ONE
‘RADICAL’
IDEA

… to improve things for people experiencing mental distress, social issues or injustice in South Australia.

FEBRUARY 2025
gathered and shared by LELAN

LELAN acknowledges the Traditional Custodians of the lands we live, work and play on. We pay our respects to elders – past, present and emerging, and the long and ongoing connection and relationship they have with Country. We acknowledge that this land was never ceded.

We are grateful for the privilege of sharing this land and recognise and are sorry for the historic and continued cost of that sharing to First Nations People.

contact LELAN:
info@lelan.org.au
0431 953 526

What We Need to Know and Do:

About LELAN

LELAN is the independent peak body in South Australia *by*, *for* and *with* people with lived experience of mental distress, social issues or injustice.

Our systemic advocacy targets the mental health and social sectors in SA, whilst our thought leadership and expertise on lived experience, leadership and governance is borderless.

It is our role to listen, truly hear and amplify what people share with us, especially those whose experiences and contributions may be unheard, silenced, dismissed or erased. We resist temptation to judge or filter what is shared because it is hard for services and systems to hear, to integrate into policy and/or practice, or because resources are not available to do anything about it.

Creating space for and including lived experience narratives in honest, visible and influential ways matters to the people who generously share their experiences and are most impacted by the decisions made.

LELAN is encouraged that organisations and systems are increasingly recognising that this should be a required element of reform and redesign efforts.

Reimagining services and rebalancing relationships, through inviting more people into decision-making processes and truly sharing power with people with lived experience, is a justice issue that benefits everyone.

The Question(s) We Asked

Over the last 5 years, every time LELAN has welcomed new members, ran a survey, put out an Expression of Interest to recruit people with lived experience for a particular purpose, or facilitated collaborative design activities with them - **we took the opportunity to ask one BIG question:**

'If you could suggest one radical or innovative idea for how to improve things for people experiencing mental health issues in South Australia ... what would you suggest?'

This question has been answered in **537** different ways by people with lived experience, predominantly consumers, in that time.

For 79 of the responses, we specifically asked for ideas on how to improve things for people experiencing suicide distress and crisis.

Why This Matters

We are documenting the unique and collectively shared ideas of 537 people with lived experience in one platform.

To witness the knowing-in-the-bones and often hard-fought knowledge that people with lived experience, and particularly consumers, have.

To honour and share their experiences, insights, contributions and solution ideas more widely.

And ensure LELAN's work is grounded in what our community tells us would make a difference.

We hold close the following sentiments that were shared with us, 'those closest to the pain are closest to the solution', and, 'adversity is our advantage'.

These 'radical and innovative ideas' do and will continue to inform and underpin LELAN's advocacy and ethic.

If we don't listen, who will?

Expand & Embed Lived Experience (Peer) Workforces

The most common theme to emerge, from **92** submissions, focused on the healing nature of lived experience / peer workers.

People told us about the immediate, transformational and long-lasting impact of peer-to-peer support from someone who has lived through similar experiences as them.

We heard that these connections, especially during times of crisis, offer deeper understanding and hope that cannot be given via clinical or other means. Most recommended access to a peer worker or lived experience worker at all stages of treatment and care.

‘I think that peer support workers and programs should become a fundamental part and role in mental health wards.

Peer support workers should be employed in these spaces, as mental health nurses are often trained solely in the medical model and can lack the understanding of mental health struggles that comes with lived experience.’

‘Peer workers in the waiting area in emergency departments – someone giving you time, someone to listen, can de-escalate many a crisis. Their listening hearts could not only hear anyone who was labeled ‘a psych case,’ they would be available to all.

If you are listened to, if you are heard with the heart as well as the mind, then maybe you will be able to breathe once more without fear.’

‘More paid peer workers for face-to-face/outreach with clients / consumers. But also involved in program development. I think having peers working in inpatient facilities is an untapped resource / opportunity.’

‘When someone is presenting with distress, a peer is the first person they should have contact with – especially at hospitals and mental health adjacent services.’

‘I have seen firsthand the impact of 1:1 psychosocial support in the community setting.

Regular support by way of peer workers or key workers in the individual's community / home has long term protective benefits that considerably lessens if not eliminates the number of Emergency Department presentations.

This support can provide regular contact, service coordination, the understanding of lived experience, long-term and short-term goal setting, and direct support with social engagement.’

‘I have found people need someone to check in and physically be there for them. I live in a retirement village. It is amazing how many residents have mental health issues.’

‘I believe that all mental health services should have, at a minimum, an equal amount of lived experience workers / peer workers and should have open opportunities for people with lived experience to partake in ongoing co-design and co-production.’

‘We need to invest in the professional development and support of the lived experience workforce so that they may use the wealth of knowledge provided by their lived experience and harness this to support others in their recovery.’

See & Centre People, Not Diagnosis

We received **63** submissions emphasising harms caused by current approaches, particularly the medical model.

We heard that people find it unhelpful when their lives are seen through a lens that medicalises their identity, that it creates an uneven power dynamic privileging a clinical and paternalistic view of a person over their own experiences.

When treatment only centres on symptoms, illness or diagnosis, people found the underlying causes of their distress could remain unrecognised, invalidated and untreated, sometimes for years or even decades.

‘I don’t believe in miracles, but I’d like to see diagnosis given less weight and for people to be treated equally and as individuals. To be treated with care and respect and not have your every word/action judged against the given diagnosis.’

‘The first step would be, I believe, to recognise and centre the role of ongoing distress and cumulative contextual stressors (particularly in repeat admissions) rather than centring on assessing behaviours.’

‘Working on treating causes not symptoms I think is needed.’

‘Mental illness labels can usually be more harmful than helpful at least from my experience and firsthand experiences of others.

Instead of labelling them, let them know they are not alone and they are not irrational / silly.

Validate their emotional experiences and work with them to help them understand where the distress is coming from and what can be done to help that. Treat the cause, don't just treat the symptoms.’

‘Respond to people’s care needs holistically from a place of empathy.’

‘We say the consumer is at the centre of care in our policies, but we have failed to make that statement a true experience for people trying to access help.’

‘Restructure mental health care systems to prioritise informed consent and shared decision-making. It would mean providing comprehensive information about treatment options, potential risks and benefits, and empowering individuals to actively participate in their care plans. This approach would not only respect individuals' autonomy and dignity but also lead to more personalised and effective support that truly meets their needs.‘

‘Give individuals' autonomy to identify their own state of mind, and to request the specific supports they might need.

For example, ’I know I need someone to keep an eye on me for the next few days, but I won't cope well if I can't have some quiet moments to myself to engage in comfort activities’ is I think something that is difficult to regulate or enact on a large scale, but I believe it makes a significant difference to how supported or hopeless people can feel following an experience of accessing support services during suicide distress or crisis.’

‘Take away some of the power held by these clinicians who promote the biomedical model of medication and treatment. People feel intimidated and feel they don't have the power to say, ‘no, this isn't good enough, find me an alternative.”

Dignity, Autonomy & Human Rights Matter

We had **47** submissions tell us that coercion in any form can be a significant barrier to receiving and accessing care, with **0** submissions telling us otherwise.

People shared that detainment, chemical restraint, physical restraint, closed wards, and/or seclusion can exacerbate mental distress, sometimes putting a person into a situation where they can no longer receive care. These experiences stay with people and does deter them from seeking help in the future.

We heard that care by force is not care, it is control.

‘Give people the power and autonomy to move through periods of distress without traumatising 'care' practices.’

‘A response that does not necessarily sedate or medicate an individual, but one where the distress is accepted and known that this distress will pass.’

‘When someone goes through depression, for many reasons, it often feels like losing our power – the power to decide for ourselves – and in my experience, it has been the most dehumanising aspect. Of course, we need support, but I believe the most important thing is the right to decide and to participate in decisions that affect our lives, having the appropriate information to do so.’

‘Give mental health patients choices (e.g. asking them to take oral sedation before intramuscular sedation under a Black Code) before forced treatment.

Giving them a sense of autonomy and control in their treatment.

Sometimes the simple answers are the best.’

‘As someone who has been in this situation, the immediate crisis becomes replaced with the need to get out before being placed under an ITO. If there was a safe space to just be and to be able to talk to someone that is not sitting in ED with the only company being a guard watching you, I think this might help the crisis to pass and next steps be decided without the threat or coercion of an ITO.’

‘Stop treating mental health issues as criminal or justice related issues.

No more Police conducting mental health welfare checks. We need mental health first responders before Police and Ambulance. We need people who are trained to deal with mental health issues and crises explicitly.’

‘Yes, managing risk and crisis is vital and absolutely must be strongly located within duty of care principals.

But there is room for change.’

‘Elimination of compulsory treatment and coercion. Or alternatively, full implementation and respect of the International Convention on the Rights of Persons with Disabilities (ICRPD).’

‘Hospitalisation can be incredibly traumatising and in some cases have the opposite effect to helping.

And often once released, people fall through the cracks and enter a cycle of hospitalisation and struggling in the community without adequate support, or in the worst case, take their lives.’

‘Hospital or detainment needs to be the last resort and used to preserve life where all other options have been exhausted, as opposed to the first option in providing care and support.’

Rethink Suicide

We heard in 42 submissions that when a person considering or planning suicide is only seen through a risk lens, it reduces their autonomy, and, ultimately, their humanity.

People talked about how suicide isn’t just a symptom, it is part of the range of emotions we all feel.

Classifying suicidality as pathology ‘others’ the person experiencing it, and frequently exacerbates the experience.

‘The taboo nature of suicidality is rife within the very systems who are meant to support us.

I believe that there needs to be some way for practitioners to be able to see those experiencing suicidality as real people (who actually don't enjoy having to live with these thoughts and stigmas attached), not seeing us as attention-seeking or 'frequent flyers' etc.’

‘For clinical staff / services to be provided knowledge and conversational tools to discuss suicide distress / crisis without the immediate reaction being to detain someone.’

‘Don't treat suicide distress / crisis as a ’symptom of mental disorder.’ Anybody can experience suicide distress / crisis and slapping them with a mental disorder label will set them up for a life of being labelled ill.

Suicidal ideation is a natural part of human emotional experience.’

‘Move further away from the biomedical model being viewed as the only answer to suicide.’

‘I want full demedicalisation of suicidality.

The attitude to just lock someone in a box until they ‘stop’ feeling suicidal is archaic and ableist. <u>We need to help people live with it</u>, rather than criminalising it.’

‘Much more work needs to be done on how we train mental health professionals to respond to risk and crisis, most are trained to be scared of it.’

‘Recognise that suicide is not irrational, or deluded, or impulsive, or uninsightful, or an arbitrary short circuit that randomly zaps within a person’s brain, or any other clever label we can cook up to belittle the legitimacy of the sufferer’s decision.

Suicide needs to be recognised as a fair, justified, rational, considered and legitimate decision that people invariably make because it is the most appropriate action available to them with regards to their circumstances.’

‘Stop trying to talk them out of it, and instead explore the pros and cons of each option in open conversation and making sure that the best decision is being made for that individual. And respecting it is, ultimately, their decision.’

‘Don’t automatically put someone who experiences suicide distress as at risk of completing suicide. I know from my own experience that they are not the same and it is important to recognise that and validate that for the person.’

Compassion & the 'Small Things' Make a Lasting Impact

There were **41** submissions that talked about the relational and healing power of compassion.

Some people named the importance of trauma-informed care, while others named that it can just be a case of kindness and empathy, and the small simple things that make all the difference.

When these practices and ways of being are core to the support provided, instead of an optional extra, the care itself was significantly more helpful and effective.

‘This is not a radical idea but something I think often gets overlooked in the emergency health care system is simple kindnesses

– offering a cup of tea, a warm blanket, and asking the person what they think will help.’

‘That they be shown patience, respect, and be listened to about what their symptoms are in the same way those brought into the Emergency Department are assessed and triaged for physical injuries or illnesses.’

‘Don't throw information, when you are at your lowest, telling me hospitalised there was no help available. It's ridiculous and incredible depressing stuff isn't going to register.

Don't dump guilt like, ’how would your family feel if you die’, that's an assumption that the person has a family, very negative!

Don't push.’

‘Human connection is everything, listening is everything, presence, empathy, non-judgemental approaches are everything.

A lot of everythings isn't there?

These simple things are often lost or not taught and I think they are critical for our flourishing as human beings.’

‘Teaching them that feeling like they do is a mental health breakdown and there is light at the end of the tunnel. Sometimes they just need to hear they are important to someone or something, their life may get better.’

‘Be more open with people, making them feel safe, letting them talk freely without the feeling of being fearful for speaking up.’

Enable Lived Experience to Influence & Lead

In **40** submissions, we heard about the importance of lived experience beyond peer support and representation, to having lived experience leadership across services, sectors, and systems at all levels.

People put a strong emphasis on how critical true understanding of people's experiences and lives are for recovery, as well as the value of lived experience story-telling as a healing practice for people and communities.

People also shared about wanting to have networks of people using their lived experience for change together.

> ‘Empower those with lived experience to guide and lead those with clinical knowledge. It is for them to fit in with us.’

‘I would never, ever wish my experiences on another person, but I have often found myself wishing that some of the professionals I have interacted with could just experience the fear and distress I felt during some of my experiences so that we could have a shared understanding.’

‘I think it would be great to have an annual ’day in the life of’ for every politican, senior official, board or management executive involved in providing services or deciding funding for services. This would require them to be coached through the day, explaining the distress that consumers feel, and then try to navigate the services they either fund, implement, or are responsible for.

It might give them the regular reality check they need to know that services aren't working, and the decisions they make have real impacts on the daily life of people.’

‘Everyone needs to hear, feel, listen to stories of lived experience workers, so that people can openly discuss their feelings and not be afraid in doing so.’

‘See people with lived experience as change agents and leaders, and implement what they say – walk the talk.’

‘Promote the recognition and value of lived experience on par with formal education within the community services industry. In the current landscape, there is a predominant emphasis on tertiary qualifications as a measure of expertise and suitability for roles within the community services sector.

However, this approach often overlooks the invaluable knowledge, insights, and resilience gained through lived experience.’

‘Radical? …
Hear us!!!

Put us in the places we need to be to make the changes – not just as peer workers and representatives, but in meaningful paid positions where the actual decisions get made.’

‘Real legislative commitments by the Government and Parliament in ensuring lived experience is used in the development of policy and services. Similar to the requirements of the Disability Inclusion Act (although this does not go far enough and does miss a lot of the mark), would mean there is accountability of the public sector and government by Parliament and its committees.’

‘Have a quota within every NGO that there must be a set number of individuals on boards, leadership positions, creating policy, that have lived experience.’

Real Awareness & Education, Where People Are

There were **28** submissions that told us community awareness should be a bigger priority.

It not only helps people support others experiencing distress, but it makes everyone better prepared should they experience it themselves one day.

There were **12** people who told us employers and workplaces need a better understanding of mental health, and **14** people identified schools as opportune places for awareness and mental health literacy to be strengthened.

‘Rid the country of stigma, fear, and discrimination.

After 20 years of Open Dialogue in Finland, rates of mental health distress dropped rapidly because people were recovering and therefore, community members felt easier about talking and discussing mental health challenges.’

‘Education for those who don't (or think they don't) have mental health challenges on how to support their colleagues, friends, family to thrive in the community.’

‘If I reflect on my own lived experience of emotional distress and mental health challenges, I believe that many could have either been avoided or the impact lessened had I had the skills required for coping with distress.’

‘Primary mental health education and resilience training in all schools.’

‘A preventative idea, such as dedicating a compulsory school subject for all year levels, focusing on self / emotional / behavioural regulation skills.

Ideally, the foundations would be self-compassion and self-acceptance. believe developing emotional intelligence from a young age is crucial to learn how to judge ourselves less, allow ourselves to be who we truly are, and love ourselves more.’

‘A public awareness campaign to promote care and positive attitudes towards people experiencing a psychotic episode. I think that this diagnosis is still misunderstood and highly stigmatised in the community, while its prevalence is quite high.’

‘Just make it more widely known that mental health challenges affect all walks of life, and can and will happen to someone you know.’

Make Navigation & Access Easier

There were **10** submissions that identified the burden of navigating systems, especially when different services do not share data or coordinate with other services.

People also told us about being given referrals, care plans, or discharge paperwork that assumed a service availability and accessibility that was not actually there.

To address this, we heard **7** submissions talk about preferring one-stop-shops, while **22** talked about the utility and accessibility of digital tools and platforms.

‘Service System integration with a no wrong door approach focused on achieving overall wellbeing.’

‘One place to get your needs met with the whole range of supports - from clinicians, to peer workers to support for carers - not different services that dont talk to each other or with criteria that states ’if you are suicidal do not call’ or trying to fit clients into boxes that are outdated and not realistic.

One place that a person can access what ever help they need and get followed up / supported through the process so they are not left to figure it out on their own, and ultimately fall through the gaps.’

‘If every single health service wasn't overloaded people would be more willing to get help earlier. We would have less of everything. Suicide, DV , addiction and child abuse as examples.

Calling for help to be put on a waitlist is not helpful.’

‘I'm trying to think of ways to allow / assist people to come together online for group support and human connection during these difficult and fearful times.

And to somehow include people who don't have laptops or even phones or are anxious about tech.’

‘Finding ways to catch people falling through the cracks before they get to distress. ... I think we need MH ambulance officers, specialists in supporting people in crisis.

You call for support 24hrs of the day and it comes. No questions asked.

Someone will come and they will work with you towards a plan that you feel comfortable with. Not just straight to the medicalised risk management ways we do things now.

‘I think that the process of being discharged from a mental health ward should be a more community integrated experience.

Where it is ensured that the patient is linked into services such as housing, foodbanks, psychologists as well as community support groups to maintain friendships before being discharged. Maybe even letting the patients continue to stay on the ward for a while during the beginning stages these services. ‘

‘Appropriate data sharing needs to happen, so the treating clinical team of the moment can be in the know of a person's experiences (fact-based, not staff-opinion-based) to reduce the number of times we have to say the same thing over and over which will build on existing trauma.

There is already the assumption that government agencies talk to each other, they can at tax time, so why not in moments of life and death (or what can feel like it)!’

Being Listened to and Truly Heard is Life Saving

There were **36** submissions that specifically emphasised the power of being heard and being accepted rather than rushing to achieve results or outcomes.

We heard that focusing on solutions without first deeply listening to someone can create barriers before healing has even begun.

People know when they have been heard and believed. It helps them feel safer and more liekly to keep speaking and reaching out. It also helps them connect to and trust their own expertise, which we all should.

‘Just take a moment to listen to the human being in front of you.

You don't need to be seen as an expert, you can just see us as human beings and hold space for us.’

‘I think the ability to hold space, listen, not try to fix or solve as a first instinct is an important skill and one that doesn't come naturally to many.

Sometimes just being heard, being seen, and feeling understood is healing enough in itself for many.’

‘Listening, holding space, and responding to each individual with intentional care and curiosity in order to be present with their distress (reducing feelings of aloneness) and see the person as their own expert.’

‘Listening to and sitting with people in distress whilst upholding their human rights.’

‘Feeling heard, seen and believed can be so powerful for sense of self and recovery.’

‘Getting someone to open up is <u>one step closer</u> to stopping a person from killing themselves.’

Broaden What 'Treatment', Care and Support Look Like

Submissions often spoke of the need for alternative and more expansive approaches to be available, including those that focus on broader wellbeing and health.

People made **24** submissions about non-clinical therapies like returning to art, music, nature, and animals. An additional 16 submissions highlighted non-Western knowledge systems and indigenous ways of being.

A further **11** submissions talked about the healing power of respite and spaces for retreat.

‘We don't need novel ideas, we need to appreciate the knowledge of thousands of years that simple things such as mindfulness, connection, and community are key.’

‘Holistic therapies - more access to alternative therapies that are culturally diverse, including creative processes.

‘Therapy animals should be more widespread.’

‘I would love to combine facilitating mental health and wellbeing workshops with an emphasis on using animals as a part of the recovery process, being involved in caring for animals to help clients build their confidence and skills. In my lived experience I’ve observed many people who experience distress and mental health respond well to therapy pets or doing volunteer work working with animals.’

‘A non-medical approach!

Having something like a retreat with beautiful gardens, a spa, and a comfortable bed to go to instead of a hospital where it feels so clinical and cold!’

‘Create a wellbeing centre that is a one stop shop and free to access.

Unlike a crisis response centre, this centre will directly focus on the social impacts of individuals experiencing mental health concerns.

The wellbeing centre will focus on creating healthy safe communities and allow individuals the chance to experience and try new things.’

‘Calm, beautiful spaces and gardens, as opposed to white clinical walls. Social connection and human contact are the real healers and this is sadly lacking for so many.’

‘I dream of a place where people can go when in distress that is out in nature, that is staffed by people with lived experience, that is trauma informed and person centred, that has things like music and options for play, yoga, safe spaces, comfy beds - basically a health retreat for people in crisis.

This is what I needed when I was in crisis.’

‘My belief is that if more money was spent on achieving and maintaining wellness, that’s easily accessible, that the more extreme management like detainment would need less money spent on it.

Crisis might not happen as much.

It’s not inevitable that I will be mentally ‘ill’ forever, I can maintain mental wellness even with a diagnosis.’

The Financial & Social Realities of Life Are Crushing

We received **22** submissions speaking to the overwhelming influence of financial distress and other social issues on mental health, including unemployment, underemployment, precarious work, low income, debt, poverty, housing instability, being unhoused, lack of affordable housing, and cost of living pressures.

These were all identified as determinants of mental distress as well as a person's ability to cope due to the significant barriers they add.

Even when people were able to get appointments, they often find rebates and subsidies run out, making the cost too high to access support for long enough to sustain recovery.

This was sometimes the difference between long-term healing or simply addressing surface-level symptoms.

> **‘We should move beyond attributing mental health challenges solely to neurochemical imbalances and take into account the broader societal factors that impact our mental health.’**

‘Most of it comes down to core human rights, stability in housing, food access, and access to mental health support.

I believe if everyone had access to a safe home, food, education, universal basic income, and support – we would see a decrease in the injustices of society.’

‘I know that lots of young people are feeling hopeless in the face of climate change, economic instability and bigotry.

Focusing on ways that young people, and people of all ages, can best manage dealing with these external stresses would be extremely beneficial.’

‘Address the housing crisis, cap rent prices, and change legislation that makes folks choose between housing and pets – with more afforable housing and support for unhoused community.’

‘A rent price cap and raising the rate of government payments (e.g. Disability Support Pension, JobSeeker).’

‘Defund the inpatient system, prevent doctors and clinicians from charging Medicare gap fees for income support recipients, and pour all available funding into community and social models that address systemic social pressures that complicate and hinder mental health recovery. Provide everyone on income support with a house. Give income support recipients the opportunity for their children to study at whatever school the choose (public or private) at no cost.

Invest in empowering the minority voices. Take the pressure off those struggle the most. Restructure the system to counter societal injustice.’

‘Why should any person miss out on a service that would be essential for their recovery because they don’t live in the same areas to where it is being delivered?’

‘Mental health affects the majority of people, not just those who can afford it.’

‘There are too many people not getting the help they need because the appointments are so expensive.’

‘Make bulk-billed psychiatrist sessions available to all mental health consumers who need a medication review.’

‘Free mental health services e.g. psychology, counselling and psychiatry for all the community.

You shouldn't get turned down, regardless of your circumstances.’

‘Radical? haha.
To take the pressure off.
To make things accessible by eliminating the barriers... such as having to prove you're clinically stressed (diagnosis), or not being worthy of treatment due to poverty. (ie. making it unaffordable).

The system is designed to crush. The radical solution is to remove the giant boot above us.’

Disrupt & Transform the Dominant Paradigm

There were **10** submissions that talked about bigger systems reforms and the risks of remaining with the status quo.

Some identified system infrastructure reforms, such as service provision in rural, regional and remote communities, while others identified system process reform, like genuine collaborative policy design.

People shared about the need for bigger changes than single programs or service evolutions. They want the very ideas that existing clinical treatment options are based on to be entirely rethought and reformed.

‘Change systems from ones of barriers and suppression / perpetuation of those experiences to ones of facilitation, inclusion, and driven by those who have lived experience expertise.’

‘I'm not sure that it is so radical to suggest that our mental health system is funded appropriately, but that would be my first suggestion.

A well-funded mental health system co-produced with lived experience, centred on a holistic understanding of trauma would be good start.’

‘Mandating authentic co-design with people with lived experience in all levels of government, peak governing bodies, and advisory bodies.’

‘Challenge our local Members of Parliament to be actively involved in the co-design process and see the rawness and reality of what is really going for people in their lives.

Encourage them to come out of their office and regular agendas and meet the faces of mental health in its entirety.’

‘The only thing that would help is a massive overhaul of the mental health system and appropriate funding. Lol.

But dead people don't vote so who cares?!’

As a lived experience-led organisation LELAN values the lives and work of people with lived experience of mental distress, social issues and injustice. Particularly those that intentionally, passionately and skilfully use their lived expertise for change.

We thank those that came before, remember those we have lost, and stand in solidarity and allyship with our communities now and into the future.

We are stronger together.

LELAN

DIGNITY, AUTONOMY & HUMAN RIGHTS