Aftercare would like to thank Mind's Allied Health Manager Gerard Bolger for his support both practically and as an ally throughout the Aftercare journey.

We would also like to thank the NWMPHN for the opportunity to develop this exciting and innovative program. By preventing death by suicide, initiatives such as these alter the lives of the not just the individual who experiences suicide, but their families, partners, friends, and the very fabric of our community.

Services who are considering starting an Aftercare of their own are warmly welcome to contact Isabelle McGovern (isabelle.mcgovern@mindaustralia.org.au or on linked in) for further insights and additional details about the project. It is hoped that in the future there will be LGBTIQA+ Aftercare support for all communities across Australia, as tailored to their distinctive regional needs.

"There is a crack in everything – that's how the light gets in"- Leonard Cohen

Aftercare Service Manual

1. Purpose

The purpose of this document is to provide an overview of how the Aftercare program was implemented by Mind Australia as part of the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and other gender and sexually diverse individuals (**LGBTIQ+**) Suicide Prevention Trials, including the lessons learnt from the program and tips for future adaptation. It is intended that this resource will enable other organisations and commissioning agents to implement a similar program to support LGBTIQA+ individuals following either a suicide attempt or thoughts of suicide.

2. Introduction

The Commonwealth Government has funded the implementation of twelve suicide prevention trial sites across Australia as part of the National Suicide Prevention Trial, which spanned a 4-year period (2016-17 – 2019-20). Each trial site was led by the local Primary Health Network (**PHN**) and aimed to improve the current evidence base around effective suicide prevention strategies for the general population and priority population groups.
The North Western Melbourne PHN (**NWMPHN**) led the only trial site in Victoria, which focused on LGBTIQ+ communities. The objectives of the Trial were to:

- Understand and address the factors that contribute to suicide within LGBTIQA+ communities;
- Increase the available evidence base on effective suicide prevention strategies for LGBTIQA+ communities; and
- Share relevant insights and information gathered from the trial with other community organisations and commissioning agents to enable them to better support local LGBTIQA+ communities.

The trial comprises a total of 8 interventions, with the Mind Australia Aftercare program being one of the interventions.

3. Context

In the last 10 years, there has been a 33% increase in the annual number of deaths by suicide within Australia (Andriessen, Krysinska, Kolves & Reavley 2019). Within this context LGBTIQA+ people have higher rates of suicidal ideation, self-harm, and poorer mental health compared to heterosexual and cisgender populations (Waling, Lim, Dhalla, Lyons & Bourne, 2019). These rates have been attributed to everyday and systemic and institutionalised experiences of discrimination, violence and harassment. (Wailing et al., 2019). The recent Private Lives 3 study (Hill, Bourne, McNair, Carman and Lyons, 2020), Australia's largest national survey of LGBTIQA+ people, has indicated that one in four (41.9%; n = 2,848) participants reported that they had considered attempting suicide in the previous 12 months. This is almost twenty times higher than the 2.3% reported among the general Australian population (Johnston et al., 2009).

A recent mixed methods study was conducted by Australian Research Centre in Sex, Health and Society in partnership with Lifeline Australia to explore the needs of LGBTIQA+ people during a time of personal or mental health crisis. Their research, which included 472 participants, highlighted key barriers to accessing a crisis support service as well as counselling and mental health support services. These included anticipations of discrimination, 'I don't want to be a burden' narratives, lack

of awareness of mainstream and LGBTIQA+ specialist counselling and mental health support services, and physical access, technological, and financial barriers. (Waling et al., 2019)

Furthermore, Thorne Harbour Health (**THH**) in partnership with Mind Australia conducted four focus groups with 29 LGBTIQA+ Mental Health Service Users. Themes of pathologising gender and sexuality, fear of police or emergency service brutality, fear of unsafe services, shame and feeling undeserving of help, the experience of services treating everyone the same with a lack of recognition of impact of oppression and historical institutionalisation were highlighted as some of the reasons LGBTIQA+ people don't seek support at time of crisis (Arnold, Holden & Muller, 2019).

As such, the focus of Aftercare is to reduce suicide and suicidal behaviour among at risk groups through the provision of a suicide prevention support service models that is peer-led, and evidence based. By definition 'aftercare' refers to the follow-up of a person presenting to health care services following either a suicide attempt or thoughts of suicide.

4. Overview of Aftercare intervention

Overview

The Aftercare Pilot Program (**Aftercare**) provides identity-affirmative support and care for LGBTIQA+ people who have experienced a suicidal crisis. As an intensive outreach service, Aftercare can provide up to three months of assistance by a mental health clinician (psychologist, social worker, psychotherapist, or occupational therapist) and an LGBTIQA+ Peer Practitioner with lived experience of suicidality themselves, who acts as a 'mentor' or exemplar for recovery. At every level, Peer Practitioners are involved in program design and implementation, ensuring that otherwise marginalised voices are involved in tailoring suicide support that reflects local community needs.

Target cohort and client profile

Aftercare was specifically designed for and with LGBTIQA+ individuals following either a suicide attempt or thoughts of suicide. Service provision included 52 clients. Noting the limitations around data gathering, of the 52 clients:

- 12 (23%) identified as bi (including 2 people questioning/not sure but feeling attracted to more than one gender);
- 8 (15%) identified as gay cismen;
- 6 (11%) identified as lesbian (4 ciswomen and 2 transwomen ;
- 1 person identified as heterosexual (but gender identity was trans); and
- 25 (48%) identified as 'something else' ie. Queer (this included people who sexually identified as being attracted to more than one gender but felt queer was a better word as it encompasses their gender identity too)

Other attributes of the clients who participate in Aftercare include:

- 5.7% of clients also identified as Aboriginal;
- 15-20% were from culturally and linguistically diverse backgrounds;
- Clients ranged in age between 14 (participating in liaison with parents and school) and 68 years of age;
- Approximately 75% of clients had made a previous suicide attempt and 25% of clients had experienced suicidal ideation;
- Most clients (85%) identified with having previous mental health issues or diagnoses. This commonly included depression, anxiety, borderline personality disorder and complex post-traumatic stress disorder;
- An estimated 40% of clients had co-occurring substance use issues, however this was not always captured on intake due to factors such as shame and worry about service exclusion criteria (Note: Aftercare was honored to work with individuals irrespective of their relationship to drugs and alcohol and would never exclude them due to this, however, individuals who had been turned away from services in the past did not feel comfortable disclosing their relationship to drugs and alcohol until rapport was established)

Service delivery output

Clients experienced collectively over a thousand episodes of service provision, including 620 peer work sessions, 20 instances of group sessions, and over 340 sessions of clinical psychology and psychotherapy. Referrals came from 22 unique referrers from 13 organizations, with 18 individuals opting to self-refer. Knowledge of Aftercare spread via word-of-mouth, advertising, and engagement

with community information sources such as JOY FM. Initially slow to start due to focusing on people using NDIS-based services rather than the general LGBTIQA+ community, Aftercare experienced a high demand for post-suicide crisis care from March 2020 until provisional service wind-up of new clients in December 2020.

Objectives and desired outcomes

The objectives of Aftercare were to:

- Address contributing factors to LGBTIQA+ suicide by providing care received by individuals (and their family – including chosen families and families of origin/supporters/first responders) following a suicidal crisis;
- Increase capacity of mainstream services to work in an affirming way with LGBTIQA+ individuals with thoughts of suicide, and increase LGBTIQA+ community access of mainstream suicide support services;
- Actively promote a socially and culturally inclusive community that honours the lived experience of people who have had thoughts of suicide and seeks to redress historical imbalances of power using a peer-led model;
- Reduce the stigma around suicide and raise awareness of suicide prevention;
- Engage in external evaluation and continual service improvement based on feedback; and
- Contribute to the evidence base of the National Suicide Prevention Trial to tailor suicide prevention programs for LGBTIQA+ communities.

The desired outcomes of Aftercare can be broken down into short-, medium- and long-term outcomes. These are described below:

Short-term:

- Aftercare is experienced as safe, accessible and inclusive;
- Improved awareness among the LGBTIQA+ community of available suicide prevention pathways;
- Increased awareness of mainstream services regarding the needs of LGTBIQA+ people experiencing suicidal crisis;
- Identification of enablers that support referral, intake and engagement for LGBTIQA+ people experiencing a suicidal crisis;
- Identification of barriers and gaps in access and support for individuals and / or families following a suicidal crisis; and
- Enhanced referral pathways across the LGBTIQA+ service system.

Medium-term:

- Improving the resilience of individuals and / or families following a suicidal crisis;
- Improving self-advocacy of individuals following a suicidal crisis;
- Improved service experience for individuals and/or families following a suicidal crisis;
- Greater collaboration between service providers (including both mainstream services and services supporting the LGBTIQA+ community); and
- Increased capacity and improved service delivery of mainstream services in LGBTIQA+ health.

Long-term:

- Reduced numbers of deaths by suicide;
- More resourced communities;
- Peer support embedded in suicide prevention services; and
- Stronger and more effective suicide prevention system.

Underlying research

Peer support has been purposefully embedded into the Aftercare service delivery model. As defined by Mead, Hilton & Curtis, 2001, peer support "is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful" (p 135). Furthermore Mead et al. 2001 highlight that peer support is the understanding of another's situation empathically through the shared experience of emotional and psychological pain.

When people identify with others who they feel are "like" them, they feel a connection (p.135). Through a shared experience, peer support has the capacity to create hope and connection following a suicide crisis (Pfeiffer et.al 2019).

As the LGBTIQ+ Health Australia Current Best Practice Guide for Suicide Prevention states, "culturally responsive support services and resources and peer-led prevention programs are vital for LGBTIQA+ communities, particularly as these are more likely to support the intersections between LGBTIQ identities and other marginalised identities and communities" (2020).

The incorporation of Peer Practitioners in Aftercare was informed by the suicide prevention framework developed by trans and gender diverse communities in Western Australia (TransFolk of WA) and the Alternatives to Suicide Model. This approach centralised a suicide prevention philosophy that aimed to "create the meaningful conditions for a life worth living" as opposed to "forcing people to live" (Radford, Wishart, Martin, 2020).

Process that was adopted to design the intervention, including processes of co-design (where relevant)

The service model for Aftercare was designed through significant consultation with major stakeholders, clinical advisors, community leaders and people with lived experience of suicidal ideation. Specifically, the consultation process included a series of focus groups with LGBTIQA+ people, the establishment of a lived experience advisory panel (LGBTIQA+ LEAD), and extensive engagement with current and previous Aftercare Peer Practitioners. The focus groups with LGBTIQA+ people and the establishment of the LGBTIQA+ LEAD are explored in more detail below:

Focus groups with LGBTIQA+ people

Four initial focus groups were conducted from late June 2019-early July 2019, and consisted of 29 individuals. The purpose of these focus groups was to assess pre-existing and commonly accessed suicide support (if any), frequently experienced barriers to access, and what LGBTIQA+ people living in the North West Melbourne region would expect as best practice during times of suicidal crisis.

Insights from this focus group included:

"Information, counselling and psychologist, people with shared experiences and GP have worked as a post-crisis support"

"Yes, it would make a difference to have LGBTIQA+ workers– representing all different intersections… as well as qualified professionals"

"What is missing in crisis support is outreach – qualified staff, assertive outreach, person focused and active listening, and having follow up services"

Other focus groups were conducted specifically with members of the LGBTIQA+ community with particular experiences, such as living in regional and remote areas and being an older LGBTIQA+ person. These spaces allowed individuals to collectively explore their nuanced needs in suicide support, and to provide guidance on the adaptability of the program to other settings.

Lived experience advisory panel (LGBTIQA+ LEAD)

As a group that meets regularly every six week, the role of LGBTIQA+ LEAD is to provide advice, expertise and support to the Aftercare and the LGBTIQA+ Affirmative Practice Training Project staff through the following activities:

- Provide feedback on the strengths and areas for improvement within Aftercare (and the LGBTIQA+ Affirmative Practice Training by THH) and how to better attune the programs to community needs as they emerge (e.g. if a particular part of the community is experiencing lower mental health or specific challenges).
- Contribute to lived-experience-informed practice to enable continued improvements in LGBTIQA+ suicide prevention.
- Provide guidance for good practice and training approaches that will support the improvement of mental health and reduction of suicide in LGBTIQA+ populations.

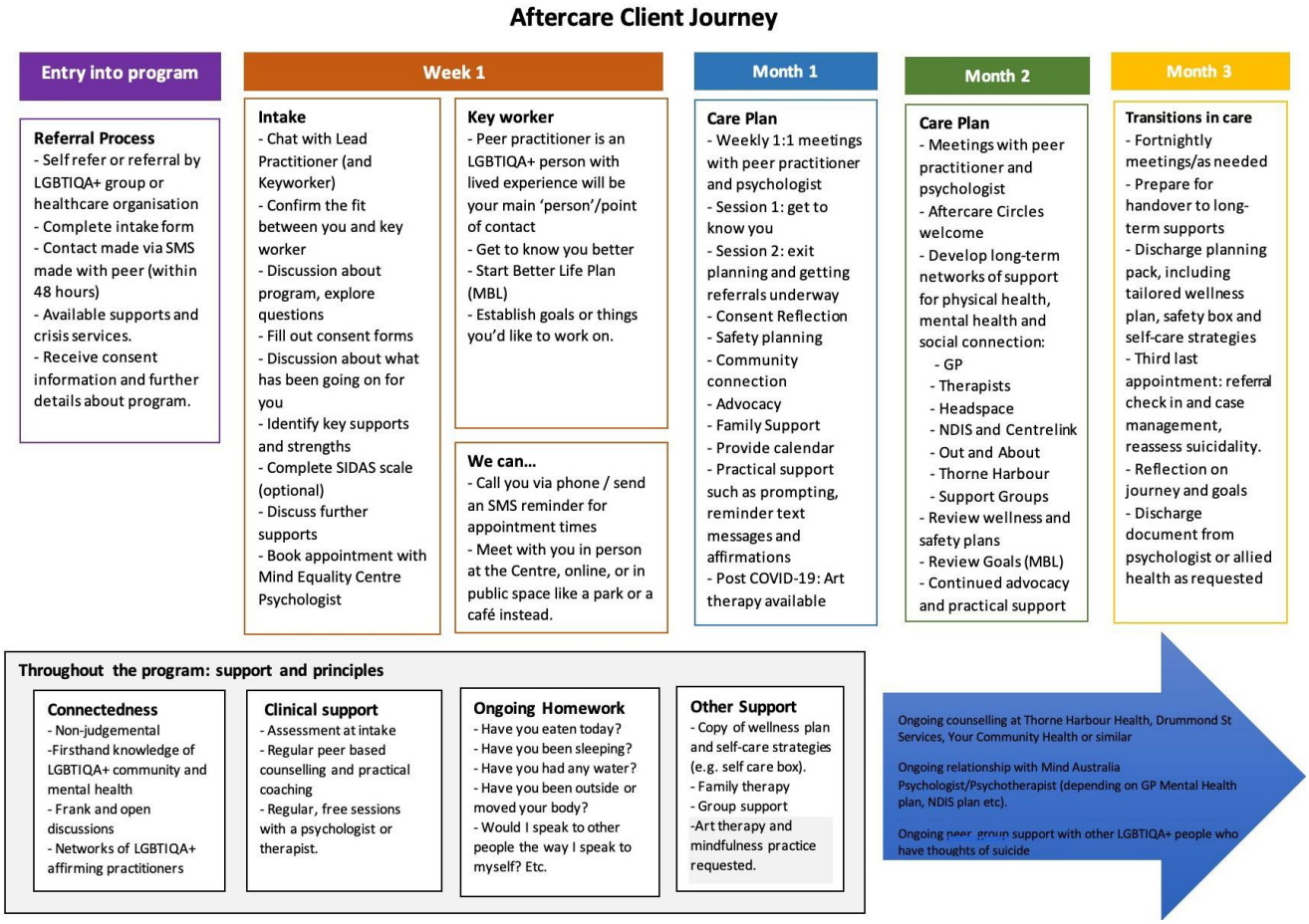
Resource: See Appendix 9 for LGBTIQA+ LEAD Terms of Reference

5. Aftercare Model of care

Aftercare is intensive and can span over a period of three months. By definition, *aftercare* refers to the "follow-up of a person presenting to health care services following either a suicide attempt or thoughts of suicide".

Aftercare includes assistance from a multidisciplinary team including a mental health clinician (psychologist, counsellor, social worker, psychotherapist, or occupational therapist) and an LGBTIQA+ Peer Practitioner with lived experience of suicidality themselves, who acts as a 'mentor' or exemplar for recovery.

The Aftercare client journey is depicted below and illustrates the different types of services provided across the three month period.



At a high-level, Aftercare's model of care involves the following stages:

1. **Referral**: Referral via current counsellor/GP/health practitioner/case manager/friend/family or online self-referral. This enables people to access Aftercare without having to wait for an appointment with another provider. Referrals are received by email, generally. Awareness of the program has been raised during the pilot and continues through community networks, word-of-mouth, the Aftercare website, and advertising on Joy FM. Formal referral sources

include LGBTIQA+ community-controlled organisations (e.g. Thorne Harbour Health and drummond street), NDIS providers and private psychologists.

2. **Access:** Once received, clients and their referrers aree contacted immediately by the Lead Practitioner with a follow up text message containing a list of emergency services and description of what engaging the services may be like to scaffold help-seeking. The Lead Practitioner calls the client to discuss program and conducts a brief assessment. A Peer Practitioner is then matched with the client following a case discussion with the Aftercare team.
3. **Intake:** Client participates in the intake process, which is led by the Peer Practitioner with the Lead Practitioner present (and ideally, also the psychologist). This involves understanding precipitating factors before suicide attempt/thoughts of suicide, current level of risk, what the client hopes to get out of Aftercare, identifying strengths, natural supports and safety planning, possible referral pathways/case management areas as well as standardised intake questions such as emergency contacts, GP contact, consent to partake in the service and so forth.
4. **Individual supports:** Sessions occur weekly with the Psychologist and Peer Practitioner for the first month or two of service depending on need, and fortnightly thereafter for a total of three months. Decisions regarding service frequency is led by the client. Where necessary, peer practitioners can provide extra support via text message or as-needed additional sessions (e.g. for instance, if a client has decided to go into hospital that week, it may necessitate an extra session and extra text messages of support and solidarity).
5. **Group supports:** Aftercare Circles, our drop-in groups program for ongoing support is available for continuity of care both during the Aftercare journey and beyond. This provides a non-judgmental space for clients to explore their thoughts of suicide without pathologisation, which is led by a dedicated Peer Practitioner Group Facilitator. Aftercare Circles is explored in more detail below.
6. **Exit:** The Peer Practitioner manages exit referral pathways and links client into identity-affirming community supports. The client also receives a safety planning toolkit including individualised strategies that work for them as well as resources such as emergency phone credit if in crisis and safety is at risk, sensory items, and personalised items from other members of the LGBTIQA+ community.

Aftercare Circles

Clients: Aftercare Circles is available to graduates or current participants of Aftercare. This ensures other dimensions of care have been addressed, direct follow up is possible if required, and Peer Practitioners can make informed risk assessments. Maximum participants per group is 8-10 people.

Principles:

The following principles underpin the way Aftercare Circles are conducted:

- Each person is honoured as the expert of their own experience;
- Relationships are based in respect and curiosity rather than judgment or fear;

- Culture of mutual respect, support and empathy;
- Freedom to interpret one's own experiences in any way; and freedom to challenge social norms;
- A willingness to sit with people in deep distress and explore thoughts and feelings without jumping to clinical interventions or a medical lens;
- Only people with personal experience of suicidal thoughts or actions may attend;
- Only people of LGBTIQA+ identification may attend;
- Facilitators openly identify with the experience of suicidal thoughts;
- Group is based on 'self-help' with a focus on relationships;
- People don't need to be experiencing a current crisis to attend; and
- Agreed confidentiality conditions.

Structure:

An overview of the structure of the Aftercare Circles are outlined below:

- Facilitators
  - 2 facilitators per session, allowing one to exit out and follow up with a client if they are needing it in the moment. Lead Practitioner to be available on standby if need be.
  - Dedicated regular facilitator;
  - Peer Practitioners to receive group facilitation training and supervision
- Key activities during session:
  - Clearly delineate space;
  - Establishing a group agreement, defining particular needs and expectations via codesign process, e.g. shared understanding that this is not formalized "therapy", with facilitators working to contain conversations that are perhaps better kept for a one-on-one context;
  - Have a beginning key talking point, as a launching point for conversation each week; and
  - Allow space for clients to direct conversation and tone of group: emergent, exploration-based space to share; and
  - Aftercare groups will be informed by some elements of Dialectical Based Theory (**DBT**) based groupwork, for example, having a group rule regarding not talking in graphic detail about suicide, but exploring situations, how they were managed, developing coping skills and discussing what worked/didn't work.
- Key activities after session:
  - Afterwards, a basic attendance note will be documented for each who attends with no specifics unless there was a particular intervention required such as follow up due to conversation flagged as at-risk which was requested during the co-design process.

Resource:
See the following for additional information:
- Appendix 1 – Aftercare Circle Group Agreement
- Appendix 4 – Aftercare session structure for peer practitioners

Delivery:

Aftercare Circles are delivered weekly online and in real life at a safe place of local LGBTIQA+ community significance, such as a queer bookshop or café (where privacy can be guaranteed, such

as a separate dining room). Groups run for two hours per session (plus breaks and time for individual follow ups). Ideally, a minimum of two groups are delivered per week that includes a session on the weekend to allow people with thoughts of suicide who work during the week to attend. The groups should also be structured around a drop-in basis, giving clients the flexibility and autonomy to determine their level of engagement.

6. Workforce

Aftercare is supported by a strong workforce of peer practitioners, mental health clinicians and a Lead Practitioner. Importantly, people with lived experience are represented across all levels of the workforce.

The role and function of each of these roles is described in more detail below:

Name of Role	Position	FTE (for the current Aftercare service)
LGBTIQA+ Lead Practitioner	As a key enabler, the Lead Practitioner also identifies with being LGBTIQA+ and having a lived experience of mental health and suicidality. It is important for people with lived experience to be represented at all levels of service delivery and management. The Lead Practitioner's role encompasses the establishment of LGBTIQA+ LEAD or equivalent; developing partnerships with key referrers and stakeholders; providing leadership and guidance on clinical and practical issues that arose on a day-to-day basis; coordinating between clients, staff, governance committees and developing resources; conducting intake assessments; and helping to administer the program in accordance with local community needs. **Resource:** See the following for additional information: - Appendix 14 - PD LGBTQIA+ Lead Practitioner (Allied Health)	1.0
Peer Practitioner	The role of Aftercare's Peer Practitioners is to translate their lived experience of mental illness and suicidality whilst being LGBTIQA+ to support the client in a purposeful, caring and responsive way. Aftercare recruited three Peer Practitioners who can act as an 'exemplar' or mentor for recovery, connecting with clients as equals with shared (and different) stories. Peer Practitioners are also able to advocate for clients and provide community connection and support in a way that only another LGBTIQA+ person can. Peer Practitioners support an average of 2-3 clients per rostered day. A minimum of three Peer Practitioners is recommended for adequate small-scale service delivery including hosting a group program (i.e. Aftercare Circles).	2.2

	Resource: See the following for additional information: - Appendix 11 – Position description for After Care Suicide Prevention - Peer Practitioner (Allied Health)	
LGBTIQA+ Psychologist	The role of a dedicated LGBTIQA+ Psychologist is to provide brief and targeted psychological supports including safety planning, as well as explore themes such as coming out, relationships, self-regulation and meaning-making. The LGBTIQA+ Psychologists collaborates closely with Peer Practitioners and work together to promote an effective working relationship that provides clinical support and case conceptualisation for Peer Practitioners. **Resource:** Appendix 13 – Position description for Allied Health Clinician – Psychologist LGBTIQA+ (Allied Health)	1.0
Peer Practitioner – Groups Facilitation	The role of Aftercare's Peer Practitioners is to translate their lived experience of mental illness and suicidality whilst being LGBTIQA+ to support the client in a purposeful, caring and responsive way. Aftercare's Group Facilitator organises, manages the administration of, and is the lead facilitator of online and in-person groups. This role is also the person that will be available for drop-in support. **Resource:** See the following for additional information: - Appendix 12 – Position description for After Care Suicide Prevention - Peer Practitioner Group Facilitator (Allied Health)	0.4

7. Supporting processes

The processes that support client's journey through Aftercare include:

- Streamlined referral processes: Clients can self-refer via the Aftercare website, in collaboration with another service provider, or simply leaving a message with their name and number and a referral form can be filled out over the phone with a Peer Practitioner. The

requirements for referral are to be LGBTIQA+, associated with the NWMPHN region, and experiencing thoughts of suicide. Clients and their referrers are then contacted via text message within 48 hours to notify them that their referral has been received and what immediate crisis supports are available afterhours.

- Intake triage: The intake triage process assesses client's current level of suicidality through reported ratings on the Suicidal Ideation Attributes Scale (SIDAS) and corresponding risk factors (e.g. sociodemographic status, previous suicide attempts, presence of self-injury, and pre-existing supports). The intake triage process occurs over 1-3 sessions depending on client needs, and explains the program in greater depth and explores the client's needs and goals. For example, the intake process includes consent, identifying natural supports and the bounds of information disclosure to those supports. In addition, intake triage also explores what clients would like from an LGBTIQA+ suicide program, where the client is currently at in different facets of their life and their aims and objectives for the future. The intake process is largely strengths based and involves the development of an interim safety plan and the creation of a risk assessment and management plan.

- Care plan: A care plan is developed at intake and is a living document that Peer Practitioners and psychologists can refer to throughout the Aftercare program. It includes a description of client needs and hopes to change over time. Typically, at the start of service provision, several key areas will be identified that the client would like to focus on. This provides the framing for the Peer Practitioner to tailor supports. For example, the Peer Practitioner may step into a case management role for referral to an alcohol and other drug (**AOD**) service; finding a new GP; talking to a parent about gender affirmation; applying for the National Disability Insurance Scheme (**NDIS**) or Disability Support Pension (**DSP**); or connecting in with local community groups. Where possible, collaboration with other service providers for a warm handover will be pursued (e.g. alongside family and carer liaison and the client's GP).

- Transition: At the end of their Aftercare journey, clients are referred to other mental health services where necessary, with quality handovers to new practitioners sought out. Frequently, clients will be referred to Aftercare from counselling services that have waitlists for several months. It is hoped that by the time the client has graduated from Aftercare, they are at the top of the waitlist and able to access those services in a healthier, more receptive space. Clients can continue to access Aftercare Groups program long term, which can act as an anchor point during transition from the program and help clients remain connected to LGBTIQA+ peers.

8. Partnerships

Aftercare has established key collaborative partnerships within the LGBTIQA+ community (described below). The purpose of these partnerships is to ensure that Aftercare meets the needs of its clients and is fit-for-purpose, accessible and inclusive. In addition, partnerships also support referral pathways for clients to deliver on the program's intended outcome of providing more integrated support for LGBQIA+ people.

The different partnerships established by Aftercare are identified below:

Consumer Advisory Group (LGBTIQA+ LEAD):

- Organisations: Thorne Harbour Health and Mind Australia.
- Purpose and Function: The role of the Consumer Advisory Group is to provide advice, expertise and support to Aftercare via the following activities:
    - Provide feedback on strengths and areas for improvement within the Aftercare (and the LGBTIQA+ Affirmative Practice Training by THH) and how to better attune the programs to community needs as they emerge (e.g. if a particular part of the community is experiencing lower mental health or specific challenges).
    - Contribute to lived-experience-informed practice to enable continued improvements in LGBTIQA+ suicide prevention.
    - Provide guidance for good practice and training approaches that will support the improvement of mental health and reduction of suicide in LGBTIQA+ populations.

- Advisory group mers must be a member of the LGBTIQA+ community, currently living in Victoria and have a lived experience of having thoughts of suicide.

Community of Practice:

- Organisations: Thorne Harbour Health, Switchboard, Drummond Street Services and Mind Australia.
- Purpose and Function: NWMPHN LGBTIQ+ Suicide Prevention Trial were invited to participate in a community of practice in order to share learnings and develop a collective sense of solidarity and collaboration. This provided peer based supervision, feedback and support.

Referral pathways:

Mind Australia worked with other organisations within the NWMPHN LGBTIQ+ Suicide Prevention Trial including THH, Switchboard and Drummond Street, to develop entry/exit referral pathways.

9. Supporting resources and other materials

A number of resources and supporting materials were used and developed as part of Aftercare. An overview of the resources and their function is described below:

- Intake and referral form: The purpose of the intake and referral form is to briefly determine current acuity level of suicidality and safety of self and others, identify emergency contacts and pre-existing supports, gauge accessibility needs and gain an initial understanding of the client to better facilitate the first intake session.

- Risk assessment: The risk assessment and management plan are completed at commencement of service delivery for all new clients and reviewed at end of service or when information becomes available that indicates a change in the client's circumstances (e.g. deterioration in mental health). This form explores current and prior risks, protective factors, external supports in place, and treatment information. Areas of assessed risk include but are not limited to: alcohol or other drugs, behavioural risks (history of using violence and aggression), mental health information, suicidality, self-injury, physical health, housing, vulnerability, and legal issues.

- Consent forms: The consent form incorporates Mind Australia's legal obligations around informing clients of their rights, confidentiality (including limits to confidentiality), and when and how Mind Australia collects their personal information to provide services to them. Consent forms were adapted to reflect the requirements of the NWMPHN and National Suicide Prevention Trial's de-identified data collection purposes and opportunities to contribute to Aftercare's evaluation.

- Identification of key supports: High quality care relies on an individual being supported in multiple ways. Client's key supports frequently include their GP, family members (chosen and of origin), friends, partners, psychiatrists, other counselling and healthcare providers, case managers, AOD workers, housing services and legal aid. Contact with these key people occurred only with the clients consent and wish, in order to co-ordinate recovery. Recognition that some clients are not 'out' to their GP or other supports was taken into account. For instance, by the client designating what information different contacts should/shouldn't know about them, and having two GP notification of service letters developed (one that identifies the service as LGBTIQA+, the other which indicates Aftercare is a generalised suicide service).

- Better Life Plan: This resource from Mind Australia supports clients of Aftercare to identify areas of their life in which they would like to be supported. This plan is designed to be completed with the Peer Practitioner and reviewed frequently to assess progress and identify areas for further support.

Resource:
See the following for additional information:

- Appendix 2 - Mind Australia key information - Welcome pack
- Appendix 3 - Meet the Therapists - Welcome pack
- Appendix 5 – Aftercare referral form
- Appendix 6 – Aftercare referral form easy English
- Appendix 7 – Consent form
- Appendix 8 – GP example letter
- Appendix 10 - Aftercare flyer for referrers
- Appendix 15 – Self and safety resource for people identifying as LGBTIQA+

Note: The risk management plan and Better Health Better Life Plan is the proprietary information of Mind Australia and should be requested directly from the organisation

10. Monitoring and evaluation processes

Due to the nature of Aftercare (i.e. being a pilot program), monitoring and evaluation was key to support continuous improvement and address any gaps or barriers identified. To measure against client-focused outcomes, SIDAS data and referral data were collected.

To measure referral-focused outcomes, the Aftercare team monitored the strength of referral pathways (i.e. # of referrals from partnering organisations) regularly and worked with partner organisations to troubleshoot any challenges.

In addition to clinical and quantitative measures, the Aftercare team also sought to seek qualitative feedback from clients and community stakeholders through 1:1 interviews and 3-month and 6-month follow-up case studies.

Finally, as Aftercare was funded by the NWMPHN as part of the LGBTIQ+ Suicide Prevention Trial, the Lead Practitioner reported fortnightly to the PHN on the following measures:

- Referrals: Number of referrals for the fortnight
- Clients: Number of active clients, new clients, graduating clients and clients on waitlist
- Sources: Identification of referring agencies / organisations and number of self-referrals
- Future referrals: Summary of projected referrals and identification of any barriers or challenges
- Support trends: Summary of operational support provided and identification of any barriers or challenges
- Staff: Number of active staff including Peer Practitioners, mental health clinicians and supporting roles

11. Potential risks and mitigation strategies

Working in a suicide space carries inherent risks regarding client death or self-injury. As such, peer workers stringently follow Mind Australia's comprehensive policies and procedures. A risk assessment is conducted upon client intake which includes a risk mitigation plan tailored to the individual, notification of Aftercare engagement to the client's GP (with their consent), as well as emergency contacts, a safety plan and client wellness and early warning signs plan. These contacts and plans may be activated if a current client or an Aftercare Circles group member expresses distress. The best defences against client risk of suicide are supportive, warm, open, and connected relationships, which Aftercare invests in as part of its above-and-beyond commitment to community care.

Some clients may be assessed on intake as requiring more intensive care than Aftercare can provide, such as hospitalisation. In this case, Aftercare ensures that the clients spot in the program is available when they are ready to engage or provide them with the option of having peer support without psychological support (so as to avoid an excess of clinical therapeutic relationships). For Aftercare Circles, alternative referrals can also be made to other groups (such as those run by Thorne Harbour Health or DISCHARGED).

Assertive follow up on both a group and individual level will always be provided by a psychologist or a peer worker if a client disclose a current plan to die by suicide or expresses acute suicidal ideation.

12. Lessons learnt

General key success enablers:

The evaluation of the Aftercare trial found that providing suicide support reduced active suicidal ideation in the vast majority of participants. Some clients (approximately 10%) found that although their thoughts of suicide were still there, they felt less alone – as isolation and hopelessness is predictor of suicide attempts.

A key success of the program was found to be the role of Peer Practitioners who were able to provide support. Peer support encompasses both offering and receiving support based on mutual understanding and the ethics of collective care. As both the peer worker and the client had experience of 'double discrimination' (the stigma of suicide and the experience of being LGBTIQA+), unique rapport was able to be established. Peer support differentiates itself from clinical models as it does not base itself on diagnostic criteria or a psychiatric lens of mental illness. In the context of LGBTIQA+ peer support, Aftercare Peer Practitioners found that empathically connecting to a person's experiences of mental ill health as seen through socio-cultural lens as opposed to an individualised, medical lens led to the best outcomes for Aftercare clients, including increased sense of community, reduced isolation, increased self-advocacy skills and political empowerment.

Similar to the results in National Suicide Prevention Adviser, *Compassion First: Designing our national approach from the lived experience of suicidal behaviour* (2020), many clients reported being previously bumped from service-to-service. Clients spoke about the power of being able to access a service that was identity-affirming and validated their experiences of minority stress. The importance of Aftercare Circles to provide ongoing group support therefore became critical as it was clear for some clients that they needed more support than what could be provided in the 3-months' timeframe of Aftercare.

Another parallel to the findings above was that exit referrals were frequently difficult to organise given that most organisations and long-term options for care such as private psychologists had significant waitlists. Aftercare Circles was thus able to 'hold' the person until they were able to fully engage with their referral source. The lack of available mental health and suicide prevention services is a sector-wide issue that will be hopefully addressed following the recommended initiatives of the Royal Commission into Victoria's Mental Health System.

Another key success of Aftercare was the ability to provide free psychological care to LGBTIQA+ who needed it with minimal wait times. This has been identified as a critical community need across multiple research domains in LGBTIQA+ mental health. However, three months is often not enough to do deeper work which is holistically preventative in the long term.

Most importantly, there were no client deaths during Aftercare service provision.

Key success enablers of Aftercare were identified to be:

- **Peer Practitioners:** In many regards, Peer Practitioners and role of lived experience sits at the heart of Aftercare. Peer Practitioners were able to provide unique insights on the needs of clients that created a conducive environment to better assess risks, understand strengths, and coherently link in to new and established supports. Peer Practitioners were therapeutically able occupy a position of solidarity, frankness and sense of 'keeping it real'

with clients which enabled a unique space of connection and client accountability outside of traditional therapeutic roles. This was especially effective for people who had utilised multiple services over the course of several years.

- **Leadership that identifies with a lived experience:** By employing a Lead Practitioner that identifies as LGBITQA+ and with a lived experience of suicidality and mental health issues themselves, Aftercare was able to elevate a lived experience philosophy that emphasises the decision-making power of people lived experience into practice. The Lead Practitioner was able to integrate the wisdom embodied by peers as well manage a team and day-to-day organisational life.
- **Relative autonomy within a mainstream organisation:** Entrusting Aftercare to respond to on-the-ground community needs meant that the team was able to focus on meeting clients where they were at in a way that was culturally safe and appropriate for the LGBTIQA+ community and could successfully tailor services rather than adopt a 'business as usual' or 'mainstream' approach.
- **Ability to adapt during COVID:** Aftercare was able to remodel itself into a telehealth delivery service in a relatively short period of time, by going from in-home outreach to telehealth only in the span of several weeks. This was partly born from necessity due to the outbreak of COVID-19 and the anxiety, isolation and loss of meaning that ensued. Our ability to adapt speaks to both the resilience of the program with the right conditions and the integrity of peer knowledge.

<u>COVID-19</u>

The outbreak of novel coronavirus occurred just as Peer Practitioners and Lead Practitioners were in the first days of their employment at Aftercare. COVID-19 impacted both Peer Practitioners and client's mental health, normal entry/exit referral pathways, and client access to the service. For example, being unable to leave the house due to being immunocompromised or not being able to afford phone/internet data to engage in a telehealth call.

Transition into lockdown involved Aftercare ceasing face to face service delivery and proactive redesign of online service delivery. Staff worked from home and engaged in daily debriefs, check ins and check outs to help foster work/life separation and sense of camaraderie during lockdowns and social isolation periods.

Coming out of lockdown required the creation of new COVID-safe space service procedures including the use of COVID-safe pre-assessments, social distancing, use of appropriate PPE etc. Greater flexibility in delivery meant that all clients were given the option to experience the whole Aftercare program via telephone or zoom calls.

Given that a number of the support groups that Aftercare would ordinarily refer to as an exit pathway for clients were no longer in operation, the Aftercare Circles was developed in consultation with Mind Australia Diversity and Inclusion department, peer advisors, and leading thinkers in suicide peer-based recovery models. As a drop-in group for clients who have graduated the service, Aftercare Circles aimed to reduce social isolation and sense of hopelessness due to COVID-19, enhance knowledge of resources they can access to strengthen community connection, and develop ongoing self-care strategies following suicidal crisis. Aftercare also budgeted for data and phone cards in order to account for at-risk clients who are otherwise unable to afford phone data.

13. Tips for adaptation and key insights

Recommendations for future implementation is structured according to the following categories:

Organisationally

- Meaningfully engage with LGBTIQA+ people with lived experience of suicide throughout the design, development, implementation and evaluation of Aftercare. This requires appropriate resourcing.
- It is not enough to have a token LGBTIQA+ person act as the voice of LGBTIQA+ communities - the conditions need to be there for that voice to speak and to be heard by service providers. This includes having a substantial number of LGBTIQA+ community members representing diverse local communities (especially trans and gender diverse folk) involved in codesign, ensuring people with lived experience have tangible decision making power and the selection of LGBTIQA+ individuals with lived experience of suicide is performed sensitively (e.g. using Roses in the Ocean advisors). The role of Aftercare is to respond to on-the-ground community needs. This requires advisors who are at an appropriate point in their recovery journey and who can sustainably advocate for the communities they represent.
- Acknowledge community trust can take years to build, which makes sense given the historical relationship of mental health institutions and the discrimination and oppression of LGBTIQA+ people.
- Be consistent with service provision and ensure that funding arrangements are long term in order to provide stability for clients, workers, and the community at large.
- Allow sufficient time for the establishment of Aftercare and ensure that each step is done thoroughly and to a high standard with realistic expected outcomes.
- Review risk management procedures in consultation with people who have lived experience of suicide and consider approaches such as the Alternatives to Suicide model.
- It is recommended that Aftercare is delivered through organisations that have the Rainbow Tick and/or can confidently provide a culturally safe workplace for LGBTIQA+ Peer Practitioners as reflected in policies, procedures, feedback systems and management processes.
- Ensure the groundwork to support diverse communities and clients with thoughts of suicide (including acute and chronic) has been completed before taking referrals.
- Rigorous and robust LGBTIQA+ specific clinical governance to wrap around the project is required to support the risk profile of the project and peer workers. The level of risk escalated by COVID-19 means that further resources and greater nuance are required as part of ther duty of care.

If the organisation is a mainstream mental health body:

- Partner with an LGBTIQA+ organisation. Do not attempt to roll out an Aftercare project without developing a strong partnership with an LGBTIQA+ community-controlled or community-led organisation. Aftercare partnered with Thorne Harbour Health to set up our Lived Experience Advisory Group, LGBTIQA+ LEAD. This meant that we were able to draw from the same pool of collective insights and wisdom as well as maintain accountability and build collaboration in the spirit of solidarity across the sector. Ideally, involve peer workers as well leadership in partnership meetings. Additionally, this means that Aftercare Peer Practitioners can also connect with other LGBTIQA+ peer workers, e.g. in HIV prevention or trans/gender diverse health care.
- Support Aftercare staff to create a LGBTIQA+ Suicide Prevention Community of Practice with other LGBTIQA+ mental health practitioners.

- Relationships are crucial to the long-term success of an Aftercare project. Actively nurture community leaders and networks such as smaller LGBTIQA+ organisations, local collectives and groups which support particular LGBTIQA+ groups (e.g. people who are refugees, disability advocacy, older LGBTIQA+ adults) which will provide both entry and exit referral pathways but also contribute to a broader landscape of cultural support.
- It is recommended where possible that all staff that clients come into contact with (including psychologists) identify as LGBTIQA+. This may mean that an LGBTIQA+ specific 'mini hub' forms within the organisation. If so, it is recommended that high-level management supports the autonomy of LGBTIQA+ peers to deliver culturally tailored services that are appropriate to the community.
- That the physical location of Aftercare is accessible and identity affirming. This goes beyond having a rainbow flag on the door and ensuring toilet signage is for all genders; for example, displaying LGBTIQA+ artwork and affirmative queer messages, creating a 'home' environment rather than a 'clinical' environment (which can be too reminiscent of hospital-based trauma), and LGBTIQA+ specific resources are available for clients to use or take home. For example, developing a community library that LGBTIQA+ folks with thoughts of suicide can take home or contribute to that includes life-affirming messages from Peer Practitioners.
- Have consistent high-level awareness, promotion and support of LGBTIQA+ mental health throughout all levels of organisation i.e. executive, communication teams, strategic branding / awareness and support to ensure the program does not get 'lost in the noise' of the wider sector and that Aftercare practitioners are not fighting on multiple fronts.

<u>Service Delivery</u>

Peer work

- There is more to peer work than simply sharing the same categorical experience as the client. Ensure that Peer Practitioners are at a point of recovery that participating in frontline suicide prevention is genuinely sustainable for them and the surrounding working environment promotes sustainable mental health, including adequate remuneration and role clarity.
- Consider hiring peer workers that reflect the demographics of referrals. Some clients do not mind or want a client belonging to a similar identity as them, however we found that trans/gender diverse/non binary clients strongly preferred to see another trans peer worker and older gay men preferred to connect with other gay men similarly aged.
- Prioritise the 'matching' process of client and peer worker as it partly determines the success of the program for that individual.
- Consider reasonable flexible working conditions for peer workers, such as working from home when needed and understanding lateness in the broader context of a peer workers mental health. That said, professional standards can foster a sense of containment in what can be a highly complex working environment.
- Have a model of supervision which includes both internal clinical supervision and the option of external supervision with a qualified mental health social work supervisor or psychology supervisor for peer workers that is separate from line management.
- Consider engaging another peer work organisation or LGBTIQA+ community leader to provide peer group supervision on a monthly basis.
- Provide regular professional development opportunities that include LGBTIQA+ specific learnings.

LGBTIQA+ clients with thoughts of suicide

- Integrate local LGBTIQA+ community feedback on Aftercare referral forms. For example, referral forms or intake procedures that use binary language, do not acknowledge chosen family, and do not ask explicit questions about preferred pronouns and preferred names are not appropriate.
- Do not underestimate the harm of misgendering a client. Ensure that peer workers and psychologists are familiar with a new client's pronouns. Train staff to kindly and confidently 'repair' the relationship with the client if this rupture in rapport occurs.
- When possible, allow potential clients to self-refer. This encourages people who may not be linked into other services or have not disclosed to others their sexuality to engage in the program using a pseudonym.
- Ensure strong communication occurs with the referrer including detailed information about level of risk, client's previous attempts to get help, supports and strengths. Sometimes clients may under-report suicidal ideation on measures such as this SIDAS due to misconceptions about being turned away from services. Validate the clients distress as 'serious enough' to warrant care.
- Immediately triage client on waitlist if they are at acute risk with an assertive outreach procedure.
- Minimise waitlist times. Ideally, clients should complete intake within 2 working days from referral.
- Be aware for the potential complexity of clients who present to an Aftercare service. Ensure trauma-informed advisors, supervisors and systems are in place to competently and intersectionally meet the needs of someone who may be experiencing extreme difficulty across multiple domains or has a long history of service use.
- Understand the impact of stigma on clients and how stigma may mediate help-seeking. Train staff in recognising countertransference and deconstructing stigmatising attitudes to particular clients, especially those living with borderline personality disorder and chronic suicidality. Compassion needs to be Aftercare's guiding practice principle.
- Clients may disengage for a variety of reasons, including feeling better, accessing another service, or simply running out of phone credit. Peer Practitioners may not feel confident with assertive follow up; if that is the case, ensure follow up, exit referral and end-of-Aftercare journey reflections/feedback occurs via the Lead Practitioner or Aftercare psychologist if a client has disengaged and is ascertained to be safe.
- Healing after a suicide attempt or thoughts of suicide does not follow a single trajectory; it ranges between individuals. For some people, 3 months of care may not be sufficient. Allocate resources to reflect a proportion of individuals who may require 6 months or longer of Aftercare services, particularly psychology.
- Equip clients to manage their own mental health and thoughts of suicide long term. This may include 'care boxes' composed of a customised safety plan (including crisis phone support), sensory items such as weighted blankets or essential oils, books, notes of support from other community members, and phone credit.

<u>Data and risk management</u>

- Many members of the LGBTIQA+ community have had difficult experiences in clinical environments such as hospitals or psychiatric settings. If collecting clinical intake information such as the K-10, reflect on the necessity of the information and if it can be alternatively garnered via semi-structured interview rather than a likert scale. Given the prior experiences of Peer Practitioners, it adds to a lack of role clarity and can be distressing for Peer Practitioners to be administering such tests and data-driven questions as it may feel like colluding with

systems that were involved in traumatic incidents. This should be done by the psychologist and avoid a 'telling the story' again overlap where possible. Future iterations of Aftercare should include consideration of appropriate tools for community.

- Do not assume clients are safely 'out' to GPs and other supports. Always check with them first regarding what kind of information to disclose and to not disclose in collaborative relationships. Consider creating two letterheads/notice of attending the Aftercare program – one which identifies the service as LGBTIQA+ specific and one which does not.
  Ensure client data is encrypted, secure and not stored on a centralised system that could risk 'outing' clients.
- Establish a Clinical Governance Committee. The majority of members in the initial proposed clinical governance committee were otherwise unavailable or had not maintained connection with Mind Australia following the original Aftercare proposal. Rather than establish a clinical governance committee as per the original proposal, THH and Aftercare developed a Lived Experience Advisory Group (LGBTIQA+ LEAD). Clinical feedback occurred through regular meetings between the Aftercare Peer Practitioners and psychologists. We were able to receive some clinical support from advisors, however, ultimately more was required. It is recommended that future versions of Aftercare include the establishment of a clinical governance committee in order to improve service efficacy, maintain cultural safety and ensure the personal safety of clients to a best practice standard. This would include well-established LGBTIQA+ mental health practitioners and medical professionals who have availability for both committee meetings and the occasional ability to sit in on a case conference. More resources are needed in order to fully develop this preventative measure.
