Invitation to an Open Conversation About Language

Key Words: SP Peer Work, strength-based, lived experience, stigma, non-clinical alternatives

Thursday September 10th was World Suicide Prevention Day (WSPD). WSPD was originally started by esteemed suicidology researcher and psychiatrist Professor Diego De Leo in 2003 with a view to it being a day when key suicide prevention research was released. At its inception it was never intended to be a worldwide awareness raising day. Since that time however, the International Association of Suicide Prevention (IASP) and the World Health Organisation (WHO) have continued to lead the promotion of this global day as one of recognition to shine a light on suicide prevention. The theme this year is *Working Together to Prevent Suicide*. Every year countless activities and events are held around the world in big and small communities alike.

Roses in the Ocean is an Australian national lived experience of suicide organisation. Ordinarily, in any other *normal* year, our organisation is involved in a number of activities and events for WSPD including hosting an annual community event in Brisbane city's Queen Street Mall. However, we know, 2020 is no ordinary year, COVID19 has made sure of that! Public events and large gatherings (even if they are to shine a light on the important issue of suicide prevention) cannot and should not be happening, no matter how important the issue is. That said, as an organisation we continue to work towards reducing the emotional pain that suicide brings to many people across Australia. One way we are choosing to do that this year is to encourage open and compassionate conversations about some of the language used when discussing suicide and particularly in relation to the language used in the newly emerging non-clinical alternative to care for people and their loved ones experiencing emotional distress relation to suicide.

In Australia, social change relating to caring for people in suicidal crisis is rapidly occurring. For starters, the suicide prevention peer workforce (SP Peer Workforce) is developing as a new workforce as is noted in (Hawgood et al., 2020). Roses in the Ocean is playing a role in the development of this new workforce in partnership with other organisations in New South Wales. We are also leading the co-design for new Alternative to ED: safe spaces that are being operationalised across all 15 of the Local Health Districts in NSW. This ground breaking whole-of-state project is funded under the New South Wales government's *Strategic Framework for Suicide Prevention in NSW 2018-23* (NSW, 2018) as part of the Towards Zero Suicide Initiative. Click on the link to learn more about the Towards Zero Suicides Initiatives and the whole-of-state approach by New South Wales.

These new alternatives to ED for non-clinical and SP peer-run safe spaces and blended workforce aftercare services represent seismic shifts in suicide prevention with New South Wales leading the way in terms of innovation and genuine models of non-clinical care for

those experiencing emotional distress and suicide attempts. With this amount of co-occurring activity, it is not surprising that there are some inevitable growing pains. One such challenge which has also come to the fore during our work in leading the state's co-design workshops with local communities with both lived experience people and health staff relates to the desire by many to change the language (including some of the clinical language) used in these new non-clinical alternatives.

We acknowledge some language used within conventional clinical services will remain relevant providing it is well-supported by those accessing these services and based on sound evidence for continuing its use. We have heard from the many people contributing in co-design workshops that much of the language that comes from a traditionally biomedical model of psychiatric treatment and systems needs to change. We have heard that this language can be problematic, stigmatising and harmful to people who live with suicidal thoughts, experiences of suicide attempts, mental health struggles, and including those who have traumatic experience of our current medical health care system. In an article by Carpiniello and Bernado, the authors highlight this point by stating 'stigma displayed toward suicide may result in severe consequences for people who have attempted suicide or who have been bereaved by suicide' (Carpiniello & Pinna, 2017). We also know there are some words that have been around for eons and have become standardised, *seemingly harmless* in relation to suicide prevention health care. We believe (having listened to those with direct lived experience) that just because certain words, phrases and clinical terms are well ingrained in clinically operated health care does not justify their continued use in non-clinical peer-led or co-led services.

Some of the biomedical language we have heard that is challenging people is listed below in Table 1. To continue to support the ongoing development of language we have also drawn on valuable work from the New South Wales Mental Health Coordinating Council, in particular their recently published second edition of Recovery Oriented Language Guide (Mental Health Coordinating Coucil, 2018).

Table 1

Disempowering language	Empowering or preferred language (eg; trauma informed, culturally competent and strengths-based language)	What's the problem with this language?
Assertive outreach	Responsive Outreach	Has power overtones – assertive implies forcing someone
Non-compliant	Declined a service, wanting to explore other options	The word compliant is problematic – it implies a need for someone to relinquish their (human) rights

Treatment resistant	The person has unmet needs or challenges that need to be resolved	The word resistant is deficit focused and implies a person is unable to be helped rather than seeing this as an opportunity to uncover why the person is not engaging – what is their unmet need or what needs resolving or alternately what is it about the treatment on offer that is not what the person wants or perhaps feels they need?
Manipulative behaviour	A person expressing unmet needs, extreme help-seeking behaviour	• Fails to acknowledge a person's behaviour is often a response to their needs not (yet) being met • It reflects judgement about culturally acceptable and unacceptable ways of seeking help. It is a term that is generally used to shame females for seeking help in ways that males tend to be culturally raised not to use. • when used in the context of suicide, it reinforces the myth that people who speak up about thoughts of suicide are not serious and are just being 'manipulative', which is a truly dangerous myth
Psychotic	Unusual beliefs and experiences	Unusual beliefs help normalise a person's experience, and challenges already stigmatising language often associated with people who are experiencing extreme mental distress. 'Psychotic' is sanist language. It

		is based on the premise that people who have a different experience of reality must have something wrong with them and that reality is defined by the majority. Again, it is a concept that reflects cultural acceptability. It is culturally acceptable to incorporate a God whose presence is 'felt' into a person's reality, but a person is 'sick' and 'unstable' if they claim the existence of anything else that other people can't see.
Suicide Attempters	A person with a lived experienced of a suicide attempt OR a person who has made a suicide attempt	This word labels and negatively stigmatises a group of people (Link & Phelan, 2006) . It falsely labels people as simply one-dimensional beings which diminishes the whole person and is not strengths-based language. It also ignores the fact that as humans we are the sum of many different public and privately held identities and belong to many groups in society.
Suicide ideation	A person who experience thoughts of suicide	An unnecessary clinical term that can be better said in plain language. This term remains widely used however and there are many different views about it.

There is also a second body of language which is emerging during our facilitation of the co-design of Alternatives to ED: safe spaces. This language is service specific and relates to the words and phrases people with lived experience of suicide are sharing with us that they would like used in these non-clinical alternatives. This language and suggested alternatives are listed in Table 2.

Table 2

Disempowering language	Empowering or preferred language (eg; trauma informed, culturally competent and strengths-based language)
Patient	Guest, visitor, attendee
Facility	Space, building location, haven, place, locale, venue, c entre, safe space, hub, service cafe
Referral	Warm connection, link recommend, connect, offer ideas, options, pathway, invitation, support
Triage	Exploring needs with the guest, welcome, wellness check, prioritisation, what's important right now, planning, talking, listening
Assessment	Discussion, what is needed right now, listening to the full story, collaborating,
Exclusion criteria	Safety boundaries, mutual expectations, appropriateness, aim of the service, is this the best place for person?
De-escalation	Addressing the person's need in the moment, conversation, relationship building, empathy, connection, calming, grounding, reducing distress, positive engagement
Risk assessed or risk managed	Working with a person to stay safe, dignity of risk, recovery plan, safety plan,
Recovery	Journey, discovery, healing, resilience. Strengths, positivity, hopefulness

As we continue to openly invite discussion on new language, we acknowledge that the suicide prevention sector has been leading the way in terms of sound evidence in support of appropriate, safe and non-stigmatising language when discussing suicide. In (Beaton et al., 2013) for example, the authors argue language associated with suicide needs to help create an environment that is conducive to people talking openly about their lived experience of suicide. Similarly, a related argument relating to stigma is noted in (Rimkeviciene et al., 2015).

For the most part language moves with the times. However sometimes language needs revisiting; and we believe now is an opportune time to further evolve language, especially as the suicide prevention peer workforce and non-clinical and aftercare alternatives emerge.

We also know that to bring about meaningful change of any kind it requires all those involved to be *working together* to bring about sustainable change. It is only through open, respectful and compassionate discussions about language that we can continue to evolve and shift where necessary the language used in these new settings. This open dialogue includes having these very same discussions with all stakeholders; including the people with lived experience of suicide, health professionals and organisational leaders collaborating in these new non-clinical alternatives to care. There is too much at stake here for us not to find ways to collaborate as a sector and help bring into being a more recovery oriented and strengths-based language when discussing and supporting people with a lived experience of suicide.

For Roses in the Ocean and our lived experience collective across Australia, it feels as if a brave new world for those experiencing suicide related emotional pain and those caring for them is finally dawning here in Australia. For all of us seeking to shift the language used in places where suicide prevention care is provided including these new non-clinical models rolling out in Australia, now is the time to be a little more kind, a little more tolerant to those who hold differing views. We need to find ways to discuss shifting and co-creating some of this new suicide prevention language with curiosity, openness and simply a shared desire to help make the world a better place for those living with and supporting those living with emotional pain, thoughts of suicide and suicide attempts and bereavement.

Our hearts and minds are open.

We invite you to do the same and come and share your views with us about how we can continue to keep *working together* to improve the language used in suicide prevention care settings, including in the new non-clinical alternatives.

An open conversation from Roses in the Ocean to you . . .

Click here to share your views.

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