Gay & Lesbian Counselling Service of NSW

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Submission by: The Gay and Lesbian Counselling Service of NSW

As telephone counsellors making up an organisation that is set up to directly address the needs of an identified high risk group; the Gay, Lesbian, Bisexual and Transgender (GLBT) members of the population, we often work with distress, loneliness, sadness and pain though isolation and mental illness. Even if the reported numbers of people who call are acutely suicidal is not a large number; the impact of suicide upon this service is immense. As a confidential service that is sometimes seen as the last resort, we hear many stories of distress and difficulties in coping from people experiencing pain. Thus, we felt that a submission to this enquiry based on our experience and research is necessary.

The submission below is based from our experience as a state-wide (NSW) anonymous telephone counselling service for the GLBT communities, their friends and families. We acknowledge that our callers are a small percentage of the larger community however their more specific issues and needs still need to be voiced.

Cost of suicide – personal/social and financial

One suicide affects all those around the person who has completed, including family, friends, and co-workers. Guilt, shame, regret, trauma, sadness, fear – there are so many responses that affected people can go through after a suicide completion. In instances where the person who has completed suicide was in an isolated situation, chances are those around will also be in a similar isolated situation, so there can be a domino effect resulting and more suicides can (and do) result.

High levels of distress and emotional intensity that in our experience is present for someone who is experiencing (or has experienced) suicidal thoughts and actions requires a great deal personal, social and financial resources in order to help. If this person is acutely suicidal, then the personal costs for them can be incredibly high though loss of employment, social contact, support and loved ones. Living with suicidal thoughts can leave little room for anything else, there can be no escape or no place to go and thus suicide seems like the only option. This is consuming for the person and also those supporting them, who feel an incredible sense of strain caring for someone who is actively/acutely suicidal, with fear of leaving the person alone and a sense of responsibility for keeping that person alive.

In terms of counselling (especially telephone counselling) there is an immediate cost to the person counselling and this spills into the social and financial costs. From a counselling point of view, suicide is costly in terms of personal time and energy. Suicidal calls (and just the potential) are emotionally draining and distressing from a personal point of view as a counsellor. The counselling experience is often defined by those we talk to who are considering suicide; we hold onto and ruminate on these calls and they can make or break counsellors. The reality is, that people who are in this much distress take time to help,

unfortunately the emotional complexity involved is difficult to deal with in a short time frame or indeed over the telephone. This leads to a sense that we are responsible, but are unable to make a difference, and further that distress at this level should be prevented rather than reacted to.

Social costs are more obvious in that services exist solely to help and support people who are feeling suicidal or have lost someone to a completed suicide. The costs in a social sense are the need for support, need for people to offer this support and to have the skill and training to support effectively. Financial costs include the provision of services essentially. Counselling and other supportive services that rely on volunteers may seem to require little funding and are thus cheap to run, however this is incorrect. The cost is somewhat hidden but there are still high costs that are often not recognised, including administration, services (electricity, phones – especially free call numbers), volunteer costs in offering their time, support services to volunteers, premises, equipment, etc.

Accuracy of reporting suicide

The accuracy of suicide reporting in Australia from a counselling perspective is under-reported (Remafedi, 1999). Completed suicides are often recorded incorrectly and attempted suicide prevented or put off, are not recorded effectively. It would be difficult to report on all cases of suicide, as it is hard to ask questions after the fact and it would appear in our experience that people are generally unlikely to talk in great depth about their impending suicide attempt.

Confidentiality issues are an issue in getting accurate statistics, especially where a person has mentioned to a health professional suicidal feeling, but it hasn't gone further. Which health professionals do you ask for statistical information from? Perhaps health organisations could offer monthly/yearly statistical reporting where appropriate and possible?

Role and effectiveness of agencies in assisting prevention of suicide

Some focussed organisations clearly do a good job of addressing areas that may lead to suicide attempts (e.g., isolation, lack of support, depression, learned helplessness, stresses related to sexual identity including homophobia and heterosexism). In these organisations it would seem that where these issues are addressed effectively, perhaps suicide as an option is ruled out or never considered. In this respect it seems these organisations are effective. Having said that; these organisations need to be accessible in the first place, people need to know they exist, how to contact and they need to be available at the right times (all times). This can enable a lifeline as and when needed.

Where a suicide attempt is imminent, an organisation needs to be able to recognise and act accordingly. In our experience, the volunteers who staff our call centre are terrified of the possibility, it is a frightening thought to think you might be the last line of defence against completed suicide; it would seem fair to assume this fear in our situation may hamper the effectiveness of suicide prevention.

Unfortunately, agencies such as general health services are not necessarily the appropriate services to manage or be effective in suicide prevention. There is a lack of knowledge, appropriate resources and appropriate training. Training is often limited to informal

knowledge transfer and general health services are staffed by people whose background and training is not necessarily conducive to supporting people with a mental health crisis.

Effectiveness of public awareness campaigns – encouraging help seeking and bringing about debate

Public awareness campaigns that we can recall seem to be centred on mental health issues, the causes of suicide, rather than creating awareness around suicide itself. The focus is on seeking help for depression (for example) not seeking help to prevent suicide attempts.

Efficacy of suicide prevention training and support for helpers

Suicide prevention training and support for community workers is not adequate for supporting people who are suicidal or have severe emotional distress. There is little formalised training and any training there is, is not uniform or necessarily accredited. There is a great disparity between what is taught and what is known. The efficacy is not established either. Community workers work in different ways and with different ethical understandings.

As an organisation running a confidential service, without real follow up service, it's difficult to measure the efficacy in the training we offer our volunteers. People calling back is generally our only sign and with a lack of effective tracking systems that meet confidentiality requirements, good measures are hard to establish. In our opinion, ongoing training and support focussed in this area should be required. In our organisation we need to consider that volunteers who sporadically take counselling shifts may not receive calls in this area often enough remember initial training and work with suicide callers.

Our focus in training is often on the causes, identifying factors and procedures around suicide calls. This is effective training though, it could always be better, especially if we were better equipped with research based on our demographic/community.

Role of targeted programs and services addressing high risk groups

The GLBT sector is an identified high-risk group when it comes to mental illness and suicide rates. Proportionally more people who identify as some part of the GLTBQI spectrum take their own lives or attempt to (Nicholas & Howard, 2002). Targeted programs to address these, including the existence of the Gay and Lesbian Counselling service of NSW (GLCS), have a key role to play in the reduction of suicide attempts and completed suicides in Australia. However, due to the concerns such as limited reporting and inadequate training, it is difficult for these targeted groups to achieve the aims they set out to achieve.

Circumstances of high-risk groups, especially GLBT individuals, such as accessing culturally competent support services, and being subjected to overt and subvert homophobia and heterosexism are not specific to the general population and thus more targeted groups are needed to address issues, with adequate funding to train and support facilitators, counsellors and support workers. Organisations such as the GLCS are accredited with Certificate III in Telephone Counselling, though with more funding and recognition, counsellors and facilitators could expand their knowledge and provide more and better services to meet the demands of people within high risk groups.

Targeted programs are of great importance as people and groups have specific needs to be met and programs have to find the right audience. For instance, some gay and lesbian people in rural areas have little contact with the 'gay community' and can feel cut off, isolated and unable to identify with anything – they just don't fit. On coming to built up areas and going to gay populated places, they may not be able to connect, so they still feel like they don't fit. Targeting in this area will be vastly different that say targeting business owners who've just gone into liquidation.

There are so many different groups and areas of risk. It would seem prudent to have generalised and focussed programs to cover as much ground as possible. Certainly community or portal arrangements where programs, services and people can be accessed for easy referral and networking would be of benefit.

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References

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