of the movement from suicidal ideation to attempt [52].

Project aims

To facilitate better policy and service responses to LGBTIQA+ suicidal behaviour in Australia, this project has two aims:

1. To generate new insights into lived experiences of suicidal behaviour within the LGBTIQA+ communities, including First Nations LGBTIQA+SB people and LGBTIQA+POC people in Australia.

2. To better understand the factors that influence and protect against suicidal behaviour in LGBTIQA+SB communities, and the practices and services experienced as helpful and supportive to prevent or manage it.

Notes on terminology

Within health and social care policies and service provision, the acronym LGBTIQA+ is often used to refer to lesbian, gay, bisexual, transgender, intersex variation/s, asexual, and other identifications. Within the acronym, LGB and A refer to sexual orientations, whereas T refers to diverse genders, and I refers to variations of sex characteristics. The Q can refer to queer which is an umbrella term inclusive of all genders, sexes, and sexualities but it also refers to questioning and includes people who may still be exploring their identity or those who do not want to be labelled. The plus within this grouping also refers to any identity not captured by the other letters, which may include men who have sex with men, pansexual people who are romantically and/or sexually attracted to people of all genders, and people who identify as non-binary where their gender identification is neither exclusively male or female and agender people who do not have a gender. The plus also reflects terms used in languages other than English referring to diverse genders and sexualities that do not easily translate into LGBTIQA+ (see appendix 1 for glossary of key terms).

In Australia, the acronym SB is sometimes added to LGBTIQA+ (LGBTIQA+SB) to acknowledge the trans women and trans men of First Nations gender-diverse people within some, but not all, Aboriginal and Torres Strait Islander communities. The use of the term sistergirl and brotherboy (SB) is an agreed national term by a majority of the Aboriginal and Torres Strait Islander trans community. The S stands for sistergirls, for those who identify as Aboriginal and / or Torres Strait Islander people and were assigned male at birth but live their lives as women, including taking on traditional cultural female practices. The B stands for brotherboys who identify as Aboriginal and / or Torres Strait Islander people assigned female at birth but identify as male or are perceived as having a male spirit [58].

We use the acronym LGBTQA+SB throughout this report to recognise the diverse genders and sexualities of our participants and acknowledge that, despite attempts, we were unable to recruit participants with intersex variation. The research design adopted an intersectional lens with an explicit focus on understanding how LGBTQA+ identification intersected with First Nations status and racial and ethnic difference. In the presentation of the data, we use the acronyms First Nations LGBTQA+SB, LGBTQA+ POC, and LGBTQA+ to represent the three cohorts whose accounts comprise this research. First Nations LGBTQA+SB refers to Aboriginal and / or Torres Strait Islander participants. LGBTQA+POC is used to identify participants who identified as a person of colour (POC). We use LGBTQA+ to refer to participants who did not identify as either First Nations or POC. In the presentation of quotations, we also highlight the gender identity and sexuality of participants at the time of the interview.

Methodology and Method

The research team worked in partnership with Switchboard Victoria, Roses in the Ocean, and community representatives to develop a methodology that centred lived experience within an intersectional approach [13]. This was informed by community psychology's commitment to progressive and generative collaborative practice, which has been used widely to work effectively with LGBTIQA+ groups [59] and Aboriginal and Torres Strait Islander communities [60]. The research aims and methodological approach were developed and refined in collaboration with representatives from partner organisations who were also part of the research team, community representatives, including First Nations LGBTQA+SB and LGBTQA+POC representatives, and the advisory group. The research team, representatives from partner organisations and advisory group members are members of LGBTIQA+ communities and have lived experience of some or all of the following: suicidal distress; bereavement from suicide; the impact of suicide in LGBTIQA+ communities; the impact of suicide in First Nations communities and LGBTQA+POC communities. The involvement of LGBTQA+SB, First Nations individuals and LGBTQA+POC representatives was vital to ensuring that the research procedures were appropriate and inclusive, and elevated rarely heard voices within research, policy development and service design. This collaborative approach was embedded throughout. Co-investigator Dr Vanessa Lee-Ah Mat, who is Aboriginal and Torres Strait Islander by genealogy, led the development of all processes and procedures related to First Nations LGBTQA+SB people. LGBTQA+POC and First Nations community representatives were consulted at all stages, including the analysis, interpretations, recommendations and training, to ensure our presentation is culturally appropriate.

Ethics

The research was designed to align with calls by the National Mental Health Commission to prioritise the lived experience of suicide within research, policy development and the design and delivery of support services (NHMC 2018). Ethical approval was granted by RMIT University (23727).

Participant Recruitment

The study was promoted by Roses in the Ocean and Switchboard Victoria with recruitment circulated through volunteer networks. Prospective participants contacted the research team via email to register their interest in the study. A short phone call was organised to go through the 'Are you Ready?' document and demographic details were collected at this time. These details were used to select interviewees to satisfy the purposive sampling criteria that was adopted to ensure the data reflected the breadth and diversity of LGBTIQA+ community. First Nations LGBTQA+SB participants contacted Vanessa Lee -Ah Mat who then organised the connection with the researcher in Melbourne.

Eligibility

To be eligible to take part in an interview, participants had to:

- Be aged 18 years or over
- Identify as LGBTIQA+
- Live in Australia
- Have experienced suicidal distress
- Read through the '*Are you Ready?*' document

Interviews

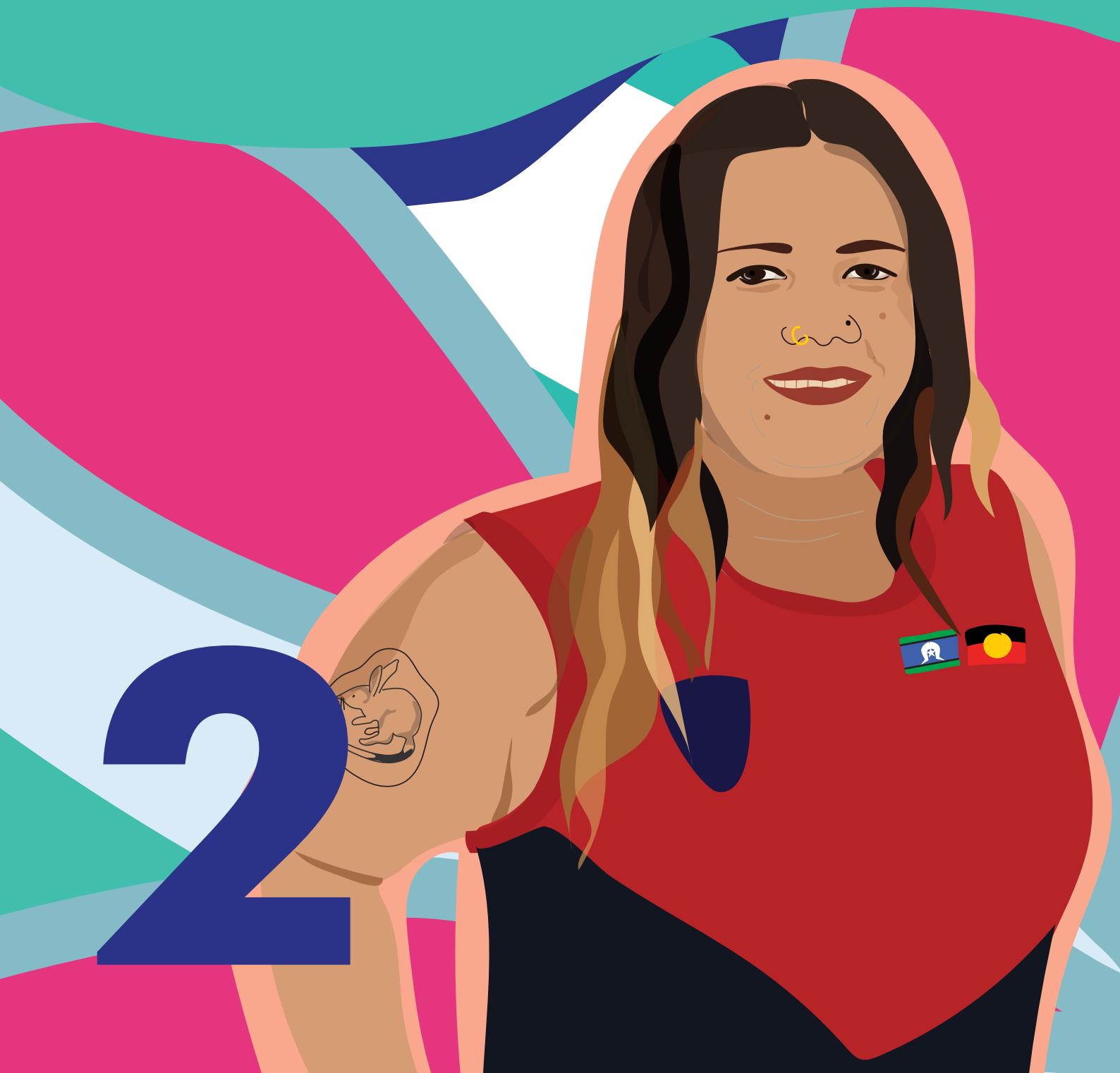
The research team were based in Victoria and Queensland but due to the ongoing COVID19 pandemic and rolling lockdowns, all interviews were conducted online and audio recorded. Twenty LGBTQA+ adults were recruited from across Australia with participants located in Queensland, Victoria, NSW, Western Australia and South Australia. Sampling sought to capture diverse experiences of suicidality and social supports and reflect the diversity of the LGBTIQA+ community in terms of gender identity, sexuality and age, with particular emphasis on recruitment of First Nations LGBTIQA+SB participants and LGBTIQA+POC. In total, 3 First Nations LGBTQA+SB people, 7 LGBTQA+POC, and 10 LGBTQA+ people were interviewed as part of the study (See appendix 2 for demographic information). While specific attempts were made, the research team was unable to recruit individuals with intersex variation. First Nations LGBTQA+SB participants had the option to be interviewed by either Vanessa Lee-Ah Mat or Nicholas Hill. Due to the sensitive nature of the interview content and in-line with men's and women's business, all First Nations participants opted to be interviewed with Nicholas and Vanessa. Vanessa also spent time debriefing participants after the interview. Interviews with LGBTQA+POC and LGBTQA+ people were conducted by Nicholas Hill or Katherine Johnson.

Analysis

Data was subjected to a rigorous thematic analysis [61] which was adapted to capture similarities and differences between each of the groups who shared their story with the research team. An initial coding framework was developed by Nicholas Hill in consultation with Katherine Johnson through reading several transcripts and in relation to current evidence on LGBTIQA+ lived experience of suicidal distress, protective factors, and support preferences, including informal and formal support. The coding framework was then presented to the advisory group and revised. Vanessa contributed to the development of the coding framework and reviewed the analysis of First Nations LGBTQA+SB interviews and presentation of quotations, as per the research team's agreement with First Nations participants.

To capture themes unique to each participant cohort and identify similarities across groups, we coded each cohort (First Nations LGBTQA+SB, LGBTQA+ POC, LGBTQA+) separately using NVivo (qualitative data analysis computer software). As coding progressed, the framework was reviewed and revised iteratively. Summaries of potential themes and concepts were then written for each group. The themes were then compared across groups to highlight similarities and differences and identify variation within groups. The analysis presented in the following sections develops a narrative of suicidal distress and available supports drawing on the experiences of the three cohorts.

Understanding LGBTQA+SB lives:
Intersectional insights



2

This chapter sets out strengths and challenges involved in LGBTQA+SB identification and highlights sources of acceptance, affirmation and connection that helped our participants to live affirmatively as LGBTQA+SB. Stories of strength are often missing from accounts of LGBTQA+SB experiences of suicidal distress. At the same time, it is important to highlight the many and diverse challenges that LGBTQA+SB people experience as they recognise and embrace their LGBTQA+SB identity and attempt to live affirmatively. Family life, friendships, and various social spaces can be significant sources of acceptance and affirmation but may also be drivers of distress and shame. LGBTQA+SB communities are potential sources of affirmation and support. However, intracommunity racism, as well other forms of invisibility and discrimination against people with intersectional experiences, means some find it difficult to connect with or feel accepted in LGBTQA+ communities.

Becoming LGBTQA+SB

Prior to finding the language and vocabulary to make sense of their gender identity and / or sexuality, many participants described feeling different from their peers. This was often an emotionally challenging time, with some participants explaining how they attempted to conceal their identity from themselves and others because of fears about acceptance, potential discrimination and anticipated discrimination. For example, one participant explained that he had grown up in 'a very traditional family, [with] traditional Asian values' with a 'Christian background.'

> *And then of course in my teens I realised that I was different; I had certain feelings. I realised that my interests and my feelings were quite different from my peers at that age. But I didn't think much of it because the concept of being LGBT or gay simply did not exist for me. Not because I was naïve! I knew what being gay meant. But it's just that I just thought that I was different and I thought that, 'Oh, this is something that will just pass'.*
>
> **SB12LE, 40s, cis male, gay, LGBTQA+POC**

The invisibility of 'LGBT or gay' people within the social and cultural context in which he grew up led this respondent to believe his same-sex attraction would pass. Another participant spoke extensively about hiding her sexuality when she was younger because of fears about how her family and friends might react:

> *And I went along with society until around the age of 20, 21, pretending to be straight and lots of lubricant of alcohol to do that, which is why I ended up with a problem with alcohol. Having to pretend, and also keep people unaware of my sexuality. I had to participate in having heterosexual relationships.*
>
> **SB02LE, 52, gender non-conforming, gay, LGBTQA+**

In the absence of supportive and affirming social connections, this participant describes the beginning of an unhealthy coping strategy they used to self-manage feelings of difference and the pressure they felt to behave as a heterosexual. The consequences of long-term self-managing strategies used to cope with early experiences of shame, concealment of identity,

and discrimination were evident within many of the accounts of participants who struggled with their emerging identity:

> *In terms of sexuality, I knew I was gay from about 13, although I knew I was different earlier. My first sexual encounter was when I was about 18 or 19, 19. I met someone online, and then I didn't do it again for a while, and then the first two years I was very ashamed about it. I did a lot of stress eating afterwards, I would go hook up with someone and then go eat junk food, so my weight has fluctuated my whole life, which has been a real battle for me.*
>
> **SB18LE, 38, cis male, gay/queer, LGBTQA+POC.**

Additionally, experiences of racism and the 'body shaming crap in the queer community', meant this participant often felt unwelcome within LGBTQA+SB spaces, including online spaces, such as Grindr. Early feelings of shame were commonly heard in participants' accounts of sexuality and desire, and suicidal distress.

Finding information about diverse genders and sexualities helped many participants to make sense of their gender identity and / or sexuality. Geographical, generational, and cultural differences in experiences were also evident. An older participant noted how awareness of LGBTQA+SB identities had changed since they were young.

> *I remember going away to uni going, 'I wasn't sexually aware'. We never talked about sex, it was just people met a partner, they got married and had kids. It was just that standard traditional lifestyle.*
>
> **SB10LE, 56, cis male, gay, LGBTQA+**

The dominance of heterosexual relationships and lack of information about diverse genders, sexes and sexualities shaped people's self-understanding and limited their ability to explore their gender identity and / or sexuality, sometimes until later in life.

Accessing information and becoming involved in LGBTIQA+ communities helped two First Nations participants to explore their identity. One participant explained how finding a label helped them to make sense of their sexuality.

> *And then when I moved to [city], I started hanging out with more open people, started hanging out with more queer people, went to a couple of equal rights rallies, and just slowly, slowly gathered some information on it and that's when I discovered what 'pansexual' meant. ... it was equal parts confusion and relief at the same time because it manifested as one of those eureka moments for me, ... it was where I heard the term and then I said, 'Cool, that's interesting, what's that?' And then you ask the question, you get the answer! And then immediately I thought, 'That's exactly what it is, great! Done! That's me, it's like that's exactly it. It feels comfortable and it feels right.'*
>
> **SB03LE, 29, cis male, pansexual, First Nations LGBTQA+SB**

Moving away from his regional community in his early twenties to a metropolitan city exposed this participant to a greater diversity of sexualities and related information. We can see how he was curious when he discovered the pansexual label and through asking questions was able to embrace a sexuality that felt 'comfortable' and 'right.'

Participants who had grown up overseas remarked that information about diverse genders and sexualities was more accessible in Australia and LGBTQA+SB people had more rights than in the countries where they had grown up. Moving from China to Australia, first as a backpacker and remaining as a student, was transformative for one participant.

> *I really started to find ... my real identities ... I think after I left China. Without that cultural and social context, I started to know more about gender and sexualities in Australia. And then I came across the term gender fluid, so I think it just clicked so well with my experience.*
>
> **SB14LE, 26, gender fluid, pansexual, LGBTQA+POC**

Within their account, they describe experiencing 'a lot of confusion and denial' and being unable to understand their gender identity when living in China. In contrast to their experience in China where they were 'not really engaged with any other queer folks,' the move to Australia allowed greater freedom to explore their gender identity until they found an identity that just 'clicked.'

Entry into queer communities and connecting with LGBTQA+SB people was a pathway to self-acceptance for many participants. For example:

> *I was really lucky as well that I happened to just find a queer community in [city]. A friend of my partner, we just ended up getting really close, and they invited me to a poetry night here in [city]. And that was where I met my first non-binary person. I was like, 'Shit, I can do this'. So I just went balls out non-binary, and it was really cool.*
>
> **SB07LE, 28, non-binary, lesbian, LGBTQA+**

This fortuitous encounter was central to the embrace and celebration of the participant's non-binary gender identity. Accessing information about the range and diversity of genders and sexualities and meeting LGBTQA+SB individuals can help people explore and understand their gender and / or sexual desires. Being able to live in an LGBTQA+SB affirmative way can moderate feelings of shame, isolation, and rejection, which are often implicated in suicidal distress [62].

The role of family

Accepting and affirming responses from family, friends, and peers offer various levels of protection against suicidal distress, while unsupportive reactions and a lack of acceptance negatively impact the mental health and wellbeing of LGBTIQA+ people. Many of our participants, particularly First Nations LGBTQA+SB and LGBTQA+ POC participants, emphasised the importance of close relationships with family, but the extent to which they were open about their gender and / or sexuality and with whom was mixed. All participants were 'out' to at least one or more family members, except for one person from the LGBTQA+POC cohort. This participant explained why he felt unable to disclose his sexuality to his parents who lived in India as well as potentially more accepting family members in Australia:

> *I've hidden myself as an individual, I'd say; of course, I cannot be my true self. But [with] some members of family here [in Australia], I can be open – a bit more open about issues, about awareness, about the community; but I can't really come to the facts and tell them that I am gay. And I think that culture is a huge part of it; being an only child is another big part of it, because you've got cultural – so many things just related to you – the expectations the parents have, the people around you have, and being so lucky that I've got such a big family, being loved by them so much, and being, at times, put on a pedestal. I was doing academically good, I was stable, kind of like the star child in the family.*
>
> **SB11LE, 25, cis male, gay, LGBTQA+POC**

In other areas of his life, this participant felt close to his parents, 'I'm blessed that I have parents who talk to me and listen to me and understand me.' Yet, he could not disclose his sexuality to family members because of the perceived pressure of cultural expectations, which are exacerbated by being an only child. Despite living in Australia amongst family members who might hold less-traditional cultural views, he does not feel he can talk about his sexuality in case his mother and father in India find out. We do not know how his family would respond, but the perceived risk of familial shame, rejection and disappointment weighs heavily and contributes to a hypervigilance and disconnection from family members.

Concerns about family acceptance of diverse genders and sexualities are well founded. Several participants recalled detrimental experiences, with some describing how unsupportive and / or disparaging comments made by family members prior to 'coming out' deepened their anxieties and fears about how their gender identity and / or sexuality might be accepted. For example, a sistergirl said:

> *My father, because he was in the community, he actually did pull me up one time when I was in my early teens. And he had a go at me. He said, 'I hope you're not going to be one of these boys.' He said the P-word, and I was upset. Mum was there, and she got up and her and Dad had a disagreement. Dad, he obviously knew things were happening with me, but Mum always kept my back. Mum, she knew, she just said to my father, 'You're not going to put a hand on him, you're not going to touch him'. My mum, she said that from day one. She knew that I was my sexuality, so without Mum stepping up and stopping my dad, I would have left home.*
>
> **SB05LE, 42, sistergirl, First Nations LGBTQA+SB**

Her mother's intervention was powerful, creating a sense of acceptance and belonging in the family home. Yet, it also shows how negative responses can cause tensions within families. Participants described how they were selective about who they told and

when, often basing their decisions on presumed responses of particular family members. One participant said,

> *I started coming out to my sister, but I've waited to come out to my parents for a long time. So, I just came out to my dad finally, but I couldn't come out to my mum. Technically, I'm a very out, gay man, everyone knows I'm gay except my mum at this point. Even though I'm really visible, working for queer rights. Professionally I'm involved in this movement for a long time. My mum still thinks I'm straight. I don't know. She knows I work for gay rights and everything, but she sees this one as a job, as a human rights job, it has a lot of benefits. I guess Asian culture is really different! But from a Western perspective, it's really hard to understand: 'It's obvious your mum knows!' But I am 100% sure, certain, that she still thinks I'm straight.*
>
> **SB09LE, 28, cis male, gay, LGBTQA+POC**

Who a person chooses to come out to is often based on perceptions of acceptance and understanding and previous experiences of disclosure to significant others. This participant reflects on his perception of 'Asian culture' and the social dynamics where he could not live affirmatively within the context of family life. As a result, the idea that his sexuality is 'unwanted' is maintained by the idea that his mum will not take the news well.

The concept 'ally' has become popular in recent years in LGBTIQA+ communities as an important form of political and emotional support. A First Nations participant emphasised the positive impact of the acceptance and affirmation shown by her grandmother.

> *And this is where people got to get it right in themselves, is if you're going to be pleasing people, you're going to be pleasing people all your life. That's what my grandmother used to say, 'We love you. Your father loves you, your mother loves you. They're the people who created you. That's all you need'. The ones who don't accept, 'Bye'.*
>
> **SB20LE, female, heterosexual, First Nations LGBTQA+ SB**

The acceptance and support she received from her grandmother helped this participant to remain strong inspite of the rejection and discrimination experienced elsewhere. We found that feeling supported and affirmed by one family member, in some family systems, could help facilitate greater understanding amongst less knowledgeable or accepting parents or siblings. A non-binary participant talked about the valuable support they received from a younger sibling.

> *My younger brother, he's four years younger than me, and when I started to come into my gender identity, he was really supportive. He was the most supportive. And I was actually outed to him by one of my friends who had very poor boundaries, and that was really scary, but he was like, 'Cool, so what does that mean?' He was just really cruisy and easy-going. He didn't really talk to my Mum about it or anyone else in the family, he kept it under wraps. But I think my Mum knew something was up. We fought a lot at that time about things and she really bared her soul to me one night saying she didn't know how to treat me or talk to me or anything like that. And that was really amazing because it really gave us the opportunity to come together and move into a space where she was respecting my pronouns and understanding my identity. She still doesn't quite get it, but she's respectful nonetheless. My brother was instrumental in putting pictures of me, like my social media pictures around the house with my pronouns on them, just everywhere. He stuck two on her headboard ... She still gets it wrong all the time, but I know that she accepts me as a non-binary person and she's trying really hard.*
>
> **SB07LE, 26, non-binary, lesbian, LGBTQA+**

The effort made by family members to understand and respect their gender identity and / or sexuality was appreciated by participants, even when incorrect pronouns or language were used, indicating that mistakes could be moved through easily if it was perceived that the other person was accepting and trying to learn how to best communicate.

Accepting family members can create a supportive environment that shapes how LGBTQA+SB individuals manage their identity and make decisions about

disclosure. However, the impact of unaccepting family members was deeply felt. For example, a trans female participant explained:

> *My older son, ... , he's 33 now, I think, he divorced himself completely from me. I haven't spoken with him for about five, six years now. I continue to send him letters and emails and stuff, but he doesn't respond. I'm not quite sure why. But the other six, I got a good relationship with them and I don't see much of them because they've all got their own families and their interests and they're all busy. ... I've still been the person that was their deeply loving playful parent when I was with them.*
>
> **SB01LE, 75, trans female, lesbian, LGBTQA+**

This excerpt highlights how acceptance can vary between family members and that some members may disconnect 'completely'. It is also important to acknowledge that family support can vary overtime with individual members developing their own understanding and knowledge of diverse genders and sexualities. This was especially the case for the parents of LGBTQA+POC participants who had grown up overseas and parents of participants who held strong religious beliefs. For example:

> *When I did come out to [my mother], which was when I was about 18, she didn't take that too well with her religious beliefs and it was a long journey, probably a good 10-year journey. But she did turn around from that to the point where she voted yes in the marriage equality survey, which was a really big deal given how strong her beliefs were.*
>
> **SB15LE, 33, cis male, gay, LGBTQA+**

This participant's mother eventually came to accept and support her son and even voted yes in the Australian Marriage Law Postal Survey, yet it took many years. Similar experiences were found amongst participants from all cultural backgrounds, but the social and cultural context of how and where participants grew up shaped awareness and understanding of LGBTIQA+ identities amongst family members. These contexts also influenced how safe participants felt when disclosing their gender identity and / or sexuality to family.

> *[I]t's been a journey for my parents to accept my sexuality or identity. So, I don't really think my parents get the concept of gender fluid, trans, or gender diverse, these concepts, because I haven't really explained to them yet. And I think it's a bit too advanced for them to know while they are still in the accepting process of my sexuality identity. My mum was firstly in denial and just pretended that the conversation didn't happen. However, deep inside my mum knows my sexuality is different to other biologically females and she was just not wanting to talk about it. My dad is actually okay with it.*
>
> **SB14LE, 26, gender fluid, pansexual, LGBTQA+POC**

This participant explains that it was easier to talk to their parents about their sexuality than their gender identity. When disclosing their gender identity and / or sexuality to others, LGBTQA+SB people often work within the parameters of the information and knowledge family members have access to and the social and cultural context in which they live. Suicide prevention services and health and social care providers need to understand that family acceptance and affirmation of LGBTQA+SB identities is not static and be able to provide support that is sensitive to changes in these experiences overtime.

Affirming friendships

Friendships were also prominent within participants' accounts of exploring their gender identity and / or sexuality and embracing an LGBTQA+SB identity. Like accounts of familial acceptance, reactions varied amongst friends. A sistergirl (SB05LE) described how her 'really close friends' supported her when she was trying to hide her identity and 'blend in' during school. She said, 'I was really kept safe with those boys, they took care of me'. For others, maintaining friendships could be difficult, and some people sought out new friendships with people who had shared experiences. Some participants explained how their concerns about receiving negative responses to their gender identity and / or sexuality shaped their social networks and influenced their ability to live affirmatively.

> *I've still got friends from over – the real good friends from over there today. But I realise now that yes, I actively distanced myself from them and started to form a life outside of them, just in case. You know, the classic scenario was losing friends and family when you came out. So, I did a lot of internal processing, and what is it? Introspection, as to what did they offer me versus what I was going to lose anyway. But as a protective factor, I distanced myself from them anyway. And those that are still my friends today just laughed their heads off and said the obvious like, 'Okay, so tell us something we didn't know.'*
>
> **SB02LE, 52, gender non-conforming, gay, LGBTQA+**

This participant said she did 'a lot of internal processing' and 'introspection' when contemplating the potential rejection and loss within her friendship group. Attempts to distance herself from friends was driven by a fear of loss, yet she retains some of these friendships today, particularly those who had already acknowledged and accepted her sexuality. We note that pervasive fears of rejection can lead LGBTQA+ people to actively distance themselves from friends, which can have long-term consequences for social connection and support.

Gender affirmation was also a particular challenge noted by some gender-diverse participants within friendships.

> *I still had one friend from high school, and we're still friends now and we lived together for a period. They struggled a bit with the transitioning into new pronouns and not using gendered language and stuff, but when I was able to be vulnerable enough to say, 'I would really prefer it if we didn't talk about me in this way anymore', they were actually like, 'Yes, of course I can do this, I can absolutely support you and use the right language'. But that was a bit hard, lots of tears and stuff like that.*
>
> **SB07LE, 26, non-binary, lesbian, LGBTQA+**

According to this participant, expressing their needs and educating their friend around the use of gendered language allowed them to maintain the relationship, though at times these discussions were upsetting. This contrasted with the process of making and maintaining friendships post-transition: 'I just met people at that point as a nonbinary person and they were just like, 'Cool, how do you want me to refer to you?' Many participants similarly indicated that making friends was less of an issue once they felt comfortable and secure in their LGBTQA+SB identification.

Participants emphasised the importance and value of friendships with people who shared their identity and / or experiences. This was particularly prominent in the accounts of participants who had multiple intersecting identities, including gender identity and / or sexuality with cultural difference or disability. For example, one non-binary participant said:

> *I think it's a joke both in disability communities and in queer communities; everyone just kind of flocks together and then we find out in hindsight that it was all the queer people, and the undiagnosed disabled people that just grouped up. So, it was a little bit of that. The sort of long-term friendships that I've retained from childhood and from high school have been with queer and disabled peers, though I did not retain many of them. The rest of them I've made through things like when I left high school, I started volunteering at a trans youth collective and I met quite a few friends there, and then you make friends with their friends, stuff like that.*
>
> **SB08LE, 23, non-binary, queer, LGBTQA+**

This participant drew on Mia Mingus's [63] concept of 'access intimacy' to explain why it was important to have friends with similar experiences to their own. They explained that having friends who also identify as having a disability and queer ensured their accessibility needs were met in public and private in a comfortable and safe way.

Participants from the LGBTQA+POC cohort, particularly those who had moved to Australia for university or work, also emphasised the value of having friends with similar cultural background to counter the dislocation they felt as a recent migrant.

> *[O]ne thing that I really miss is having long-term friends that you could trust, because, since I moved here, I had to build friends all over again. I had to make friends all over again. So – and true friendships really took time to build, it's not something that happens overnight. So back in my home country I could actually, oh, I could say that I could rely on a long-term friend for emotional support, moral support. There's also that cultural similarity, and so there is – I didn't have to explain a lot and then people – and my friends could understand me and say, 'Oh, I know what you're saying, I know what you're going through'. Whereas here sometimes there is a bit of a cultural difference.*
>
> **SB13LE, 40s, cis male, gay, LGBTQA+POC.**

Long term friendships are a vital source of emotional and moral support, as this excerpt demonstrates. Establishing supportive networks takes time and their absence can increase a person's vulnerability. Even when people had more-established friendships in Australia or had grown up here, participants talked about the value of cultural understanding within friendship networks. Making friends with people from a similar cultural background could make it easier to navigate instances of racism and discrimination that some participants experienced.

Friendships were valued sources of advice and support for our First Nations participants. Two Aboriginal and Torres Strait Islander participants explained how the advice, support, and love they received from friends helped them to feel 'safe' and 'comfortable'. Another First Nations participant described her role as a leader within the community where she lived:

> *'[T]hey follow me. I'm a leader. They come with me. We're going clubbing, I'll come with you. I don't need people to drive me. I'm my own spearhead woman.*
>
> **SB20LE, female, heterosexual, First Nations LGBTQA+ SB**

The emphasis on her leadership qualities is used to highlight her independence as a 'spearhead woman', yet friends were also important partners within social activities. Thus, for all cohorts, acceptance and affirmation by friends can help mitigate the effects of living in a white settler heteronormative society which includes, regular experiences of invisibility, discrimination and inequality organised around gender, sexuality and race.

LGBTQA+SB identification, intersecting identities, and social life

Social acceptance of diverse genders and sexualities shaped our participants' confidence to live in LGBTQA+SB affirming ways and celebrate their identity. Perceptions of safety and support for LGBTQA+SB people across different social contexts were strongly associated with self-acceptance of gender identities and / or sexualities. Many people noted how social acceptance had grown over the years and said this helped them to make sense of their gender identity and /or sexuality and feel safe and affirmed. Some participants compared increased social acceptance with the lack of acceptance they experienced growing up when people made 'hurtful' comments, including using the 'P-word'. First Nations participants noted that community awareness and acceptance was slowly changing, particularly through First Nations LGBTQA+SB people openly living within their communities:

> *[I]t's people like that [who] take little progressive steps to create the space so that one day it will be big enough for you to walk into so that you can exist freely until the whole world suddenly becomes safe, you know. So, yeah, I mean that's more informal stuff, I get it. But in terms of the actual cultural support, formally speaking, it's non-existent as far as I can tell. … It's accepted quietly and informally among Torres Strait Islanders, I know that, but to speak about it openly hasn't really happened until like the last maybe five years or so.*
>
> **SB03LE, 29, cis male, pansexual, First Nations LGBTQA+SB**

According to this participant, there is still a lack of broad cultural support for LGBTQA+SB community members. Although he notes how awareness and 'cultural support' is slowly increasing as more LGBTQA+SB individuals lived openly within the community.

Participants who had grown up overseas talked about their initial excitement about moving to a country with greater perceived social support and legal protections for LGBTIQA+ identifying people. They felt there were more resources available to explore and embrace their LGBTQA+SB identity, and to live in a way that affirmed and celebrated their identity.

> *When I moved here, I was quite – to be honest – I was quite proud that I was telling everyone. You know how they make that joke about vegans, that you meet a vegan and the first sentence you'll say is, 'Hey, I'm vegan'. It's the same thing that I was doing myself as well, meeting everyone and saying, 'Hey, I'm gay. Hey, I'm gay'. And of course, I might sound frantic, but then again, I think that was a way that I could celebrate myself without prejudice, without fear, because I knew, of course, that in this country you can't discriminate me, and you've got all these legal aspects in place, as compared to the background I come from. So, I think that was a point that I just started celebrating myself and telling people.*
>
> **SB11LE, 25, cis male, gay, LGBTQA+POC.**

This participant was less fearful about homophobia in Australia compared with his home country. Social acceptance of LGBTIQA+ people helped him to celebrate and embrace his identity as a gay man for the first time.

Settling into a new country, however, was not always easy, with some participants reporting significant experiences of cultural prejudice and racism. They explained how their initial excitement about living in a more accepting society quickly dissolved as a result. The transition into a new country where participants suddenly found themselves belonging to a racial minority was particularly challenging for some participants. Two participants explicitly noted how their racial identity became more prominent than their sexuality in many contexts. One LGBTQA+POC participant spoke extensively about the challenges of navigating a predominately white society:

> *I had to deal with Australian society and I have to deal with those problems that I'm having with white people. Also, at the time, ... I was working as a waiter at the Chinese restaurant and that's how you get all those things, even worse. It's hard you know? Especially that the Chinese restaurant was one in the suburbs, a very white suburb, so you won't get any Asian or black people ... It's all white people. I'm happy they're appreciating the Asian culture and stuff. I'm not Chinese, I don't even appreciate the Chinese culture, whatever. But I was working there because I looked ... Chinese ... White people think it's appropriate, but it's not appropriate for us, and always tried to speak Chinese. And everyone asked a lot of inappropriate questions: 'Where did you come from?' I can guarantee nine out of ten commented on my English.*
>
> **SB09LE 28, cis male, gay, LGBTQA+POC.**

Experiences of racism, discrimination and a lack of cultural awareness were identified as significant challenges across multiple contexts but, in this extract, the focus is on work. The impact of racist comments and culturally inappropriate questions is distressing. Discrimination experienced at work compounds the sense of cultural isolation and racism experienced by this participant within other spaces, including university and the queer community. These types of experiences contribute to a splitting of identity, where cultural identity is more strongly associated with the experience of suicidal distress than his sexuality. Navigating intersecting identities within a predominately white, colonial, heteronormative, and binary gendered society was challenging for many of our LGBTQA+POC participants, despite the general acceptance of LGBTIQA+ people.

Participants explained how navigating 'heteronormative' and binary gendered expectations within their day-to-day lives could leave them feeling marginalised and emotionally depleted. Religious faith and cultural background also shaped how comfortable participants were with their identities. Three participants identified as still practicing their religion (one from the First Nation cohort and two from the LGBTQA+POC group) and, of these, two participants described their Christian faith as a source of strength and resilience. Other participants described how a perceived lack of social acceptance within their religion motivated them to conceal their identity:

> *I had all those kinds of cliched moments, like pray the gay away, and all that kind of stuff, and made deals like, 'If you don't let me be gay, I'll be a good Christian,' all that kind of rubbish. Yeah. However, I would say that even though I was not openly gay with anyone, and I wouldn't say I'm a clichédly queer person, I was able to keep in the closet, I guess.*
>
> **SB18LE, 38, cis male, gay/queer, LGBTQA+POC**

This participant describes how he hid his identity and attempted to 'pray the gay away' when he was younger and involved with the church. Other participants who had grown up with a strong faith explained how moving away from their religion helped them to better accept their LGBTQA+SB identity.

Our participants described how acceptance and affirmation of diverse genders and sexualities varied across a range of institutional and organisational contexts. Feeling safe and affirmed as they navigated organisational spaces and institutional contexts often required constant vigilance and emotional labour. School was often a difficult and challenging time. It was here that many people became aware of their

gender identity and sexual attractions and desires. Bullying and their effects were a common feature of many accounts. This participant talked about unlikely allies in high school, where they were not 'a popular person' and had a lot of disagreements about gendered expectations.

> *But yeah, talking to these two sisters, they let me talk and do a lot of the working out. And there were concepts like sexuality and gender and the challenges in society that I could actually do. I had airtime. And the irony is that they were Catholic nuns, but they were not the ones who were sending me to the principal's office during class. They were the ones who were, you know, 80-90 plus years old. And so, they would listen. They go, 'Well, that's a good point. It'll be interesting how that fits into your life'. Or they had very nice broad views. But actually, they were quite inclusive and still let me be.*
>
> **SB16LE, 47, non-binary/agender, pansexual/demisexual, LGBTQA+**

Finding allies and having someone to talk to about troubles and concerns at school can help LGBTQA+SB people manage the effects of the invisibility and discrimination they experience.

Perceived support shaped how participants navigated organisational and institutional spaces. For some people, it was important to live openly but for others, concerns about potential consequences meant they concealed their LGBTQA+SB identity. A First Nations LGBTQA+SB participant explained: 'I was in a high position as a team leader, and I was starting off … but I didn't want to put that out there' (SB20LE). Another participant (SB07LE) said they left an unsupportive workplace 'not because [they] felt a threat of violence, but more just like this would be a lot of effort'. The 'effort' that it can take to educate colleagues and promote organisational change can be challenging for LGBTQA+SB people.

Living affirmatively however could be challenging in less accepting institutional and organisational spaces. One older trans female participant described how she worked hard to be socially accepted by fellow residents in the retirement village where she moved after a period of homelessness.

> *I've become so much a part of the community and the last few people that I got comfortable with were a couple of ladies who are staunch Christians from the old [religious social service] situation and it took me a couple of weeks to work on the last one who was like, 'What is this person doing? He's going against the typical injunction that men should not wear women's clothes'. But I just gently greeted her, 'Hello, how are you, [person's name]? Nice day.' [I just was] gently loving towards her and she's now my best mate.*
>
> **SB02LE, 75, trans female, lesbian, LGBTQA+.**

To live in an affirmative way and find social acceptance within the retirement village, this participant describes how they had to navigate transphobic responses from other residents. Being responsible for fostering LGBTQA+SB acceptance within different organisation and institutional contexts can be exhausting. The need for vigilance and emotional labour on the part of LGBTQA+SB people to ensure they can live in an affirming away (free from discrimination) is an ongoing process and remains a challenge when transitioning into new and unfamiliar settings such as workplaces and aged care.

Connecting to LGBTQA+SB communities

Many participants spoke about their connections to LGBTIQA+ communities. Attending queer events, becoming involved with LGBTIQA+ organisations, and feeling part of a community helped many to accept their gender identity and / or sexuality and live affirmatively. Yet, it is important to note the ambivalence felt by some about LGBTQA+SB spaces and others disclosing experiences of discrimination and lateral violence. For participants living in regional and rural areas, accessibility of queer events and LGBTIQA+ organisations, as well as visibility, were central challenges. One First Nations participant said:

Visibility was a particular concern in smaller communities which could limit the ability of LGBTQA+SB people to form connections with similarly identified individuals; in this case, younger First Nations LGBTQA+SB people. This participant said she encouraged younger First Nations LGBTQA+SB people to attend events because 'it's a good space' and said 'it's an awesome support' for people in the community. Another participant (SB06LE) who lived in a regional area noted how she was able to make sense of her sexuality through her participation in 'a kink scene'. Connection to different communities can help people experiment with, make sense of, and embrace a gender identity and / or sexuality that better aligns with their sense of self.

Not all experiences of connection with LGBTQA+SB communities were positive. Some questioned how well the various groups gathered under the LGBTQA+SB umbrella co-existed, whereas others were critical of the 'superficiality' within some queer communities. Feeling unwelcome or being judged negatively within LGBTQA+SB spaces were prominent experiences in many participant accounts. For example, a gay male participant from the LGBTQA+POC cohort said:

> *I love being queer, however, there's a lot of issues with the queer community. It's very racist, it's very sizeist, it's very classist ... cis-gendered white men can be very difficult.*
>
> **SB18LE, 38, cis male, gay/queer, LGBTQA+POC**

Prejudice and discrimination encountered within the queer community, attributed to the normative attitudes of gay white cis men, can undercut a person's pride in their identity and contribute to feelings of community exclusion if they do not fit that norm.

Experiences of discrimination, particularly racism but also transphobia and misogyny, were identified by several participants as a barrier to any sense of feeling safely connected to or part of 'the LGBTIQA+ community'. A LGBTQA+POC participant described how he attempted to create a safe community for himself:

> *I started really specifically dating only Asians and only people of colour. I met really nice people. Yeah, that also helped me to just feel better, back on track at some point, and I stopped doing that after a while. Then I met my best friend, another Asian person, so we moved in together as housemates for a while. It really helped me to just create a really safe environment, at that personal level.*
>
> **SB09LE 28, cis male, gay, LGBTQA+POC**

This extract illustrates how this LGBTQA+POC managed suicidal distress, which he attributed to the lack of cultural visibility and racism he experienced in Australia. To avoid racial discrimination encountered on dating apps, he decided to only date 'Asians' and 'people of colour'. We also see how his friendship with another queer Asian person – who he also lived with – helped him to create a 'really safe environment' at a 'personal level'. Finding safety and living in a way that affirms all aspects of a person's identity can be emotionally challenging.

Some people may choose to reject parts of queer communities they perceive as unwelcoming or hostile. A trans female participant described the impact of the intra-community discrimination she experienced:

> *I feel mostly connected now to the bi-plus communities, and lateral hostility's important to mention because it has led to the stressing situations at times on many angles in terms of my, we'll say, involvement in the communities, rather than just being an individual citizen, and most of the time the biggest problem is cisgender gay men who are any of biphobic, transphobic, misogynistic. And I'm feeling less and less connected to – I use the term 'the rainbow infrastructure' – the bit of the rainbow communities that is visible, the organisations, the activist part. I'm sick of the way people behave and I just want some calm and peace and inner contentment in my life that that part is not giving, and unfortunately trans communities particularly are not giving it much either.*
>
> **SB19LE, trans female, bisexual/pansexual, LGBTQA+**

To find 'peace' and 'contentment,' this participant describes how she distanced herself from broad sections of the LGBTIQA+ community and found stronger and safer connections within the bi-plus community. While the established research literature suggests that connection to LGBTIQA+ communities may be protective against suicidal distress, intra-community discrimination and normative pressures was challenging and distressing for some of our participants. Discrimination experienced within LGBTQA+SB communities can contribute to significant stress and harm and must be acknowledged and addressed alongside the insidious impact of homophobia, transphobia and racism in society generally. It is important to recognise that change needs to happen within LGBTQA+SB communities, and that elements of these communities may be safer and more welcoming for people who are fat, disabled, black, brown, First Nation, bi and/or trans.

Chapter Two Highlights

- LGBTQA+SB identification does not directly lead to experiences of suicidal distress.
- Embracing an LGBTQA+SB identity can be a powerful protective factor but people may find it difficult to live affirmatively, particularly when younger. Fears about acceptance and experiences of discrimination contributes to the denial and concealment of gender identity and / or sexuality.
- Visibility of LGBTQA+SB people, access to positive role models and information about diverse genders and sexualities, and affirming relationships are strong protective factors.
- LGBTQA+SB affirming responses from family members and friends were viewed as protective. Acceptance and understanding can take time and vary between family members and friends. Establishing safe and supportive friendships, households, and community connections that respond to all aspects of a person's identity can take time, particularly for LGBTQA+POC and LGBTQA+ people with a disability.
- Connection to culture is important for First Nations LGBTQA+SB people but living in First Nations communities may be isolating because of a lack of knowledge about LGBTQA+SB identities and discrimination.
- LGBTQA+SB communities are potential sources of affirmation and support. However, intracommunity racism, invisibility of, or discrimination against, some genders, sexualities, and intersectional experiences, means some find it difficult to connect with or feel excluded from LGBTQA+ communities.

Experiencing suicidal distress

3

To better understand LGBTQA+SB experiences of suicidal distress we explored how our participants talked about suicidal thoughts, feelings, and attempts within the context of their daily lives. Suicidal distress was described in relation to temporal rhythms with varying levels of intensity. Individual accounts pointed to a range of social, cultural and economic stressors, not all of which were directly associated with their LGBTQA+SB identification. Some participants reported discrete and acute episodes of suicidal distress, whereas others described more regular and pervasive experiences that fluctuated in intensity. What is evident from people's accounts is that suicidal distress can begin at an incredibly young age, and participants often found ways of living with suicidal thoughts and feelings throughout their lives. In the following sections we explore these experiences.

Suicidal distress starts early and can be occasional or constant

Many participants across the three cohorts located their first experience of suicidal distress within their high school years and early twenties. For a few participants, however, suicidal distress was initially experienced in childhood. Participants who reported early experiences of suicidal distress tended to describe more regular and pervasive thoughts, feelings and behaviours, where suicide was a constant possibility that they had to manage on an almost daily basis. One participant, who also identified as 'mad' and 'crip,' said:

> *I would identify as, I guess, chronically suicidal, and I think the first time that I remember being suicidal would've been when I was three or four, possibly even earlier but you know, 'memory'. I have been thinking about death since I was very young.*
>
> **SB08LE, 23, non-binary, queer, LGBTQA+**

> **'I can't afford to stop doing stuff every time I'm in crisis. It would be lovely if I could, but unfortunately, I cannot'.**

This participant uses the term 'chronic' to refer to their experience of suicidal distress as ongoing and ever present. They later highlight the challenge of constantly having to navigate this distress: 'I can't afford to stop doing stuff every time I'm in crisis. It would be lovely if I could, but unfortunately, I cannot'. This indicates that suicidal distress can become normalised for some people, if they are also able to find ways to cope and manage the intensity of their feelings while continuing to live.

Suicidal thoughts and feelings can disrupt everyday interactions and impact everyday life.

At times it becomes really difficult because of these constant thoughts, constant hits that just come across. Some days I just wake up and think, 'It would be much better if I just did it'. And I think it's just cowardice – not cowardice – it's cowardice and courage of my own self, that I think I am not just pushed to a point, to be honest, that I do it. But I do have these thoughts constantly. In the middle of a conversation, having a laugh with friends, it just clicks, 'What's the matter of all this?' There's no point of any of these things. It'll be better off if I do it. … I have these thoughts. I know I'm not going to action them. But I also know, I'm aware that I have these thoughts. I've had them constantly from when I was about 20.

SB11LE, 25, cis male, gay, LGBTQA+POC

This participant highlights the difficulty of living with the constant background of suicidal thoughts and the exhausting impact of negotiating a tension between a self-perception of 'cowardice' or 'courage' because he 'would probably never do it.' In contrast, other participants reported less frequent or episodic experiences of suicidal distress that were often related to a particular temporal, social or cultural context. For example, one participant used the analogy of 'falling into a pit' but surviving because the moment of pain passed quickly:

I don't think I would've killed myself. It was more like – to me it's all on a spectrum of feeling down, then you get to, 'Oops, you fell into a pit there'. Maybe that wasn't the spectrum, whatever, but you kind of reach the somewhat extreme end anyway, and then it passes. As I said, I know the analogy of a headache is probably not suitable, but it was like that. You're in a moment of pain and then it passes.

SB17LE, 44, cis female, bisexual/ homoromantic, LGBTQA+POC

However, We cannot assume that early or first experiences of suicidal distress are always manageable. a First Nations LGBTQA+SB participant described a single experience of suicidal distress, which culminated in an attempt for which she was briefly hospitalised:

I went that day, I remember. My aunty was away. [Description of attempt removed]. And I thought, 'Well, nobody's going to help this pussy now. She's coming with me!' But the voices in my head, 'You're gonna be nothing. You're gonna be this. What's the use?' All the lies in your head. And then I woke up in the mental hospital … I woke up … And I looked, the curtain was blowing, and I was, 'Why am I here?'

SB20LE, 50, female, heterosexual, First Nations LGBTQA+SB

Responding to suicidal distress: fear, hopelessness and intention

Participants used emotional terms related to fear, such as 'scary' or 'horrifying' to describe their suicidal distress. For example, one trans female participant recalled the first time they encountered the 'horrifying thought of suiciding' at the age of 15 (SB01LE). She later went on to describe a lifetime of suicidality. Another participant recounted a particularly fearful time when she experienced what she described as 'suicidal impulses':

I had that experience of suicidal impulses on three – no, the fourth occasion is when I asked for help. So, it happened about – over the space of a year I'd say it happened four times, and on the fourth time I became scared about what was happening.

SB02LE, 52, gender non-conforming, gay, LGBTQA+

A LGBTQA+POC participant explained how she 'really tried working on stuff,' such as her mental health and identity, after a suicide attempt. The return of suicidal thoughts was described as frustrating and contributing to a sense of hopelessness

Impulses were experienced several times over the course of the year before she 'became scared about what was happening'. Significantly, this was not the first time this participant had experienced suicidal thoughts. Their account indicates that some people delay seeking support for their suicidality and attempt to manage on their own. It also highlights how emotions related to suicidal distress can shape help-seeking. Living with persistent and intrusive thoughts about suicide was exhausting for many participants. A LGBTQA+POC participant explained how she 'really tried working on stuff,' such as her mental health and identity, after a suicide attempt. The return of suicidal thoughts was described as frustrating and contributing to a sense of hopelessness:

> *...I haven't had another attempt since then, but I'd say the ideation has been weirdly consistent. It definitely goes away for a couple months at a time but, other times, it just comes back in the form of an intrusive thought of all this is crap. And I think a lot of people who struggle with their identity or with mental health issues get to that point where you've really tried working on stuff. But if you're going to regress back to square 1 again, what's the point, that that's the intrusive thought and that's where the ideation stems from for me.*
>
> **SB13LE, 24, cis female, pansexual/ demisexual, LGBTQA+POC**

Many participants, particularly those who had experienced a suicide attempt or reported more pervasive experiences of suicidal distress, centred feelings of hopelessness, isolation, and fears about the future within their narratives of suicidal distress. A First Nations participant recounted a slow build-up of pressure across multiple aspects of their life, including work, family and sexuality, which contributed to a sense of hopelessness and concerns about the future:

> *I was 27 and I thought you know what, at that time I thought with everything building up, I had thought, 'If this is how it's going to be for you forever, you need to just stop now,' because that was where my thinking was at the time. I just thought like there was no way forward anymore and that was a combination of insecurities surrounding my craft as a [profession], my ability to be [a professional], my sexuality because I still hadn't worked it out at that point properly, or at least I didn't realise how it applied to me, also with my family relations, that's roughly where it all – like just there were so many unanswered questions and that's why I thought, 'Alright, this is it, 27 club, here we come'.*
>
> **SB03LE, 29, cis male, pansexual, First Nations LGBTQA+SB**

This participant's account shows how people experiencing suicidal ideation or crisis can move quite quickly from thoughts to a suicide attempt. The experience described took place on his 27th birthday when, he explained, he 'got a little too stoned'. While several contributing factors are identified, what is emphasised is the feeling that 'everything was building up' and his concerns about the future ('there was no way forward'). The cumulative effect of multiple stressors is a sense of hopelessness about the future, difficulties within interpersonal relationships, and sense of isolation. It is important to understand how concerns about the future and lack of hope within the felt experience of suicidality can penetrate deeply into everyday life and limit the effectiveness of protective factors that may be present, such as strong familial relationships.

Few studies explore how LGBTIQA+ individuals develop a suicidal disposition or acquire the capability to suicide. We did by ascertaining how our participants responded to the intense fears and emotions that suicidal thoughts prompted, and how thoughts and feelings related to planning and intention. For example, one participant recounted how a 'survival mechanism' kicked in when they 'realised' they were experiencing suicidal thoughts:

> *When I realised what kind of thoughts I was having, I was really scared. And I think my survival mechanism got activated at that time, like my brain was trying too hard to find the reason why I should keep living rather than why [don't I make a plan, blah blah]. So – which was a good thing actually.*
>
> **SB14LE, 26, gender fluid, pansexual, LGBTQA+POC**

In response to feeling 'really scared' about the possibility of suicide, they explained how they focused on identifying why they 'should keep living', instead of developing a plan. In contrast, many other participants described how they developed a suicide plan and / or attempted suicide. Several participants recalled feeling more ambivalent about their intention to suicide but described how they became 'reckless' or 'careless,' doing things that might 'risk' death. For example, one participant explained how he had moved from using self-harm as a strategy for managing his emotional pain to a suicide attempt:

> *It got to a point where I did attempt suicide [action removed]. At the time it was more of like, 'I'll do this and see what happens,' sort of thing. I don't think there was a definite decision in my head that this is what I'm going through with and at all costs, but it's like I just wanted to see where that path led at a point.*
>
> **SB15LE, 33, cis male, gay/homosexual, LGBTQA+**

According to his account, the attempt was a form of exploration or possibility, rather than the outcome of a clear aim or intention to die. Even when a person had a purposeful plan or intention to suicide, moments of indecision or an interruption could act as an effective intervention. For example:

> *I remember when I was 17, I got very dramatic and I wrote a suicide note and I took my car and I went and drove out somewhere and I had this complete plan and everything. And then I just couldn't bring myself to [do] it. Then I came back and everyone was so distressed and it was like, 'Oh no, I didn't do it, like don't worry'.*
>
> **SB04LE, 30, non-binary, queer/lesbian, LGBTQA+**

After deciding not to suicide, this participant returned home and minimised the seriousness of their situation. Rather than seeking or receiving appropriate support, they downplayed their suicidal distress and attempted to manage other people's reactions by describing their own acute moment of distress as 'dramatic'.

Some participants however recounted multiple attempts, indicating that some LGBTQA+SB people will develop a clear intention to die:

> *To be honest, I don't know if this makes sense, but it's a bit of a blur. Even at the time it was a bit of a blur. I think I just planned my next one. I always felt like I was planning the next time I was going to kill myself. Definitely for the first time I was planning the next one, and I was a bit scared, I think. I was in a bit of shock and regret.*
>
> **SB18LE, 38, cis male, gay/queer, LGBTQA+POC**

Despite feeling 'scared,' we can see how an attempt can sometimes roll into the next. This quotation points to the need for intervention and support that can disrupt this cycle. Participants who experienced suicidal distress more consistently highlighted how quickly they could feel suicidal, particularly when feeling depressed. For instance:

> *And then if I slipped down once, it was just like a straight fall and not like a gradual fall. So, if I got into a depressed episode, it was just straight to suicidal ideation.*
>
> **SB13LE, 24, cis female, pansexual/ demisexual, LGBTQA+POC**

Two participants offered similar analogies to describe how suicide became almost an automatic response in times of despondency. A trans female participant (SB01LE) suggested that constant suicidal thoughts could become a 'neurological pathway,' whereas a LGBTQA+POC participant described suicidal behaviour as a form of 'addiction':

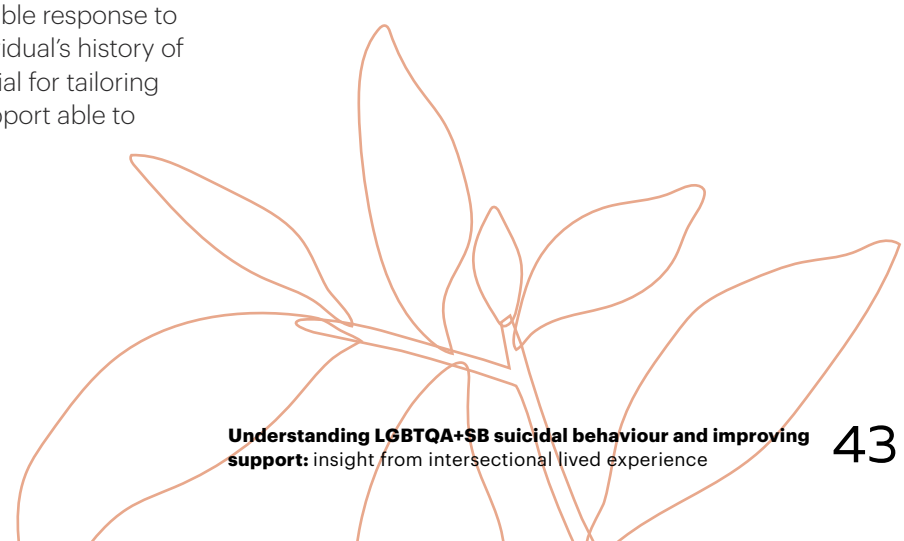
> *I don't know, maybe I'm talking out of my arse, but to a friend I would describe it as kind of like an addiction or like an Alcoholics Anonymous; it's something that, if you've attempted suicide, or you've been serious about it, it's something that's always in the back of your head. It's like a craving you've got to control, that's what it's like for me sometimes. … . The thoughts are always there, but the reality of doing it has only probably occurred another five or six times since I was 15.*
>
> **SB18LE, 38, cis male, gay/queer, LGBTQA+POC**

These analogies indicate that suicidal behaviour can become an acceptable form of action for some individuals when they are unable to cope. Once an attempt has been made, the action becomes more acceptable to the person as a reasonable response to acute distress. Understanding an individual's history of suicidal distress and behaviour is crucial for tailoring interventions and providing timely support able to disrupt plans to suicide.

Accounting for LGBTQA+SB suicidal distress

When invited to describe why they felt suicidal, participants pointed to a range of psychological, social and cultural factors. Many of the experiences are set out in Chapter 3, such as direct experiences of discrimination and violence related to diverse genders and sexualities, as well as indirect forms of homophobia and transphobia, including the erasure, invisibility, and silencing of LGBTQA+SB people living in a white settler, heterosexist and cisnormative society. These direct and indirect experiences contributed to deep feelings of social and cultural isolation, shame, and disconnection.

> **The role of direct and indirect discrimination was often more complex and profound for participants living with intersectional identities, particularly for First Nations LGBTQA+SB and LGBTQA+POC participants, but also those who identified as 'crip,' 'mad' and neurodiverse, and those participants located in rural and regional areas.**



LGBTQA+SB suicidal distress: The role of gender identity and sexuality

Among participants, gender identity and sexuality featured in accounts of suicidal distress, yet it was rarely identified as the sole cause. Their accounts problematise the association of LGBTQA+SB identities with suicidality by illustrating that it is actually the consequence of social and cultural factors, which include experiences of discrimination, shame, (lack of) family acceptance, relationship breakdown, and navigating white settler, heteronormative, and binary gender social and cultural norms at school, work and in other institutional settings. For example:

> *Suicidal thoughts started at quite an early age, back in the times when I was in the closet in high school. It was just really hard to be a high schooler and gay kid, and if you're not only gay, if you're just really feminine gay, it's complicated, very, in a country that has very proud military history and socialist background and everything. It starts from high school, but it was still manageable.*
>
> **SB09LE, 28, cis male, gay, LGBTQA+POC**

This participant traces his formative experience of suicidal distress to when he was living as a closeted 'gay kid' in his country of origin. A country that he described as valuing masculinity, socialism, and a proud military history – values that he felt his gender-nonconformity distinguished him from. Another participant said:

> *I think it's just that the pressure of me coming out, pressure of my parents having to go through that, pressure of me finding a partner, pressure of just living life the way that I want to, and I probably would never be able to do it. All these things that tell me there's no point in probably living anymore, at times.*
>
> **SB11LE, 25, cis male, gay, LGBTQA+POC**

This second participant from the LGBTQA+POC cohort points to 'pressure' from multiple sources including living authentically, 'coming out' and fears about the potential impact on his parents.

The build-up to 'coming out' and / or embracing an identity within the LGBTIQA+ collective was a challenging time for many of our participants.

The build-up to 'coming out' and / or embracing an identity within the LGBTIQA+ collective was a challenging time for many of our participants.

For example, a trans female participant states that she spent many years repressing difficult emotions and feelings prior to coming out:

> *[S]o I mentioned that sort of coming out as trans was that sort of taking the crater lid of the volcano, or taking the lid off the boiling-over pot, call it what you will. And I think it did open up a lot of feelings and emotions that I'd repressed. And a lot of the time, and once I released that and sort of – or to use that other analogy, just below the soil – there was a huge sense of overwhelm. Emotions would just come bubbling out and I wasn't centred or grounded. And it was incredibly difficult. And there were times, I remember, where some days I just couldn't get out of bed; it was just there was so much information going on. My whole being was just saying, 'You've got to lie down'. I'd try to get up and I'd just lie down again. And I think when I consider so much of what happened in the first part of my life, that I often summarise it is that if my true direction to be who I am and where I am now was to go north, I was definitely going 180 degrees south.*
>
> **SB19LE, 56, trans female, bisexual/ pansexual, LGBTQA+**

In the process of identifying and coming to terms with her authentic self, she reflected on her early life and was overwhelmed. Finding and embracing an identity can help people to make sense of difficult early experiences but this can also present challenges in terms of navigating the future. While gender identity and / or sexuality were discussed widely within

participant explanations of their suicidal distress, they were sometimes resisted and even absent within some narratives:

> *[I]f someone was to ask me is it my sexuality and/or gender that is linked to my inner chaos, pain or suicidal ideations when they arise, or the deep and dark spaces, I would say, 'No'. Not as the line. Not as the reason. Not because it's not part of it. I would say feeling the constancy of exclusion and/or rejection. And coupled with not knowing how to step into a future, that is the bigger contributor to why I would not want to be around. So yes, obviously being today pansexual and demisexual, polyamorous and neurodivergent, all these things contribute to why people may then reject or be dishonest or suspicious of my motives and therefore treat me poorly. And that's a hard one, across the board. But it's... all of that will link to being rejected and not being able to express easily who or where I'm at.*
>
> **SB16LE, 47, non-binary/agender, pansexual/demisexual, LGBTQA+**

This participant reminds us that it is important to contest the idea that gender identity and sexuality is the key driver of suicidality. Rather, it is the experiences of social and cultural rejection associated with homophobia, transphobia and racisms that shape how LGBTQA+SB people experience and embrace their gender identity and / or sexuality. The drivers of this participant's suicidal distress are linked to their gender identification, sexuality and neurodivergent identity, but it is the sense of isolation and lack of hope for the future that are nominated as the 'bigger contributors.' Navigating the violence and discrimination, erasure and invisibility associated with living within heterosexist society are implicated in LGBTQA+SB experiences of suicidal distress in complex and diverse ways.

Shame and suicidal distress: the role of discrimination, violence and exploitation

Most participants found it difficult to identify a single factor when accounting for their suicidal distress, instead pointing to a complex array of stressors, including family violence, sexual abuse, conversion therapy, poor experiences at school, as well as debilitating shame and dislike of self.

A LGBTQA+POC participant stated:

> *[S]chool was absolute shit. I was really struggling with the sexuality... I didn't have friends, I hated everything about me. I didn't like the way I looked. I didn't like being brown. You name it, I couldn't deal with it.*
>
> **SB18LE, 38, cis male, gay/queer, LGBTQA+POC.**

A constellation of factors is identified by this participant as contributing to their suicide attempt at the age of 15. While his sexuality is implicated in the narrative , it sits alongside family violence, social isolation, and experiences of racism. Shame relating to not conforming to heteronormative expectations and gender roles featured strongly within people's early experiences of suicidal behaviour. These experiences were often tied to bullying, experiences of violence, and trying to fit in.

At least one participant experienced sexual abuse. He explained how he had an 'affair' with the counsellor at the religious school he attended and described how he sought support from the counsellor when the counsellor's wife found out and began contacting him. At the recommendation of the counsellor, he accessed phone-based support through a Christian organisation that, unknown to him at the time, offered conversion therapy:

> ***Q: What was your experience of the interaction with the conversion therapist?***
>
> *A: That was probably singlehandedly the biggest [issue in] my feelings of suicide. I was quite distressed before that and quite vulnerable before that, given everything else that was unfolding, but that definitely pushed me down the path where I felt I had no choice. If I didn't go through this process and if I didn't do it successfully, I would have to end my life because I just couldn't see any way of, I guess this ideal of a Christian male that was being presented to me and the way I felt, I couldn't see any of that ever marrying up. That got progressively worse the longer I participated.*
>
> **SB15LE, 33, cis male, gay/homosexual, LGBTQA+**

Despite feeling 'progressively worse' the longer he participated in the conversion therapy, he felt it was important to 'successfully' complete the process. His attempt to conform to the imagined ideal of a 'Christian male' profoundly contributed to the shame and distress he felt.

The role of interpersonal violence was also evident within several participant accounts:

> *I was a complete woman now. And then he went and had an affair. And that was the man I loved. And then he said, 'If you leave, I will kill you. I will hunt you'. So, I'm thinking, 'I can't have anybody else'. I couldn't think about – because he was my first proper real relationship. And I was, 'That's it, might as well just do myself'. Because the thoughts in my head, how he played me that two years. He was seeing that other girl I had, ..., I had that feeling. But then on top of that, they used my past to do that. She did. He knew, but then they turned it around to try and make it, 'You should leave. She won't give you children.' Used that card. And one of the other friends told me, and I was, 'But how does she know? Where does this come from?' From family. My own family tells these people. So, I had to come to terms thinking, 'Wow, first they didn't want me to, now they want me to, and now they don't want me to. I don't know, I'm confused'. So, when I asked them, I said, 'Who's told you about me?' 'Your cousin'. Well, that's something else. I lost it.*
>
> **SB20LE, 50, female, heterosexual, First Nations LGBTQA+SB**

Elsewhere this participant explained, 'I did try to suicide, yes. But that's because I had nowhere to run'. The isolation and vulnerability experienced as a result of violent threats by her then partner is compounded by the discovery that her cousin had disclosed her gender identity without her consent. The emotional impact of this betrayal illustrates how interpersonal relationships can significantly contribute to suicidal distress. Navigating heterosexual norms and experiences of erasure, invisibility, violence, discrimination, and abuse can generate feelings of isolation, shame and hopelessness, which may in turn contribute to suicidal distress.

The role of cultural dislocation and suicidal distress

LGBTQA+SB people are more likely to experience suicidal distress because of the multiple forms of discrimination they encounter. The shame and fear of rejection they internalise early in life can be isolating and foster a sense of hopelessness. First Nation LGBTQA+SB and LGBTQA+POC also described how they had to negotiate the ongoing effects of colonisation, widespread racism, and the impact of spoken and unspoken cultural norms that threaten to alienate them from cultural ties and communities. Some of the LGBTQA+POC cohort of participants and one First Nations LGBTQA+SB participant pointed specifically to the role of cultural dislocation and isolation within their experience of suicidal distress.

> *And growing up in a place where I didn't feel like anyone else was having thoughts like I was, whether it be mental health or cultural or gender and sexuality, I just felt really, really alone and misunderstood. And yeah, I think my next attempt was when I was about 17.*
>
> **SB13LE, 24, cis female, pansexual/ demisexual, LGBTQA+POC**

Another participant described the impact of immigrating to Australia 'from a country where [he] was part of the majority in terms of ethnicity, and after coming here ... [he] became a minority overnight'. He said he experienced suicidal distress a second time because his career in Australia had not turn out as planned:

> *After moving here my career didn't turn out quite the way that I was expecting, because I was doing quite well in my home country, so I was doing quite well. And because after moving here I had a hard time trying to build my career, so over the years, and there was one stage when my health was affected as well, I had some health issue, and so it was very, very tough. So it just went down. It was very, very tough, it was very tough, I think for the last – I would even say since I moved here, really, because life didn't quite turn out the way that I was expecting it to be career-wise.*
>
> **SB11LE, 40s, cis male, gay, LGBTQA+POC**

This participant highlights the challenges of establishing his career in a country where he was now part of a 'minority' group. Rather than a direct line being drawn between cultural and racial dislocation on the one hand and suicidal distress on the other, the effects are more subtle. It is the implications of the move on his career that are linked to his suicidal distress. Some, though not all, LGBTQA+POC participants similarly emphasised the impact of the social isolation they experienced growing up in Australia.

Experiences of cultural dislocation were also evident in one First Nations LGBTQA+SB participant's account. He explained how the cultural dislocation and isolation he felt when he was sent to boarding school at the age of 12 contributed to his experience of depression and suicide:

> *But the depression, I think, kicked in because I was suddenly alone, you know. Everything I knew, I mean, you know. I think because desperation, as far as I know – desperation. Depression, as far as I know, is a feeling of despair. Like there's no way out, like you've got no choice, and that does have an effect on you at some point and I feel like those who do get clinically depressed, not clinically, those who do get depressed, I feel like it's one of those things that sits in the background as a mental health condition, is that it just sits in the background and then sort of builds and builds and builds and crops up until it's actually very present, until it can manifest as having a blue day, or a blue period, or just, you know, a feeling of like this is not going well, something is really wrong, I don't feel great. So, I made an attempt on my life at 12 because there was so much confusion and isolation and a lot of loneliness that had suddenly built up in the space of just under six months.*
>
> **SB03LE, 29, cis male, pansexual, First Nations LGBTQA+SB**

The social isolation, confusion, and loneliness this participant felt after 'being pulled out of the environment [he] knew and grew up with on the islands ... safe, insulated community, simple lifestyle, get up, go to school, come home, go to church on Sunday' contributed to his depression. According to his account, the depression built up 'in the background' until it intruded into his daily life manifesting as a 'blue day or a blue period' and later a suicide attempt. The accounts of First Nations LGBTQA+SB and LGBTQA+POC participants presented here suggest a need for culturally appropriate supports because of the impact of racial stressors, particularly when disconnected from culture and community.

Learning to live with and manage suicidal distress

Many participants across the three cohorts described using strategies to manage suicidal distress and improve their wellbeing. For some participants, these were self-taught and focused on managing suicidal distress when it occurred or were based on activities they enjoyed. Other people adopted and / or adapted strategies they discovered online or were suggested to them by mental health professionals. Participants often talked about small strategies and techniques they used to help them to navigate and manage suicidal distress. Humour was identified as a useful tool by two participants. One participant explained:

> *[H]umour helps. Funny things, but also the ability to laugh at myself. My escape from the world is professional wrestling, which is a great relief from the seriousness of some of the things I do in my life, and the experiences that I have in mental health. And it's just – I'm well aware that it's premeditated, all that sort of thing, and it's just a great sense of – it is just a form of escapism but it does settle my mind in its way.*
>
> **SB19LE, 56, trans female, bisexual/ pansexual, LGBTQA+**

Humour is described as a form of escapism and relief from the 'seriousness' of this participant's work and mental health concerns. Other participants variously described how exercise, spending time outdoors, going for long drives, creative activities, and their faith were helpful in creating the space needed for them to manage suicidal distress.

Across the accounts, developing self-awareness and self-acceptance were central to living with and responding to suicidal distress. One participant highlighted the importance of learning to accept difficult feelings and thoughts:

> *The biggest thing for me is always making space in my life for me to not be okay. If things aren't going well, it's about acknowledging that and paying attention to it. So that's step one, because before I would just ignore it. And the sort of self-care things like have a bath or do mindfulness and that kind of stuff, they're not as important to me really.*
>
> **SB07LE, 26, non-binary, lesbian, LGBTQA+**

Self-care ('mindfulness and that kind of stuff') is positioned as secondary to acknowledging and accepting difficult feelings and thoughts. They contrast this with how they 'would just ignore it [suicidal distress]' when they were younger. Other participants described how they learnt techniques to recognise early signs of suicidal distress and ways of responding. For example, one participant spoke positively about the steps they had learnt from a psychiatrist to recognise and respond when they were not 'in good shape':

> *To know when I'm in good shape is two simple things: one is, I'm happy to socialise and I like to dress well. In other words, I'll put on a nice skirt and some stockings and my good shoes and pretty dress or a blouse or something and do my hair nicely, a little bit of makeup and feel that beautiful woman self that I really am and go out and find somebody to talk to. If I'm happy to do those, then I know that I'm in good shape. ... To know when I'm deteriorating, as soon as I realise that I'm avoiding company and avoiding conversation and seeing people ... and when I start to slop around in my pyjamas all day. So again, the dressing and the socialising were my indications of*

> *I'm not functioning very well and when I'm really down in the dumps, I just won't get out of bed unless I absolutely have to. And to get back on track, all I need to do, I need to actually get out of bed, shower, shave and do my hair nicely and dress nicely and go and find somebody to talk to and it's amazing how just doing those two simple things just brings me back to a – I'm a carer. I love people. ... And then I know when I'm coming back to normal or to a good state is when I actually am happy to be dressed well and talking to people.*
>
> **SB01LE, 75, trans female, lesbian, LGBTQA+**

This extract illustrates how strategies that improve self-awareness can be helpful in managing difficult feelings and thoughts. Through understanding what she enjoyed when she was feeling good, this participant was able to develop a strategy that helped them to feel better.

Personal relationships were identified by many of our participants as central to their wellbeing. Fostering caring relationships and participating in social activities were nominated by First Nations LGBTQA+SB participants as a way for people to pull themselves out of a slump and improve their wellbeing. One participant said that it was important to take care of family and friends:

> *[T]aking care of yourself is just as important as taking care of those around you and I think we exude care for ourselves and others when we just keep up the daily things, as in checking in on someone regularly, asking how they are, keeping fair tabs on them in terms of making sure you wish them a happy birthday. It's the little things that keep the worst things at bay, the little things you do every day.*
>
> **SB03LE, 29, cis male, pansexual, First Nations LGBTQA+SB**

While social connection and activities are important, they were not always effective at reducing suicidality, as this excerpt suggests:

> *Going to the beach, going out for lunch, going up the valley to the creek, hanging out with the dogs, hanging out with my friends' kids. Because I'm a really outgoing [person], most of the time, bubbly person that loves being around people and loves talking with people, so reminding myself that that person is in there sometimes sparks me to get out of a slump. It's different, it depends – my lows are different every time, obviously, as you would expect, so those things might work this time but then another time I could just be totally ambivalent to it and tell everyone to fuck off.*
>
> **SB06LE, 33, cis female, pansexual, LGBTQA+**

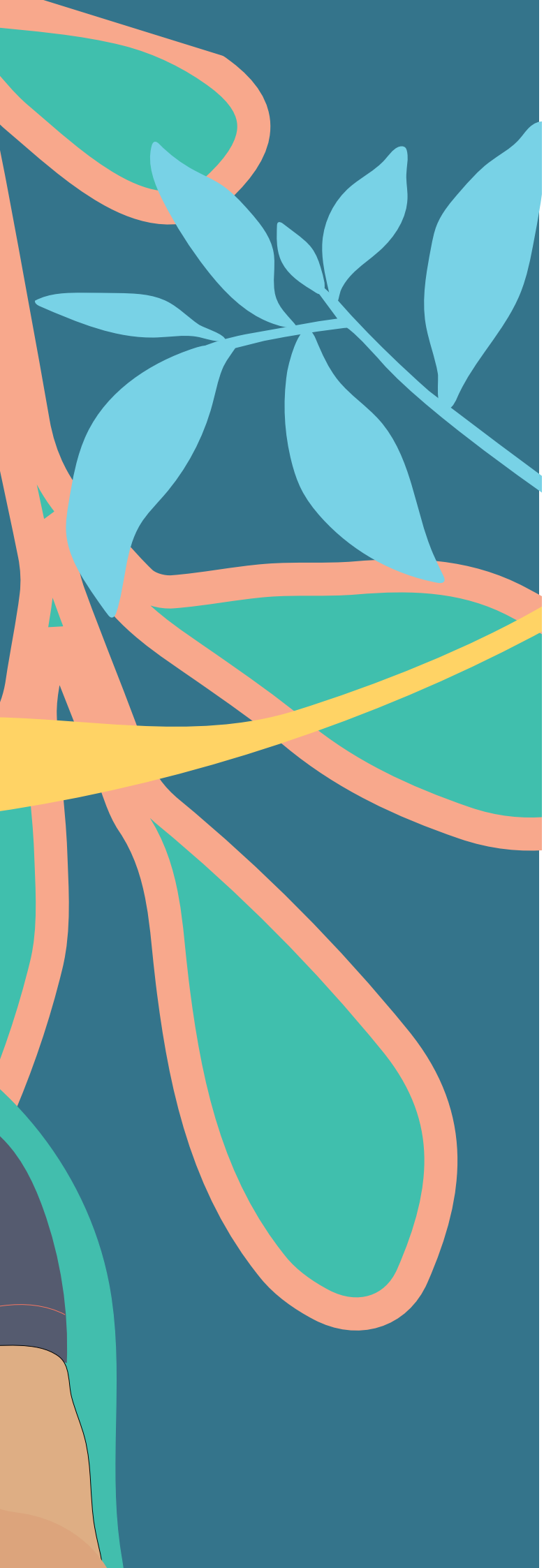
Maintaining social connections and being outdoors with her dogs are strategies this participant used to 'get out of a slump.' However, her caveat that these activities do not always work suggests that there may be times when alternative forms of informal or formal support and intervention are required. This point resonates across many of the accounts, with participants using self-management strategies and techniques to navigate suicidal distress in tandem with both formal and informal supports. Increasing awareness health and social care practitioners, as well as family, friends, of the challenges LGBTQA+SB communities face can increase the resources and tools LGBTQA+SB people can draw on to manage suicidal distress.

Chapter Three Highlights

- Suicidal distress for LGBTQA+SB people can begin early in life and may be experienced as discrete episodes or may be more pervasive. Not all LGBTQA+SB people who experience suicidal ideation or feelings or self-harm, will attempt suicide.
- Attempting to live affirmatively in a white settler, heterosexist society with cisnormative expectations has negative impacts upon LGBTQA+SB people. The cumulative effects of feeling invisible, experiencing discrimination, and sense of shame, hopelessness about the future, and challenges in interpersonal relationships can contribute to suicidal distress.
- Living with suicidal distress is exhausting and can significantly disrupt daily life and limit LGBTQA+SB people's ability to form and maintain social connections.
- Gender identity and sexuality can feature in different ways within suicidal distress but are rarely the sole cause. Other psychosocial factors may be implicated such as homelessness, family violence, unemployment, and concerns about the future.
- Racism and cultural isolation can be significant drivers of suicidal distress for First Nations LGBTQA+SB people and LGBTQA+POC.
- LGBTQA+SB people can find ways to live with suicidal distress. Having access to a wide range of formal and informal support and strategies help people to manage suicidal behaviour.

Help-seeking and informal support for LGBTQA+SB suicidal behaviour

4



In Chapter 2 we illustrated how positive and negative experiences in a range of social contexts, including family, friendship networks, and diverse institutional and organisational context, including education and work, shaped LGBTQA+SB lives. These contexts were also identified as spaces by our participants where their gender identity and / or sexuality, and other aspects of their identity were understood, affirmed and celebrated, allowing them to live affirmatively. There is growing evidence of the benefit of support provided by meaningful others for reducing suicidal distress, particularly support from family and friends. However, difficulty in asking for help can mean that LGBTIQA+ individuals are sometimes left without support and may only access support at the point of crisis [29]. In this chapter we present experiences of help-seeking behaviour, including challenges, before focusing on participants' experiences of 'informal support,' particularly the role of family, friends, online support and LGBTIQA+ community groups and networks.

Seeking help for suicidal distress

Help-seeking plays a significant role in the provision of timely and appropriate informal and formal support for LGBTQA+SB people experiencing suicidal distress. This section examines at what point LGBTQA+SB people seek support, who they turn to and how they ask for help. Seeking support was identified as a challenge by many of our participants, although their accounts indicate help-seeking behaviour often changes over time, with people becoming more adept at managing their suicidal distress. Most of our participants pointed to numerous occasions where they concealed what they were feeling from others or did not access support. This was particularly prominent in participant accounts of suicidality when they were younger and experiencing suicidal distress for the first time. For instance, when asked how they managed their suicidal distress in their teenage years, a non-binary participant remarked, 'I was a complete nut. I was just very emotional. I would just ride it out' (SB04LE).

Initial attempts to seek help could be fraught, with participants describing unhelpful and even homophobic responses. One participant described how he sought support from church leaders when he was younger:

> *I told my church leaders... They knew that I was struggling with all this stuff, but they didn't know how to deal with it, so we had one conversation and then I realised how uncomfortable [they were], so then I stopped again. I just kept everything to myself. None of my friends really understood, so I just didn't tell them.*
>
> **SB18LE, 38, cis male, gay/queer, LGBTQA+POC**

Feeling heard when disclosing suicidal distress is essential to building the trust needed for support to be effective. Yet, this excerpt indicates that the inability of these church leaders to respond adequately 'to all this stuff'. The actions and responses of significant adults in young people's lives, particularly when it involves gender identity or sexuality, can contribute to the silencing of young people and concealment of suicidal distress.

Some participants also described how it was sometimes difficult to judge when they needed help. For example:

> *At least for me it was a frog in hot water scenario where, I guess, I didn't realise I was ... really on the edge until that day where I was like I need to do something right this very minute because I don't know how to go on otherwise.*
>
> **SB15LE, 33, cis male, gay/homosexual, LGBTQA+**

> **Feeling heard when disclosing suicidal distress is essential to building trust needed for support to be effective.**

Identifying when he needed help was a struggle for this participant. He said he was attending regular counselling appointments at the time and expressed surprise that his psychologists had not recognised the extent of his distress. Even when participants were aware of their distress, it could sometimes be difficult to take the next step and ask for help. This point was reinforced by a LGBTQA+POC participant who, at the time of the interview, had not accessed support:

> *It's been very rare for me to find somebody to talk to and totally be honest with. And it's hard for me to – I don't know much about – if I can have – I know that [support service] is one program that [LGBTIQA+ organisation] does for suicide prevention, but I don't think I pushed myself to a point where I would call them and tell them, 'I'm going to do this'.*
>
> **SB11LE, 25, cis male, gay, LGBTQA+POC**

He later said: 'I know these resources exist to help; it's just that it's really hard to go out and accept and start taking help'. Despite his awareness of available supports, in this case LGBTIQA+-led services, the participant is reluctant to ask for help. Knowing where to go, fear and perception of responses, and a person's willingness to seek support, significantly shape help-seeking behaviours.

Many of our participants were selective about where and to whom they went for help. They reported seeking informal support from partners, family, friends, colleagues, and accessing formal supports through their GP, psychologist or psychiatrist, online and phone-based support and via LGBTIQA+-led organisations. Trust and safety were key factors identified by our participants that guided help-seeking behaviour:

> *I'll only ever go to them with specific problems related to that aspect of my life and that's how I have learnt to make it work, you know. I've got friends and one or two family members that I talk to about everything, everything that crosses all of the borders and all of the boxes, but there's only one or two people who do that for me. I keep a pretty tight curated list of it in my head of just like who I know to talk to about when, you know.*
>
> **SB03LE, 29, cis male, pansexual, First Nations LGBTQA+SB**

Knowing who this participant could speak to 'about everything' determined which family members and friends he turned to for support. The perceived quality of the relationship and ability of individual family members to provide support significantly shapes who and where LGBTQA+SB people will go to for help. Even when people disclosed their suicidal distress to others, they could do so in abstract ways or seek to minimise their distress. One LGBTQA+ participant said: 'I'm quite private about that sort of stuff, so I don't generally tell people I'm in crisis.' They went on to explain:

> *If it's in a peer context, it'll be in the sense like, I'll make a joke about how much I want to kill myself or something of that nature. So, it'll be more like low key. Or in a clinical context I do have a psychologist and I might make reference to it in a big abstract way, but not in any way that it could be construed as in 'I am currently in crisis way'.*
>
> **SB08LE, 23, non-binary, queer, LGBTQA+**

Even in spaces that could be perceived as supportive, some participants found it difficult to express and / or disclose their distress. Elsewhere, this participant expressed concern about the safety of mental health inpatient settings for them as a 'mad,' 'crip' and queer person. Perceptions of privacy and safety influence whether or how LGBTQA+SB people disclose their suicidality within formal support spaces.

Concerns around disclosure varied considerably and were linked to the social and cultural context in which our participants lived. Several participants described the challenges of disclosing suicidal distress within the workplace, with some people actively concealing their distress from colleagues. People were often worried about stigma and the potential impact on their career:

> *I knew that potentially, even though I was working for a fantastic organisation, that by declaring that I was feeling suicidal that could be my career gone. Because we're at that, I don't know, the turning point I think right now, so some industries and organisations are getting on board with seeing how they are responsible for the mental health of their staff and that suicide is a mental health issue, yet ... there's still that stigma and that shame attached to it. So, anyway, I wasted my manager's time for about 45 minutes, and there was no other way to ask for the help other than to say, 'I'm feeling suicidal, I'm at risk, you need to take my keys off me.' So I did that and it paid ... it served me well. I was supported and escorted by my manager to my GP. My manager wanted to call an ambulance and I said, 'No, please don't, let me have the dignity to walk out.' So, she did that and she took me to my GP.*
>
> **SB02LE, 52, gender non-conforming, gay, LGBTQA+**

Despite working for a 'fantastic organisation', the potential career risk associated with disclosure figures prominently, and is underpinned by feelings of shame and concerns about stigma. These fears are however outweighed by the need for immediate support, and the participant's ability to finally vocalise it. We can see how the manager's ability to listen to what the participant wanted and respond accordingly was appreciated. Understanding concerns around disclosure and the way shame and stigma influence LGBTQA+SB help-seeking behaviour for suicidality can improve pathways to support. Increasing our understanding of when someone might need support and who they feel comfortable talking to can contribute to the development of more effective responses and confidence in the ability of family, friends, colleagues, and service providers, amongst others, to offer help and support to LGBTQA+ SB people.

Informal support and LGBTQA+SB suicidal behaviour

In the rest of this chapter, we outline participants' experiences of seeking support through informal channels including from family, friends, online and LGBTIQA+ communities.

Family support

Participants described a range of support received from family members, with some variation in experiences evident across the three cohorts. The role of familial support was particularly prominent within the LGBTQA+ cohort and the accounts of First Nations LGBTQA+SB participants, who included references to aunties, uncles, and cousins. There was less family support reported by our LGBTQA+POC participants, which might be attributed to the fact that several participants' families lived overseas.

Talking with family members, as opposed to mental health professionals, about their challenges could sometimes help participants build resilience and manage suicidal thoughts and feelings. A First Nations LGBTQA+SB participant described how they went to their family for support instead of a therapist or counsellor:

> *I didn't go to therapists and counsellors, and this person and that person. I went to my parents. I sat with my mum. I sat with my grandparents and, 'You're a woman. What's wrong? Sorry, what did they say?' I said, 'No, they keep mocking'. 'No, go and deal with them'. This is how it was. And it wasn't frowned upon. It was just first time for our community, and in the Torres Strait.*
>
> **SB20LE, female, heterosexual, First Nations LGBTQA+SB**

The affirmation and encouragement provided by this participant's mother and grandmother helped her manage the discrimination and prejudice she was experiencing within her community. Other participants said they were reluctant to disclose their suicidal distress with family or felt their family did not want to know. A participant from the LGBTQA+ cohort explained how her family 'squashed it quickly' when she told them about her suicidal thoughts and feelings (SB16LE). Another from the LGBTQA+POC cohort decided not to tell her parents how she was feeling because she wanted to protect them:

> *I know for me, it's not like I want to alarm my parents. I would never contact them about it, weirdly enough. I wouldn't even tell my siblings because I feel like I'm not close to them. It's really just friends I would contact. I think the main thing is pre-emptive stuff. I feel like a lot of people can't tell their family, unless they're close to them.*
>
> **SB17LE, 44, cis female, bisexual/ homoromantic, LGBTQA+POC**

She hints that her unwillingness to disclose was related to feelings of lack of 'closeness' and points to important factors such as trust and safety that underpin relationships where someone feels able to openly talk about their distress. For this participant, she was more likely to tell her friends when she needed support rather than her family. Understanding the quality and dynamics of familial relationships can be helpful in determining what informal support may be available to LGBTQA+SB individuals and how likely they are to be able to reach out to family and share their feelings.

Where family support had been received it was often described positively, but it is important to recognise that it can appear in a range of forms, from emotional to more instrumental support. For example, one participant explained how their mother had provided them with practical support when they were in a mental health inpatient unit, but struggled with the emotional aspects:

> *Mum's ... she's very much someone who is on the ball when it comes to medical stuff. She knows the language, she knows what to do, what to say, all that sort of stuff. So, she was really supportive in that way, but in terms of emotionally to me she was pretty absent, and it was more about how upset she was that I was in this position. But that was the relationship that we had anyways, I was very much her parent. So, she was supportive in that sort of way and taking me there and coming to visit me every day.*
>
> **SB07LE, 26, non-binary, lesbian, LGBTQA+**

Pre-existing family dynamics and relationship patterns can shape the type of support that is available. Practical support is appreciated, but it is notable for participants when family members are unable to offer emotional support.

One participant described how her parents 'didn't understand the concept of mental health' when she was younger and, as a result, she 'didn't get professional support after an attempt':

> *I got quite a bit of stigma from my family around stuff like that. Any time that I self-harmed or had suicidal attempts or anything like that, they would – they're very different now. I feel protective of them in that way, but I know I don't need to. They would say pretty harmful things like, 'If you'd really wanted to do it, then you would have'. Stuff like that, just very gaslighty, very not helpful things and just made me feel more crap about my situation. Yeah. I just had to push all those thoughts back down. I just said, 'Maybe they're right, if I really wanted to do it, then I would have and I've just failed at another thing', sort of thing. Yeah, I don't think there really was much of a recovery from that, as opposed to – 'that happened, let's just keep going'.*
>
> **SB13LE, 24, cis female, pansexual/ demisexual, LGBTQA+POC**

Her parent's lack of knowledge about how to support mental health contributed to harmful responses and this resulted in further stigmatisation and a sense of failure. Yet, this participant indicated that her parents have changed, and she now feels protective of them. While not always the reason, limited knowledge and awareness of mental health issues, suicidal distress and LGBTQA+SB lives can contribute to stigmatising and upsetting responses by family members.

As noted previously, participants across the three cohorts indicated that they struggled to articulate feelings of suicidal distress when they were younger. The inability to ask for help could limit what support was provided by family members. For example, one participant said:

> *I couldn't articulate what I was feeling to my mum because I didn't know how to... I was struggling to figure out what was going on with me, let alone to be able to articulate it to a therapist, let alone my mum. And it was just not, like I could not find the words. I had no real way of figuring it out at the time, you know. So basically, I made some excuse about how I was feeling. My mum thought I was basically screwing up at school. I think she got that impression, that I just wasn't paying attention and that I was wasting this marvellous opportunity that had been granted to me. She has come around eventually, but you know, it took the better part of the last 20 years to get there.*
>
> **SB03LE, 29, cis male, pansexual, First Nations LGBTQA+SB**

In this excerpt we can see how this participant found it difficult to explain what he was feeling to his mother. He explains how he 'made some excuse' which his mum interpreted as him 'screwing up at school' and 'wasting this marvellous opportunity'. These two quotations suggest that it is important to recognise that we can all change and that while negative responses are hurtful and damaging it is possible to recover relationships. Furthermore, an individual's ability to describe what they are feeling and the capacity of individual family members to respond appropriately and provide support can change overtime.

Friends

Many of our participants highlighted the value and described the benefit of the support provided by friends. One participant attributed her happiness to her support network:

> *I'm happy, I've got a lot of friends now. Before, I had to find my way, but now I'm open and I'm a lot stronger, and at least I've got the network and support around me who still supports me.*
>
> **SB05LE, 42, sistergirl, First Nations LGBTQA+SB**

The benefits of social connection are evident within this excerpt. It was not always easy to ask for help from friends. One participant explained how they learnt to receive support from friends:

> *[O]ne of the therapists that I had really emphasised to me that I need to be open and honest with my friends and my family, the people that I trust and really open a narrative with them, like a dialogue with them about my mental health. So now in my life, it's actually in the last I reckon six years or seven years, like my mum and a couple of my really good friends, I know I can talk to them as soon as I feel like, 'Oh my god, I'm in a bit of a crisis.' And there's these people ... are not like 'Oh my god, whatever.' They're just like, 'Okay, what do you need to do? What can I do for you and what do you need to do'?*
>
> **SB04LE, 30, non-binary, queer/lesbian, LGBTQA+**

Elsewhere this participant emphasised the isolation they felt growing up and the homophobic violence experienced at the hands of their step-father. This participant, explains how, through the encouragement of their therapist, they learnt to ask for help from friends and family when it was needed. Support provided by friends can be instrumental or emotional and contribute to the mental health and wellbeing of LGBTQA+SB people.

Trust was a common theme within participant accounts of the informal support provided by close friends. Participants could be selective about who they disclosed their suicidal distress to. One participant explained:

> *Going back to [friend's name] – who was a friend – who was like, 'We all know you're gay, what are you talking about', stuff, and even back to – who was a [friend's name] as well – my best friend from Uni ..., but it was just more that acceptance again. But it was just you could have an open conversation, and that's where you felt comfortable, and for somebody like me it was probably better in a one-on-one conversation. ... If I was safe, if it's somebody that's – pull me out of a situation that I was in, and then just went, 'Okay, it's one-on-one, I'll take you home, or I'll do this or I'll do that', and just being there at the end of the phone to a certain extent going, 'If you need to talk, just ring'. But I have to be comfortable with that. I have to know that that conversation is not going to go anywhere else, so it's a trust thing.*
>
> **SB10LE, cis male, gay, LGBTQA+**

The way individual friends provided support is important, as this excerpt indicates. Demonstrations of acceptance and understanding helped to foster the safe space where this participant felt safe enough to disclose what they were feeling. When asking friends for help, LGBTQA+POC participants often turned to people who had a similar cultural experience to themselves. This was particularly the case for LGBTQA+POC participants who had immigrated to Australia. One participant explained why they sought support from a friend who was also from China when they were feeling suicidal:

> *The reason why I chose them, so she's a friend from China, we've always been in touch, and I know she kind of knows my gender identity, at least her understanding would be I'm a gender non-conforming person, and she respects that. And also, I think she has that open mind to hear about my life in Australia with the same understanding about my cultural heritage. If I choose a counsellor in Australia, I wouldn't feel the counsellor can make much sense about my experience in China. I think there was – also she, her psychology background is also [solely] in China so that's the reason why I chose her.*
>
> **SB14LE, gender fluid, pansexual, LGBTQA+POC**

We can see how their friend's ability to understand her experience in Australia through a similar cultural lens is helpful. Yet, it is also important their friend was aware of and respected their gender identity. Concerns about the level of cultural knowledge held by Anglo-Australian counsellors meant this participant preferred to talk to friends about their distress. While awareness and understanding of their cultural background was important for LGBTQA+POC participants, a lack of understanding about LGBTIQA+ identities could limit what type of support was available.

A LGBTQA+POC participant emphasised the need for support around his sexuality from people within the LGBTIQA+ community:

> *Even the friends here, they're really nice and everything, but of course they're not from the [LGBTQA+] community, so they don't really understand the struggle that I go through. They don't really understand, at times, the prejudice that I have to feel, because they have not been through that.*
>
> **SB11LE, 25, cis male, gay, LGBTQA+POC**

Elsewhere, this participant emphasised the acceptance and safety he felt when he was with friends from India. Yet, in this excerpt we see how the support they can offer is limited because they do not understand the fear and prejudice he feels around his sexuality. Trust and mutual understanding are crucial factors when considering what type of support might be provided by friends, but this can vary, particularly for LGBTQA+POC who have recently arrived in Australia.

The perceived depth and quality of friendships also played a role in how support was sought and provided by friends. According to several participants, the intimate and biographical knowledge that comes with long-standing friendship was helpful because friends were able to identify when they needed help without them asking for support. One LGBTQA+POC participant explained how his friends can 'decipher [his] codewords' and are good at 'monitoring' him:

Honestly, when I'm feeling shit, I message my friends, 'Bring me cake', because I just need a friend to talk to me and just remind me. Or sometimes they just send me cake and, I tell you what, that also very much helps. Yeah, I think to me, in those moments, I don't necessarily need a service, I just need people around me.

SB18LE, 38, cis male, gay/queer, LGBTQA+POC

This excerpt illustrates that not all LGBTQA+SB people experiencing suicidal distress will seek support from friends by actively disclosing their suicidal distress. It also suggests that social connection can help reduce suicidal thoughts and feelings. Support from friends could also be provided without directly discussing suicidal thoughts and feelings. Another participant described themselves as 'quite private' and said they generally did not tell people when they were 'in crisis':

Q: So you're not necessarily going to disclose that you're in crisis, but when you, say, reach out, what does that look like?

A: I guess it would just be initiating an interaction. There are particular – I have no way to describe this – but you know how when you get to know someone you get to know their linguistic habits and the text body language?

Q: Yeah.

A: I assume that the people who know me well have also gotten to know that about me, and generally when I'm not doing so well people respond a little bit faster, so I assume there is something that I do differently when I reach out to people when I'm not doing so well than when I am doing a bit better. I don't know what it is.

SB08LE, 23, non-binary, queer, LGBTQA+

This excerpt illustrates how the intimate knowledge of personal traits and characteristics held by this participant's sister and friends, means they can recognise when they are 'not doing so well' and be in contact more quickly. Seeking and receiving support from friends can take subtle forms.

Online support

Several participants described the benefits of participating in online spaces for building social connection, but also emphasised issues of confidentiality and trust. One participant described how they adapted an approach recommended by a health professional. She said she set up an online support group with trusted friends:

...she put me on to a text network approach, or an SMS network where six people – if you're having a bad run – you can check in at 10:00 each day and you don't have to say anything, just say, 'Better today.' 'Not so good today.' That's one technique that has worked. And I've morphed that into a – as it's called on Facebook – a secret group that only the people in it know it exists and what's in there. I've trusted people where I can release feelings, thoughts, opinions, call it what you will, and also possibly reach out to them. So, I do have that support network as well, and they're people I know who will listen, they won't judge, etc., and they will be there if I'm in a really bad way. I trust them, that group, actually more than my own more public Facebook page.

SB19LE, 56, trans female, bisexual/ pansexual, LGBTQA+

This extract highlights the value of regular check-ins via personal SMS through an online support group when this participant was in a 'really bad way.' The closed nature of the group facilitated the trust needed for her to be able to openly 'release feelings, thoughts, opinions.' Knowing that people will 'listen' and 'won't judge' is identified as helpful. A space where she can 'reach out' to trusted people online is an important source of support for this participant.

The lack of easily accessible support for people with intersectional experiences often meant that people looked for online groups to fill this gap. A LGBTQA+POC participant said they often explored gender and sexuality forums online and were sometimes able to find helpful information and support through them, particularly when there were shared cultural experiences:

So, there's subtle Asian traits that was something that was a fad two years ago or last year, but it was the first really big Facebook group where a lot of, often Asian, people that were born in a white country had just joined this group and we were sharing all these weird niche experiences that our parents have brought us up with, and that was really connecting. And then from there, all these subgroups started being made. And first there was subtle Asian mental health, which is great. And then there was identified a need within there for subtle queer Asian traits or something, and that's been amazing. It's been so good to navigate stuff like how culture affects your presentation of ADHD, or how culture affects your relationship with your partner and your relationship with your parents. And some people have really wholesome stories, a lot of us have really not wholesome stories. But it's fantastic to meet like-minded people within that online format, where people are sharing their real stories, and you can find that non-traditional form of help-seeking and see that there are other options out there.

SB13LE, 24, cis female, pansexual/ demisexual, LGBTQA+POC

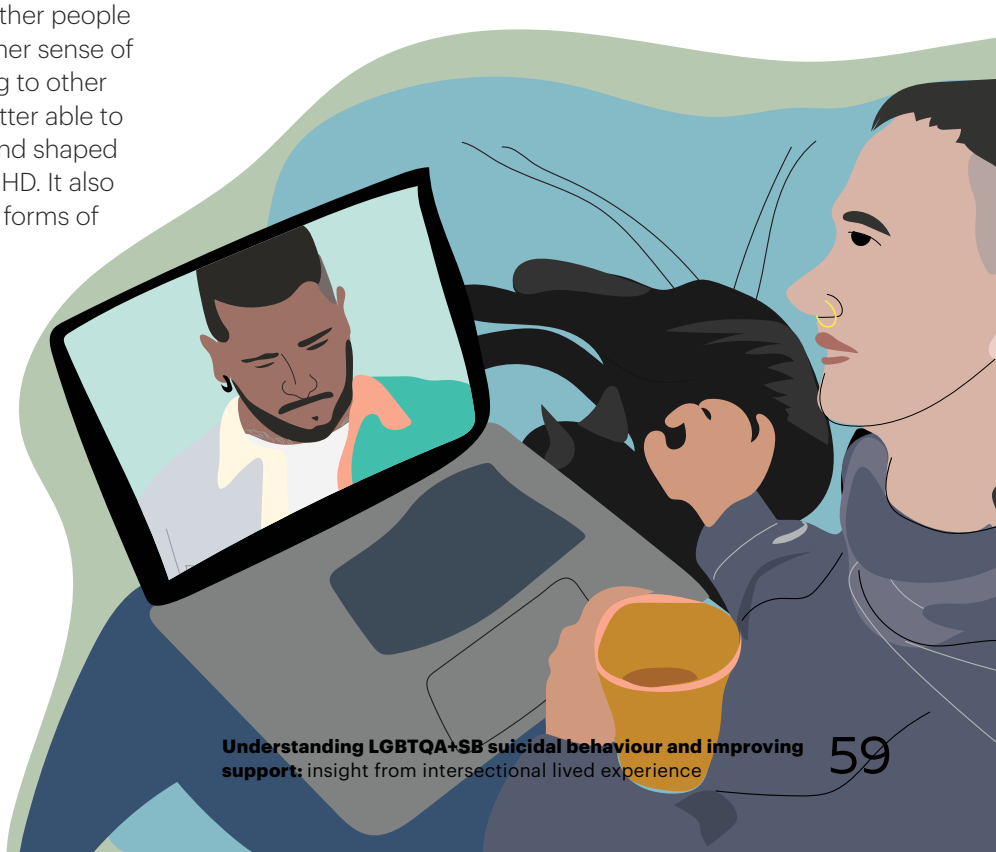
This participant identified searching online for information and support as a 'strong protective factor' for her. We can see how sharing experiences of growing up in a white society with other people who have an Asian heritage is vital for her sense of connection to others. Through listening to other people's stories this participant was better able to understand how her cultural background shaped her relationships and experience of ADHD. It also increased her awareness of alternative forms of support.

Another participant also found that online forums offered a unique form of support. Despite being reluctant to disclose experiences of suicidal distress online, because 'queer circles' and 'disability circles' are quite small, they appreciated the topics discussed:

[B]ecause of the way that the [online space] developed there's quite a high proportion of neurodivergent people in the server, so a lot of the conversations, particularly in the more serious groups, tend to skew towards people's experiences of disability and madness and critiquing systems they've interacted with and things like that, which is very generative in ways that I haven't always experienced in those sorts of, 'There is a correct way to talk about recovery' spaces.

SB08LE, 23, non-binary, queer, LGBTQA+

The topics discussed in recovery spaces are contrasted with the more systemic concerns held by online members with intersectional experiences of 'disability and madness'. These discussions are 'generative' for this participant because they match their own experience. Finding and participating in trusted online spaces where intersectional experiences are visible and discussed can address gaps within the broader health and social care system and foster a sense of shared experience and connection.



LGBTIQA+ Communities

Many participants across the three cohorts emphasised the importance and value of the support they received through LGBTIQA+ communities. One LGBTQA+ participant said, 'I can't emphasise enough how important community and relational healing has been in my journey and trying to figure out what the heck is going on inside me' (SB07LE). Another participant from the LGBTQA+POC cohort felt there was a greater possibility of connecting with and receiving support within LGBTIQA+ communities:

> *I think the benefits of a community like ours is they provide a sense of belonging, potential friendship, just a sense of connection with other people who are similar, who might understand you in a way that you felt like you might not have been. So, I think these are actually really good at mental illness prevention.*
>
> **44, cis female, bisexual/homoromantic, LGBTQA+POC**

They highlight that connecting through LGBTIQA+ communities can play an important role in supporting mental health and addressing suicidality. A First Nations LGBTQA+SB participant similarly identified the importance of the 'quiet' support provided by peers living in the community where he had grown up:

> *I'd be remiss if I didn't mention all of these gay people who were in the background, you know. There was a lot of invisible mending happening, you know, throughout, where those who knew, those who were silently allied, and those who were out, we were all very quietly taking care of each other. I didn't realise that at the time. When I did realise it was quite recently with the likes of [researcher] and some of the gay men and women I grew up with and worked with and went to school with and it was just this very slow in the background kind of thing and it was really beautiful. And I say beautiful specifically because it wasn't present, but it's like a guardian angel, you know. There's people here who you can't see, watching out for you. You are being taken care of. We can only do it in very small, meaningful ways, but it can be done.*
>
> **SB03LE, 29, cis male, pansexual, First Nations LGBTQA+SB**

Community-based support can occur in subtle ways. We see here how the loose network of 'gay men and women' this participant had grown up with looked out for and took care of one another. The knowledge that someone else is there, taking care of him, is meaningful and 'mending.' Understanding the ways in which community-based support facilitates belonging and social connection can help inform approaches to theorising how support and relationships work as interventions.

Not all accounts were positive and these point to areas for improvement. Several participants expressed concerns about the level and quality of support available and the widespread need within LGBTIQA+ communities. One participant explained:

> *I think it's a huge issue that people who are relatively prominent in our communities need support themselves, but the thing is we're sort of seen as the bedrock for other people to lean on, and we have to be 'strong,' whatever that means. But what happens when we need support? And this came to the fore particularly four years ago when we had the stupid postal survey, but the leaders, who did we turn to? What support did we have? And the reality is also that – I mentioned lateral hostility, which has happened a lot in the advocacy and community involvement. Some so-called community leaders are not people I really want to hang out with. I can't stand them on many levels. So, it's a really tricky thing.*
>
> **SB19LE, 56, trans female, bisexual/ pansexual, LGBTQA+**

The issue of leadership is introduced here. First, in terms of the mental health impact on community leaders, who are expected to be 'strong' and carry the weight of widespread discrimination while continuing to campaign for justice. Second, the quality of leadership and internal community disagreements are raised, including the issue of lateral hostility that can be distressing and fragment the forms of community support available. Facilitating opportunities to build meaningful social connections could play a key role in addressing some of the isolation and alienation people may have and act as a protective factor against future suicidal distress..

Chapter Four Highlights

- Seeking support for suicidal distress can be a challenge, particularly when younger. Help-seeking may improve overtime as First Nations LGBTQA+SB people, LGBTQA+POC, and LGBTQA+ people learn where and to whom they can turn for support.
- Concerns about stigma and perceptions of safety, trust, and confidentiality significantly shape help-seeking practices.
- Support provided by family members is appreciated and valued, particularly by First Nations LGBTQA+SB and LGBTQA+ people. There is potentially less family support available to LGBTQA+POC people whose family are overseas or for LGBTQA+SB people where there might be cultural or religious sensitivities.
- Support provided by friends is valued by LGBTQA+SB people. However, people with intersectional experience may find it difficult to receive informal support that caters to all aspects of their identity (i.e. LGBTQA+SB identity and cultural / faith background).
- Trusted online spaces can fill support gaps and facilitate social connections between LGBTQA+SB people with intersectional experiences, particularly people with less visible gender identities and sexualities, LGBTQA+POC, and LGBTQA+ people with a disability.
- Support received through LGBTQA+SB communities is valued but experiences may vary significantly across groups. A lack of diverse representation in LGBTQA+SB communities can mean the availability of informal support is limited for less prominent genders and sexualities, First Nations LGBTQA+SB people and LGBTQA+POC.

The role of formal mental health support for LGBTQA+SB suicidal behaviour

The findings presented in this chapter focus on First Nation LGBTQA+SB, LGBTQA+ POC, and LGBTQA+ experiences of a range of formal supports for suicidal behaviour. These include GPs, psychologists, psychiatrists and other counselling services, acute mental health services, such as emergency departments and mental health inpatient services, and phone and online-based support. All but one of our participants had accessed a form of mental health and / or formal peer-based support at some point. Many had experience with talking therapies, predominately with psychiatrists and psychologists, but some had utilised counselling services available through their church, school, or via a phone-based service. Identifying and accessing an appropriate support service was a key challenge, with accessibility issues related to participants' own lack of knowledge about where and how to access services. These challenges were often compounded by barriers encountered within the healthcare system, which include limited knowledge and awareness about gender, sexuality and cultural diversity, a lack of appropriate services in rural and regional areas, and financial cost.

Navigating barriers to mental health and other supports

Participants described a lack of understanding amongst GPs and other professionals in the health and social care sector about the circumstances and challenges experienced by LGBTQA+SB people. A lack of understanding combined with limited awareness of what was available within a complex health and mental health system meant many participants did not know where to go. Knowledgeable service providers and readily accessible services could help LGBTQA+SB people to feel safe when they are experiencing suicidal distress. A First Nation LGBTQA+SB participant highlighted the 'struggles' that young Aboriginal and Torres Strait Islander people face when attempting to access services related to their gender identity and / or sexuality within communities across Australia:

> *Generally, they need to feel safe, whichever or whatever they're accessing, whether it's their local, or the urban or the city centre... so they can have an understanding, and maybe a counsellor as well or a contact number in these specific areas, whether it's a clinic, whether it's a neighbourhood centre, whether it's your local GP or hospital. I reckon there should be those clear pathways of information contacts, yeah, and a safe space for that information to get through. Whether you can identify an aunty or an uncle, or they can identify a member of their family that's going through a crisis, or they can identify someone that's trying to find their way, and the information is there.*
>
> **SB05LE, 42, sistergirl, First Nations LGBTQA+SB**

Creating a safe space where people can access information and / or identifying a supportive Aunty or Uncle who knows someone with similar experience, is vital. In addition, this sistergirl identifies several potentially appropriate sites, indicating that the more informed all of these services are, the more likely young Aboriginal and Torres Strait Islander LGBTQA+SB people are going to have a positive experience and get the support they need.

However, general practitioners (GP) are crucial as they are often the first place people seek support outside of trusted informal networks. For our participants, GPs played a substantial role in providing support, identifying psychiatric and psychological support, making referrals, and, in a few cases, providing prescriptions for antidepressants. Finding a GP who understood diverse genders and sexualities was important for many of our trans and gender-diverse participants but also those who identified as bisexual, pansexual and demisexual.

> *... the number of GPs that I had seen in my life basically, up until I found [medical clinic], I had not found a GP who understood what I was talking about when I would talk about how I have confused feelings about my gender or about why I'm depressed.*
>
> **SB01LE, 75, trans female, lesbian, LGBTQA+**

This participant emphasised the importance of finding a GP who understood trans mental health needs. She explained that through this GP she was able to access a trans and gender-diverse specialist service where she was finally able to make sense of her distress for the first time. GPs are central to accessing traditional mental health services, but a lack of awareness and understanding of the context of LGBTIQA+ lives and their relationship with mental health and suicidal distress can limit what support is provided.

A knowledgeable GP is especially important when participants' lack of understanding of the mental healthcare system is also a barrier to support, as it was for LGBTQA+POC participants who had immigrated to Australia for study or work. One participant described how they turned to their friends for support because they did not know how to find a counsellor or navigate the 'health infrastructure' in Australia:

> *I didn't know where to go for professional counselling, I didn't know because I was so new, right? And I didn't know how the infrastructure, the health infrastructure, or how the system worked. So, most of my support then came from friends and people that I knew, or people who regarded me as a friend. It was not through a social worker and a client kind of a relationship; it wasn't like that.*
>
> **SB12LE, 40s, cis male, gay, LGBTQA+POC**

This was a common experience reported by some of our LGBTQA+POC participants. Their limited knowledge about the health care system constrained their ability to make active choices about who they saw and, by extension, limited their access to culturally appropriate support:

> *Yeah, I didn't know that reviews for psychologists or anything were a thing. And when I eventually went to [city], I think that was the first time that I really had the agency to choose a lot of the people in my life. And I was like, 'Oh, I wonder if that's a thing.' And I Googled a lot specifically around, I think, youth mental health type stuff and also different cultures and read a lot of reviews like who could hold the most space, who felt really welcoming?*
>
> *SB13LE, 24, cis female, pansexual / demisexual, LGBTQA+POC*

To find support that was inclusive of her cultural identity and experience, this participant describes how she turned to Google. Through reading reviews of different psychologists, she was able to identify a psychologist whom she believed could 'hold the most space, who felt really welcoming'. This choice only became an option after moving to a metropolitan city where there were more counsellors available, and she was asked by a GP who she would like to see. Even where choice was an option, our participants identified many barriers to actively making an informed choice when accessing a service:

> *The amount of choice still feels quite limited because – how do I put this – when I would see psychiatrists and things, my experiences of that was quite poor, but even in the better terrible relationships I had with the psychiatrists it would be like 'here's this psychiatrist that I found that isn't actively hostile towards me for being queer, I can afford to see them, and they're not actively – well, they're not overtly hostile to me most of the time around a lot of disability stuff.' But then there's still that element of 'I don't really have any other people to go to and I feel kind of locked into this relationship'. Particularly because there are really long wait times, there are [inaudible] services that are unsafe and some hard-to-find services that are unsafe, it's very expensive to try and establish whether or not you can trust someone, the free or low-cost services even worse on wait times.*
>
> **SB08LE, 23, non-binary, queer, LGBTQA+**

We see here how waiting lists and financial cost limit choice and results in some people receiving inappropriate or substandard care. In this case, the participant felt they needed to settle with a particular psychiatrist because they felt 'locked in,' with no other options available. A lack of choice and poor interactions with individual therapists can create further vulnerabilities and add to the distress a person might be experiencing at the time.

Geography often limited what services were available and accessible to participants living in regional and rural areas. A few participants described travelling substantial distances to access support that understood and was responsive to LGBTQA+SB lives. A First Nations participant emphasised the challenges First Nations LGBTQA+SB people living in regional and remote communities experience when attempting to access support because of limited transport and issues with phone and internet access. She said it was only by travelling to the nearest regional city that she was able to access the information she needed to make sense of her gender identity and sexuality:

> *So, I went and saw a service, and I asked – I think it was in [regional city] when I went down. It was in [regional city] I did ask, and they ended up sitting down with me and having a bit of a yarn, the meaning of each term, where you sit. I think that's where I have asked those questions, and I wanted to find my direction, yeah, where I was.*
>
> **SB05LE, 42, sistergirl, First Nations LGBTQA+SB**

Finding a service where she was able to have 'a bit of a yarn' about terms related to gender identity and sexuality helped this sistergirl to find her 'direction.' The requirement to travel introduces additional financial barriers, on top of the financial cost of psychological and psychiatric support, that was also prohibitive for many.

The financial cost of formal support was particularly prohibitive when participants were studying, between jobs, in low-paid employment or under-employed. Identifying schemes that could reduce the costs of services was helpful. For example, a First Nations LGBTQA+SB participant talked about the benefits of being able to access a psychologist for free because of the GPs knowledge and awareness of the Closing the Gap campaign:

> *I spoke to my GP and I said listen, 'What I'm feeling is not good, like I feel like I'm coming apart'. And so, he ends up doing a little minor assessment of me, you know, it was like, 'And do you have suicidal thoughts? Yes, one – infrequently, five – very frequently,' you know, those questions. We go through a couple of those and he just said look, 'You're clearly ranking very high on all of this so I have a list of therapists here, psychologists here that you can start seeing, we'll put you on a health care plan, you're indigenous so you're covered under Closing the Gap for a series of free and, if not, discounted sessions, so here are some therapists'. I picked the free one, started seeing a psychologist, and then slowly started to unpack everything that was wrong with me.*
>
> **SB03LE, 29, cis male, pansexual, First Nation LGBTQA+SB**

His account highlights how free or heavily discounted services can increase the likelihood of individuals accessing a psychologist or psychiatrist when needed. It also illustrates the vital role that GPs can play in linking LGBTQA+SB individuals into appropriate and affordable formal mental health support.

Timely referrals are crucial when LGBTQA+SB people are experiencing suicidal distress and attempting to navigate a complex healthcare system:

> *[O]ne of the main things I think is it needs to be more understanding that people with mental health issues that access these services, a lot of the time aren't going to feel comfortable advocating for themselves. If they are really seeking help and wanting help, like, why the fuck are there these extra barriers where you have to make the phone calls yourself?*
>
> **SB04LE, 30, non-binary, queer/lesbian, LGBTQA+**

This participant notes the need for assistance in accessing support and the need for warm referrals. Active referrals and quick responses from appropriate services once contacted were crucial for helping participants feel safe and supported when they were experiencing suicidal distress.

> *I was in a really critical moment and I was desperate for help. I just really needed that. [LGBTIQA+ organisation] was not the only organisation that I reached out. There was several others, but [LGBTIQA+ organisation] was the first, and very fast. It just took one or two days for them to schedule a meeting, so they just called me and reassured me, and assured that, 'We help you. We need information, and we're going to assign another person of colour for you to discuss.' It was really easy. Next day I get another call, 'Which date do you want to come?' It was really convenient, really fast, this way. That's exactly what I needed.*
>
> **SB09LE, 28, cis male, gay, LGBTQA+POC**

Elsewhere this participant from the LGBTQA+POC cohort described how he had attempted to access university-based counselling services without success. In contrast, the speed with which an appointment was made by the LGBTIQA+ organisation and the tailoring of support to his cultural needs was 'exactly' what he needed at the time.

Talking therapies: Cultural diversity and support for LGBTQA+SB people

Many participants described how they wanted to find a therapist who understood or was at least aware of the challenges faced by LGBTQA+SB individuals. One participant explained why he felt this was necessary:

> *I guess it was never a fear of discrimination per se, it was more about just understanding, just having that baseline understanding about what that experience was like, having a shared kind of experience of what it might be like growing up gay in either a religious environment or a regional environment. It's just one less thing that you have to explain.*
>
> **SB15LE, 33, cis male, gay/homosexual, LGBTQA+**

Participants actively sought out psychologists and psychiatrists who were accepting and aware of LGBTQA+SB issues. Others highlighted the benefits of receiving specific support around their LGBTQA+SB identification as part of the process of addressing their suicidality. A trans female participant explained:

> *I finally tracked down a psychologist who knew what she was talking about. She was recently graduated from university, had done her masters in gender and sexuality, identified as part of what we would now call say 'rainbow communities', and used the word 'transgender', and explained it pretty well for someone who was assigned male like myself, and it all became clear. The reason for that is I think that in terms of mental health, the transgender issue/gender issue had become like, I personally call it the topsoil. And so okay, I dug through the topsoil and cleared that away, and now we can have all the layers underneath, and that's going to be very relevant in mental health terms.*
>
> **SB19LE, 56, trans female, bisexual/pansexual, LGBTQA+**

This experience followed an earlier description by this participant of a harmful encounter with a psychiatrist and psychologist, one of whom attempted conversion therapy. Finding a psychologist with awareness and knowledge about transgender health and mental health after a long period searching enabled this participant to understand her gender and how her experiences shaped her suicidal distress and mental health.

Participants from the LGBTQA+POC cohort placed similar emphasis on the benefit of seeing a mental health practitioner who could respond appropriately to issues related to their LGBTQA+ identity, as well as their cultural and racial experience. One LGBTQA+POC participant felt that her sexuality was 'secondary to a lot of things' and something she was 'okay-ish to work out alone'. Yet, she powerfully described the impact of a psychiatrist who engaged with her cultural experience and sexuality, as a 'game changer':

> *I remember the first psychiatrists that wrote out this huge – they write these very big, assessment, things about your presentation and stuff like that. And she wrote the most – I'd never been so seen in my life, when she just spoke about the cultural aspects that I had briefly mentioned and she tied them into the assessment. Not just the presentation of my symptoms, but it was my symptoms within the context of my culture and within the context of my sexuality and my relationships with other people. And that was a complete game changer and yeah, I'm incredibly inspired by that and standards have been incredibly heightened by that.*
>
> **SB13LE, 24, cis female, pansexual/demisexual, LGBTQA+POC**

According to this participant, it was the first time her cultural identity had been acknowledged by a psychiatrist. The sense of feeling seen demonstrates how vital it is for practitioners and service providers to work with intersectional experience in the context of LGBTIQA+SB mental health and support for suicidal distress.

Unfortunately, some participants felt, at times, they needed to educate health and social care practitioners about diverse genders and sexualities. An LGBTQA+POC participant highlighted the two years it took for her psychotherapist to understand her sexuality:

> *It took a while for me to educate her about it though. She seemed to think I was gay because of that emotional attachment to women. I said, 'No, that's not how it works.' I felt like I had to educate her over two years basically, what my sexuality is and what my bisexuality is, in particular. She obviously wasn't biphobic or anything, but kind of like a lot of straight people. Not very aware. Obviously very highly intelligent, but not everyone is expected to know about bisexuality, admittedly and then a lot of bisexuals don't even understand that there are different types of bisexuality either.*
>
> **SB17LE, 44, cis female, bisexual/ homoromantic, LGBTQA+POC**

The psychotherapist's lack of awareness of bisexuality is linked to living in a heterosexist society that renders this participant's sexuality invisible. The lack of cultural awareness and understanding of individual psychologists, psychiatrists and counsellors was a concern expressed by several LGBTQA+POC participants. This participant described his apprehension:

> *[O]ften I questioned whether they really understood. When I said something that meant a lot to me, or something was important to me, I wondered whether they understood the intensity with which that thing or that issue meant something to me. I often had doubts that okay, maybe they understood but I'm not sure whether they understand the magnitude.*
>
> **SB12LE, 40s, cis male, gay, LGBTQA+POC**

The lack of cultural awareness demonstrated by his counsellor meant that this participant often questioned whether they were fully aware of the significance of the issues or events he recounted during their sessions. This gap in understanding was experienced as a lack of support and is not conducive to creating a safe environment where people can easily express the depths of their distress and feel heard.

A First Nations LGBTQA+SB participant highlighted how Aboriginal and Torres Strait Islander people may want to access LGBTQA+SB health and social care services but feel too scared. The visibility of LGBTQA+SB services and issues of confidentiality within communities were central concerns. One First Nation LGBTQA+SB participant made the following suggestion:

> *And when I talk to the other people, they don't go to that queer place, LGQ or whatever it's called. Because it's too colourful. It just looks so gay that nobody wants to go there.*
>
> **SB20LE, 50, female, heterosexual, First Nations LGBTQA+SB**

This excerpt highlights the problem of highly visible LGBTQA+SB services within regional and remote communities. A 'colourful' service is readily identified in community and may prevent people from accessing LGBTQA+SB support because of concerns about stigma and discrimination. Making it a 'normal house, like a normal doctor's clinic' would remove this potential barrier she suggested. While the importance of Aboriginal Community Controlled Health Services (ACCHS) was emphasised by all First Nation LGBTQA+SB participants, the need to foster safety and trust was emphasised by one participant. In her experience, she said First Nations LGBTQA+SB people were often concerned about confidentiality when accessing ACCHS:

We just said, look, we need to get somebody that's mutual. Mutual, that means we're not going to try and get another Indigenous person, whether they're from community or whether they're out of community, we're going to have to get a non-Indigenous person working within the centre for that confidentiality, and if they have to drive in and drive out, or fly in, fly out, that will make that access comfortable and easier, of feeling that they can access that service. I believe now, we went through that, where we had Indigenous workers from our community, from the four sites, and people were frightened of talking to that individual because they were related to that individual as well.

SB05LE, 42, sistergirl, First Nations LGBTQA+SB

In this excerpt we can see how the support provided through community-controlled organisations can be challenging. Familial relationships and visibility within the community can create fear amongst some First Nation LGBTQA+SB people accessing services within remote and regional communities because of a lack of community acceptance of diverse genders and sexualities. Finding ways to ensure confidentiality can foster the sense of trust and the safety of First Nations LGBTQA+SB people need when accessing support.

Creating safety in acute mental health services

Many participants across the three cohorts had contact with acute mental health services, which included the emergency department (ED) and mental health inpatient services. This was often following a suicide attempt or when participants were experiencing a suicidal crisis. People reported various experiences of acute mental health supports and follow-up support. One participant described the positive role that the ED and 'a bloody good GP' can play in intervening in a suicidal crisis:

[T]here's only two places that actually can help: one is the emergency department of the local hospital and two is a bloody good GP, because nobody else has the authority to refer or to take the steps necessary. I wish over the years, somebody had referred me or put me in their car like the [health service] lady did, she put me in her car and she wasn't going to let me out of her bloody car until she got me to [inpatient setting] and booked me into a locked ward. And that – I'm sure that saved my life. I was in such a terrible state, being homeless and being jobless. At that stage, I was almost familyless because I'd kind of abandoned them all to go to [country]. And yet being in [hospital], put there by the [health service] lady got me to a stage where they actually had the authority to do what they needed to do to make sure that I – let me stay there for those couple of weeks and got the strategy and the help that I needed.

SB02LE, 52, gender non-conforming, gay, LGBTQA+

The time spent within a mental health inpatient setting is described as lifesaving by this participant. It's here that she received the psychiatric support and housing support that helped her to better manage her suicidal distress. Encounters with the emergency department and acute mental health services are opportunities for LGBTIQA+ people to be connected into psychosocial services able to address factors contributing to a person's suicidal distress. Many participants were more circumspect, however, with some reporting unhelpful and even troubling experiences, and others stating that they actively avoided acute mental health services. In the following excerpt, a participant ambivalently describes experiences within the ED and an inpatient unit after two separate suicide attempts when she was in her teens:

> *So, I ended up in the ER and then recovery from then was just more therapy, more medication. Yeah, I didn't have a really long inpatient stay or anything, and I struggled with – it's hard to say, pretty chill suicidal ideation.*
>
> **SB13LE, 24, cis female, pansexual/ demisexual, LGBTQA+POC**

The description of the limited inpatient stay, therapy and medication suggests the support provided following this attempt was inadequate. Two participants described how they were fearful of attending an ED and being admitted to a mental health inpatient unit. One participant who also identified as 'mad' and 'crip' explained:

> *One of the reasons I am very afraid of being in an inpatient setting is specifically because of the ways I'm disabled. I would not be safe there, would not be well there, and it would be extremely detrimental to both my physical and mental health.*
>
> **SB08LE, 23, non-binary, queer, LGBTQA+**

The vulnerability they felt in relation to their disability and mental health is readily apparent. Inpatient settings are perceived as unsupportive and harmful. Another participant was concerned they would not receive appropriate care when they were taken to hospital after a suicide attempt:

> *In emergency, I've seen people go and come in the mental health, in the sexual health. I see all them coming and I'm thinking, 'I know they won't help me. It's just all temporary, band-aid health. But then they're going to know my story. I'm not going in there and tell them, and then they're going to go tell somebody else, and somebody else. Somebody's going to read my records'.*
>
> **SB20LE, 50, female, heterosexual, First Nations LGBTQA+SB**

We can see how the issue of confidentiality and concerns about stigma related to having made a suicide attempt and their gender identity within a small community shapes this participant's perception of safety within the ED.

The fears expressed by the two participants above are not without foundation, another participant described a challenging experience within a mental health inpatient setting:

> *That was just a really shit experience as well. The psychiatrist that I saw there, obviously it was terrifying going to this hospital and the bed was really uncomfortable. The nurses were also so aggressively gendering me that I was like this is obviously not a space where I can be out. So, I was just not out in that space. The psychiatrist was this old man who, we just did not connect, and I'd never seen a psychiatrist before this point either, so I didn't really know what to expect. But again, I had that guarded like 'I don't want to tell you about my stuff'.*
>
> **SB07LE, 26, non-binary, lesbian, LGBTQA+**

Evident within this excerpt is the fear this participant felt at staying in a mental health inpatient setting. A lack of connection with the psychiatrist and misgendering by the nurses contributed to concealment of their non-binary gender identity and support needs. These fears are a barrier to necessary care and support and point to the need for alternative forms of support that are better able to respond to the unique needs and concerns of LGBTQA+SB people. Understanding how particular sites and services can contribute to LGBTQA+SB experiences of vulnerability and distress can help policy makers and service providers develop appropriate service models and care models.

The value of alternative supports

Beyond GPs and more traditional forms of therapy, our participants utilised a range of support services, including phone and web-based chat services, smartphone applications, online message boards and group therapy. Phone supports were the most common, with participants often describing their short-term benefits:

> *The formal support comes usually in the form of calling Lifeline and that does help. That does help, but that's a very rare one I use and that usually only occurs if I am having some kind of, not panic attack really, but if I'm having some kind of mental crisis usually in the middle of the night. Like, just I feel some kind of existential dread and I do feel like if I don't tell someone now, I'm going to collapse, you know? Like, hyper anxiety just kicks in. So, that's usually when I call Lifeline. It's just like okay, I need to get this out of my system and I've got to get it out now and then I will have to deal with it first thing in the morning.*
>
> **SB03LE, 29, cis male, pansexual, First Nations LGBTQA+SB**

Contacting a phone-based helpline in a crisis is an established and widely recognised form of help-seeking for LGBTQA+SB people experiencing suicidality. We can see how this participant uses Lifeline to work through immediate concerns when no other services are available, but he indicates there is still more work to do. This suggests the need for immediately accessible supports in times of crisis, but also for ongoing support ('in the morning'). Other participants identified phone-based support as less helpful, with one person describing the support provided as 'useless' (SB07LE) and another stating that it was delivered in a 'formulaic and robotic' (SB15LE) way. Participants were unlikely to return to a phone or web-based service where they felt the support was unhelpful.

Where participants were able to access online information and support tailored to the needs of LGBTIQA+ individuals it was appreciated. One LGBTQA+ POC participant explained how he utilised a web-based chat service to find LGBTIQA+ related information, including 'a queer psychiatrist' (SB18LE). Another participant recounted a positive experience of online supports through a youth-focused mental health organisations but also identified problems:

> *It was very much a subgroup of that much bigger group, and it was like an open forum. So, there are specific little bits, like pockets, where some people would express some of their sexuality, but it wasn't protected or anything and it wasn't a big community. I'd say the biggest one was [mental health organisations], which was specifically youth and mental health. And they did have a, I think it's called a space, that was about gender and sexuality. And I've never posted anything, but just going on that and reading people's experiences, it really helped because even though they didn't explicitly say their cultural background or anything, but where they said they had some trouble at home or they were just exploring that, it just really helped to hear their experiences.*
>
> **SB13LE, 24, cis female, pansexual/ demisexual, LGBTQA+POC**

Hearing about other people's troubles at home and exploration of their gender and sexuality within smaller groups was helpful even when cultural background was not explicitly mentioned. A shared understanding can help people feel understood, safe, and supported and prevent disconnection from needed support. Yet, we can also see why LGBTQA+POC youth may experience online groups as unsafe. The lack of protection and limited confidentiality within a small online community are highlighted within this participant's account.

Phone-based applications were also found to be helpful by one participant:

> *Headspace was recommended to me – someone, it was probably a therapist, and that was before they were paid. So now you have to pay for a subscription. But I accessed it and it was free, and it was amazing. It's more like mindfulness meditation. So, I'd pull up to uni and sit in the car – I'd get there early, sit in the car and do my mindfulness meditation. It was visualising because I'm a very visual person, so it was really good.*
>
> **SB07LE, 26, non-binary, lesbian, LGBTQA+**

Elsewhere this participant described how the pressure to do well as university contributed to their suicidal distress. The flexibility of the mindfulness application was particularly helpful allowing them to take a break and manage their emotions when needed.

Facilitated workshops and group therapy programs were also found to be helpful by some participants. These were often focused on concerns or challenges faced by participants and were not always LGBTIQA+ focused. One LGBTQA+ participant said, 'What really works best for me is group work'. She explained how she had participated in an 'evidence-based trauma-informed [group] therapy' program during a stay within a private residential treatment facility. She explained the benefits, 'It helped me to ground myself and start to accept that I'm an okay human, still worthy' (SB02LE). Another participant described the benefits of attending a workshop organised by an international student organisation:

> *I saw their advertisement online, and it said free, so I decided to attend that meeting. I saw other international students who's mentally really going through a lot, so we had this two-day workshop where we're writing our story, sharing stories, and reading and storytelling. I think that really helped me as well. After that session, my psychologist, like, 'Hey [participant name], next session which day you want you to go?' 'I think I'm done for now. It's okay for me now to just go on and end our sessions.' That also really helped me. I'm the only gay person there, so I saw not only Asians, I saw many black people, Indian, brown Asians, very diverse, all people of colour, and there were straight people, students, and I just heard their story and we just – I don't know, I almost cried, and I just felt the emotion and storytelling and sharing is really strong and important and powerful tool for people to connect and get used to each other. I think that really helped me to move on as well.*
>
> **SB09LE 28, cis male, gay, LGBTQA+POC**

The visibility of the needs and concerns of people of colour in a group setting, and the opportunity to exchange stories about his experiences in Australia with fellow international students was helpful for this participant, even though he was 'the only gay person there'. This highlights how racial identity can be a more significant contributor to suicidal distress than sexuality and / or gender identity and points to the importance of designing services for people of colour as this may be the key access point for LGBTQA+POC experiencing suicidal distress.

Chapter Five Highlights

- Limited knowledge about what safe, effective and affirmative care and the complexity of the mental health system are significant barriers to timely support, particularly for LGBTQA+POC who had recently arrived in Australia and people seeking help for the first time.
- A lack of understanding of LGBTQA+SB experiences amongst health and social care practitioners and even hostile and discriminatory responses means services can be experienced as unsafe and even harmful.
- GPs are key sources of support and the central access point for referrals to affirmative, psychiatric, psychological, and other mental health services.
- Geographical location, lengthy wait times, and out of pocket expenses are barriers to effective support. Timely responses, active referrals, and schemes such as Closing the Gap for First Nations LGBTQA+SB people and the Better Access initiative can raise awareness and facilitate access to appropriate and effective support.
- Visibility of LGBTQA+SB services within First Nations communities and concerns about confidentiality within Aboriginal Community Controlled Health Services can be a barrier to support for First Nations LGBTQA+SB people.
- Alternative supports such as phone and web-based chat services, smart phone applications and group therapy are important. However, concerns about quality, affirmation of LGBTQA+SB identities, ability to respond to intersectional experiences, and confidentiality can be effective barriers.

The role of LGBTIQA+ specialist support in responding to LGBTQA+SB suicidal distress

6

In this chapter we present insights from lived experience about where support for LGBTQA+SB people experiencing suicidal distress should be available and who is best placed to provide it. We explore the tension between generalist mental health support and support provided by LGBTIQA+ community organisations. The need for support addressing all aspects of a person's identity, was emphasised by our First Nations LGBTQA+SB and LGBTQA+POC participants. As with other forms of support, key issues identified within participant accounts related to issues of accessibility, trust and affirmation of all aspects of identity. Many found LGBTIQA+ services to be more affirmative than mainstream formal support, but there are still challenges to be met to improve accessibility and inclusion for those located at the intersections, including First Nations status and race, but also some gender identities, sexualities, geographical location, faith background, and disability.

LGBTIQA+ inclusive services versus LGBTIQA+ community-led support

Within the interviews there was a significant tension between LGBTIQA+-inclusive health and social care supports, and services provided by LGBTIQA+ organisations and individuals. The need for greater awareness of and sensitivity to LGBTQA+SB identities within health and social care spaces was a strong theme across participant accounts, with improvements required within spaces presented as 'LGBTIQA+ inclusive'. Some participants emphasised that it is important not to assume that suicidal distress is linked to gender identity and/or sexuality, but it is important to understand how individuals personally identify as part of delivering effective support:

> *I don't think there should be any assumptions made on people who walk in the door, and I feel like stuff needs to be tailored to each person depending on how they personally identify with all parts of their life, and it should be handed back to us to tell them how we want to be spoken about, how we identify. Just given that opportunity because then [it's] out in the open, everyone understands – from the get-go it's an open book, everyone understands where everyone else stands, how they want to be spoken about, that sort of thing. It's just being a little bit more respectful.*
>
> **SB06LE, 33, cis female, pansexual, LGBTQA+**

Tailoring supports through greater understanding of an LGBTQA+SB service user's lived experience and identity is essential. Sensitive inquiries via a form or questions about a person's gender identity and / or sexuality can facilitate more respectful interactions and promote trust in services.

To adopt more affirmative and appropriate responses, one participant suggested that there was a need for greater awareness of the lived experience of diverse genders and sexualities amongst LGBTQA+SB individuals, community organisations, and mental health professionals:

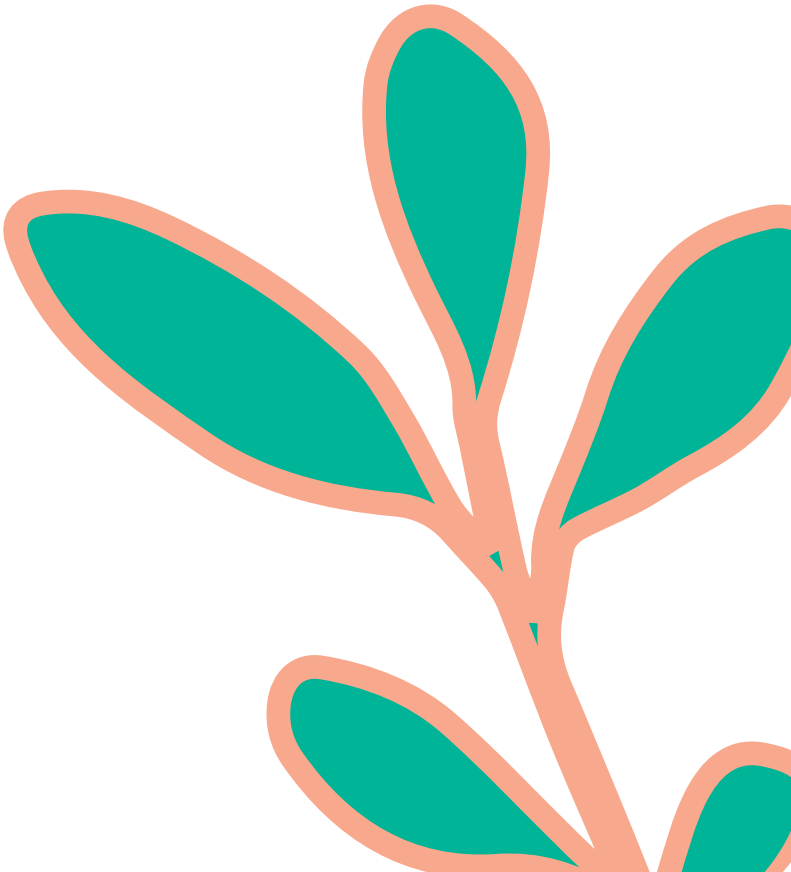
> *And because over time I've realised at the bottom of my emotional pit, if I can put it that way, I'll say people in rainbow communities have various emotions and feelings at the bottom of their pit, you know, judged, shamed, all that sort of thing. Mine – and because of the whole school experience and some family stuff, the two at the bottom of mine that I feel very mistrustful – or you might say wary – but also abandoned. And so just affirming people. I know that sounds incredibly basic, but people don't do it. So many professionals are just stuck on their own particular approach to mental health, and I have to say, I did try – I went to a health professional for two sessions whose focus was cognitive behavioural therapy, and I never went back to him. I think that CBT is an incredibly damaging approach for people in our communities or people who've experienced massive trauma; it's very un-affirming. And so, I think now what would help immensely is people need to be more trauma-informed, and not just mental health professionals but workplaces and everything else. And LGBTIQA+ organisations, for their entire team and how they operate, not just what they do with clients or out there, but within.*
>
> **SB19LE, 56, trans female, bisexual/ pansexual, LGBTQA+**

Reflecting on how she often felt mistrustful because of family and school experiences, this participant highlights the need for more LGBTIQA+ affirmative responses, which includes acknowledgement of past trauma and shame. Traditional therapeutic responses such as cognitive behavioural therapy are discounted as potentially damaging because they are perceived as 'un-affirming'. Improving the ability of all staff within LGBTIQA+ organisations to recognise and respond to the needs of LGBTQA+SB people who have experienced trauma will improve support provided to clients, as well as colleagues.

The need for greater visibility of LGBTQA+POC within all services, and tailoring of specific support, was ovserved by several participants. One LGBTQA+POC participant highlighted the lack of services able to cater to all aspects of his identity:

> *...kind of like counsellors from the community who reach out and cater to people from immigrant backgrounds, because this is what I am; I'm a gay immigrant in this country, gay person of colour immigrant in this country, and that is something that is left behind at times.*
>
> **SB11LE, 25, cis male, gay, LGBTQA+POC**

According to this participant, support for his identity as a 'gay person of colour' was not readily identifiable or available in Australia. This meant he often felt invisible within services. LGBTQA+POC participants also called for greater awareness of the issues they face because of their intersectional experience. This includes racism, both within and outside of LGBTIQA+ communities and, for some, limited family support. Effective and appropriate supports provided by community organisations must respond to the needs of all LGBTQA+SB community members, particularly First Nations LGBTQA+ people and LGBTQA+POC. This requires a greater commitment to recognising and responding to the diversity within LGBTQA+SB communities and the unique lived experience of LGBTQA+SB individuals.



Accessing LGBTIQA+ community-led support

All of our participants were aware of LGBTIQA+-led organisations and health and social services that provided various supports for people experiencing suicidal distress. Participants who accessed LGBTIQA+ services appreciated a community-led approach because they were found to be more affirming and have a better understanding of the needs and challenges experienced by queer individuals. One participant talked about the benefits of accessing a queer GP:

> *My general observation is my doctors were probably very good – my doctor in [city], my doctor down here is very good – because it's not so much it's one on one, but it's specific to me. It's about understanding what my needs or whatever are.*
>
> **SB10LE, cis male, gay, LGBTQA+**

He appreciated the support he received from his GP. The fact that they were accessed through an LGBTIQA+ medical clinic meant that they were more likely to affirm his sexuality and understand his needs. A First Nations LGBTQA+SB participant explained why she visited an LGBTIQA+ sexual health service in the regional area where she lived:

> *I suppose I really wanted to go and just identify what my sexuality was. Whether I was going to be coming out as more of a sistergirl or more being portrayed as a male gay person; the image. It was more or less the image I was wanting to find, my sexuality, because I did give up drinking and that was my next step into, 'Okay, what do I want the community seeing me as?' Being perceived as being a normal straight/gay male, or wanted to be perceived as being a sistergirl? But I was asking those questions because I didn't know at the time those different terms, and the meanings behind it, yeah.*
>
> **SB05LE, 42, sistergirl, First Nations LGBTQA+SB**

Through talking to a counsellor at the service, this sistergirl was able to safely explore the meaning of different terms. This support helped her to understand the differences between labels and make sense of her identity. In addition, LGBTQA+POC participants expressed a need for support that bridged the gap between their LGBTQA+ identity and cultural background:

> *I feel like I've been involved in a lot of mental health advocacy generally, but there seems to be gaps about specific parts of my identity. I have to just talk about depression and anxiety to the masses and so particularly that's from a white lens a lot of the time, and I can't talk about the queer side of me or the CALD side of me, even though they're sides. Yeah, so [LGBTIQA+ organisation] was fantastic to find that intersection where we could actually focus specifically on suicide advocates and suicide prevention and queer advocacy, which I thought was a fantastic opportunity and a much-needed part within the system.*
>
> **SB13LE, 24, cis female, pansexual/ demisexual, LGBTQA+POC**

According to this participant, significant gaps exist within mainstream services that contribute to certain aspects of her identity and experience being invisible. The value of LGBTIQA+ organisations that can support individuals and groups who live at the intersections of queer identity, suicidal distress and race is illustrated by this positive appraisal of an organisation doing this work.

Accessing peer-support either in person or via phone and web-based chat services run by LGBTIQA+ organisations was also described positively by several participants. One participant said it was initially 'a bit intimidating' accessing services through an LGBTIQA+ youth organisation but it had helped them to become more embedded within the queer community. Another said:

> *Twice I've called up to chat and I think again, like in the service, people are different and so you can get different response and experience from everyone but both times I had quite a good experience. Even though it was more venting than anything else – rather than active problem-solving – I found that experience helpful.*
>
> **SB15LE, 33, cis male, gay, LGBTQA+**

This participant highlighted his good experiences with a peer support phone service but also alludes to potential issues with the consistency of what can be provided ('You can get different responses and experience from everyone'), noting that the focus was more on 'venting' than problem solving. The value of this type of support was reinforced by another participant who recounted a more negative experience with a peer support phone service where they felt the emphasis was on redirection and problem solving.

> *Q: Why did you contact [phone service]?*
>
> *A: I was not in a particularly good place. And my experience of feeling shitty is generally if I wait long enough, I will eventually stop wanting to kill myself – but it's the waiting that gets you. But I was feeling particularly hopeless about a very specific thing and I was like okay, I just need to talk to someone about this, I've never contacted [phone service] before, maybe this will be useful. After I contacted them, I was like I can see why most of my friends use these sorts of things specifically to make them stop feeling suicidal and start feeling angry.*
>
> *Q: Why did you feel angry? Can you talk about that experience, if it's not too much trouble?*
>
> *A: It didn't make me rage build or anything, I was just kind of frustrated because the person just didn't really engage with what I was saying and they were trying to refer me out to things that I didn't need or want. I really just needed someone to let me vent about the thing I was upset about and be like, 'Yeah that's shit.'*
>
> **SB08LE, 23, non-binary, queer, LGBTQA+**

Rather than a referral, this participant stated that they wanted someone to listen and engage with their concerns.

Peer-based services were mostly perceived as helpful, but issues of anonymity and confidentiality were raised by some participants. One LGBTQA+ person said they felt comfortable accessing LGBTIQA+ phone-based peer support services but expressed some reservations because of her involvement within queer advocacy and leadership (SB19LE). She expressed concern about how peer workers might respond if they recognised her. LGBTIQA+ organisations are better positioned to understand and respond to the concerns of LGBTQA+SB individuals and communities but need to consider issues of visibility, trust and how they respond to the expressed needs of individuals accessing support.

Improving access to LGBTIQA+ support services

Raising awareness about the availability and role of LGBTQA+ community-led services was suggested by several participants as a way of improving access to support. Increasing knowledge about the protectivity and efficacy of LGBTQA+SB community support for suicidal distress amongst mainstream health and social care services could facilitate the development of health referral pathways for LGBTQA+SB people experiencing suicidal distress into LGBTIQA+ community-led organisations:

> *I know these exist already in some form, but I guess just greater awareness and maybe even referrals to things like community groups and organisations. I guess recognising that this is a really key part of people's wellbeing, that attachment and that connection to other people and having that built into a referral process. Even if someone's experiencing mental health crisis, that you've got your counsellor, you've got your [LGBTIQA+ organisation], you've got your psychologist that you can see. You might be seeing your GP to get some medication, but another essential pillar is trying to build these new relationships and in the process you might learn something about yourself or that might help to shift the focus away from your current tumultuous experience and emotions onto other people.*
>
> **SB15LE, 33, cis male, gay, LGBTQA+**

According to this participant we must actively look beyond generalist health and social care practitioners as the sole providers of support. He perceives the need for an additional support pillar to psychologists and medication, which facilitates social connections and building relationships. LGBTIQA+ organisations, he asserts, are uniquely placed to do this.

Increasing the services hours of LGBTIQA+-led phone support services would ensure support was available when required. One participant recounted how he often needed support at two or three o'clock in the morning when many of the LGBTIQA+ phone lines were not operating:

> *So I think the phone calls definitely help, drop-in centres, just somewhere that's accessible, and that's what I see even now, is that a lot of the areas that offer support have limited hours because of funding – they don't have the volunteers, they don't have the permanent resources – so as a result they're not accessible and that's where I think kids fall through the cracks because there's nowhere to go. So what do you do? You go to a pub or a nightclub or somewhere where it's my people and I feel comfortable, which sometimes it's not the right place to be.*
>
> **SB10LE, cis male, gay, LGBTQA+**

According to this participant, funding should be used to increase the operating hours of phone services and drop-in centres. Without this support, he suggests LGBTIQA+ individuals may 'go to the pub or nightclub' which may not be the 'right place to be'. There is a vital role for the LGBTIQA+ sector to increase awareness and establish referral links between services such as GPs, talking therapies and LGBTIQA+ community groups and organisations that can help build a supportive infrastructure, that can produce and sustain LGBTQA+SB wellbeing and reduce suicidal distress.

Responding effectively to the needs of LGBTQA+SB individuals with intersectional identities

The need for more diverse representation within organisations, policy development and service design was expressed strongly by participants with less visible gender identities and sexualities, as well as First Nations LGBTQA+SB participants and LGBTQA+POC. A trans female participant called for more diverse representation within LGBTIQA+ community-led services to promote inclusive service provision:

> *I prefer the term broader community, and yes, we need specialised services as well. Particularly for groups like trans and bi, we want to know that we're going to be truly included, because there are some so-called LGBTIQ organisations that really have barely moved beyond G and have only just got to L, and then for all their use of the acronym, they're not supportive and inclusive. And they include some organisations … I would not go near [service name] or if I was in Sydney, I wouldn't trust [service name]. For all their talk about their diversity, they're not and that's been proven time and again for trans and bi people. We want to go to a service that is peer led, and that means trans, not just LGBTIQ+.*
>
> **SB19LE, 56, trans female, bisexual/ pansexual, LGBTQA+**

A lack of representation in the leadership of 'LGBTIQ organisations' has, this participant argues, resulted in an acutely felt invisibility of 'trans and bi people' and lack of appropriate support.

Similar concerns about representation within queer organisations were raised by several LGBTQA+POC participants. One participant expressed this point strongly:

> *Inclusion on a really meaningful level is really important. Now, I've seen a lot of, on the surface, it's a lot of inclusion and diversity, but if you just entered that surface, if you just peel off that surface, it's just very white-centred services, white-centred approach in every mental health thing.*
>
> **SB09LE, 28, cis male, gay, LGBTQA+POC**

The commitment of LGBTIQA+ organisations to inclusion and diversity is described by this participant as superficial. As noted, white-centric mental health services and limited awareness and knowledge of 'queer people of colour's experience' can be alienating and dislocating. Another participant made a similar point and suggested adopting an intersectional approach to the design of services:

> *Perhaps this is a good first step, which is to include people who have lived at the intersections, people from multicultural backgrounds, faith backgrounds, those people who live in different intersections, to really be involved in some of the setting up of the framework, policy planning, service provision.*
>
> **SB12LE, 40s, cis male, gay, LGBTQA+POC**

This extract calls for greater representation within consultation processes but also within the leadership and design of LGBTIQA+ organisations and services. According to this participant, increasing opportunities for LGBTQA+POC to contribute to policy development and service design will benefit queer people 'living at the intersections'.

A First Nations LGBTQA+SB participant similarly identified a lack of support for LGBTQA+SB Aboriginal and Torres Strait Islander people within LGBTIQA+ services and identified the need for First Nations LGBTQA+SB-led services:

> *For non-Indigenous, there's a lot of support. For Indigenous, there's none. They follow the non-Indigenous. We go to those groups, but then they sit quietly. They don't have the reins. They need to have the reins. And when you come back to community, and then that's their space, then you invite the elders into that space. And the elders respect that space. But it's our space. And then you find that there's gay elders there. So that's their space too. It's for anyone. Because we are the community.*
>
> **SB20LE, 50, female, heterosexual, LGBTQA+SB**

In contrast to fostering inclusion through diverse representation within LGBTIQA+ organisational leadership positions, and participation in policy development and services, this participant highlights the need for First Nations LGBTQA+SB community-controlled responses. According to her, First Nations LGBTQA+SB people 'sit quietly' within non-Indigenous spaces, which suggests that their support needs are unmet. The inclusion of 'gay elders' in community-led services would mean that culturally appropriate support and interventions are available for First Nations LGBTQA+SB individuals experiencing suicidal distress. Developing effective and culturally appropriate supports for LGBTQA+SB people seeking support requires a stronger commitment to diversity and inclusion through increasing representation of diverse genders and sexualities, First Nations LGBTQA+SB people, and LGBTQA+POC within queer organisations.

The role of LGBTQA+SB peer support

Peer-workers were viewed as one way to increase the safety and understanding of LGBTIQA+ people accessing services. This could be through LGBTIQA+ community-led organisations or generalist health and social care services. In the following excerpt a participant explains the benefits of a peer worker:

> *I was talking to her the other day, and I was like, 'God'! It would just – made such a huge difference to me five years ago coming into a space and having to deal with people that just I'm not comfortable dealing with. And having someone there that's like, 'I got you, I'm not going to be shocked about things and' – I don't know, I think that's just a little bit more appropriate, is to have people that identify as queer in some capacity that's there to talk to if you're in a crisis. Because I feel like as well in my experience, and for other people as well I know, sometimes your life, if you're queer, can be a little bit more complex or a little bit more – just some people might not quite understand what is happening or what's going on or whatever, if they're not aware of queer issues. Having to explain all that extra kind of stuff on top of being in a crisis is just shit. Like you just want someone to be there and reassure you that it's going to be okay and, also you are seen, and you're not alone.*
>
> **SB04LE, 30, non-binary, queer/lesbian, LGBTQA+**

This quotation illustrates how LGBTQA+ people experiencing suicidal distress can feel uncomfortable accessing mainstream services because they feel unsure about how individual health and social care practitioners may respond to their gender identity and / or sexuality. Having access to a peer worker can help LGBTQA+SB individuals accessing mental health supports to feel safer and more comfortable because there is someone who understands the complexity of queer lives. One participant described why having 'LGBT peers' would help her to feel 'safe and comfortable':

> *I guess because the topic of sexuality and my life journey with my sexuality is a very personal one and so is suicide. So, if this was to ever happen for me again and they created some peer spaces, that was what was on offer, it would have to be LGBT peers because I'm in the most vulnerable state that I could possibly be in, I don't need anything else going wrong, like somebody calling me butch, do you know what I mean? So yeah, it would definitely be a bonus and extra support that would make me feel safe and comfortable with them, yeah.*
>
> **SB02LE, 52, gender non-conforming, gay, LGBTQA+**

According to her, LGBT peer workers and peer spaces would reduce the risk of homophobic comments. Instead of replacing other forms of support, peer support would be a 'bonus'. Peer workers can help to address some of the sensitivities and vulnerabilities that LGBTQA+SB people experience both within and outside of generalist health and social care services.

While peer-based and community-controlled services were felt to be helpful, participants strongly emphasised the need for confidentiality and safety and pointed to a problem of discrimination and prejudice *within* LGBTIQA+ communities. One LGBTQA+ participant highlighted the importance of trust in peer-run services:

> *I think one thing that I would be impressed to see in a prevention program would be something like Trans Lifeline. It's I think the only Lifeline in the US that is committed to never calling emergency services on someone. It's also staffed entirely by trans people and is for trans people, hence the trans part of that. But I think also peer programs can be really good programs that explicitly carry in critical frameworks, mad studies frameworks, harm reduction frameworks. But I think also one of the problems I have with peer networks is some people will never be safe or feel safe relying on community for care because of things like saneism and ableism and stuff like that, and that's something that we can't pretend doesn't happen.*
>
> **SB08LE, 23, non-binary, queer, LGBTQA+**

Trust, according to this participant, needs to occur on two levels. The first is the way the peer service relates to the broader mental health system. Trans Lifeline is offered as a potential model because it is tailored for trans people and is 'committed to never calling emergency services on someone'. It is a service where people can openly discuss their suicidality without the fear of being hospitalised. The second level points to the need for increased visibility of people with intersectional experience. It suggests that education is needed to address the 'saneism' and 'ableism' that exists within the LGBTIQA+ community and that there needs to be greater diversity within peer programs. Peer-led services can help people to feel safe and comfortable but only if there is awareness about intersectional identities and the lived experience of suicide.

Some participants pointed to the potential role that digital information and online peer support programs might play in reducing suicidality. Online information can help people to feel less isolated and alone. For example, one LGBTQA+POC participant explained the benefits of greater online visibility of LGBTIQA+ people: 'Everything I see on queer TikTok is helpful and really inspiring me to be more confident in myself'. Another participant felt that providing peer

support online and in-person could allow greater flexibility for LGBTQA+POC seeking support:

> *It would be something that would be able to be accessible, like a collective that has LGBTQA+POC people that are of lived experience. And it can be LGBTQA+POC professionals within the suicide prevention area, it can be just advocates or just general people. And have that group and then that group can manifest in ways of regular meetups in Zoom or in person, or just similar to a forum, like an ongoing group chat where people can be anonymous if they want to be. And your profiles where people put who they want to be, and their pronouns and have a different avatar if they want, just better control that level of how else you are, and how you are, because I think, for me, I had all these different things going because at different points I would be more confident in who I am and so I had to navigate into a different space if I wanted to retract. And I think if I could have a singular space where I feel like I am going to be accepted because there are people like me there, but I'm able to control what people see potentially and how I engage with that group, that would be really good.*
>
> **SB13LE, 24, cis female, pansexual/ demisexual, LGBTQA+POC**

We again see a call for support tailored to LGBTQA+POC needs. This time, however, this support can be provided by LGBTQA+POC professionals or peer support workers. The use of an avatar would allow service users to access support in a way that feels safe for them, and with the potential to protect their anonymity. Greater flexibility in service design and innovations in support provision has the potential to increase the agency of LGBTQA+POC to access support that responds to all aspects of their identity. LGBTQA+SB peer support has the potential to promote safety and address support needs within generalist mental health services and LGBTIQA+ community-led organisations, but the peer support workforce must reflect the diversity within LGBTQA+SB communities, particularly First Nations LGBTQA+SB and LGBTQA+POC.

Chapter Six Highlights

- There is a strong preference for LGBTIQA+ community-led services because they are felt to be more affirmative.
- Services badged as LGBTIQA+ inclusive were appreciated but there is a need for greater awareness and understanding of diverse genders and sexualities amongst health and social care practitioners.
- Access to LGBTIQA+ peer workers within mainstream health and social care services can help LGBTQA+SB people to feel safe and comfortable.
- First Nations LGBTQA+SB participants wanted Aboriginal and Torres Strait Islander LGBTQA+SB community-led services where Elders could be present.
- LGBTIQA+ peer phone and chat cased services can be helpful but LGBTQA+SB people may have concerns about the consistency and quality of support provided, as well as confidentiality.
- More work is needed within LGBTIQA+ community-led services to ensure that the support provided responds to all aspects of a person's identity, including First Nations status, race, but also less visible gender identities and sexualities, geographical location, disability, and faith.

Future directions for supporting LGBTQA+SB people experiencing suicidal distress

7

In this concluding chapter we summarise key findings and present a series of recommendations to inform policy and practice in Australia with the aim of improving the lives of First Nations LGBTQA+SB, LGBTQA+POC and LGBTQA+ people who experience suicidal distress. It is evident that affirmation of LGBTQA+SB identification can be a strong protective factor against suicidal distress and there is significant strength and resilience to be found within LGBTQA+SB communities. At the same time, our findings highlight the ongoing challenges and cumulative impact of attempting to live affirmatively within a white settler heterosexist society with binary gendered expectations. While gender identity and / or sexuality featured in different ways within participant accounts of suicidal distress, it was rarely the sole cause with multiple and compounding stressors identified. Understanding the socio-cultural context in which LGBTQA+SB people attempt to live affirmatively must be the starting point for effective and affirmative policy development and service responses aimed at reducing LGBTQA+SB suicidal distress.

Our findings challenge the one-size-fits-all approach evident within many LGBTQA+SB focused suicide prevention, postvention, and mental health initiatives. Experiences of both mainstream services and LGBTIQA+ community-led services reported by participants suggest there is limited understanding of intersectional experiences within the service landscape. The process of forming an LGBTQA+SB identity is complex and can vary depending on intersectional experiences, including age, geographical location, First Nations status, cultural and religious background. In addition to challenges related to LGBTQA+SB identities, cultural dislocation and experiences of racism can contribute to and exacerbate suicidal distress for First Nation LGBTQA+SB people and LGBTQA+ POC. Greater attention to the experiences of LGBTQA+SB people located at the intersections, particularly First Nations LGBTQA+SB and LGBTQA+POC, but also people from diverse cultural and faith backgrounds, geographical locations, and disability, will ensure policy and services targeting LGBTQA+SB suicidal distress reflect the heterogeneity and diversity of queer communities.

Help-seeking can be a challenge, particularly when experiencing suicidal distress for the first time, but may improve with time as people develop a better understanding of what works for them and where they can access support. Developing referral pathways, reducing out of pocket expenses and ensuring LGBTQA+SB affirming services are available, particularly in regional areas, will facilitate access to safe and effective supports. Improving awareness and understanding of LGBTQA+SB lives within services can help practitioners to work more effectively and affirmatively with clients and address issues of trust and confidentiality raised by participants across the three cohorts. Employing LGBTQA+SB peer workers within mainstream services can increase perceptions of safety and confidence. Particular care is needed to improve access to culturally safe, confidential and LGBTQA+SB affirmative services for First Nations LGBTQA+SB people. With appropriate and effective support, LGBTQA+SB people can and do find ways of living with suicidal distress.

Informal and formal support received through LGBTQA+SB communities is valuable. However, the availability and quality of supports for LGBTQA+SB people located at the intersections can vary considerably. Increasing the visibility of First Nations LGBTQA+SB, LGBTQA+POC and less prominent genders and sexualities within queer communities, alongside addressing issues of racism and other forms of social exclusion will improve social connections. A strong preference was expressed for LGBTIQA+ community-led services across the three cohorts because practitioners are perceived as having a base line understanding of the unique life experiences of queer communities. It is important to note that First Nations LGBTQA+SB people identified a need for Aboriginal and Torres Strait Islander LGBTQA+SB community-led services. Diversifying the LGBTIQA+ community workforce and improving the ability of services to respond to intersectional experiences will ensure First Nations LGBTQA+SB people and LGBTQA+POC can bring their whole selves into community-led services.

Overall, this report identifies the need for targeted policy interventions, increased resourcing of LGBTIQA+ community-led services, the development of LGBTQA+SB affirmative services, and whole of community responses to reduce the burden of suicidal distress on First Nations LGBTQA+SB, LGBTQA+POC, and LGBTQA+ communities and individuals.

Recommendations

Setting the policy context

- Policy interventions can improve the socio-cultural environment for First Nations LGBTQA+SB, LGBTQA+POC and LGBTQA+ people, help them feel affirmed in their gender, sexuality, racial, and cultural identities, and reduce feelings of shame, fear and stigma implicated in suicidal distress.
- Targeted early intervention will help to reduce suicidality over an LGBTQA+SB person's lifetime.
- All policies must be developed and evaluated with LGBTQA+SB people who have lived experience of suicide (including First Nations LGBTQA+SB) to ensure interventions are responsive to the heterogeneity of LGBTQA+SB communities and reflect intersectional experiences.
- When commissioning suicide prevention, postvention, and mental health services, policy makers must include LGBTQA+SB lived experience within service design and ensure services will attend to intersectional LGBTQA+SB experiences, including First Nation LGBTQA+SB people and LGBTQA+POC.
- LGBTQA+SB affirmative and safe support must be available and accessible regardless of who someone is, where they are living, their financial position, or cultural background.

Developing appropriate and affirmative support

- LGBTIQA+ community-led services, Aboriginal Community Controlled Health Services, mainstream mental health services, must work harder to foster trust, safety, and perceptions of confidentiality for LGBTQA+SB people accessing support.
- LGBTIQA+ community led organisations are best placed to deliver appropriate and affirmative support for LGBTQA+SB people experiencing suicidal distress.
- Aboriginal Community Controlled Health Organisations need to actively work with First Nations LGBTQA+SB people to develop services for Aboriginal and Torres Strait Islander LGBTQA+SB people experiencing suicidal distress.
- LGBTQA+SB people need to feel confident when accessing a service that all parts of their identity will be recognised and affirmed, particularly First Nations LGBTQA+SB people and LGBTQA+POC
- Increasing the visibility of services for LGBTQA+SB people experiencing suicidal distress, strengthening referral pathways between mainstream mental health services and LGBTIQA+ community-led services, and ensuring timely access will improve outcomes.
- Health and social care providers should undertake mandatory training provided by LGBTIQA+ organisations to improve knowledge and awareness of LGBTQA+SB lived experiences of suicidal distress, with particular emphasis on trans and gender diverse issues, intersectional identities, and the socio-cultural context of LGBTIQA+SB lives.
- When allocating resources and developing support, prevention and postvention services for First Nations LGBTQA+SB, LGBTQA+POC and LGBTQA+ people, providers must have demonstrable understandings of and affiliations with those communities.

Improving community responses to suicidal distress

- Access to positive information about First Nations LGBTQA+ SB, LGBTQA+POC, and LGBTQA+ people and communities will promote understanding amongst families and friends and improve their ability to respond affirmatively.
- Targeted campaigns to address racism and reduce cultural isolation may help to improve the wellbeing of First Nations LGBTQA+SB people and LGBTQA+POC.
- Developing resources, awareness campaigns, and providing a platform for community role models can improve the literacy of LGBTQA+SB suicidal distress within queer communities, normalise help-seeking, facilitate conversations, and reduce associated stigma and feelings of shame.
- Training should be made available outside of service provision settings to resource people in broader communities to support LGBTQA+SB people who experience pervasive, on-going, or repeated experiences of suicidal distress.

Knowledge and training

- LGBTIQA+ community-led services need training to better address issues of race, disability, and gender diversity, including training to improve understanding about suicidal behaviour and appropriate forms of support for First Nations LGBTQA+SB people and LGBTQA+POC.
- LGBTQA+SB focused training and education of Aboriginal health workers is required to keep First Nations LGBTQA+SB population safe. Extra training should focus on improving the social and emotional wellbeing services offered by Aboriginal Community Controlled Health Services by training and supporting Aboriginal health workers to better understand and support LGBTQA+SB people.
- Making LGBTQA+SB lived experience of suicide training accessible to health and social care organisations, LGBTQA+SB communities, family and friends will facilitate awareness and increase confidence to talk about LGBTQA+SB suicidal distress, improve available support and facilitate help-seeking.
- Resources are needed to promote understanding of LGBTQA+SB suicidal distress and improve the ability of policy makers, service providers, LGBTIQA+ communities, First Nations communities, culturally diverse communities, families, and friends to respond appropriately and effectively.
- Specific LGBTQA+SB suicide prevention training should be developed for workplaces and education settings to support managers to respond affirmatively and effectively to LGBTQA+SB students and employees experiencing suicidal distress.

Further Research

- Further research is required to evaluate the effectiveness of suicide intervention approaches aimed at LGBTQA+SB people, including LGBTQA+SB lived experience of suicide initiatives, and LGBTQA+SB peer-led support.
- All research for, on or about LGBTQA+SB must have a First Nations LGBTQA+SB researcher as part of the chief investigator team, in the advisory group and available for debriefing First Nations LGBTQA+SB participants.
- More research is needed about how and where to provide confidential and appropriate supportive services for First Nation LGBTQA+SB people.
- Further research is needed to explore how maintaining connection to culture can reduce suicidal distress and promote wellbeing for First Nations LGBTQA+SB and LGBTQA+POC.
- To develop appropriate services for people with intersex variation, further research is needed to understand the experiences of suicidal distress for this population group.
- To develop resources to improve the ability of LGBTQA+SB communities, family, extended families of choice, households, and friends to respond to suicidal distress, research is needed to understand the lived experience of providing informal support.

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GLOSSARY OF TERMS

Asexual
A person who experiences little or no sexual attraction and identifies as such. Asexuality does not preclude an individual from experiencing other kinds of attraction, such as romantic, platonic or aesthetic.

Bisexual
A person who is romantically and or/sexually attracted to more than one sex or gender. Sometimes termed multi-gender attraction.

BIPoC
Acronym of Black, Indigenous and People of Colour. People of Colour (PoC) is an umbrella term referring to all people who are not white. The addition of Black and Indigenous as separate terms reinforces the fact that Black and Indigenous individuals and communities face continual systemic racism and discrimination in ways that other people of colour may not experience. The term BIPoC highlights these specific injustices which can often be obscured or forgotten when talking about PoC more broadly.

Brotherboy
Term used by Aboriginal and Torres Strait Islander people to describe gender diverse people who have a male spirit

Chosen Family/Queer Family/Family of Choice
Nonbiologically related familial and/or close bonds that an individual considers their family or community. Common among the LGBTQIA+ community, where familial ties are often strained due to lack of acceptance of one's gender or sexual identity.

Cis/Cisgender
A person whose gender aligns with the gender they were assigned at birth.

Cis-normativity
The predominant and pervasive social attitude that privileges people whose gender aligns with the one they were assigned at birth and the assumption that all people are cisgender.

First Nations
Descendants of the original inhabitants of the many different countries, tribes, and language groups that make up the land now called Australia.

Gay
A person who primarily experiences romantic and/or sexual attraction to people of the same sex and/or gender. Historically gay has been a term used to describe men who are attracted to other men, but some women and gender-diverse people choose to describe themselves as gay.

Gender Diverse
Refers to a range of genders expressed in different ways.

Gender Identity
An individual's personal sense of their own gender.

Heteronormativity
The predominant and pervasive social attitude that views heterosexuality as the normal or preferred sexual orientation.

Heterosexual/Straight
A person who is attracted romantically and/or sexually to people of only gender different to themselves.

Homophobia
Intolerance, hatred and fear of people who identify with diverse sexual identities or express sexual behaviours outside of heterosexual intercourse. Homophobia often manifests as discrimination, violence and aggression toward LGBTIQA+ people and communities.

Intersectionality
A theory that recognises that people have various social identities (race, gender, sexuality, class, etc) that coexist and shape their experiences of systemic oppression and discrimination

Intersex/Variation of Sex Characteristics
Some of many terms used by people who are born with a broad range of physical or biological sex characteristics that do not fit medical norms determined for female and male bodies. There are many different variations of sex characteristics, for some these include chromosomes, hormones and anatomy. There are many different terms used by individuals that help to describe their identities and bodies.

Lesbian
A woman who primarily experiences romantic and/or sexual attraction to other women.

LGBTIQA+
Abbreviation of Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual and other gender and sexually diverse individuals. The + included in the LGBTIQA+ acronym encapsulates all gender and sexual identities that are not encompassed by the former letters. Other acronyms such as LGBTIQ and LGBTIQ+ are also commonly used.

Lived Experience (of suicide)
Personal knowledge and understanding about a specific topic based on first-hand experience and involvement. Someone with a lived experience of

suicide can mean that they have experienced suicidal thoughts, survived a suicide attempt, cared for someone through suicidal crisis or been bereaved by suicide.

Non-binary
A term describing gender identity more diverse than the binary of male and female. Non-binary may express genders beyond male or female, along with male and female and changing gender identity (sometimes referred to and as gender fluidity).

Peer Work / Peer Support
Peer work refers to work based on shared lived experience to provide care and support to others. Peer workers in the mental health space can use their own experiences of mental illness and recovery to engage and support people accessing mental health care. In the context of peer LGBTQIA+ workers, the specific experiences that one can have due to their sexuality and/or gender identity can help to provide a safer, more open environment for other LGBTQIA+ individuals. Due to these common life experiences, peer workers can foster authenticity, safety, advocacy, inclusion and community within their work.

Postvention
Activities and intervention related to supporting and helping people bereaved by suicide. This may include counselling, support groups, support from medical professionals etc. This aims to reduce the heightened risk of those bereaved by suicide and promote healing.

Protective factor
Characteristics (can be on a biological, psychological, family, community level) that is associated with a lower likelihood of a negative outcome.

Queer
A term to broadly describe diverse gender identities and sexual orientations, particularly where someone feels other terms do not fully encapsulate all parts of their own gender and/or sexual identity. In the past 'queer' was used as a derisive term and for some, particularly among older LGBTIQA+ people, may still conjure hurtful associations. For others, 'queer' is a politicised term reclaimed in resistance to the societal pressures created and sustained by heteronormativity and cis-normativity.

QTIPoC
Acronym of Queer, Transgender and Intersex People of Colour. People of Colour (PoC) is an umbrella term referring to all people who are not white. QTIPoC is often used to highlight the diverse and varied experiences due to this population's overlapping or intersecting identities and related systems of oppression or discrimination.

Sexual Orientation
Describes the romantic and/or sexual attraction that a person feels toward other people.

Sistergirl
Term used by Aboriginal and Torres Strait Islander people to describe gender diverse people who have a female spirit

Suicidal ideation
Someone's experience of thoughts of suicide, especially when those thoughts are chronic or persistent in nature

Suicidal feelings
A state of extreme anxiety or pain in which a person is seriously contemplating or planning to end their life.

Suicide attempt
A deliberate act of harming oneself with intent to die.

Trans/Transgender
Someone whose gender does not exclusively align with the one they were assigned at birth. Trans can refer to someone's history rather than their gender. For example, a woman assigned male at birth might refer to themselves as a "woman", "a woman with a trans history" or a "transgender woman".

Transphobia
Intolerance, hatred and fear of people who are transgender that is often expressed through violence, discrimination and aggression toward transgender people.

+
Included in the LGBTIQA+ acronym to encapsulate all gender and sexual identities that are not encompassed by the former letters.

Demographic characteristics of interview participants

ID Number	Age	Country of Birth	Gender Identity	Sexuality	First Nations	Cultural / Ethnic Background	LGBTQA+POC	Location
SB01LE	75	UK	Trans female	Lesbian	No	Caucasian	No	Metropolitan
SB02LE	52	Australia	Gender non-conforming	Gay	No	European	No	Metropolitan
SB03LE	29	Australia	Cis male	Pansexual	Yes	First Nations	No	Regional
SB04LE	30	New Zealand	Non-binary	Queer / Lesbian	No	Pakeha	No	Metropolitan
SB05LE	42	Australia	Sista girl	Sista girl	Yes	First Nations	No	Regional
SB06LE	33	Australia	Cis - female	Pansexual	No	Caucasian	No	Regional
SB07LE	26	Australia	Non-binary	Lesbian	No	Anglo-Australian	No	Metropolitan
SB08LE	23	Switzerland	Non-binary	Queer	No	Anglo-Australian	No	Metropolitan
SB09LE	28	Mongolia	Cis male	Gay	No	Mongolian	Yes	Metropolitan
SB10LE	56	Australia	Cis male	Gay	No	Anglo-Australian	No	Metropolitan
SB11LE	25	India	Cis male	Gay	No	South-east Asian	Yes	Metropolitan
SB12LE	40s	Asia	Cis male	Gay	No	Chinese	Yes	Metropolitan
SB13LE	24	Australia	Cis female	Pansexual and Demisexual	No	Vietnamese/ Malayasian/ Chinese	Yes	Metropolitan
SB14LE	26	Chinese	Gender fluid	Pansexual	No	Chinese	Yes	Regional
SB15LE	33	Australia	Cis male	Gay/ homosexual	No	Caucasian	No	Metropolitan
SB16LE	47	New Zealand	Non-binary/ agender	Pansexual/ demisexual	No	Polish / Australian	No	Metropolitan
SB17LE	44	Vietnam	Cis female	Bisexual / Homoromantic	No	Vietnamese/ Australian	Yes	Metropolitan
SB18LE	38	Sri Lanka	Cis male	Gay/Queer	No	Sinhalese	Yes	Metropolitan
SB19LE	56	Australia	Trans female	Bisexual / Pansexual	No	Anglo-Jewish	No	Metropolitan
SB20LE	50	Australia	Female	Heterosexual	Yes	First Nations	No	Regional

APPENDIX