LGBTIQ+ SUICIDE PREVENTION TRIAL

Overall Trial Evaluation |

Evaluation Report

IMPACT — CO.

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ACKNOWLEDGEMENT

We wish to acknowledge Aboriginal and Torres Strait Islander Peoples as Traditional Custodians of the lands, waters and winds across Australia and pay our respects to Elders past and present, and emerging young leaders.

We acknowledge the sorrow of the Stolen Generations and the impact of colonisation on Aboriginal and Torres Strait Islander Peoples. We recognise the ongoing pain and trauma inflicted to this day on Aboriginal and Torres Strait Islander Peoples.

We also would like to pay our respects to those amongst the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and other gender and sexually diverse communities who have contributed towards promoting equality and improving the health and wellbeing of their peers, children, families, friends, and Country. We honour the Elders in the diverse communities of which we are a part of and we celebrate the extraordinary diversity of people's bodies, genders, sexualities, relationships and other forms of identities that they represent.

Finally, we would like to acknowledge and recognise the contributions from individuals and communities who have generously shared their lived experience, knowledge, and wisdom to inform this evaluation.

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GLOSSARY OF TERMS

Bisexual	A person who is romantically and or/sexually attracted to more than one sex or gender.
Gay	A person who primarily experiences romantic and/or sexual attraction to people of the same sex and/or gender.
Gender identity	One's personal sense of their own gender. The physical features one is born with (sex assigned at birth) does not necessarily define their gender. Gender is complex and there are a diverse range of gender identities.
Intersectionality	Intersectionality is a framework that recognises the multi-dimensional nature of human existence. It recognises that people can have multiple, co-existing identities that shape how they perceive and relate with the world around them and at its core, fosters inclusion and promotes diversity.[1]
Intersex	People who are born with a broad range of physical or biological sex characteristics that do not fit medical norms determined for female and male bodies. There are many different variations of sex characteristics, for some these include chromosomes, hormones and anatomy.
Lesbian	A woman who primarily experiences romantic and/or sexual attraction to other women.
LGBTIQ+	Abbreviation of Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and other gender and sexually diverse individuals. Other acronyms such LGBTIQ and LGBTIQA+ are used throughout this evaluation with the same intent where it forms part of the name of an organisation, service or resource.
Mental ill-health/mental illness	A clinically diagnosed health issue that affects how a person feels, thinks, behaves, and interacts with other people
Peer support	Peer support refers to support that is delivered based on shared lived experience to provide care and support for others. Peer workers in the

[1] Reynolds V. Intersectionality [Internet]. Intersect; 2010. Available from: http://www.lgbtiqintersect.org.au/learning-modules/intersectionality/

	mental health space can use their own experiences of mental illness and recovery to engage and support people accessing mental health care. In the context of peer LGBTIQ+ workers, the specific experiences that one can have due to their sexuality and/or gender identity can help to provide a safer, more open environment for other LGBTIQ+ individuals. Due to these common life experiences, peer workers can foster authenticity, safety, advocacy, inclusion and community within their work.
Postvention	Activities and intervention related to supporting and helping people bereaved by suicide. This may include counselling, support groups, support from medical professionals etc. This aims to reduce the heightened risk of those bereaved by suicide and promote healing.
Queer	A term to broadly describe diverse gender identities and sexual orientations, particularly where someone feels other terms do not fully encapsulate all parts of their own gender and/or sexual identity.
Sexual orientation	Describes the romantic and/or sexual attraction that a person feels toward other people.
Suicidal ideation	A state of extreme anxiety or pain in which a person is seriously contemplating or planning to end their life.

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Background

The National Suicide Prevention Trial was a suicide prevention initiative funded by the Commonwealth Government across 12 different sites across Australia over a 4-year timeframe. Each of the trials sites were led by a local Primary Health Network (**PHN**) and aimed to improve the current evidence base around effective suicide prevention strategies for priority population groups and the broader population.

The trial site led by the North Western Melbourne PHN (**NWMPHN**) was focused on LGBTIQ+ communities in the North West of Melbourne (referred from here on as the '**Trial**'). Recognising the lack of evidence-based suicide prevention frameworks/models for LGBTIQ+ communities, the Trial was collaboratively designed by NWMPHN, the Taskforce (which is a group of LGBTIQ+ people, people with a lived experience of mental ill-health and suicide, and representatives from the mental health and suicide prevention service system that was actively involved in the Trial) and the Black Dog Institute. A community-specific systems-based suicide prevention framework (referred hereon in as the '**Trial Framework**') was designed by drawing on the Lifespan Model developed by the Black Dog Institute, the National LGBTI Health Alliance Mental Health and Suicide Prevention Framework, NWMPHN's Mental Health System of Care and other available evidence and effective suicide prevention strategies for LGBTIQ+ communities.

Overview of Trial

The Trial Framework was used to inform the identification of the 8 interventions that make up the Trial. These interventions are identified below:

1. *Aftercare* – Providing support to a person after a suicide attempt or someone who is experiencing suicidal ideation.
2. *Postvention* – Developing a Suicide Postvention Response Plan for LGBTIQ+ communities to support the broader community and/or organisations that have experienced the loss of an LGBTIQ+ person to suicide.
3. *LGBTIQA+ Mentoring Projects* – Providing mentoring and peer support to LGBTIQ+ individuals, groups and their families.
4. *Capacity Building* – Delivering LivingWorks Start, safeTALK and ASIST training to individuals across the North Western Melbourne region that play a role in suicide prevention and intervention for people who are LGBTIQ+.
5. *LGBTIQ+ Affirmative Practice* – Delivering training to first responders and frontline health and social service providers to build their capacity in providing affirming care.
6. *Peer and Community Leaders* – Researching the role of peer and community leaders in providing mental health crisis support to LGBTIQ+ communities and identifying ways to better support them.
7. *Campaign* – Conducting a marketing campaign within the North Western region of Melbourne to encourage the broader community to take action against discrimination towards LGBTIQ+ communities.
8. *Wellness Grants* – Offering small grants to encourage local organisations to implement initiatives that (i) support greater inclusion for LGBTIQ+ communities, (ii) address stigma/discrimination and (iii) raise the awareness of effective suicide prevention initiatives.

Evaluation objectives

Impact Co. was engaged to undertake an evaluation of the Trial and address the 3 key evaluation questions that were agreed with NWMPHN:

- *Design* - To what extent was the Trial designed effectively?
- *Implementation* - To what extent was the Trial implemented effectively?
- *Outcomes* - To what extent were the intended outcomes of the Trial achieved?

Evaluation findings

The findings from the evaluation are summarised below according to each of the evaluation questions identified above.

Design - To what extent was the Trial designed effectively?

The Trial was found to have been designed effectively by accurately reflecting the needs of LGBTIQ+ communities and the state of the mental health and suicide prevention service system in the North West of Melbourne. This was driven by the co-design, systematic and evidence-informed approach adopted to design the Trial:

- *Co-design:* The design of the Trial was identified to be underpinned by a lived experience as it was driven by the Taskforce, which comprised of people who are LGBTIQ+, people with a lived experience of mental ill-health and/or suicide, and the organisations that work with them. On balance, Taskforce members were able to contribute in equal manner to inform the direction of the Trial. However, there were certain barriers that made it challenging for certain individuals to engage. These barriers included the size of the Taskforce and not proactively addressing power imbalances within the Taskforce.
- *Systematic:* The Trial was designed in a holistic manner, recognising that a multiple levers/factors would need to be addressed to drive change for LGBTIQ+ communities.
- *Evidence-base:* The Trial was effectively informed by a combination of (i) lived experience from people who are LGBTIQ+ and people with mental ill-health/lived experience of suicide; and (ii) leading practice suicide prevention frameworks and other relevant evidence.

The evaluation findings around the design of the Trial are explored in more detail in Section 7 of this report.

Implementation - To what extent was the Trial implemented effectively?

The Trial was found to have been delivered effectively using a Collective Impact model. The evaluation findings around the implementation of the Trial are summarised below according to the 5 elements of Collective Impact (i.e. common agenda, continuous communications, mutually reinforcing activities, backbone infrastructure and shared measurements).

- *Common agenda:* The objectives of the Trial were clearly communicated, but the role of the Taskforce could have been further clarified.

- *Continuous communications*: There was effective communication throughout the Trial, particularly between NWMPHN and each of the commissioned organisations.
- *Mutually reinforcing activities:* The Trial activities were found to complement one another and were aligned to the objectives and desired outcomes of the Trial. There were however missed opportunities to better collaborate and share knowledge across the Trial.
- *Backbone infrastructure:* NWMPHN played a critical role in supporting the outcomes of the Trial by collaborating effectively with the Taskforce and commissioned organisations and effectively supporting the coordination of activities across the Trial.
- *Shared measurements:* NWMPHN was identified to have been able to effectively monitor the progress of the funded activities, whilst empowering and providing commissioned organisations with sufficient autonomy to leverage their own expertise and experience. However, embedding evaluation earlier on in the implementation of the Trial would have enabled more effective assessment of the funded activities and capturing of the outcomes achieved.

The evaluation findings around the implementation of the Trial are explored in more detail in Section 8 of this report.

Outcomes - To what extent were the intended outcomes of the Trial achieved?

The Trial effectively met the needs of the LGBTIQ+ communities and suicide prevention service system in the North West of Melbourne. It was also found to have achieved the following short and long-term outcomes that aligned with the intended outcomes of the Trial:

Timeframe	Outcomes achieved
Short-term outcome	**Knowledge and understanding:** The Trial has led to a deeper understanding of the needs of LGBTIQ+ communities and how to deliver effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities
	Awareness: The Trial has led to better awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities
	Relationship: The Trial has helped to strengthen the sense of community connection among people who are LGBTIQ+ and partnerships between organisations that support LGBTIQ+ communities
	Capacity: The Trial has led to an increase in capacity for LGBTIQ+ communities, service providers and to a lesser extent the general community. Collectively, this has helped to increase the overall capacity of the service system to provide effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities.
Longer-term outcome	**Stigma** The Trial has helped to or will likely reduce stigma against LGBTIQ+ communities in the longer-term
	Resilience: The Trial has helped to or will help to enhance the resilience of LGBTIQ+ communities in the longer-term.

	Self-harm and suicidality: The Trial will lead to lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities in the longer-term

Across the Trial there were critical themes that enabled/supported the outcomes identified on the previous page. These *enabling themes* are identified below:

1. **Community-specific –** The Trial was deliberately designed to be safe and fit-for-purpose for LGBTIQ+ communities, recognising that mainstream suicide prevention models were not appropriate for LGBTIQ+ people.
2. **Co-design** – The relevant stakeholders (i.e. people who are LGBTIQ+, people with a lived experience of mental ill-health and/or suicide, and the organisations that work with them) were engaged and empowered to drive the design of the Trial.
3. **Involving peers in service delivery** – Peers were actively involved in the delivery of a number of interventions, enhancing the sense of safety and efficacy of the services provided.
4. **Collaborative relationship between commissioning agent and commissioned organisations** – Trust and mutual respect between the NWMPHN project team and the commissioned organisations enabled all parties to effectively navigate the unexpected issues and challenges that arose during the Trial.
5. **Commissioning community-controlled organisations** – Community-controlled organisations who were commissioned to deliver on the interventions brought a number of unique strengths that helped to enhance the outcomes achieved through the Trial.

On the other hand, there were also themes that limited the outcomes achieved or made it more challenging for them to be realised. These *limiting themes* are outlined below:

1. **Co-design** – There is still room to improve the way people with a lived experience are engaged and embedded in co-design. This includes:
   - Proactively addressing potential power imbalances
   - Better taking into consideration intersecting identities
2. **Staff safety –** There were instances during the Trial where LGBTIQ+ staff safety was not sufficiently prioritised, adversely impacting their experience and wellbeing. This typically occurred in situations where there were LGBTIQ+ individuals working within a mainstream organisation.
3. **Nature of the Trial –** The time-limited nature of the Trial created further uncertainty in the service system, making it difficult for individuals to navigate an already complex service system and reinforce the notion that the service system is not willing to make long-term investment into creating safe and culturally-appropriate services for people who are LGBTQ+.

The evaluation findings around the outcomes of the Trial and the enabling and limiting themes identified above are explored in more detail in Section 9 of this report.

Recommendations

NWMPHN, along with other PHNs, operates at the intersect of the funding and policy reform environment and the local service system. Operating within these two domains, NWMPHN plays the following three, key roles (as depicted in the diagram below):

- Advocacy – Amplifying voices from the local community and service system to inform new policy and funding reforms;
- Commissioning – Identifying service gaps and needs in the community, and procuring services and programs to address them; and
- System enabler – Strengthening the capacity of the service system and its constituents.

***Note**:* It is understood that the roles identified above are not mutually exclusive, meaning that there are instances where an activity may fit under multiple roles. Because of this, the roles are intended to provide a frame in which to understand how the recommendations from the evaluation can help to inform the work of NWMPHN moving forward.

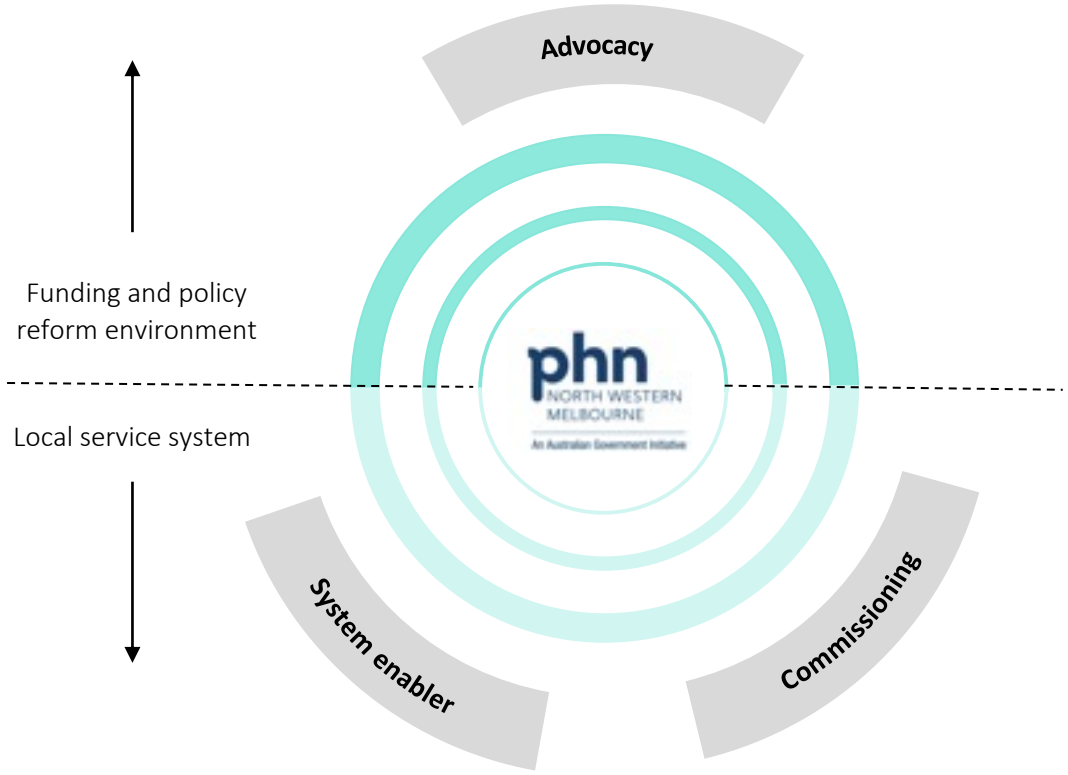

Figure 1 - Role of NWMPHN across the funding and policy context and local service system

The recommendations for this evaluation are categorised according to the 3 roles described above and summarised below:

Role	Outcomes achieved
Advocacy	**Recommendation 1:** Advocating across all levels of Government and amongst other PHNs to collectively prioritise the needs of LGBTIQ+ communities across Victoria and Australia
	Recommendation 2: Advocate for longer-term funding structures
Commissioning	**Recommendation 3:** Continue to prioritise supporting LGBTIQ+ communities in future commissioning efforts
	Recommendation 4: Embed co-design across all stages of the commissioning process
	Recommendation 5: Proactively adopt an intersectional lens to service/program design and implementation
	Recommendation 6: Prioritise community-controlled organisations in future commissioning efforts
	Recommendation 7: Define a set of guiding principles to inform future commissioned programs/services for LGBTIQ+ communities
	Recommendation 8: Empower commissioned organisations and build collaborative relationships
	Recommendation 9: Strengthen project management approaches to maintain continuity of thinking
System enabler	**Recommendation 10:** Invest to build capacity at the system and organisational level
	Recommendation 11: Embed evaluation in programs/services earlier on
	Recommendation 12: Proactively share learnings from this Trial

These recommendations are explored in more detail in Section 10 of this report.

CONTEXT AND INTRODUCTION

1. PURPOSE

The purpose of this document is to outline the evaluation findings and recommendations for future consideration from Impact Co.'s overall evaluation of the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and other gender and sexually diverse (**LGBTIQ+**) Suicide Prevention Trial (**Trial**) being implemented by the North Western Melbourne Primary Health Network (**NWMPHN**).

Note: As this specific reports explores the Trial in its entirety (rather than the specific interventions that make up the Trial), this report should be read in conjunction with the intervention-specific evaluation reports.

2. CONTEXT

LGBTIQ+ people are at a higher risk of self-harm and suicidality compared to the general population.[2] There are significant limitations that exist in Australia to determine how many LGBTIQ+ people die by suicide each year. However, a large survey of Trans and Gender Diverse (**TGD**) young people in Australia, aged 14-25, found that almost half (48.1%) had attempted suicide and 79.7% had self-harmed.[3] This compares to a rate of attempted suicide within the general population of approximately 3.6%.[4] In addition, recently published data from the US reports that LGBTIQ+ young people aged 12-29 accounted for 24% of all people nationally who died by suicide.[5] This rate is more than seven times the estimated proportion of the population who are LGBTIQ+ in the US. These rates have been attributed to everyday and systemic and institutionalised experiences of discrimination, violence and harassment.[6,7,8,9] The higher rates of suicide among LGBTIQ+ communities discussed above is exacerbated by a higher prevalence of mental ill-health and psychological distress. According to the Private Lives 3 survey, bisexual and pansexual participants had poorer mental health and higher levels of psychological distress compared to lesbian or gay participants. Conversely, cis-gendered participants had overall better mental health than those who identify as trans or non-binary.[10]

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[2] QLife. Suicide prevention: A QLife guide for health professionals [Internet]. Suicide prevention and LGBTI people. Available from: https://qlife.org.au/uploads/17-Suicide-Prevention.pdf

[3] Strauss P, Cook A, Winter S, Watson V, Wright Toussaint D, Lin A. Associations Between Negative Life Experiences and the Mental Health of Trans and Gender Diverse Young People in Australia: Findings from Trans Pathways. Psychol Med. 2019:1-10.

[4] Johnston AK, Pirkis JE, Burgess PM. Suicidal Thoughts and Behaviours Among Australian Adults: Findings from the 2007 National Survey of Mental Health and Wellbeing. Australian & New Zealand Journal of Psychiatry. 2009;43(7):635-43.

[5] Ream GL. What's Unique About Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth and Young Adult Suicides? Findings From the National Violent Death Reporting System. J Adolesc Health. 2019;64(5):602-7.

[6] Leonard W, Pitts M, Mitchell A, Lyons A, Smith A, Patel S, et al. Private Lives 2: The second national survey the health and wellbeing of GLBT Australians. Melbourne, VIC: Australian Research Centre in Sex, Health & Society & La Trobe University; 2012.

[7] Leonard W, Lyons A, Bariola E. A Closer Look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians. Melbourne, VIC: Australian Research Centre in Sex, Health & Society & La Trobe University; 2015.

[8] Perales F. The health and wellbeing of Australian lesbian, gay and bisexual people: a systematic assessment using a longitudinal national sample. Aust N Z J Public Health. 2019;43(3):281-7.

[9] Kay B. Lesbian, gay, bisexual, and transgender health issues, disparities, and information resources. Med Ref Serv Q. 2011;30(4):393-401.

[10] Hill A, Bourne A, McNair R, Carman M, Lyons A. Private Lives 3 The health and wellbeing Of Lgbtiq People in Australia. Melbourne: La Trobe University; 2020.

Having a sexual orientation, gender identity or intersex status that goes beyond the cis-gendered and heteronormative narrative in itself is not a risk of suicide or poorer mental health.[11] The drivers behind the increased risk relate to societal factors including stigma, prejudice, and discrimination.[12] In a healthcare setting, LGBTIQ+ people face significant barriers when accessing services, which may lead to delays in seeking medical help and decreased use of services. A recent mixed methods study was conducted by Australian Research Centre in Sex, Health and Society (ARCSHS) in partnership with Lifeline Australia to explore the needs of LGBTIQ+ people during a time of personal or mental health crisis. This research (which included 472 participants) highlighted key barriers to accessing safe crisis support services as well as counselling and mental health support services. These barriers primarily revolved around experiences of discrimination and perceptions of lack of safety, as a result of widespread 'heterosexism' that is common within healthcare practices.[13] The environment (the institutional micro-climate) of mainstream healthcare delivery, where medical models of sex and gender prevail and assumptions regarding sexual orientation are founded on heteronormative paradigms, increase the reluctance of LGBTIQ+ patients to disclose their sexual or gender identities and reduce help-seeking behaviour.[14] Consequently, failures to screen, diagnose and treat important medical problems may arise and the inhibition of providing whole-of-person care, in itself a form of discrimination, perpetuate the discrepancies in health outcomes and general wellbeing.[15] Overall, mainstream medical services were the most frequently type of health service visited by LGBTIQ+ people.[16] However, this type of service was associated with lowest proportions of people who felt that their sexual orientation or gender identity was 'very or extremely' respected. This was compared to other forms of health services including those that cater exclusively for LGBTIQ+ communities and mental health services. It is worth noting that the experience of discrimination and safety concerns varied substantially between different gender identities, sexual orientations and individuals with an intersex variation within LGBTIQ+ communities. Overall, gender identity was less respected in mainstream health services than sexual orientation; people who identified as transgender or intersex reported higher incidences of unconscious and unintentional bias and discrimination and fewer reports of acceptance.[17]

It is important to recognise that experiences of discrimination and lack of safety in healthcare settings, may also be influenced by other factors including (but not limited to) patient age, race, location, and whether they have a disability.[18] Intersectionality is a framework that recognises the multi-dimensional nature of human existence.[19] It recognises that people can have multiple, co-existing identities that shape how they perceive and relate with the world around them and at its

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[11] QLife. Suicide prevention: A QLife guide for health professionals [Internet]. Suicide prevention and LGBTI people. Available from: https://qlife.org.au/uploads/17-Suicide-Prevention.pdf

[12] QLife. Suicide prevention: A QLife guide for health professionals [Internet]. Suicide prevention and LGBTI people. Available from: https://qlife.org.au/uploads/17-Suicide-Prevention.pdf

[13] Victorian Department of Health. Community health pride: A toolkit to support LGBTIQ+ inclusive practice in Victorian community health services. Melbourne: Victorian Government; 2021. Available from: https://www.vgls.vic.gov.au/client/en_AU/search/asset/1301510/0.

[14] Gay and Lesbian Rights Lobby. In their own words: Lesbian, gay, bisexual, trans* and intersex Australians speak about discrimination. Department of Prime Minister and Cabinet; 2013.

[15] Australian Medical Association. AMA Position statement: Sexual diversity and gender identity [Internet]; 2002. Available from: https://www.ama.com.au/media/ama-position-statement-sexual-diversity-and-gender-identity.

[16] Palotta-Chiarolli M, Sudarto B & Tang J. Navigating intersectionality: Multicultural and multifaith LGBTIQ+ Victorians talk about discrimination and affirmation. Melbourne: AGMC/MASC/DPC; 2021.

[17] Hill A, Bourne A, McNair R, Carman M, Lyons A. Private Lives 3 The health and wellbeing Of Lgbtiq people in Australia. Melbourne: La Trobe University; 2020.

[18] Hughes M. Health and well being of lesbian, gay, bisexual, transgender and intersex people aged 50 years and over. *Australian Health Review*. 2018;42(2):146.

[19] Reynolds V. Intersectionality [Internet]. Intersect; 2010. Available from: http://www.lgbtiqintersect.org.au/learning-modules/intersectionality/

core, fosters inclusion and promotes diversity. It allows for understanding that a person may experience multiple forms of overlapping oppression or challenges and how these may vary across different contexts such as in healthcare or workplace settings.[20] LGBTIQ+ people who also identity as youth, culturally or linguistically diverse, Aboriginal and Torres Strait Islander as well as those who have a disability, live in remote or rural areas, or are experiencing homelessness are some examples where concurrent identities shape the experience of being a LGBTIQ+ person in Australia.[21] People at the nexus of multiple identities have higher risks of psychological distress and discrimination may require extra support protect their mental and physical health and wellbeing.[22]

Developmental stressors including the disclosure of identity are also known to contribute to a higher suicide risk, particularly in younger LGBTIQ+ people. Research has highlighted that young LGBTIQ+ people aged 16-27 years are more than five times more likely to report attempting suicide.[23] This age group encompasses the late adolescent and early adulthood period where the development of multiple identities arise and distress surrounding 'coming out' occurs.[24] At this time, young LGBTIQ+ people may experience feelings of low self-worth, isolation, shame and internalise homophobia.[25] It is important to recognise that many young people have a history of attempting suicide prior to disclosure.[26]

Compounding the impact of a higher prevalence of psychological distress and history of suicide attempts by people within LGBTIQ+ communities, a majority of people do not seek help in a crisis.[27] The reasons for this are complex and multifaceted. Low rates of help seeking behaviour may reflect systemic issues relating to service access, which includes the anticipation of discrimination, as well as the impact of prior experiences with crisis or non-crisis support services (mainstream and LGBTIQ+ inclusive), and other physical, financial and technological factors. According to an Australian-based survey of LGBTIQ+ people, perceptions around being 'queer enough' and concerns about safety, confidentiality, and difficulties regarding seeking support from someone with a similar background or lived experience are additional contributors to low crisis support use.[28]

The factors contributing to a higher prevalence of mental ill-health and suicide among LGBTIQ+ individuals identified above (i.e. stigma and discrimination towards people who are LGBTIQ+; lack of nuanced understanding of the needs of LGBTIQ+ individuals in mainstream healthcare settings; and low help-seeking behaviour) have informed the design and development of the Trial which is discussed in more detail in the sections below.

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[20] Palotta-Chiarolli M, Sudarto B & Tang J. Navigating intersectionality: Multicultural and multifaith LGBTIQ+ Victorians talk about discrimination and affirmation. Melbourne: AGMC/MASC/DPC; 2021.

[21] Hill A, Bourne A, McNair R, Carman M, Lyons A. Private Lives 3 The health and wellbeing Of Lgbtiq people in Australia. Melbourne: La Trobe University; 2020.

[22] Victorian Government. Intersectionality [Internet]. Delivering the reform for Victoria's diverse communities. Victorian Government; 2020. Available from: https://www.vic.gov.au/family-violence-reform-rolling-action-plan-2020-2023/reform-principles/intersectionality

[23] Suicide Prevention Australia. Fact Sheet: LGBTIQ+ suicide prevention [Internet]; 2021. Available from: https://www.suicidepreventionaust.org/wp-content/uploads/2021/02/Fact-Sheet-LGBTIQ-Populations.pdf

[24] Skerret DM, Kolves K & De Leo D. Suicidal behaviours in LGB populations: A literature review of research trends. Brisbane: Australian Institute for Suicide Research and Prevention; 2012.

[25] LGBTIQ+ Health Australia. A snapshot of mental health and suicide prevention strategies for LGBTIQ+ people [Internet]; 2021. Available from: https://d3n8a8pro7vhmx.cloudfront.net/lgbtihealth/pages/549/attachments/original/1620871703/2021_Snapshot_of_Mental_Health2.pdf?1620871703

[26] QLife. Suicide Prevention: A QLife guide for health professionals [Internet]. Suicide prevention and LGBTI people. Available from: https://qlife.org.au/uploads/17-Suicide-Prevention.pdf

[27] Suicide Prevention Australia. Fact Sheet: LGBTIQ+ suicide prevention [Internet]; 2021. Available from: https://www.suicidepreventionaust.org/wp-content/uploads/2021/02/Fact-Sheet-LGBTIQ-Populations.pdf

[28] Waling A, Lim G, Dhalla S, Lyons A & Bourne A. Understanding LGBTI+ lives in crisis. Australian Research Centre in Sex, Health & Society Lifeline Research Foundation. La Trobe University & Lifeline Australia; 2019.

3. 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 general population and priority population groups.

NWMPHN was leading 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 LGBTIQ+ communities;
- Increase the available evidence base on effective suicide prevention strategies for LGBTIQ+ 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 LGBTIQ+ communities

NWMPHN worked closely with a LGBTIQ+ people, people with a lived experience of mental ill-health and suicide and representatives from the mental health and suicide prevention service system (referred to as the '**Taskforce'**) to co-design the Trial in order to meet the objectives above and designed the individual interventions that collectively make up the Trial.

Impact Co. was engaged to undertake an evaluation of the overall Trial and the 8 interventions that are part of the Trial.

TRIAL OVERVIEW

4. TRIAL OVERVIEW

4.1 Background

Recognising the lack of evidence-based suicide prevention frameworks/models for LGBTIQ+ communities, the Trial was collaboratively designed by NWMPHN, the Taskforce the Black Dog Institute (noting that Lifespan Model developed by the Black Dog Institute underpinned a large number of the Commonwealth and State-based suicide prevention trials that were implemented). Through a series of co-design workshops in August and September 2017, a community-appropriate systems-based suicide prevention framework (referred hereon in as the '**Trial Framework**') was designed by drawing on the Lifespan Model developed by the Black Dog Institute, the National LGBTI Health Alliance Mental Health and Suicide Prevention Framework and NWMPHN's Mental Health System of Care.

This Framework is presented below:

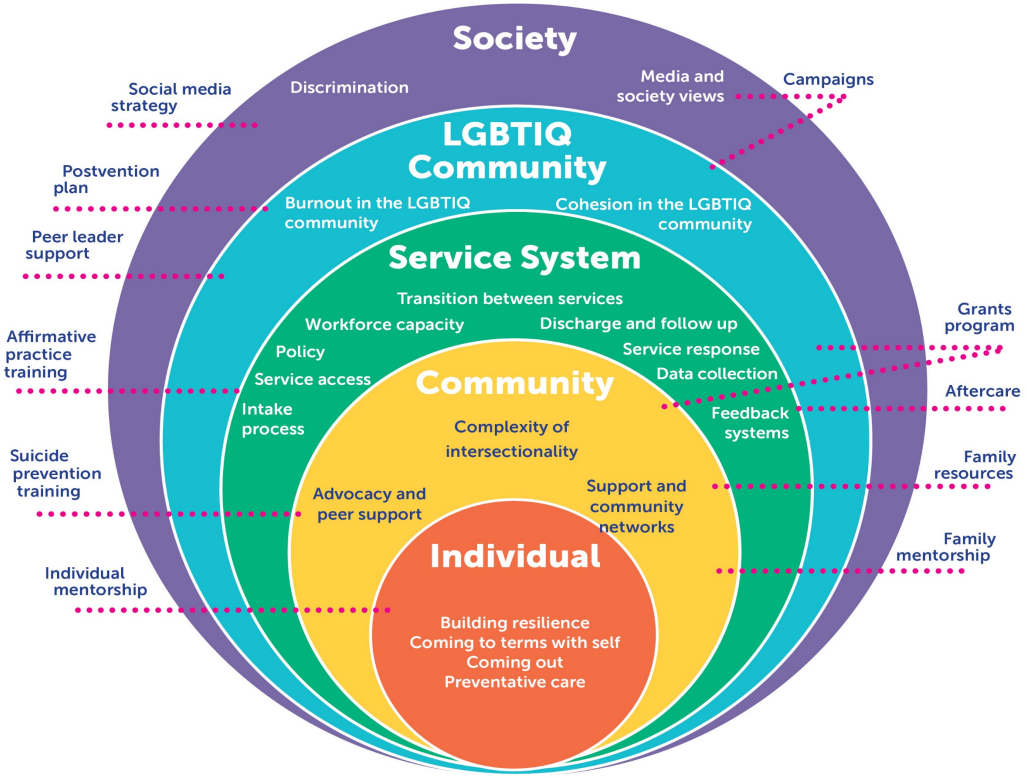


Figure 2 - Trial Framework developed by the Taskforce

The Trial Framework was used to inform the identification of the 8 interventions that make up the Trial. These interventions along with the organisation that has been commissioned by NWMPHN to deliver the intervention are identified below:

Intervention	Commissioned organisation
Aftercare – Providing support to a person after a suicide attempt or someone who is experiencing suicidal ideation	Mind Australia
Postvention – Developing a Suicide Postvention Response Plan for LGBTIQ+ communities to support the broader community and/or organisations that have experienced the loss of an LGBTIQ+ person to suicide	Switchboard
LGBTIQA+ Mentoring Projects – Providing mentoring and peer support to LGBTIQ+ individuals, groups and their families	drummond street services
Capacity Building – Delivering LivingWorks Start, safeTALK and ASIST training to individuals across the North Western Melbourne region that play a role in suicide prevention and intervention for people who are LGBTIQ+	LivingWorks
LGBTIQ+ Affirmative Practice – Delivering training to first responders and frontline health and social service providers to build their capacity in providing gender affirming care	Thorne Harbour Health
Peer and Community Leaders – Researching the role of peer and community leaders in providing mental health crisis support to LGBTIQ+ communities and identifying ways to better support them	Australian Research Centre in Sex, Health and Society (**ARCSHS**) at La Trobe University
Campaign – Conducting a marketing campaign within the North Western region of Melbourne to encourage the mainstream community to take action against discrimination towards LGBTIQ+ communities	The Shannon Company
Wellness Grants – Offering small grants to encourage local organisations to implement initiatives that (i) support greater inclusion for LGBTIQ+ communities, (ii) address stigma/discrimination and (iii) raise the awareness of effective suicide prevention initiatives	Various* ***Note:*** * 9 separate organisations have been awarded grants as part of this intervention.

Table 1 - Description of Trial interventions

4.2 Trial output

The Trial achieved the following outputs across the 8 interventions

	Trainers trained	Individuals trained	Individuals supported	Community members reached	Research projects completed
Mind Australia Aftercare			50		
Switchboard LGBTIQA+ Suicide Postvention Response Plan					1
drummond street LGBTIQA+ Mentoring Projects			237		
LivingWorks Start, LGBTIQ+ safeTALK and LGBTIQ+ ASIST	26	472			
Thorne Harbour Health Affirmative Practice	45	1,687			
ARCSHS Lean on Me research					1
The Shannon Company Speaking Up Speaks Volume Campaign				APPROX. 2,500	
Various Wellness grants		62		75	
TOTAL	71	2,159	287	APPROX. 2,500	2

Table 2 - Trial intervention output

4.3 Timeframe

The Trial commenced in June 2017, with the establishment of the Taskforce and design of the framework for the Trial; and concluded in June 2021. The evaluation started in December 2019 and concluded in September 2021.

EVALUATION OVERVIEW AND CONTEXT

5. EVALUATION OVERVIEW

5.1 Objective

The diagram below depicts the evaluation of the Trial. There are two key elements to the evaluation:

- The first element focuses on the evaluation of the Trial in its entirety. This explores (i) how NWMPHN and the Taskforce contributed to the design of the Trial, (ii) the relationship between interventions and (iii) how the interventions collectively contribute to the desired outcomes of the Trial; and
- The second element focuses on the evaluation of the 8 interventions identified on the previous page that make up the Trial.

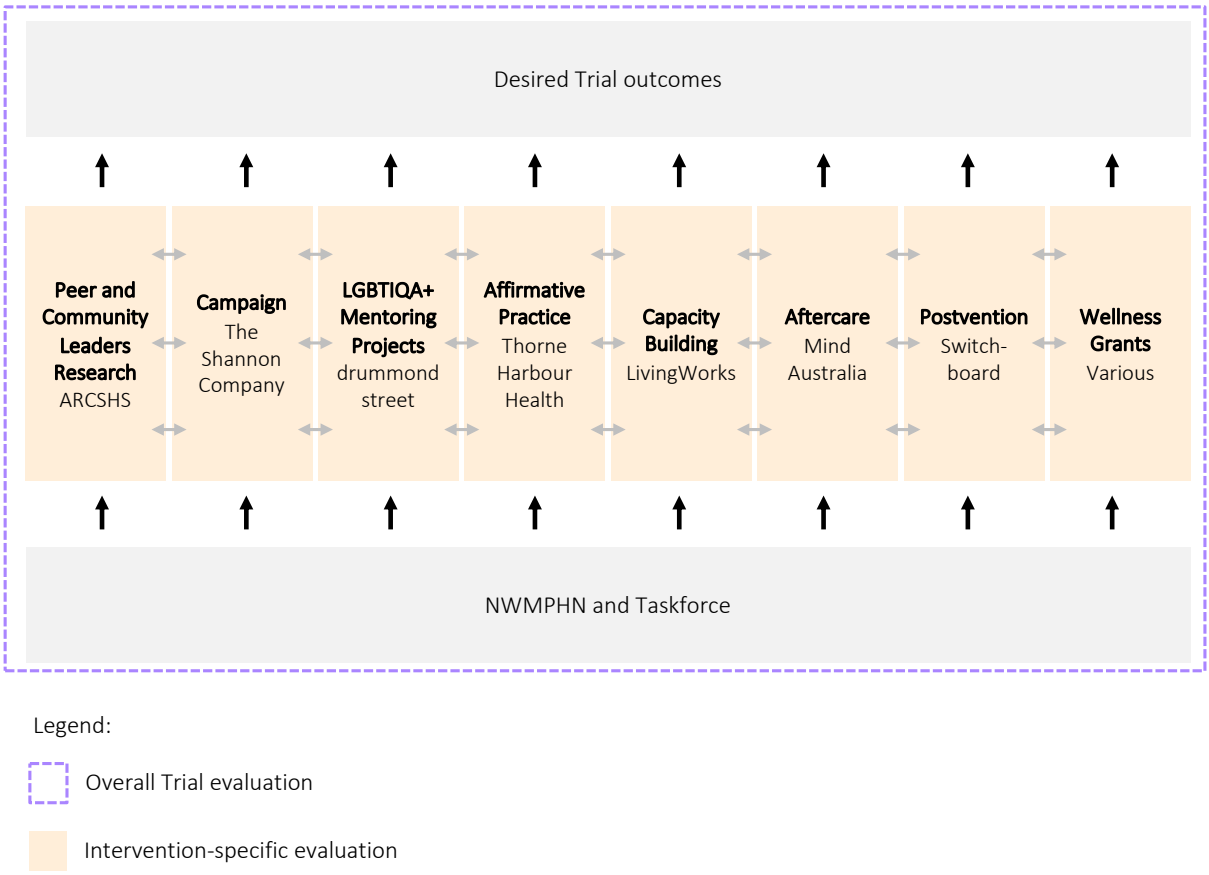


Figure 3 - Key elements of the evaluation of the Trial

As noted in Section 1, this evaluation report specifically relates to the Trial in its entirety and should be read in conjunction with the 8 other intervention-specific reports.

The objectives of the evaluation of the Trial are identified below:

- Assess the quality of the intervention design and implementation;
- Determine the contribution that the co-design process makes to the quality of the intervention;
- Determine the significance of the relationship between the components of the framework;
- Determine the quality of the partnerships with, and collaboration between, stakeholders within the Trial; and
- Inform ongoing program design and delivery and policy development.

In order to address the objectives above, the following, 3 evaluation questions were identified and agreed with NWMPHN:

- Design - To what extent was the Trial designed effectively?
- Implementation - To what extent was the Trial implemented effectively?
- Outcomes - To what extent were the intended outcomes of the Trial achieved?

The table below describes how the evaluation questions above address the objectives of the evaluation (noting that some of the evaluation objectives will be addressed through the intervention-specific evaluations).

Evaluation objectives	Evaluation question			
	To what extent was the Trial designed effectively?	To what extent was the Trial implemented effectively?	To what extent did the Trial achieve its intended outcomes/ objectives?	Intervention-specific evaluation questions
Assess the quality of the intervention design and implementation			X	X
Determine the contribution that the co-design process makes to the quality of the intervention	X	X		X
Determine the significance of the relationship between the components of the framework	X	X	X	
Determine the quality of the partnerships with, and collaboration between, stakeholders within the Trial	X	X		
Inform ongoing program design and delivery and policy development	X	X	X	X

Legend:

Overall trial evaluation

Intervention-specific evaluation

Figure 4 - Evaluation questions

5.2 Evaluation participants

There are 4 participant groups involved in the evaluation of the Trial:

1. NWMPHN – NWMPHN received funding from the Commonwealth Government to commission the Trial. It initiated the establishment of the Taskforce to help inform the design of the Trial and also led the process of commissioning the relevant service providers to deliver each of the interventions.
2. Taskforce – The Taskforce evolved from the NWMPHN LGBTI Mental Health and AOD Service Provider's Network that was in place before the National Suicide Prevention Trials were implemented by the Commonwealth Government. The Taskforce consists of LGBTIQ+ individuals with a lived experience of mental ill-health and suicidal ideation; service providers supporting LGBTIQ+ communities (including both mainstream service providers and LGBTIQ+ community-controlled organisations), research institutions and advocacy bodies. The membership of the Taskforce is identified in more detail below:

    - drummond street services
    - Thorne Harbour Health (VAC)
    - Transgender Victoria
    - Bisexual Alliance
    - St. Vincent's Hospital
    - Merri Health
    - Carers Victoria
    - Mind Australia
    - headspace
    - Switchboard
    - EQUINOX
    - Orygen
    - Minus 18
    - YSAS
    - Vic Transcultural Mental Health
    - Sunbury Cobaw Community Health
    - Australian Research Centre in Sex, Health and Society
    - Family Safety Victoria
    - Representatives with lived experience

3. Commissioned organisations – These are the organisations that were funded to deliver on each of the Trial's interventions. In total 16 organisations were funded through this Trial.
4. Intervention beneficiaries – These are the individuals/communities that are the cohorts of focus for each of the interventions.

Input from all 4 stakeholder groups were leveraged to develop this evaluation report. Quotes from the different stakeholder groups are provided throughout this evaluation report using the following colour-coding

Stakeholder group	*Colour-coding for quotes*
Quote from a NWMPHN staff	
Quote from a Taskforce member	
Quote from a commissioned organisation	
Quote from an intervention beneficiary	

5.3 Approach

The approach to undertaking the evaluation for the Trial is depicted at a high-level below.

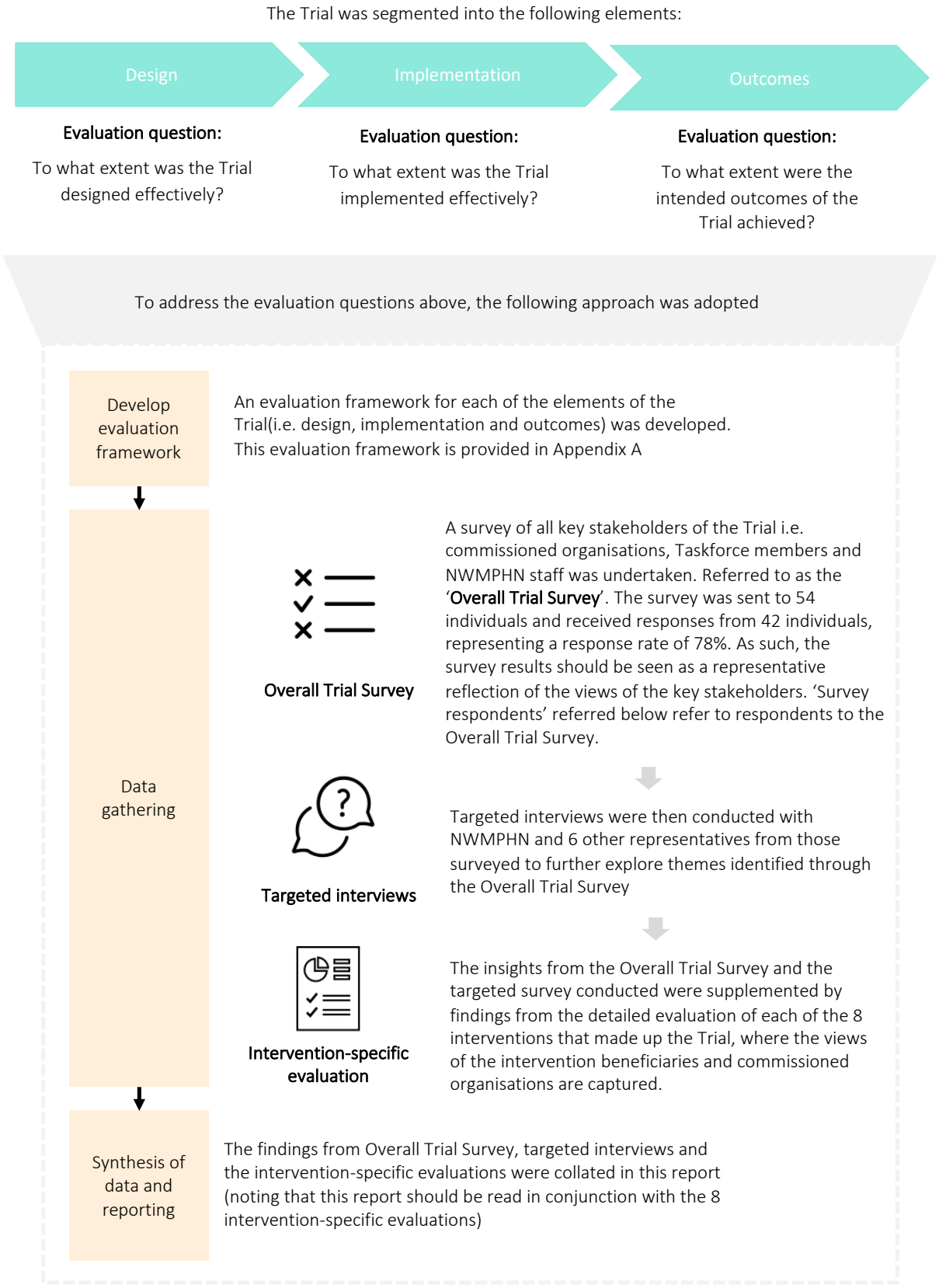


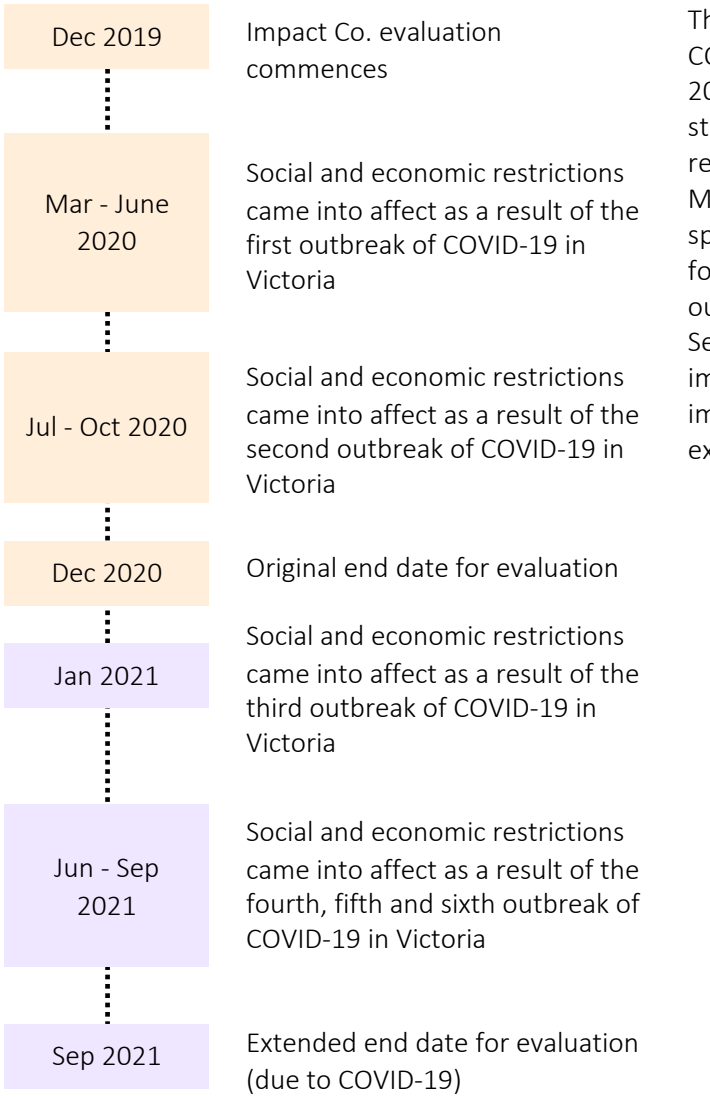
Figure 5 - Overview of evaluation approach

Additional detail on our approach is provided in Appendix A.

6. EVALUATION CONTEXT

There are a number of external contextual factors that have impacted this evaluation. These are identified below and should be noted when considering the findings of the evaluation outlined in Sections 7 - 9 of this report:

6.1 COVID-19 pandemic



There was an outbreak of the COVID-19 virus in Victoria in early 2020, which ultimately led to stringent social and economic restrictions being put in place in March 2020, to slow down the spread of the virus. This was then followed by a number of other outbreaks between July 2020, and September 2021, severely impacting this evaluation. The impacts of these restrictions are explored further below:

Figure 6 - Timeline of evaluation

- *Delays to the delivery of the Program* - The restrictions put in place as a result of COVID-19 meant that in-person interactions had to be limited as much as possible. This forced the commissioned organisations and Impact Co. to adapt the design of the interventions and evaluation respectively to take place in a virtual environment, where engagements were primarily conducted via teleconference or phone. There were significant implementation challenges with this, particularly during the early stages of the transition process where new processes and systems had to be developed and established in a very short time. This resulted in a period of hiatus for a number of the interventions and the evaluation as workarounds to the restrictions were being put in place, limiting the amount of information gathered within the timeframe for this evaluation.

- *Delay of evaluation* – The completion of this evaluation was extended to 30 September 2021 to take in consideration the impacts of COVID-19.
- *Limited ability to engage* – Social interaction, community access and business activity were severely limited between March 2020 and December 2020 due to the COVID-19 restrictions. This had a significant impact on the general mental health and wellbeing of the broader community and made it a very challenging time for intervention beneficiaries. As a result, only a limited amount of consultation and data gathering was able to be conducted to inform the findings of this evaluation.

6.2 Trial and system-wide initiatives impacts

There were a number of other initiatives outside the National Suicide Prevention Trial targeting LGBTIQ+ communities in the North West of Melbourne. It is likely that these other initiatives would have had some impact on the participants of the Program, and consequently the findings of this evaluation. Due to the broad nature of these initiatives (and most other programs and services delivered in the health and social services sector), it is difficult to assess the extent to which these other initiatives have impacted the Trial. As such, it should be noted the outcomes identified through this evaluation may not be fully attributed to the activities of this Trial only.

6.3 Deaths by suicide within LGBTIQ+ communities

There were a number of unfortunate deaths by suicide of LGBTIQ+ people in late 2020, resulting in a significant outpouring of grief and support from LGBTIQ+ communities. In respect and recognition of the difficult news, the data gathering activities as part of this evaluation were put on hold during the month of December 2020 and resumed again in late January 2021 to allow the community sufficient time to grieve and the local LGBTIQ+-specific service providers, such as Switchboard and Thorne Harbour Health to focus on supporting the community.

EVALUATION FINDINGS

7. EVALUATION FINDINGS – DESIGN

7.1 Evaluation overview – Trial Design

This section of the report outlines the findings in relation to the design of the Trial, addressing the following evaluation question:

Leading practice indicates that interventions are most effective where they are co-designed, recognise the broader system in which the intervention takes place, and are informed by the best evidence:

- Co-design
  Effective intervention design should be tailored to the needs of the intervention recipients[29]. One of the many advantages of the co-design process is that it recognises that particular community groups are not homogeneous and should be supported in way that takes into consideration their intersecting identities. For example, the needs of LGBTIQ+ people from CALD communities are varied even within the broader umbrella of LGBTIQ+. Co-design emphasises the need to prioritise user perspectives and preferences in the design of an intervention and involving them in critical decision-making processes, deliver 'agency, advocacy and real-world impact' in the process.[30]

- Systematic
  A systems approach to solving complex problems is commonly applied to a range of problems in health and other sectors across the world.[31] A systems approach acknowledges the multi-faceted nature of problems and takes into account a broad range of perspectives, drivers and levers in order to develop more robust solutions at the same time as enabling those stakeholders to own the process and outcomes. The LifeSpan Model by BDI is an example of a systems approach to addressing suicide that brings together various elements of a service system and community (e.g. clinicians, emergency services, schools etc), to provide a holistic approach to reducing suicidality.[32]

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[29] Bailey J, Mann S, Wayal S, et al. Sexual health promotion for young people delivered via digital media: a scoping review. Southampton (UK): NIHR Journals Library; 2015 Nov. (Public Health Research, No. 3.13.) Chapter 3, Considerations for the design and development of interventions. Available from: https://www.ncbi.nlm.nih.gov/books/NBK326992/

[30] VicHealth. How co-design delivers agency, advocacy and real-world impact. Available from: https://www.vichealth.vic.gov.au/letter/articles/vh-letter-45-co-design.

[31] OECD (2017), Systems Approaches to Public Sector Challenges: Working with Change, OECD Publishing, Paris, https://doi.org/10.1787/9789264279865-en.

[32] Black Dog Institute, Suicide Prevention Implementation. Available from: https://www.blackdoginstitute.org.au/education-services/suicide-prevention-implementation/

- Evidence-based
  A critical element of effective design in healthcare interventions, particularly in an environment where the is a need to ensure public funding is appropriately targeted, is ensuring that interventions reflect are informed by evidence (recognising that evidence can come in multiple forms)[33]. Forms of evidence can include practice evidence (i.e. evidence gained through working with a particular cohort or within a specific sector), lived experience evidence, research and data.[34]

The elements above provide the framework to evaluate the design of the Trial. The table below outlines this framework in more detail:

Overarching evaluation question	Element	Sub-questions to explore
To what extent was the Trial designed effectively?	Co-design	Was the design of the Trial adequately driven by people who are LGBTIQ+?
		Was the design of the Trial adequately driven by people with a lived experience of mental ill-health and suicide?
		Did everyone on the Taskforce have an equal voice (i.e. was everyone's input equally considered and respected) and were they able to contribute in an equitable manner to the design of the Trial?
		Was there sufficient diversity (e.g. sexual identity, gender identity, cultural background etc) in the composition of the Taskforce?
		Were the right people (i.e. with the relevant expertise and experience) involved in the Taskforce to inform the design of the Trial?
	Systematic	Did the design of Trial effectively take into consideration the needs of LGBTIQ+ communities in the North West of Melbourne?
		Are there gaps in the design of the Trial?
	Evidence-based	Was the design of the Trial adequately informed by research and contemporary practice?

Table 3 - Evaluation questions for the design of the Trial

[33] Brownson, R. C., Fielding, J. E., & Maylahn, C. M. (2009). Evidence-based public health: A fundamental concept for public health practice. Annual Review of Public Health, 30(1), 175–201.

[34] Suomi A, Freeman B & Banfield M. Framework for the engagement of people with a lived experience in program implementation and research. Australian National University. Available at: https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/anu-lived-experience-framework.pdf

7.2 Summary of findings – Trial Design

The table below provides a summary of the findings in relation to the design of the Trial

Element	Finding
Co-design	**Finding 1:** The Trial was adequately led by people who identify as LGBTIQ+ and, to a lesser extent, people with a lived experience of mental ill-health and suicide.
	Finding 2: On balance, Taskforce members were able to contribute in equal manner to discussions. However, there were certain barriers that made it challenging for certain individuals to engage, including the size of the Taskforce and lack of proactive addressing of power imbalances.
	Finding 3: There was diverse representation of members on the Taskforce, but there could have been a greater focus on intersectionality to ensure that other forms of identities were appropriately represented
	Finding 4: The individuals who informed the design of the Trial had the necessary expertise and experience
	Finding 5: The design of the Trial (including the adaptation of the BDI Lifespan Model) reflected the needs of LGBTIQ+ communities in the North West of Melbourne
	Finding 6: The Trial was designed in way that considered the state of the mental health and suicide prevention service system in the North West Melbourne
Systematic	**Finding 7**: The Trial was designed as a system, recognising that a multiple levers/factors would need to be addressed to drive change for LGBTIQ+ communities.
	Finding 8: The scale of change required to adequately transform the service system to address the needs of LGBTIQ + communities effectively and safely is significant and cannot be fully addressed through a time-limited, catchment-specific series of interventions.
Evidence-based	**Finding 9:** The Trial was informed by a combination of (i) lived experience from people who are LGBTIQ+ and people with mental ill-health/lived experience of suicide; (ii) leading practice suicide prevention frameworks and other relevant evidence.

Table 4 - Summary evaluation findings for the design of the Trial

7.3 Detailed findings – Trial Design

The findings related to the design of the Trial are presented in more detail below.

Co-design

Finding 1: The Trial was adequately led by people who identify as LGBTIQ+ and, to a lesser extent, people with a lived experience of mental ill-health and suicide.

There was strong agreement that the Trial was led by people who are LGBTIQ+, referencing the individuals on the Taskforce who were LGBTIQ+. This result indicates that the Trial was true to its commitment to be underpinned by co-design principles; and reflected leading practice in 'community-led' approaches.

94% of people agreed with the statement below.

Statement: The design of the Trial is adequately driven by people who are LGBTIQ+

[n = 36 responses (out of 42 survey respondents)]

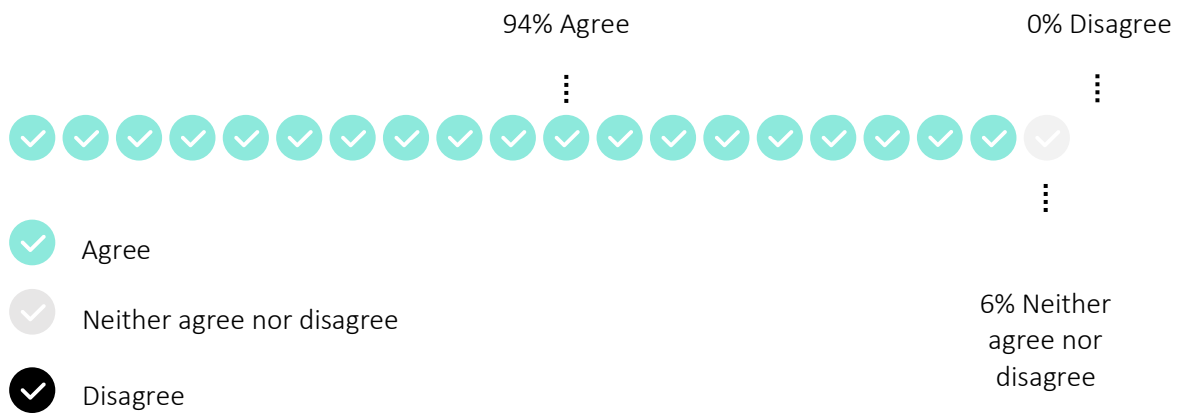


Figure 7 - Extent of agreement with " The design of the Trial is adequately driven by people who are LGBTIQ+"

> *"*One of the biggest outcomes of the trial was giving LGBTIQA+ people an opportunity to lead suicide prevention initiatives." – *Commissioned organisation*

There was also agreement that those with a lived experience of mental ill-health and suicide informed the design of the Trial. Although the extent of agreement by survey respondents was lower than the above finding 79% of respondents still agreed with the statement below.

Statement: The design of the Trial is adequately driven by people with a lived experience of mental ill-health and suicide

[n = 34 responses (out of 42 survey respondents)]

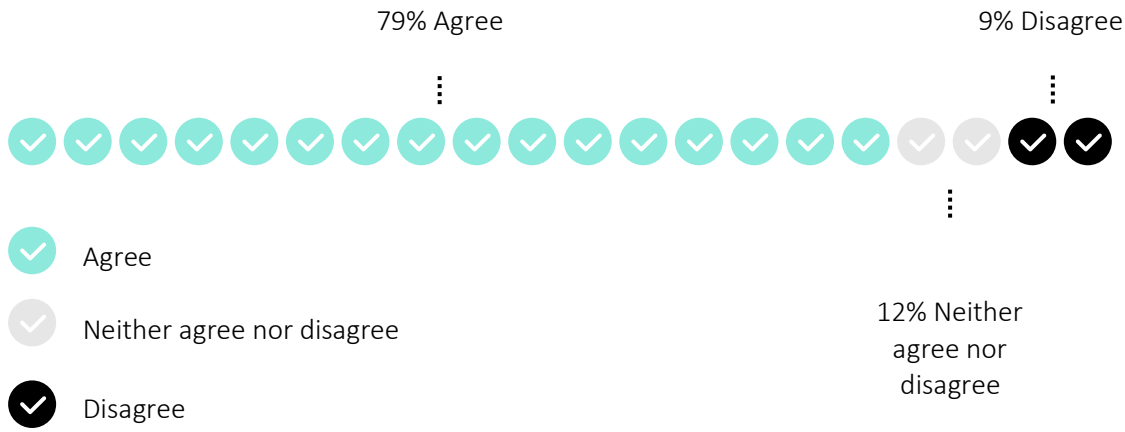


Figure 8 - Extent of agreement with " The design of the Trial is adequately driven by people with a lived experience of mental ill-health and suicide"

Despite the agreement that the Trial was adequately driven by people who are LGBTIQ+ and people with a lived experience of mental ill-health and suicide, it should be noted that staff turnover within the Taskforce, NWMPHN and comissioned service providers made it challenging for continuity of thinking to be maintained between personnel changes, adversely impacting the perception of co-design.

"I came on board once the tender had been arranged with my organisation, as a new staff member, meaning I was not part of the design phase therefore unable to engage with co-design of the trial. We began our own co-design, with pre-determined goals and interests (i.e. handed a top down approach from the trial at the head of decision-making)" – Commissioned organisation

"There was no continuation in the original Taskforce group, which made it feel a bit lost. It felt like the project was getting passed from one group to another without having the same people there from the start"– Commissioned organisation

Finding 2: On balance, Taskforce members were able to contribute in equal manner to discussions. However, there were certain barriers that made it challenging for certain individuals to engage, including the size of the Taskforce and lack of proactive addressing of power imbalances.

Respondents also broadly agreed that that everyone had an equal voice in the Taskforce, but this view was not universal. Based on the responses to the Overall Trial survey, only 71% agreed with the below statement and over a quarter of respondents identified that they were either neutral on or disagreed with the statement below.

Statement: Everyone on the Taskforce had an equal voice (i.e. everyone's input was equally considered and respected) and was able to contribute in an equitable manner to the design of the Trial

[n = 28 responses (out of 42 survey respondents)]

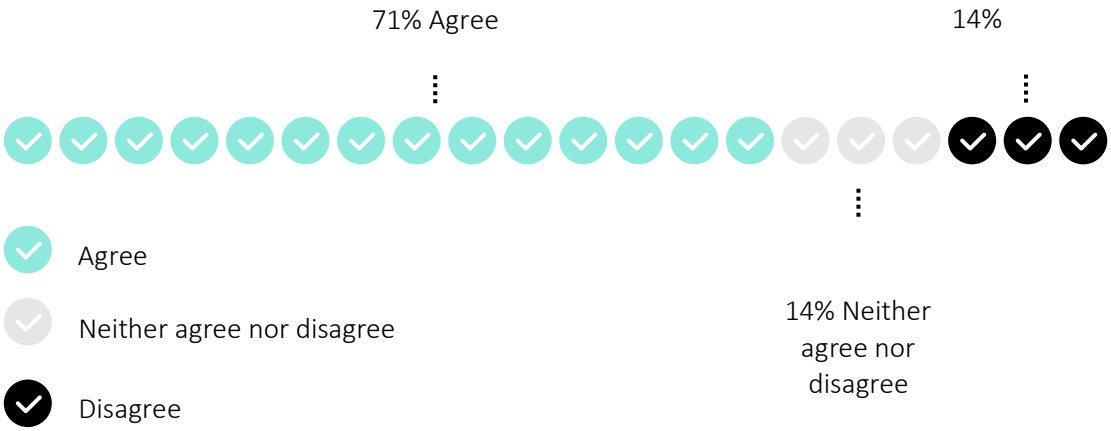


Figure 9 - Extent of agreement with " Everyone on the Taskforce had an equal voice (i.e. everyone's input was equally considered and respected) and was able to contribute in an equitable manner to the design of the Trial"

It was identified that there were a number of challenges for some members of the Taskforce to contribute effectively to discussions:

- *Size of the Taskforce* - The membership of the Taskforce was identified to be upwards of 30 individuals, making it difficult for everyone to be able to meaningfully contribute and provide input on a regular basis. It also made it challenging for certain individuals to feel comfortable to engage in such a large forum (noting that NWMPHN did make attempts to create smaller settings for engagement through activities such as World Cafe during Taskforce meeting).

> "The taskforce intended to be a bringing together of different voices from within the LGBTIQA+ community yet it was too large to function as a working body or provide members with opportunities for growth and learning through their participation" – *Commissioned organisation*

> "The Taskforce was so large that I didn't even know who was on it" – *Taskforce member*

- *Power imbalance* – There was a lack of focus on proactively addressing potential power imbalances that may exist within the Taskforce, limiting the contribution that certain individuals felt comfortable making during discussions. Power can be interpreted through a myriad of lenses and be expressed in many different ways. Traditionally in projects such as these, the main lens of power applied is to consider those with and without identified lived experience. However, power can also take the form of (i) social power and privilege (e.g. power due to cultural background, education and language); and (ii) positional power (e.g. power due to an individual's position within an organisation), among many other forms. It was identified that more could be done to address differences in power that existed among the Taskforce (e.g. by proactively giving opportunities to particular individuals to contribute and explicitly calling out the power imbalances that exist).

> *"*If we (people from marginalised backgrounds) are not put at the centre and deliberately given an opportunity to contribute, we will continue to be at the margins" *– Taskforce member*

> *"It can be sometimes difficult to contribute when there are CEOs and peer workers in the same room" – Taskforce member*

Finding 3: There was diverse representation of members on the Taskforce, but there could have been a greater focus on intersectionality to ensure that other forms of identities were appropriately represented

On balance, it was identified that there was sufficient diversity (e.g. sexual identity, gender identity, cultural background etc) in the composition of the Taskforce as identified through the level of agreement received from the Overall Trial Survey for the statement below:

Statement: There was sufficient diversity (e.g. sexual identity, gender identity, cultural background etc) in the composition of the Taskforce

[n = 30 responses (out of 42 survey respondents)]

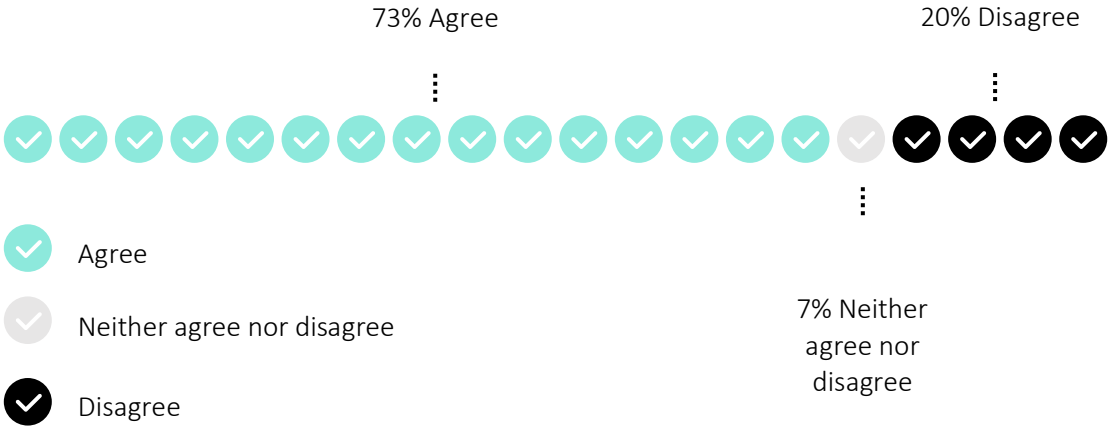


Figure 10 - Extent of agreement with " There was sufficient diversity (e.g. sexual identity, gender identity, cultural background etc) in the composition of the Taskforce"

However, it should be noted that this statement did receive higher levels of disagreement in comparison to other statements in the Overall Trial Survey. When explored further, it was identified that whilst there was a focus on ensuring appropriate diversity from the perspectives of (i) sexual orientation; (ii) gender diversity and (iii) lived experience of suicide, there were still limitations/gaps with the overall diversity of the Taskforce. In particular, the following was identified:

- There was an over-representation of individuals who are already active contributors to the mental health and suicide prevention service system, highlighting the limited number of 'experts' in suicide prevention within LGBTIQ+ communities.
- There was a lack of focus on intersectionality and a lack of representation of individuals of other intersecting identities such as different ages, faiths, abilities, geographies and other forms of identities on the Taskforce.

> *"The design relied heavily on the White normative LGBTIQA+ identities. It lacks cultural diversity and intersectionality. It's only mentioned as a buzz word without a proper exploration and understanding on the topic, with minimum meaningful participation from individuals with intersecting identities in relation to culture, faith, ethnicity, and LGBTIQA+ identities" – Taskforce member*

> "The trial design was good. There were some groups not represented or not represented adequately" – *Taskforce member*

Finding 4: The individuals who informed the design of the Trial had the necessary expertise and experience

Responses to the Overall Trial Survey indicate that the Trial was informed by the right mix of people, who had the necessary capability and experience (including lived experience). This reflects the efforts made by NWMPHN to bring together leading organisations and individuals across the sector and community to participate in the design process.

82% of survey respondents agree with the statement below:

Statement: The right people (i.e. with the relevant expertise and experience) were involved in the Taskforce to inform the design of the Trial

[n = 35 responses (out of 42 survey respondents)]

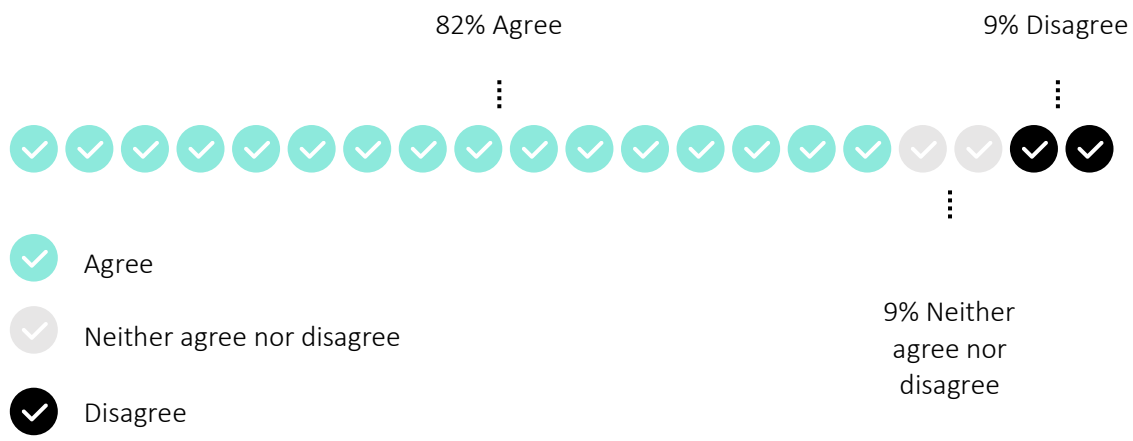


Figure 11 - Extent of agreement with "The right people (i.e. with the relevant expertise and experience) were involved in the Taskforce to inform the design of the Trial"

Finding 5: The design of the Trial (including the adaptation of the BDI Lifespan Model) reflected the needs of LGBTIQ+ communities in the North West of Melbourne

Another strength of the Trial was highlighted to be the adaptation of the BDI Lifespan Model to the unique needs of LGBTIQ+ communities in the NWMPHN region. The recognition that LGBTIQ+ communities required a more nuanced approach to suicide prevention that is different to mainstream suicide prevention models led to a number of positive outcomes through the Trial (see Section 9 on outcomes below).

89% of respondents agreed that the needs of the LGBTIQ+ communities in North West Melbourne were effectively considered.

Statement: The design of Trial effectively takes into consideration the needs of LGBTIQ+ communities in the North West of Melbourne

[n = 38 responses (out of 42 survey respondents)]

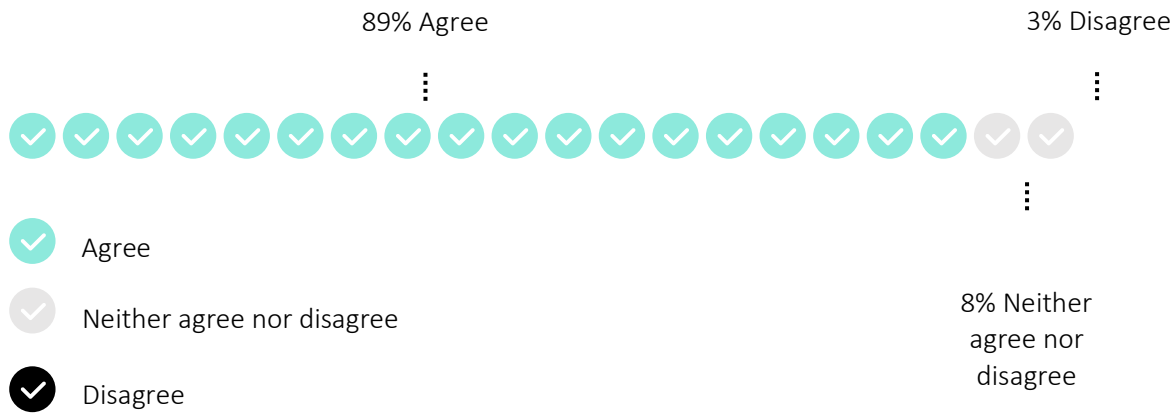


Figure 12 - Extent of agreement with " The design of Trial effectively takes into consideration the needs of LGBTIQ+ communities in the North West of Melbourne"

Systematic

Finding 6: The Trial was designed in way that considered the state of the mental health and suicide prevention service system in the North West Melbourne

The Trial reflected the current state of the mental health and suicide prevention system as one which doesn't have an LGBTIQ+ - specific suicide prevention/intervention service and lacks safety for LGBTIQ+ individuals.

79% of survey respondents agreed with the statement below:

Statement: The design of Trial effectively takes into consideration the state of the mental health and suicide prevention service system in the North West of Melbourne (i.e. the Trial takes into consideration the strengths and gaps of the mental health and suicide prevention service system in the North West of Melbourne)

[n = 38 responses (out of 42 survey respondents)]

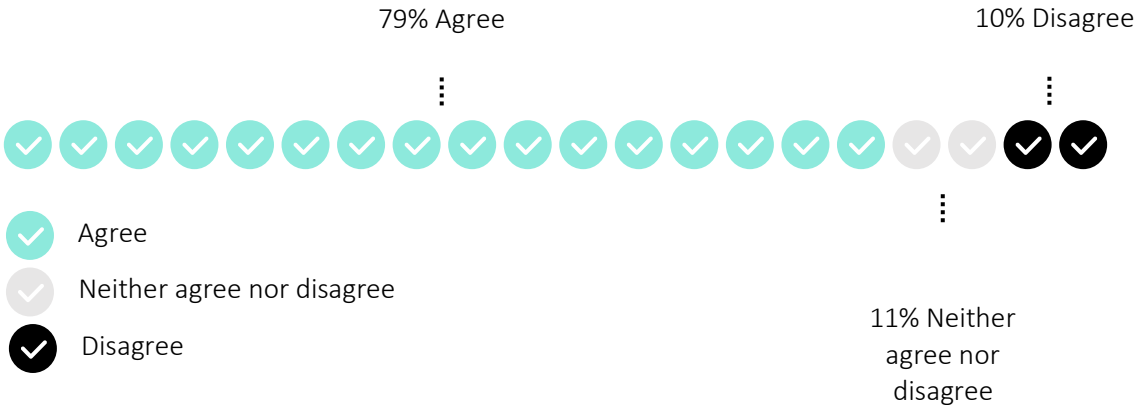


Figure 13 - Extent of agreement with "The design of Trial effectively takes into consideration the state of the mental health and suicide prevention service system in the North West of Melbourne"

Finding 7: The Trial was designed as a system, recognising that a multiple levers/factors would need to be addressed to drive change for LGBTIQ+ communities.

It was recognised that the Trial took into consideration the complexity of the issue at hand and was designed in a multi-faceted manner (as informed by the Trial Framework). The following elements were highlighted as ways the Trial operated in a systemic manner:

- Its focus across the spectrum of suicide prevention – From prevention, intervention (including early intervention) and postvention;
- Its focus on LGBTIQ+ – specific and mainstream services; and
- Its focus supporting individuals, community, service system, LGBTIQ+ communities and society (as informed by the Trial framework).

"I think the design was multifaceted and tried to strengthen a number of different areas - prevention, intervention by mainstream services and aftercare. It was well thought out" – Taskforce member

"I think the adaptation of the Lifespan model, prioritising the eleven focused interventions across five key areas (individual, community, service system, LGBTIQ community and society) was an innovative, comprehensive and inclusive approach that supported a broads suite of commissioned activities required in this area as no one way or strategy is able to respond to the dynamic and multi-faceted drivers of suicide in the Australian context" – Taskforce member

Finding 8: The scale of change required to adequately transform the service system to address the needs of LGBTIQ + communities effectively and safely is significant and cannot be fully addressed through a time-limited, catchment-specific series of interventions.

It was identified that there were gaps in the design of the Trial, with only 29% of the survey respondents agreeing that "There were no gaps in the Trial". When explored further, it was identified that this reflects the scale of work required to better support the mental health and wellbeing of LGBTIQ+ communities. As identified in the introductory section of this report, LGBTIQ+ communities are at a greater risk compared to the general population across a number of different fronts (including but not limited to the prevalence of mental ill-health, rates of self-harm and suicide and rates of discrimination). The extent of change in current practice, mindset and culture needed to ensure that LGBTIQ+ communities receive effective, appropriate and safe services is significant and cannot be underestimated. The Trial, whilst being able to achieve a number of positive outcomes, is ultimately still limited in terms of timeframe, funding and geography. This sentiment is reflected in the high levels of disagreement with the statement above. However, it should be noted that the challenges in relation to the nature of the Trial is recognised by NWMPHN. In order to address this, a number of program manuals that document the approach and learnings for the following interventions: (i) Aftercare; (ii) LGBTIQA+ Mentoring Projects; and (iii) Affirmative Practice, were developed as part of the Trial. These will be shared with other PHNs, funders, community organisations and service providers to enable other organisations to establish a similar intervention, enabling the learnings and outcomes from the Trial to be sustained beyond its lifespan.

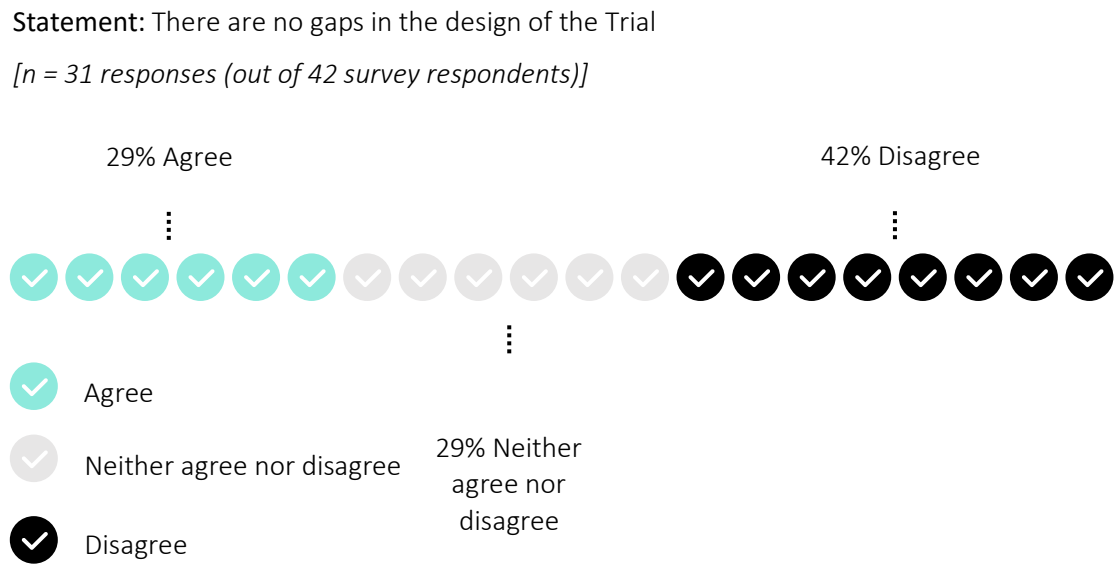


Figure 14 - Extent of agreement with "There are no gaps in the design of the Trial"

Evidence based

Finding 9: The Trial was informed by a combination of (i) lived experience from people who are LGBTIQ+ and people with mental ill-health/lived experience of suicide; (ii) leading practice suicide prevention frameworks and other relevant evidence.

76% of survey respondents agreed that the Trial was informed by research and contemporary practice overall.

Statement: The design of the Trial is adequately informed by research and contemporary practice

[n = 38 responses (out of 42 survey respondents)]

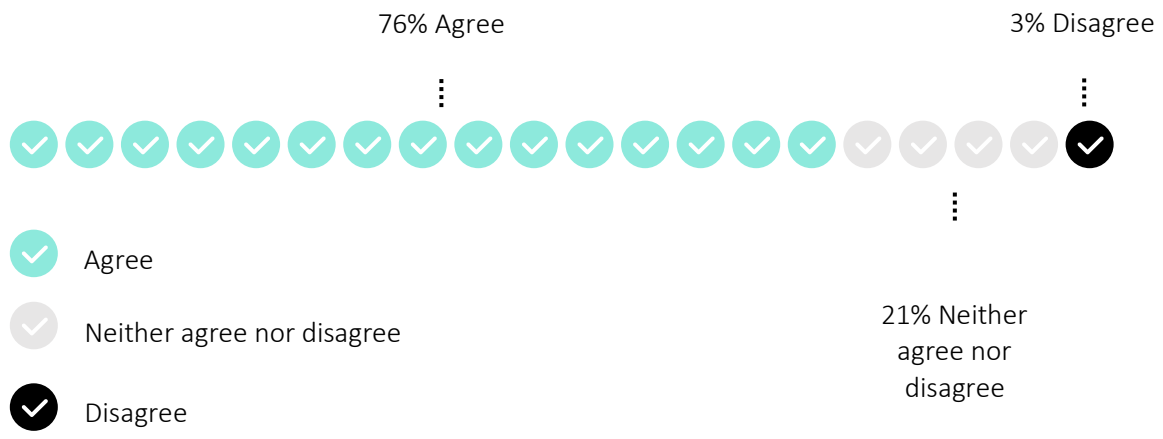


Figure 15 - Extent of agreement with "The design of the Trial is adequately informed by research and contemporary practice"

As identified previously, an extensive co-design process was adopted with the Taskforce in the design of the Trial, enabling it to be effectively informed by lived-experience (and practice-based) 'evidence'.

In addition, based on relevant documentation provided by NWMPHN (see example below), it is also understood that a structured and evidence-based approach was used to determine the different interventions that would form a part of the Trial. This included aligning interventions with leading practice suicide prevention frameworks (e.g. BDI Lifespan Model and the National LGBTI Health Alliance Mental Health and Suicide Prevention Framework) and known suicide prevention strategies that are underpinned by research and evidence.

Reference to existing suicide prevention frameworks

Reference to suicide prevention research and evidence

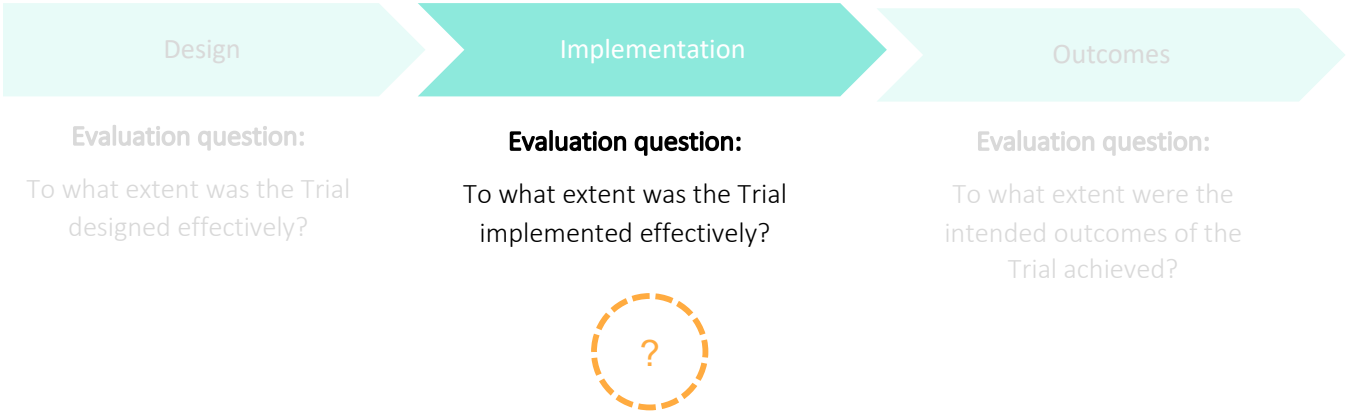
	Problems identified	Blackdog model	LGBTI Health Alliance strategy	Prioritisation considerations	Research based recommendations Evidence based interventions
Intake Process	Communication • Language – negative and assumptive, misgendering, non-affirmation of gender/LGBTI, binary service system, questions asked/not asked, needs to be in various forms (i.e. Interpreted, visual etc.), appropriate information/resources (also for family) Services • Discriminatory, not responsive or affirming. Emergency department, branding of specialist services – not knowing where one fits. Consequence • Disengage or miss out on services, increased risk	**Improving emergency and follow up care for suicidal crisis** **Using evidence based treatment for suicidality** **Equipping primary care to identify and support people in distress**	**Inclusive and Accessible Care:** LGBTI people will experience equitable access to mental health and suicide prevention services and receive support that is appropriate to their experience and responsive to their needs.	**Target Group:** Three quarters of sample reported having a regular GP (of this 69% reported GP aware of their sexuality) (PL2) LGBT people were more often getting psychiatric treatment from GPs than psychologists and psychiatrists (although this is suggested to be due to fear of discrimination (Skerrett & Mars, 2014) Building the capacity for LGBTI-mental health promotion within and beyond the mental health sector involves linkages and co-ordination between: - Mainstream mental health services - Mainstream mental health and LGBTI health and community organisations; and - Mental health and other, non-health services and programs that provide opportunities for health promotion such as: – Educational institutions – Local council programs; and – Disability, aged care and housing services. (GU) Personnel in health services are respected by young people and could play a greater role in supporting SSAGQ young people through process of disclosure. (WTI3)	**Inclusive Practice Training – mainstream services:** Health services undertake training in GLBT sensitive service delivery and promote inclusiveness through waiting room posters and service promotion. (WTI3) Health professionals need training to take sexual histories in a non-judgmental manner with young people and understand best options for referrals and information. (WTI3) GLBTI inclusive practice – mandating in all government funded health and human services (PL2) Improve services perceived to be substandard (e.g. Broadening cared beyond gender affirmative care, upskilling of current service providers and ensuring that services are safe and inclusive spaces. (TP) GP training could reduce suicide death rates by 6.3% in general population – LGBTI data unknown (Krysinska et al., 2016) LGBTI-professional development and diversity training for key workforces, Organisational leadership initiatives that model inclusion & training in mental health promotion (GU) **Inclusive Practice Training – Students:** Professional education and training programs that prepare people to provide mental health care including physical residency programs, graduate programs in nursing, psychology and social work etc. and other mental health and human services programs to develop and provide comprehensive, empirically based education about LGBTI mental health needs and suicide risk. (Haas et al, 2016) **Mental Health capacity building – LGBTI organisations** Increasing the capacity of LGBTI-health services to deliver mental health and suicide prevention programs to LGBTI people (GU) **Gatekeeper Training:** Training health professionals and gatekeepers to mental health services and the general public appears to be best practice (Skerrett & Mars, 2014)
Accessing of services	Young people • Dependant on family for advocacy and access to services, unaware of available services Rural/remote areas • Lack of services, discretion accessing services, issues with privacy and confidentiality Intersections • Low income = lack of access, access to LGBTI skilled CALD interpreters, mental health stigma Barriers • Issues with funding/waitlists/delays, Eligibility criteria does not accommodate a lot of people/identities/communities, Barriers to care and gender affirming treatment, fear/history of discrimination Lack of access • lack of known networks and service providers, Access online – even for counselling. Experience • Refusal of treatment/denial of rights, Medicalisation and pathologisation of gender and sexuality, people in inappropriate services, discrimination				
Workforce development	Skills development • Poor understanding of LGBTI issues, culture and intersections, lack of acknowledgement of trauma and family violence, focussing on wrong issues (ie AOD instead of discrimination), not asking appropriate questions, knowing how to talk about issues, unaware of available resources (inc. online)				

Figure 16 - Excerpt from Taskforce meeting output during the design stages of the Trial demonstrating the effective consideration of leading practice, research and evidence

8. EVALUATION FINDINGS – IMPLEMENTATION

8.1 Evaluation overview – Trial Implementation

This section of the report outlines the findings in relation to the implementation of the Trial, addressing the following evaluation question:



The concept of Collective Impact emphasises the importance of cross-sector coordination to achieve a common societal goal.[35] There are five key elements of the collective impact approach, which Impact Co. has leveraged to frame its evaluation of the implementation of the Trial:

- Common Agenda
  A common agenda is essentially a shared understanding of the problem, and a joint approach to solving it. Even amongst organisations that appear to have similar goals, often their approaches to achieving them vary greatly. When partnering to achieve an apparently common goal, these variances can undermine success.

- Continuous Communication
  Effective and continuous communication between parties is an important success factor of the Collective Impact model. Regular meetings, a shared vocabulary, and a sense that their interests will be considered are amongst a number of factors to a genuinely productive level of communication between stakeholders.

- Mutually Reinforcing Activities
  To create a collective impact, a diverse group of stakeholders must work together, completing activities in a coordinated manner. The activities undertaken should be mutually reinforcing and build on one another, rather than operating in silos.

- Backbone Infrastructure
  Coordinated activities between separate organisations requires backbone infrastructure to support them. The Collective Impact framework considers the 'backbone' to be a separate organisation that can project manage and coordinate the collective effort.

[35] Kania, John, and Mark Kramer. "Collective Impact." *Stanford Social Innovation Review* 9, no. 1 (2011): 36–41. https://doi.org/10.48558/5900-KN19.

- Shared Measurement
  The common agenda, and overall effectiveness of the effort, relies significantly on a shared measurement system. This system (and supporting infrastructure / organisation) will collect data and measurements consistently, and communicate the results back to those participating in the effort.

The Trial, in bringing together various stakeholders (from people with a lived experience, to service providers and research institutions) to work towards the shared goal of addressing suicide rates among people who are LGBTIQ+ in the North West of Melbourne, with the coordination support of NWMPHN as the backbone organisation, closely resembled a Collective Impact initiative. As such, the 5 Collective Impact elements describe provides a framework to evaluate the implementation of the Trial.

The table below outlines this framework in more detail:

Overarching evaluation question	Element	Sub-questions to explore
To what extent was the Trial implemented effectively?	Common agenda	Was there a shared understanding of the objectives and desired outcomes for the Trial?
		Was there clarity around the role of the Taskforce to support the outcomes for the Trial?
	Continuous Communication	Was there effective communication throughout the Trial?
	Mutually reinforcing activities	Were the activities implemented as part of the Trial aligned to the Trial's objectives and desired outcomes?
		Did the activities implemented as part of the Trial complement one another?
		Was there effective collaboration and integration between the activities of the Trial?
		Was there effective knowledge sharing throughout the Trial?
	Backbone infrastructure	Did NWMPHN work in a collaborative manner with the Taskforce?
		Did NWMPHN work in a collaborative manner with the funded organisations (i.e. organisation that received funding as part of the Trial)?
		Were the funded organisations (i.e. organisation that received funding as part of the Trial) effectively held

		accountable to deliver on their contracted obligations during the Trial?
		Was NWMPHN's approach to monitoring and managing the progress of funded activities effective?
		Were the activities implemented during the Trial effectively coordinated?
	Shared measurement	Were the objectives and desired outcomes for the Trial measured using clear success measures?

Table 5 - Evaluation questions for the implementation of the Trial

This framework forms the structure in which the findings related to the implementation of the Trial are outlined in the following sections.

8.2 Summary of findings – Trial Implementation

The table below provides a summary of the findings in relation to the implementation of the Trial

Element	Findings
Common agenda	**Finding 10:** The objectives of the Trial were clear
	Finding 11: The role of Taskforce could have been further clarified.
Continuous Communication	**Finding 12:** There was effective communication throughout the Trial
Mutually reinforcing activities	**Finding 13:** The Trial activities complemented one another and were aligned to the objectives and desired outcomes of the Trial
	Finding 14: There were missed opportunities to collaborate and share knowledge across the Trial
Backbone infrastructure	**Finding 15:** NWMPHN played a critical role in supporting the outcomes of the Trial
	Finding 16: NWMPHN collaborated effectively with the Taskforce and commissioned organisations.
	Finding 17: NWMPHN was able to effectively support the coordination of activities across the Trial
Shared measurement	**Finding 18:** More effective outcomes measurements were needed during the Trial
	Finding 19: NWMPHN was able to effectively monitor the progress of the funded activities, whilst empowering and providing them with sufficient autonomy to leverage their own expertise and experience.
	Finding 20: NWMPHN was able to hold the commissioned organisations to account

Table 6 - Summary of evaluation findings for the implementation of the Trial

8.3 Detailed findings – Trial Implementation

The findings related to the implementation of the Trial are presented in more detail below.

Common agenda

Finding 10: The objectives of the Trial were clear

It was identified that there was a collective understanding of the objectives and desired outcomes for the trial. 78% agreed with the statement below:

Statement: There was a shared understanding of the objectives and desired outcomes for the Trial

[n = 36 responses (out of 42 survey respondents)]

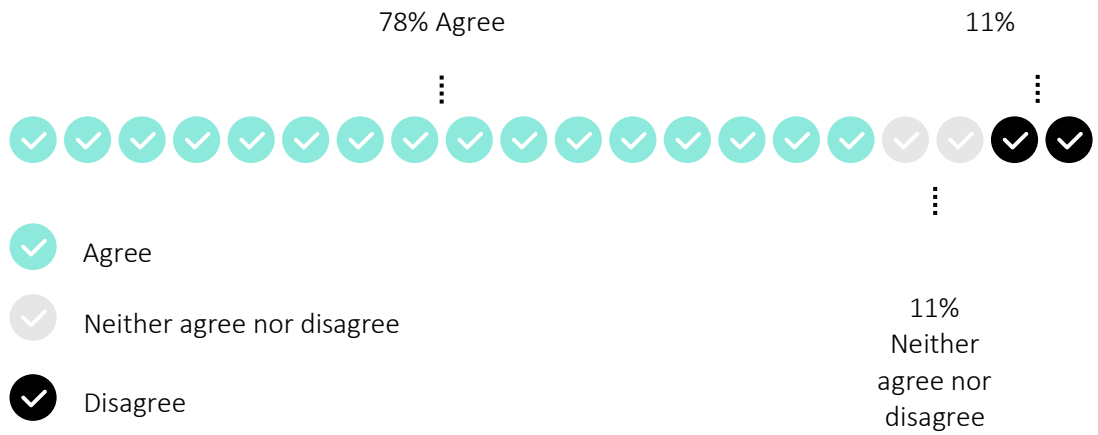


Figure 17 - Extent of agreement with "There was a shared understanding of the objectives and desired outcomes for the Trial"

Finding 11: The role of Taskforce could have been further clarified.

There was however less clarity around the role of the Taskforce in supporting the Trial to achieve its objectives, with almost a quarter of respondents indicating that the role of the Taskforce wasn't clear. 62% of respondents agreed with the statement below:

Statement: There was clarity around the role of the Taskforce to support the outcomes for the Trial

[n = 34 responses (out of 42 survey respondents)]

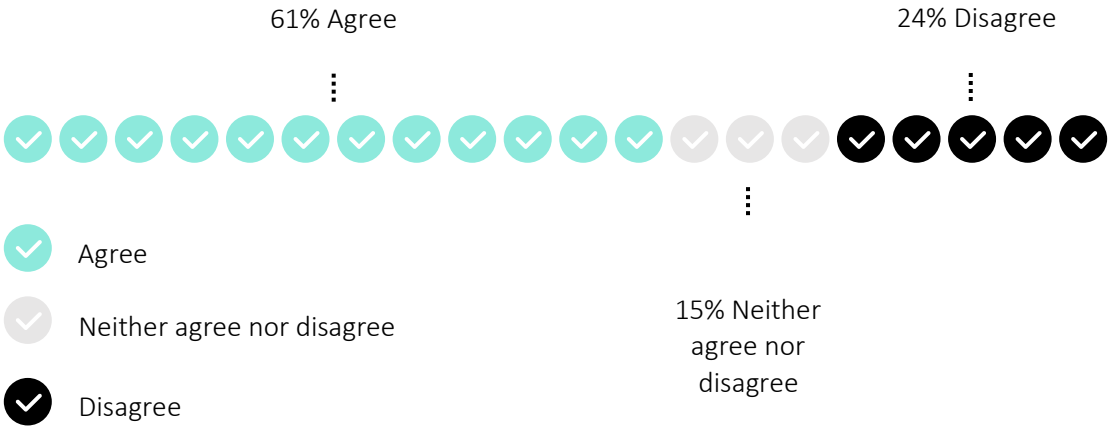


Figure 18 - Extent of agreement with "There was clarity around the role of the Taskforce to support the outcomes for the Trial"

It is understood the following factors led to challenges around role clarity for the Taskforce:

- *Turnover among Taskforce members and NWMPHN staff* - There was significant turnover in NWMPHN staff and Taskforce members throughout the term of the Trial, which made it difficult to maintain continuity of relationships and thinking in relation to the overall direction of the Trial. This had an adverse impact of people's understanding of the role of the Taskforce.

  "Turnover at all levels made it really difficult to keep up-to-date with what was happening on the Taskforce" – Taskforce member

  "Delays in progress and communication in the trial occurred at different times due to staffing changes in both NWPHN and organisations. These were unavoidable and ultimately resolved." – Commissioned organisation

- *Changes in the role of the Taskforce over the duration of the Trial* – The role of the Taskforce changed a number of times throughout the Trial. It was identified that its role was clearer during the early stages of the Trial when the main focus of the Taskforce was to support the design of the Trial. This role became vague once all the interventions in the Trial had been commissioned. In addition, it was unclear whether the Taskforce would be playing a governance role (where it would have a greater remit to directly influence the direction of each of the interventions) or whether its role was more concerned with monitoring and

providing advice to NWMPHN (where it would have a more limited remit to influence the direction of each of the interventions).

> *"We had envisaged that the Taskforce would evolve to support the monitoring, evaluation and ongoing improvement of the activities in the Trial, but that didn't happen explicitly. We should have been clearer" - NWMPHN*

The factors above meant that members of the Taskforce (individuals and commissioned organisations) weren't always clear on their role. This made it challenging for individuals on the Taskforce to maximise their contribution and also for the Taskforce as a whole to direct its energy and efforts to areas that needed it the most. For instance, it was identified that discussions during the Taskforce meetings were sometimes focused on administrative and operational issues of the Trial rather than strategic ones. This does not represent the best use of the meeting time between the Taskforce and the primary focus of its role. Identifying common challenges/themes across the interventions in the Trial before each Taskforce meeting and using the meeting itself to address the challenges/themes identified, would have been a better way to leverage the experience and expertise of the Taskforce.

> *"During the meetings it was more an opportunity for updates to be provided to us in a more formal setting compared to an email." – Commissioned organisation*

Continuous communication

Finding 12: There was effective communication throughout the Trial

There was overall agreement that there was effective communication throughout the Trial. 72% of respondents agreed with the statement below:

Statement: There was effective communication throughout the Trial

[n = 39 responses (out of 42 survey respondents)]

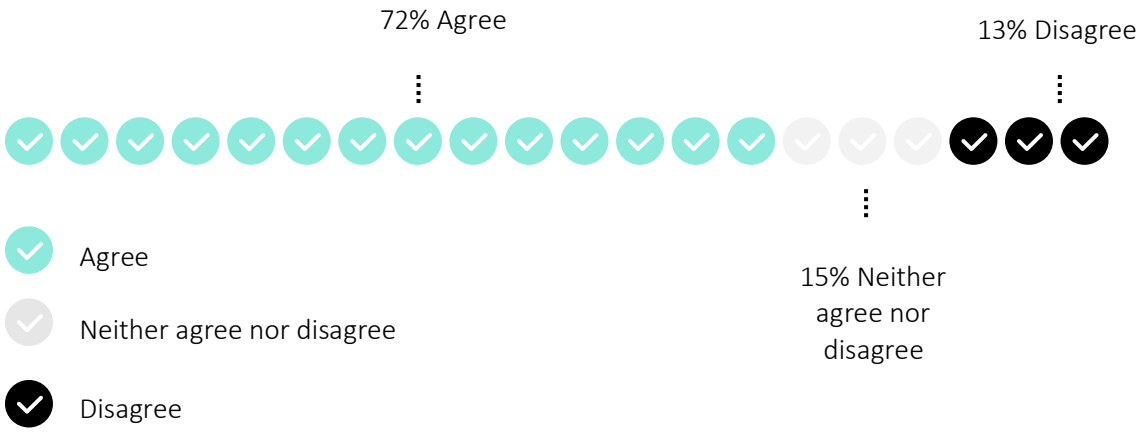


Figure 19 - Extent of agreement with "There was effective communication throughout the Trial"

However, it was identified that communication between the Taskforce and the commissioned organisations could have been improved to better support:

- Commissioned organisations to better understand the thinking that led to the design of the Trial and the identification of each of the intervention; and
- Collaboration and integration between individuals and organisations (within and outside the Trial).

"Designers of trial did not seem to maintain regular contact with people who were implementing it." – Commissioned organisation

"I think that we could have done a better job of regular communication with the Taskforce and providers (as a collective) to ensure that there were connections made where appropriate etc" – NWMPHN

Mutually reinforcing activities

Finding 13: The Trial activities complemented one another and were aligned to the objectives and desired outcomes of the Trial

It was the collective view of those surveyed that the activities implemented as part of the Trial aligned to the Trial's objectives and desired outcomes. 92% of survey respondents agreed with the statement below:

Statement: The activities implemented as part of the Trial were aligned to the Trial's objectives and desired outcomes

[n = 37 responses (out of 42 survey respondents)]

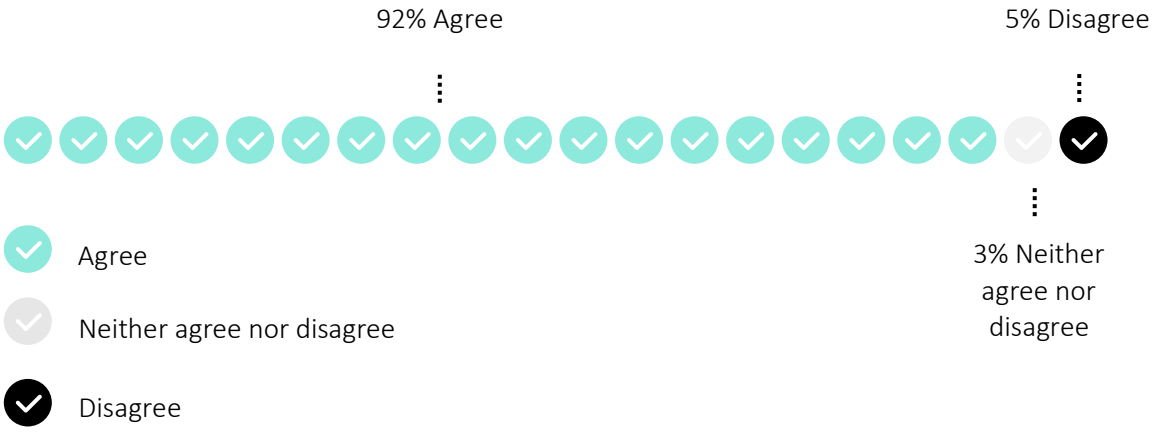


Figure 20 - Extent of agreement with "The activities implemented as part of the Trial were aligned to the Trial's objectives and desired outcomes"

There was also strong agreement that the activities implemented as part of the Trial were complementary to one another, with 86% agreeing with the statement below:

Statement: The activities implemented as part of the Trial were complementary to one another

[n = 36 responses (out of 42 survey respondents)]

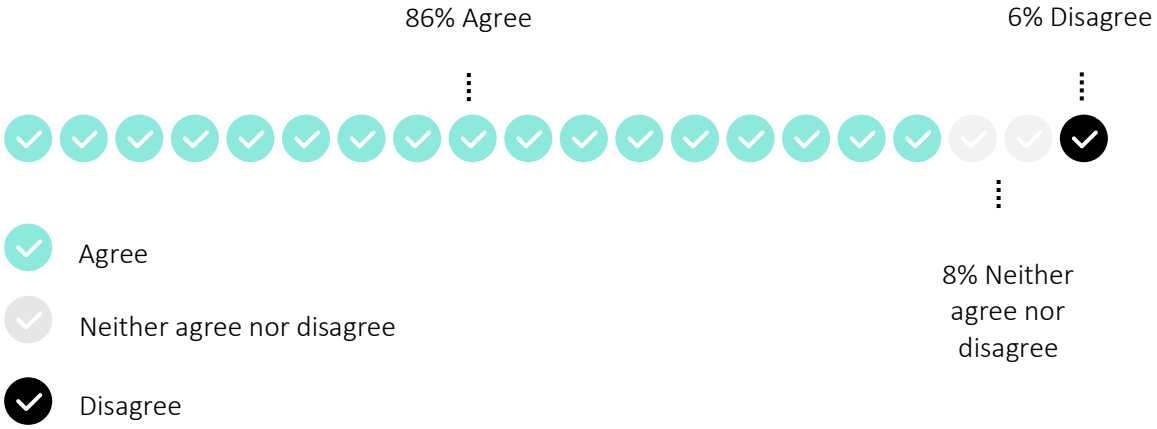


Figure 21 - Extent of agreement with "The activities implemented as part of the Trial were complementary to one another"

The responses to the two statements above also demonstrates the effectiveness of the design process, as it is evident that the activities were carefully and intentionally designed to be aligned to the key objectives of the Trial and be mutually reinforcing.

Finding 14: There were missed opportunities to collaborate and share knowledge across the Trial

A potential area for improvement for the Trial was identified to be the extent of collaboration and knowledge sharing between Trial activities and service providers. As indicated by the responses to the two statements below, there were lower levels of agreement compared to other statements in the Overall Trial Survey (64% and 68% of survey respondents disagreed to both statements).

Statement: There was effective collaboration and integration between the activities of the Trial

[n = 33 responses (out of 42 survey respondents)]

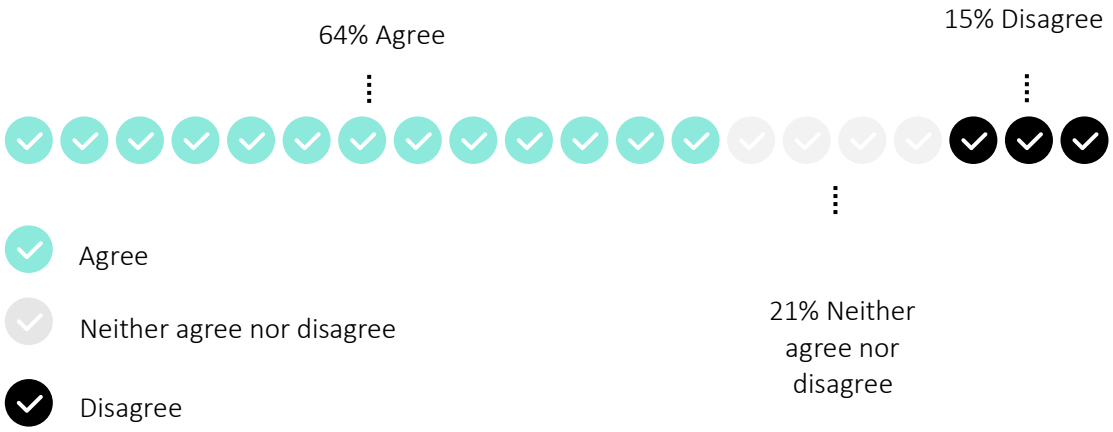


Figure 22 - Extent of agreement with "There was effective collaboration and integration between the activities of the Trial"

It was identified that there were missed opportunities to leverage the semi-regular Taskforce meetings to support collaboration and knowledge sharing across the Trial. Instead of using the meetings to proactively identify shared lessons and opportunities to work together, Taskforce meetings were mainly used as an opportunity for commissioned organisations to report back on the progress of their respective interventions.

Statement: There was effective knowledge sharing throughout the Trial

[n = 38 responses (out of 42 survey respondents)]

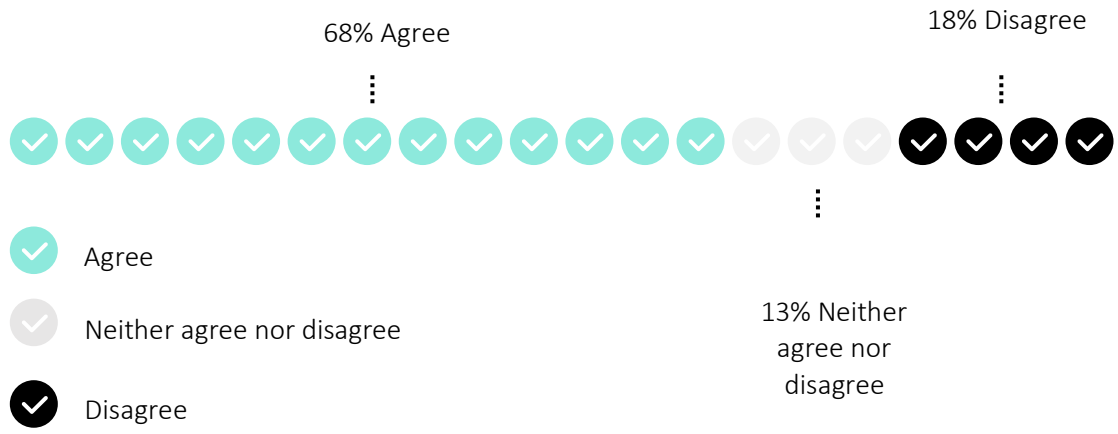


Figure 23 - Extent of agreement with "There was effective knowledge sharing throughout the Trial"

> *"*The Taskforce had insufficient power to shape or influence the funded activities and their outcomes. It was a good group that reflected diversity within LGBTIQA+ communities, yet at several of the meetings presentations were given by people who were not working on LGBTIQA+ suicide prevention, which was a shame, because there were great opportunities for those who had been involved over the years to learn from each other and support one another's work.*" – Commissioned organisation*

However, the above should not detract from the cross-sector collaboration that was achieved through the Trial, including:

- Partnership between LivingWorks and staff from LGBTIQ+ community-controlled organisations to deliver the LGBTIQ+ safeTALK and LGBTIQ+ ASIST training;
- Formation of a Community of Practice between individuals involved in the Mind Aftercare, Switchboard LGBTIQA+ Suicide Postvention Response Plan, drummond street LGBTIQA+ Mentoring Project and Thorne Harbour Health Affirmative Practice training; and
- Expansion of referral networks and connections through the Taskforce.

> *"*The Community of Practice between Drummond St, THH, Switchboard and Mind really made a big difference.*" – Commissioned organisation*

Backbone infrastructure

Finding 15: NWMPHN played a critical role in supporting the outcomes of the Trial

NWMPHN played an active commissioning role throughout the Trial, where it worked closely with stakeholders in the Trial to maximise the outcomes achieved. Taskforce members and commissioned organisations alike commented positively on the commitment displayed by the NWMPHN project team and the amount of effort invested in building relationships with key stakeholders involved in the Trial. The fact that a number of the project team members identified as being LGBTIQ+ was recognised by many as key strength of the Trial (i.e. that there was LGBTIQ+ people represented at all levels of the Trial, from governance, to commissioning, to actual service delivery, further reinforcing the 'co-designed' nature of the Trial).

"NWMPHN were always great to deal with, always caring, accommodating, understanding and flexible." – Commissioned organisation

"The NWMPHN have been incredibly dedicated and passionate throughout this trial and we have been grateful for their incredible support. Thank you and great work to everyone at the NWMPHN." *– Commissioned organisation*

"Many of the implementation successes were largely due to very passionate workers at the funded services and at the NWMPHN. Where there were shortfalls in the implementation process, it was the genuine rapport among those working in LGBTIQA+ suicide prevention that sustained the activities and helped them achieve their goals. I think this comes down peer work in LGBTIQA+ space - LGBTIQA+ people who work in these roles are often passionate activists who want to see the futures for LGBTIQA+ people changed. This was a strength of the trial: LGBTIQA+ identifying workers at the NWMPHN and leading the funded initiatives." – Commissioned organisation

"We have worked with a lot of PHNs, but NWMPHN is definitely up there" - Commissioned organisation

"[NWMPHN staff] were engaging, focused and well informed and applied responsive and safe practices to encourage inclusive participation reflective of power relations and co design principles during all phases of the project with exceptional relationship building skills to integrate the many perspectives and ideas that emerged from the design phase." – Taskforce member

Finding 16: NWMPHN collaborated effectively with the Taskforce and commissioned organisations

There was agreement that NWMPHN worked effectively with the Taskforce and each of the commissioned organisations. 83% of survey respondents agreed that NWMPHN worked in a collaborative manner with the Taskforce, and 79% agreed that NWMPHN worked in a collaborative manner with commissioned organisations.

Statement: NWMPHN worked in a collaborative manner with the Taskforce

[n = 38 responses (out of 42 survey respondents)]

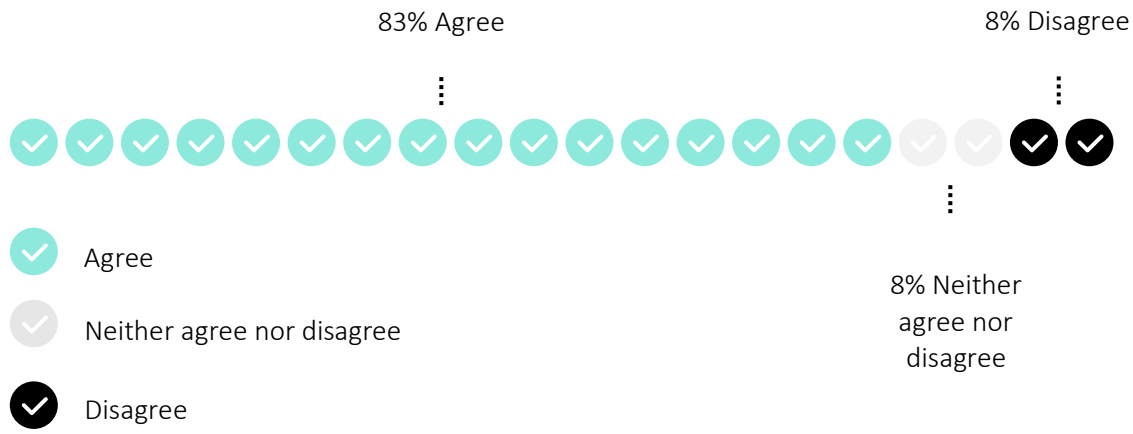


Figure 24 - Extent of agreement with "NWMPHN worked in a collaborative manner with the Taskforce"

Statement: NWMPHN worked in a collaborative manner with the funded organisations (i.e. organisation that received funding as part of the Trial)

[n = 38 responses (out of 42 survey respondents)]

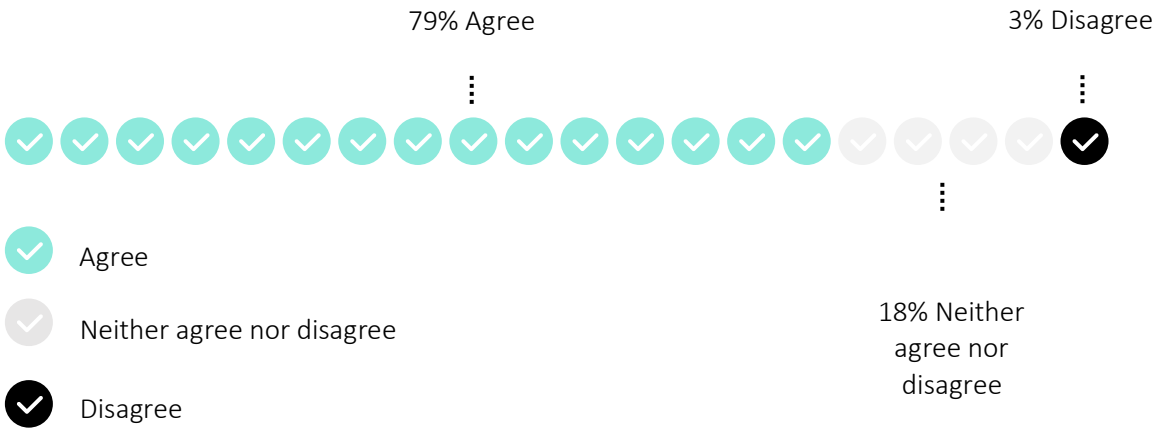


Figure 25 - Extent of agreement with "NWMPHN worked in a collaborative manner with the funded organisations (i.e. organisation that received funding as part of the Trial)"

NWMPHN was actively engaged in the implementation of the Trial and worked closely with service providers to ensure the Trial delivers positive outcomes for LGBTIQ+ communities. This was particularly important during the COVID-19 pandemic which required significant modification of all the interventions that were commissioned as part of the Trial to adapt the restrictions put in place.

"NWMPHN were always engaged in key decision making. It never felt like it was a 'tick and flick' exercise from them" – Commissioned organisation

*"*COVID really threw a spanner in the works, but the NWMPHN were quite flexible and understanding. We were also able to adjust our project to make the most of the situation.*" – Commissioned organisation*

Finding 17: NWMPHN was able to effectively support the coordination of activities across the Trial

There was also agreement that the activities of the Trial were effectively coordinated by NWMPHN (noting the comments earlier around there being opportunities for improvement in terms of how much collaboration and knowledge sharing occurred across the Trial and between commissioned organisations), with 84% of survey respondents agreeing to the statement below:

Statement: The activities implemented during the Trial were effectively coordinated

[n = 37 responses (out of 42 survey respondents)]

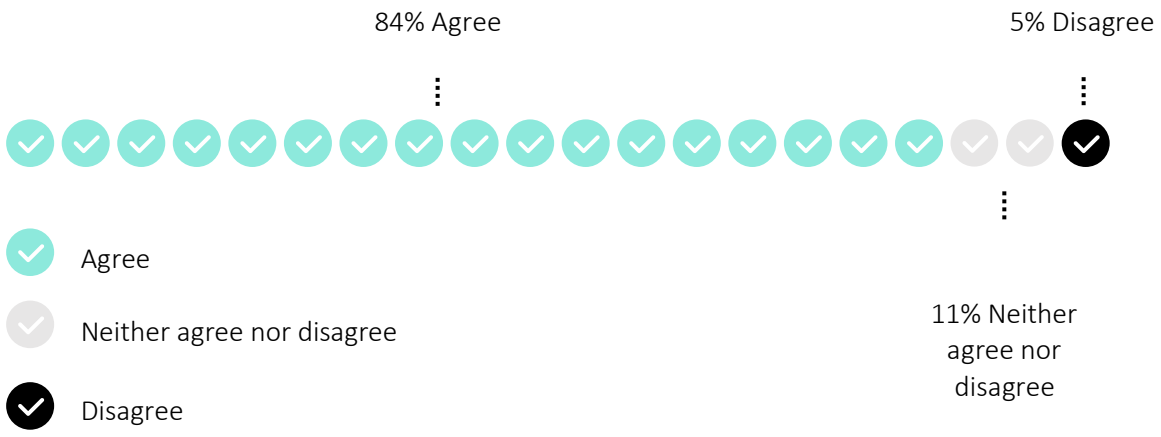


Figure 26 - Extent of agreement with "The activities implemented during the Trial were effectively coordinated"

Shared measurement

Finding 18: More effective outcomes measurements were needed during the Trial

Another area for improvement for the Trial is ensuring that clear indicators are put in place to measure the progress against the objectives and desired outcomes of the Trial. As indicated below, only 57% of survey respondents agreed that the objectives and desired outcomes for the Trial were clearly measured, with a high proportion of respondents disagreeing or being neutral to the statement. It was identified that the evaluation of the Trial should have commenced during the design stages to ensure that appropriate consideration was given to how the outcomes of the Trial will be measured.

> *"I wish there was more evaluation support earlier." – Commissioned service provider*

Statement: The objectives and desired outcomes for the Trial were measured using clear success measures

[n = 35 responses (out of 42 survey respondents)]

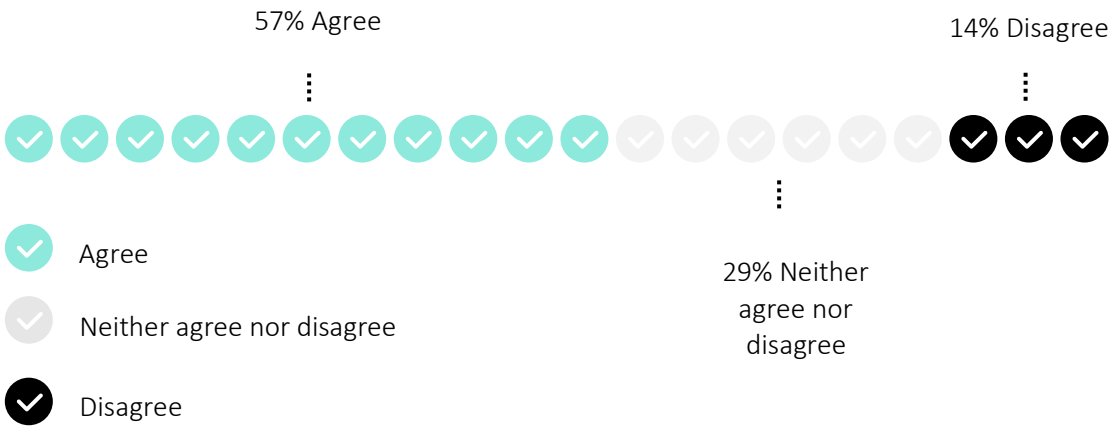


Figure 27 - Extent of agreement with "The objectives and desired outcomes for the Trial were measured using clear success measures"

Finding 19: NWMPHN was able to effectively monitor the progress of the funded activities, whilst empowering and providing them with sufficient autonomy to leverage their own expertise and experience.

Despite not having clear outcomes measures, NWMPHN was able to effectively monitor and manage the progress of funded activities. 74% of survey respondents agreed that NWMPHN's approach to monitoring managing the progress of funded activities was effective. NWMPHN's focus on building strong relationships with the commissioned organisations and its collaborative approach was identified as a key enabler to this. NWMPHN maintained regular contact with the commissioned organisations throughout the Trial, and in doing so, stayed up-to-date with progress of each interventions.

Statement: NWMPHN's approach to monitoring and managing the progress of funded activities was effective

[n = 35 responses (out of 42 survey respondents)]

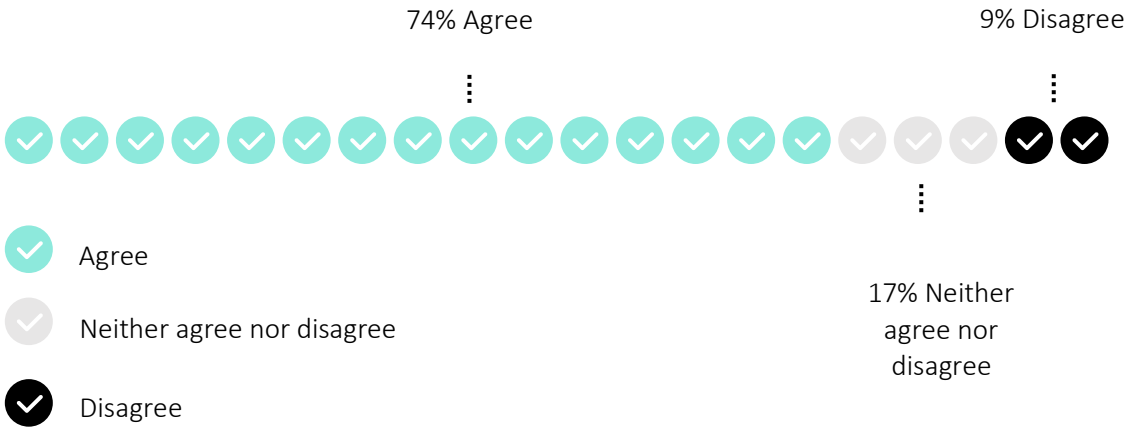


Figure 28 - Extent of agreement with "NWMPHN's approach to monitoring and managing the progress of funded activities was effective"

It was also identified that NWMPHN's approach to progress monitoring and performance management was empowering. Commissioned organisations were trusted and given adequate flexibility and autonomy to design and deliver their respective interventions in a way that met the needs of LGBTIQ+ communities. Their expertise and experience working with LGBTIQ+ communities were recognised and respected. An example of this was during the early stages of the COVID-19 pandemic when there was the option of transitioning the delivery of LGBTIQ+ safeTALK and LGBTIQ+ ASIST online. This was discussed between LivingWorks and NWMPHN and agreement was made to wait until face-to-face training could resume as based on LivingWorks' experience, delivering both trainings virtually would have detracted from the experience and learning outcomes of participants.

"We were never pushed to compromise the quality of the training at any point. It was very nourishing to see that from a funder." – Commissioned organisation

"We were trusted to do what we needed to do in the best interest of our community" - Commissioned organisation

Finding 20: NWMPHN was able to hold the commissioned organisations to account

Recognising the lack of clear outcomes measures identified in Finding 18, NWMPHN's approach to working with commissioned organisations and monitoring their progress enabled it to hold these organisations to account, ensuring that they delivered against their contracted deliverables. 82% of survey respondent agreed with the statement below.

Statement: The funded organisations (i.e. organisation that received funding as part of the Trial) were effectively held accountable to deliver on their contracted obligations during the Trial

[n = 34 responses (out of 42 survey respondents)]

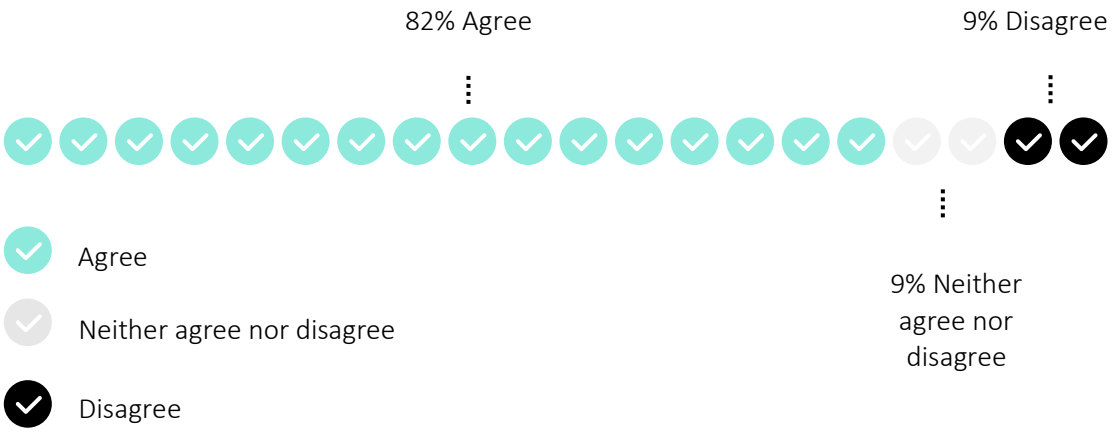


Figure 29 - Extent of agreement with "The funded organisations (i.e. organisation that received funding as part of the Trial) were effectively held accountable to deliver on their contracted obligations during the Trial"

9. EVALUATION FINDINGS – OUTCOMES OF THE TRIAL

9.1 Evaluation overview – Trial Outcomes

This section of the report outlines the findings in relation to the outcomes of the Trial, addressing the following evaluation question:

The outcomes of the Trial are explored according the intended short-term and long-term outcomes of the Trial. These have been adapted from the program logic of the Trial and the program logic of the individual interventions that make up the Trial. The framework below is used to assess the outcomes of the Trial and forms the structure in which the findings are outlined in the following sections.

Overarching evaluation question	Timeframe	Element	Sub-questions to explore
To what extent did the Trial achieve its intended outcomes?	Overall	-	Did the Trial effectively met the needs of the LGBTIQ+ communities and suicide prevention service system in the North West of Melbourne?
	Short-term	Knowledge and understanding	To what extent did the Trial lead to a deeper understanding of the needs of LGBTIQ+ communities?
			To what extent did the Trial lead to a deeper understanding of effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities?
		Awareness	To what extent did the Trial lead to an increase in awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities (including LGBTIQ+ specific and mainstream services)?
		Relationship	To what extent did the Trial lead to a stronger sense of community connection (i.e. relationships with other people who are LGBTIQ+ and sense of belonging to the LGBTIQ+ community) among people who are LGBTIQ+?

			To what extent did the Trial lead to stronger partnerships between organisations that support LGBTIQ+ communities?
		Capacity	To what extent did the Trial lead to an increase in capacity of the service system to provide effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities?
			To what extent did the Trial lead to an increase in capacity of LGBTIQ+ communities to respond more effectively to suicide (i.e. by supporting themselves or each other)?
			To what extent did the Trial lead to an increase in capacity of the general community to respond more effectively to suicide?
			To what extent did the Trial lead to an increase in capacity of services providers (including mainstream providers and LGBTIQ+ specific service providers) to deliver services and supports that are safe and inclusive for people who are LGBTIQ+?
	Longer-term	Stigma	To what extent has the Trial or will the Trial likely lead to a reduction in stigma against LGBTIQ+ communities?
		Resilience	To what extent has the Trial or will the Trial likely lead to an increase in resilience of LGBTIQ+ communities?
		Self-harm and suicidality	To what extent has the Trial or will the Trial likely lead to lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities?

Table 7 - Evaluation questions for the outcomes of the Trial

9.2 Summary of findings – Trial Outcomes

The table below provides a summary of the findings in relation to the outcomes of the Trial

Element	Finding
Overall	**Finding 21:** The Trial effectively met the needs of the LGBTIQ+ communities and suicide prevention service system in the North West of Melbourne
Short-term outcome: Knowledge and understanding	**Finding 22:** The Trial has led to a deeper understanding of the needs of LGBTIQ+ communities and how to deliver effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities
Short-term outcome: Awareness	**Finding 23:** The Trial has led to better awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities
Short-term outcome: Relationship	**Finding 24:** The Trial has helped to strengthen the sense of community connection among people who are LGBTIQ+ and partnerships between organisations that support LGBTIQ+ communities
Short-term outcome: Capacity	**Finding 25:** The Trial has led to an increase in capacity for LGBTIQ+ communities, service providers and to a lesser extent the general community. Collectively, this has helped to increase the overall capacity of the service system to provide effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities.
Longer-term outcome: Stigma	**Finding 26:** The Trial has helped to or will likely reduce stigma against LGBTIQ+ communities in the longer-term
Longer-term outcome: Resilience	**Finding 27:** The Trial has helped to or will help to enhance the resilience of LGBTIQ+ communities in the longer-term.
Longer-term outcome: Self-harm and suicidality	**Finding 28:** The Trial will lead to lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities in the longer-term

Table 8 - Summary of evaluation findings for the outcomes of the Trial

9.3 Detailed findings – Trial Outcome

The findings related to the outcomes of the Trial are presented below.

Note: When reviewing the insights below, each of the outcomes identified below references the individual interventions that contributed to it. A selection of quotes/commentary from the intervention-specific evaluations has been included below to add 'colour' to each of the outcomes, please review the relevant intervention-specific evaluation reports for more substantive information on how each of them led to the identified outcomes.

Overall Outcomes

Finding 21: The Trial effectively met the needs of the LGBTIQ+ communities and suicide prevention service system in the North West of Melbourne

The Trial met the needs of LGBTIQ+ communities and the suicide prevention service system in the North West of Melbourne. 74% of respondents agreed with the statement below, validating the insights gained previously which identifies that the Trial:

- Was appropriately informed by people who are LGBTIQ+ and people with a lived experience of mental ill-health and suicide; and
- Took into consideration the state of the mental health and suicide prevention service system in the North West of Melbourne.

Statement: The Trial effectively met the needs of the LGBTIQ+ communities and suicide prevention service system in the North West of Melbourne

[n = 31 responses (out of 42 survey respondents)]

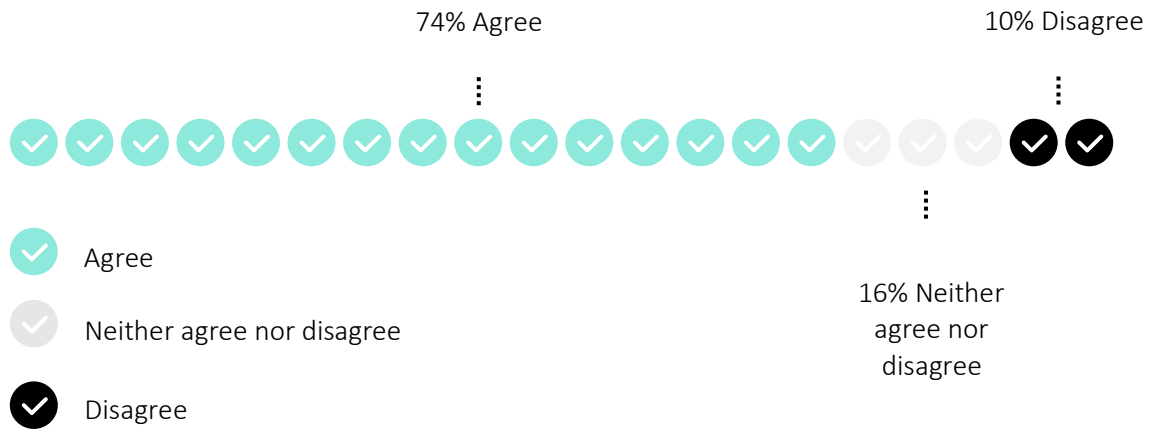


Figure 30 - Extent of agreement with "The Trial effectively met the needs of the LGBTIQ+ communities and suicide prevention service system in the North West of Melbourne"

A key contributor to this is the strong focus on co-design adopted through the design and implementation of the Trial, which was discussed previously.

Figure 44 provides a summary of the specific interventions that have contributed to this outcome. Please refer to the relevant intervention-specific evaluation report for further information.

“I have never felt so accepted and accommodated by a mental health program” – Intervention beneficiary

“I have walked away from the training smiling, even though it was a kind of tough topic to talk about with the increase suicide rates etc. I just felt that we approached the topic in such an open and positive way that I really got a lot out of it.” – Intervention beneficiary

“It (the training) felt like such a safe space to discuss topics and learn.” – Intervention beneficiary

“I felt invited at all stages (of the design process for the training) to provide input.“ – Intervention beneficiary

Short-term outcome: Knowledge and understanding

Finding 22: The Trial has led to a deeper understanding of the needs of LGBTIQ+ communities and how to deliver effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities

There was strong agreement that the Trial led to a deeper understanding of the needs of LGBTIQ+ communities, with 85% agreeing with the statement below.

Statement: The activities of the Trial have led to a deeper understanding of the needs of LGBTIQ+ communities

[n = 41 responses (out of 42 survey respondents)]

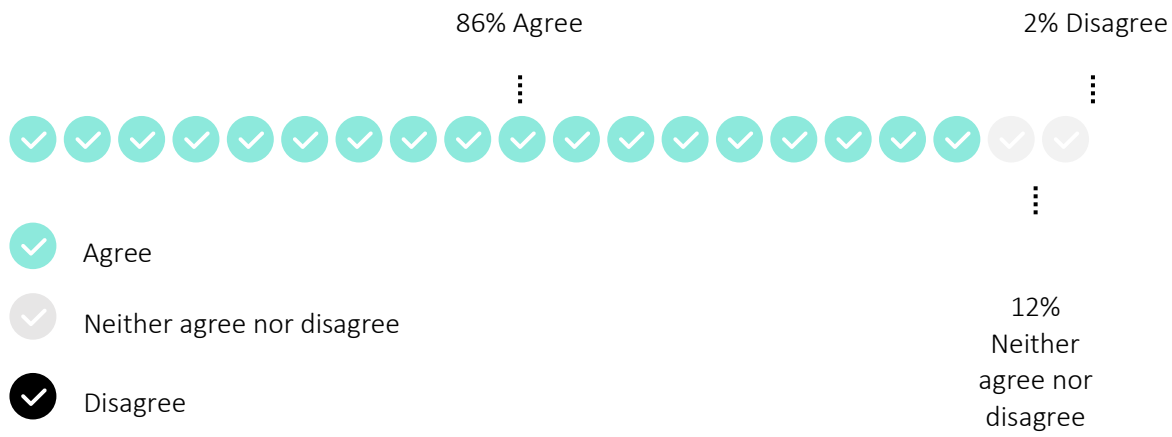


Figure 31 - Extent of agreement with "The activities of the Trial have led to a deeper understanding of the needs of LGBTIQ+ communities"

"This document (LGBTIQA+ Suicide Postvention Plan) is a window into what it might mean to be in a queer community and have a suicide happen as opposed to having an outsider's perspective" – Intervention beneficiary

"What Person X has been able to produce as part of this project really is at the top ranks of the international postvention field because she has come from an evidence-informed view from the perspective of the people the plan is designed for. So the other plans that are out there whether they are Australian or international, are very much focused on the generic, heteronormative, "white" kind of view. There's very little for any minority groups… So I would say that in doing this, she really is kind of at the cutting edge." – Intervention beneficiary

"What I like about Lean on Me is that [it shines a light on] how are queer people keeping queer people alive in 2021 - my hope is that it will create more of a dialogue.." – Intervention beneficiary

An even greater number of survey respondents believe that the activities of the Trial led to a deeper understanding of effective and safe suicide prevention, intervention and postvention supports, a key aim of the Trial, with only 5% disagreeing. 92% of respondents agreed with the following statement:

Statement: The activities of the Trial have led to a deeper understanding of effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities

[n = 39 responses (out of 42 survey respondents)]

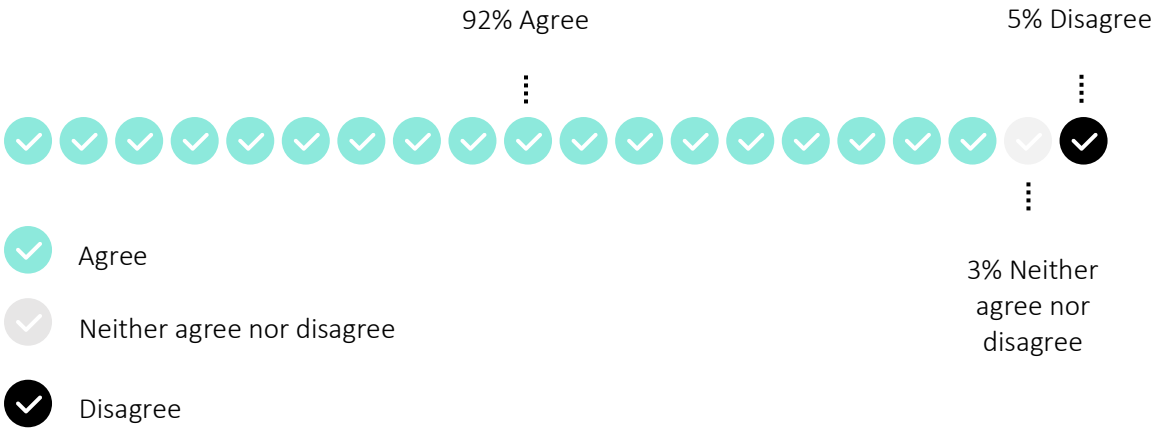


Figure 32 - Extent of agreement with "The activities of the Trial have led to a deeper understanding of effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities"

"The Trial we incredible and highly effective in raising visibility and awareness of LGBTIQ+ communities inclusive of suicidality in our communities" – *Taskforce member*

"The Trial has started and enabled dialogue for LGBTIQ+ communities across Vic and nationally" – NWMPHN

"The complementing nature of having the psychologist and peer worker worked very well" - Intervention beneficiary

"(There is a) Different relationship with therapist compared to peer. With a peer there is space for vulnerability, shared experiences and opportunities for shared learnings. It's a real sense of reciprocity." – Commissioned organisation

Figure 44 provides a summary of the specific interventions that have contributed to this outcome. Please refer to the relevant intervention-specific evaluation report for further information.

Short-term outcome: Awareness

Finding 23: The Trial has led to better awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities

Survey respondents identified that the Trial has helped to increase the awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities. 79% of respondents agreed with the statement below.

Statement: The activities of the Trial have helped to increase the awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities (including LGBTIQ+ specific and mainstream services)

[n = 38 responses (out of 42 survey respondents)]

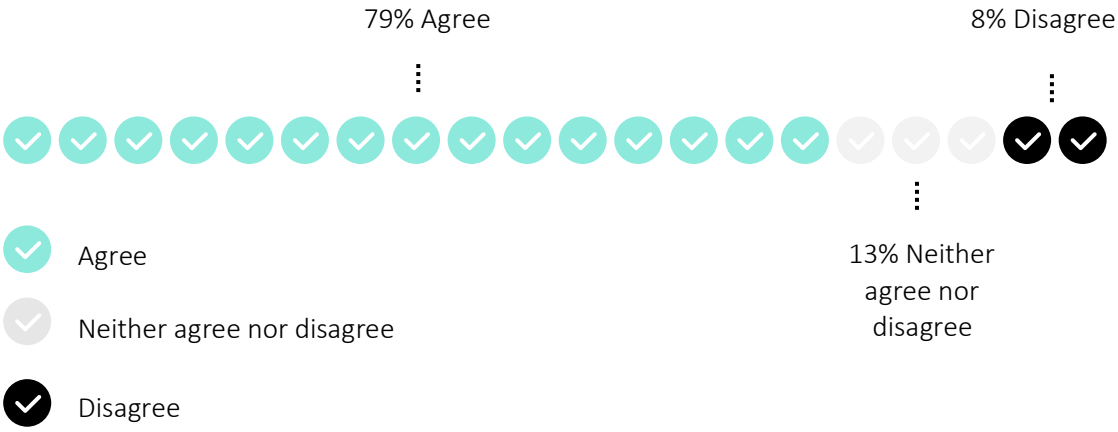


Figure 33 - Extent of agreement with "The activities of the Trial have helped to increase the awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities (including LGBTIQ+ specific and mainstream services)"

Figure 44 provides a summary of the specific interventions that have contributed to this outcome. Please refer to the relevant intervention-specific evaluation report for further information.

"I now know that there are places to go, people to talk to, ways to get advice and help if needed, that are outside my family and outside my town" – Intervention beneficiary

Short-term outcome: Relationship

Finding 24: The Trial has helped to strengthen the sense of community connection among people who are LGBTIQ+ and partnerships between organisations that support LGBTIQ+ communities

77% of survey respondents agreed that the Trial has strengthened relationships and connection within LGBTIQ+ communities. Given the challenges around feeling isolated during the COVID-19 pandemic and the importance of community connection in supporting health and wellbeing, the Trial also played a significant role in supporting people who are LGBTIQ+ during a challenging time over the last 2 years.

Statement: The activities of the Trial have helped to strengthen the sense of community connection (i.e. relationships with other people who are LGBTIQ+ and sense of belonging to the LGBTIQ+ community) among people who are LGBTIQ+

[n = 30 responses (out of 42 survey respondents)]

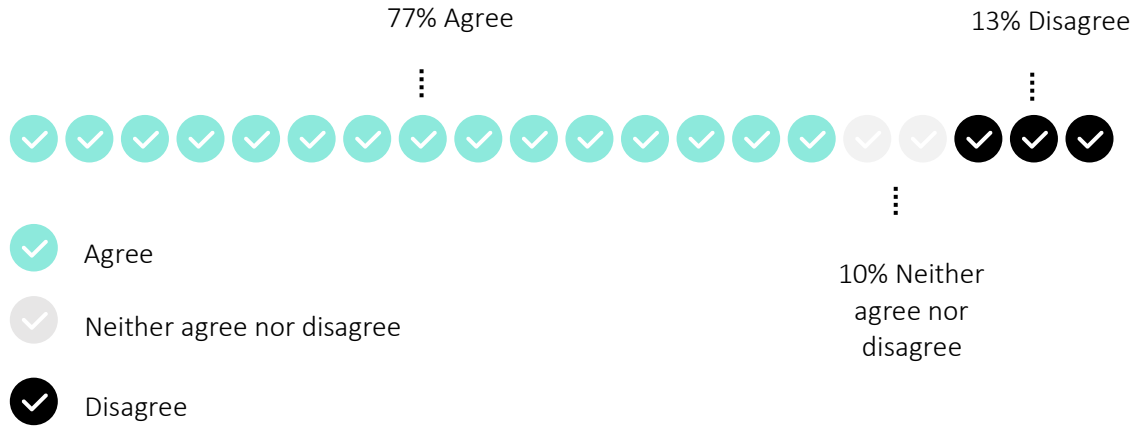


Figure 34 - Extent of agreement with "The activities of the Trial have helped to strengthen the sense of community connection (i.e. relationships with other people who are LGBTIQ+ and sense of belonging to the LGBTIQ+ community) among people who are LGBTIQ+"

"Having knowledge that there are trans and GD people out in VIC that I haven't met before has been really reassuring to me in terms of connecting with the queer community. I was feeling like it was just my bubble of friends and I wanted to know more about people of different ages and backgrounds in the same community." – Intervention beneficiary

"My sense of identity has developed through this program and through my interactions with my mentor" - Intervention beneficiary

"Feeling like I am not alone" - Intervention beneficiary

There was also agreement that the Trial supported organisations that work with LGBTIQ+ communities to build relationships and strengthen partnerships with one another.

Statement: The activities of the Trial have helped to strengthen partnerships between organisations that support LGBTIQ+ communities

[n = 39 responses (out of 42 survey respondents)]

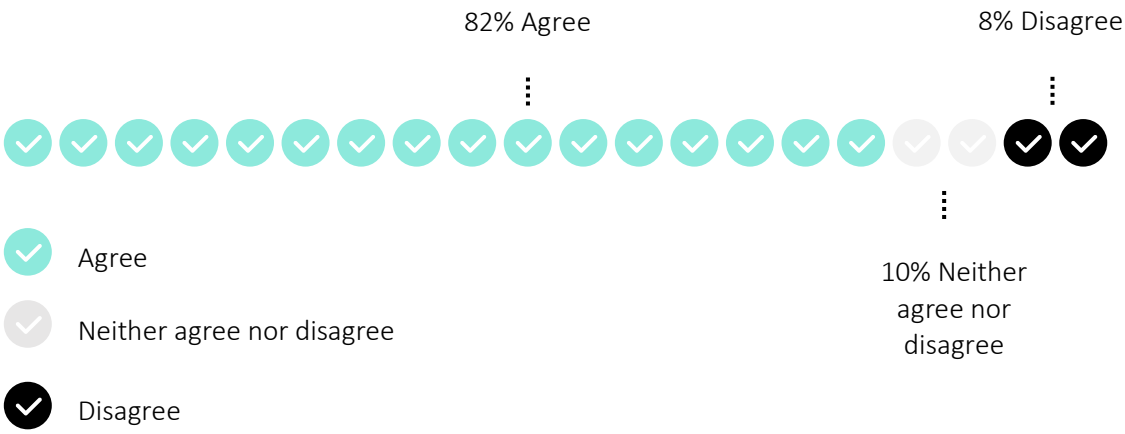


Figure 35 - Extent of agreement with "The activities of the Trial have helped to strengthen partnerships between organisations that support LGBTIQ+ communities"

"I have noticed more synergies between LGBTIQ+ services, we've got community of practice which helps strengthen our knowledge and how we refer people onwards" – Commissioned organisation

"Overall found it to be really collaborative, and very much in the spirit of this suite of programs all together in MH and wellbeing promotion sector. All trying to work together to promote healthier and healthier community and generally that was my experience. I particularly valued their collaborative style of thinking which was important and aligned to values of trial" – Intervention beneficiary

Figure 44 provides a summary of the specific interventions that have contributed to the outcome above. Please refer to the relevant intervention-specific evaluation report for further information.

Short-term outcome: Capacity

Finding 25: The Trial has led to an increase in capacity for LGBTIQ+ communities, service providers and to a lesser extent the general community. Collectively, this has helped to increase the overall capacity of the service system to provide effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities.

It was identified that the Trial has increased the capacity of LGBTIQ+ communities to respond to suicide more effectively (by either being more capable in terms of supporting themselves or each other) and service providers (including mainstream providers and LGBTIQ+ specific service providers) to deliver safe and inclusive services for LGBTIQ+ communities. 84% and 77% of survey respondents agreed to the following two statements respectively.

Statement: The activities of the Trial have helped to increase the capacity of LGBTIQ+ communities to respond more effectively to suicide (i.e. by supporting themselves or each other)

[n = 32 responses (out of 42 survey respondents)]

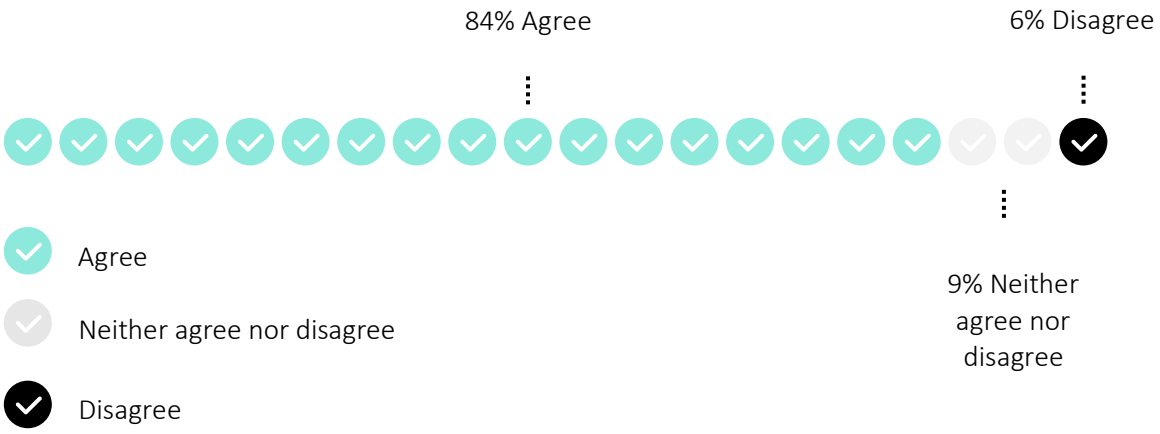


Figure 36 - Extent of agreement with "The activities of the Trial have helped to increase the capacity of LGBTIQ+ communities to respond more effectively to suicide (i.e. by supporting themselves or each other)"

"I feel that I trust my own voice now and am more confident. Before this program, I was always cautious with what and how I say things. With anxiety and challenges with mental health, it's hard to trust your own voice" - Intervention beneficiary

Statement: The activities of the Trial have helped to increase the capacity of services providers (including mainstream providers and LGBTIQ+ specific service providers) to deliver services and supports that are safe and inclusive for people who are LGBTIQ+

[n = 36 responses (out of 42 survey respondents)]

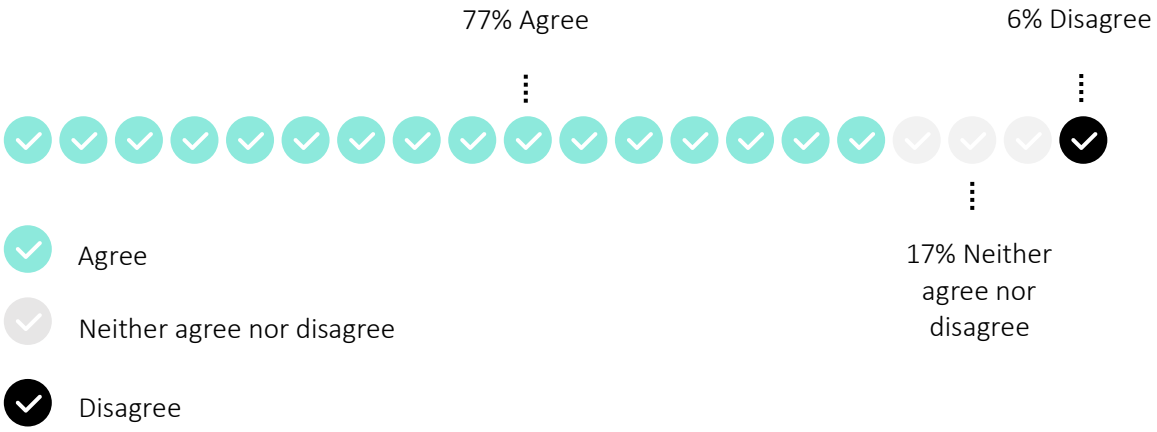


Figure 37 - Extent of agreement with "The activities of the Trial have helped to increase the capacity of services providers (including mainstream providers and LGBTIQ+ specific service providers) to deliver services and supports that are safe and inclusive for people who are LGBTIQ+"

"It (the training) validates existing knowledge, they know they are on the right track but also gives you new content and new ways to improve current practice" – Intervention beneficiary

"At the organisational level, it (the training) also creates a culture shift, where we are explicitly saying that we will become a safer and more inclusive organisation for staff" - Intervention beneficiary

There was also agreement that the Trial has helped to build the capacity of the general community to respond to suicide (noting that this was to a much lesser extent compared to the increase in capacity for LGBTIQ+ communities and service providers). This is unsurprising given the focus of the Trial on targeting people who are LGBTIQ+ and the mainstream service system (rather than general population). The only interventions that would have been accessible to the general population would have been the LivingWorks LGBTIQ+ safeTALK and LGBTI+ ASIST; and the Switchboard LGBTIQA+ Suicide Postvention Response Plan. However, as the engagement efforts for both interventions were targeted at LGBTIQ+ communities and service providers, the reach into the general community was minimal.

Statement: The activities of the Trial have helped to increase the capacity of the general community to respond more effectively to suicide

[n = 32 responses (out of 42 survey respondents)]

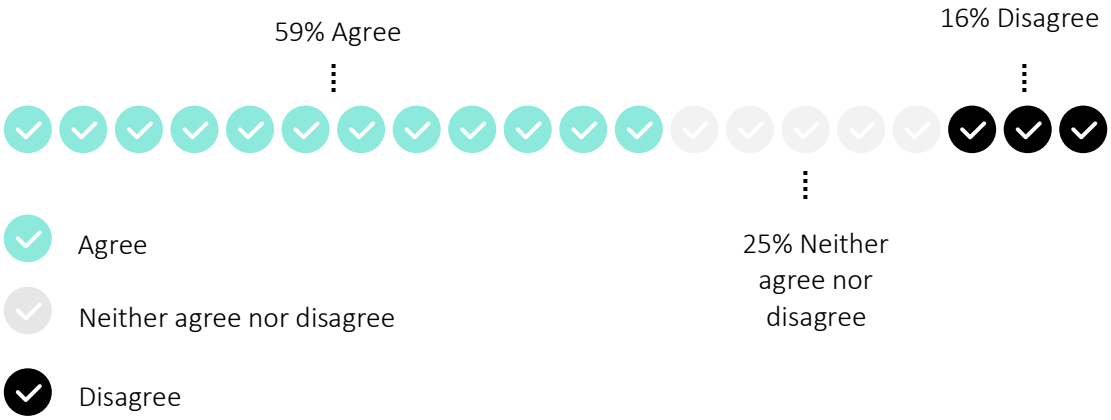


Figure 38 - Extent of agreement with "The activities of the Trial have helped to increase the capacity of the general community to respond more effectively to suicide"

"ASIST course has given me courage to ask, listen & talk about suicide. Before the course I would not have had the courage or knowledge to ask." – Intervention beneficiary

"I have recently done training about suicide in my cert IV in mental health as well as the online START program, however, the ASIST training has given me the knowledge and confidence to assist someone to safety rather than just on referring to someone else" – Intervention beneficiary

The increase in capacity for LGBTIQ+ communities, service providers and to a lesser extent the general community, collectively helped to increase the overall capacity of the service system to provide effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities, with 72% of survey respondents agreeing with the statement below.

Statement: The activities of the Trial have helped to increase the capacity of the service system to provide effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities

[n = 37 responses (out of 42 survey respondents)]

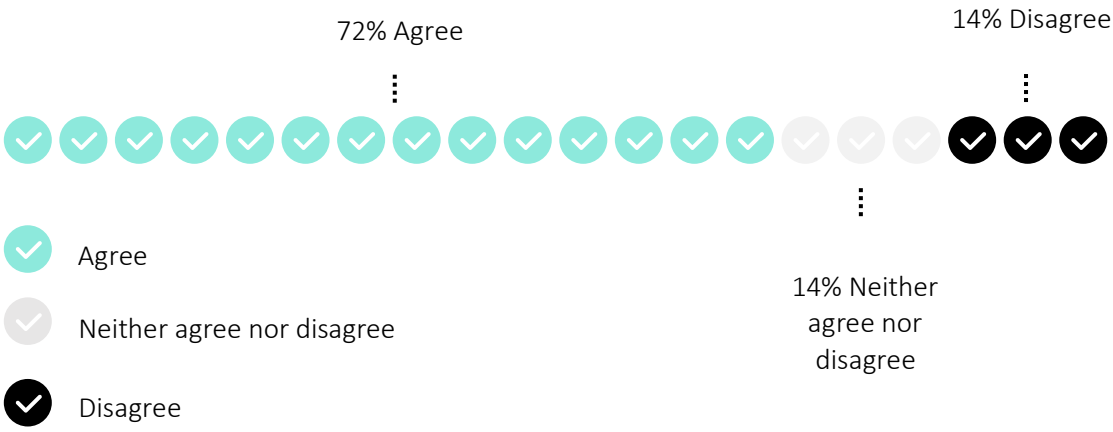


Figure 39 - Extent of agreement with "The activities of the Trial have helped to increase the capacity of the service system to provide effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities"

"There were a number of really important outcomes of activities throughout the trial - specifically the improved access to training for the general community, and the improved ability to respond to the LGBTI community by mainstream services (eg affirmative practice) - beyond access to LGBTIQ specific services, I think these were hugely important" - NWMPHN

"In working alongside and with mainstream organisations, the onus is always on the LGBTIQA+ organisation to upskill and build capacity through partnership for the other organisation to understand and effective work in a LGBTIQA+ program. Unfortunately, this aspect of the work is rarely funded and remains largely invisible. This capacity building that is embedded in the process of running programs is likely to be what has the most enduring impact on reducing stigma and building a mainstream workforce supportive of LGBTIQA+ people." – *Commissioned service provider*

Figure 44 provides a summary of the specific interventions that have contributed to the outcome above. Please refer to the relevant intervention-specific evaluation report for further information.

Longer-term outcome: Stigma

Finding 26: The Trial has helped to or will likely reduce stigma against LGBTIQ+ communities in the longer-term

In the longer-term, the majority of survey respondents believed that the activities of the Trial will help to reduce stigma in the broader community against LGBTIQ+ communities. 74% of survey respondents agreed with the statement below:

Statement: The activities of the Trial have helped to or will likely reduce stigma against LGBTIQ+ communities

[n = 34 responses (out of 42 survey respondents)]

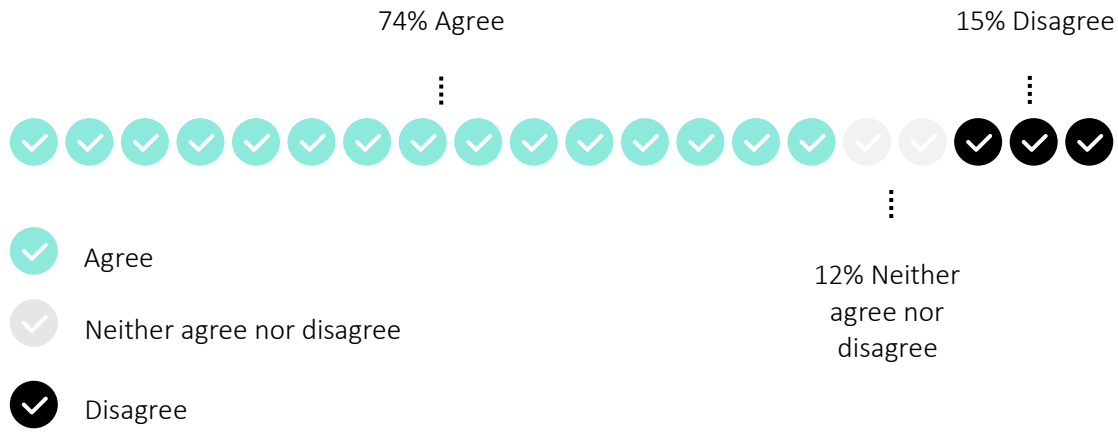


Figure 40 - Extent of agreement with "The activities of the Trial have helped to or will likely reduce stigma against LGBTIQ+ communities"

Figure 44 provides a summary of the specific interventions that have contributed to this outcome. Please refer to the relevant intervention-specific evaluation report for further information.

"The more people get exposed to diversity the more literate people are about responding to discrimination" - *Intervention beneficiary*

"The diversity of the group has made me think about how I judge and interact others" - Intervention beneficiary

Longer-term outcome: Resilience

Finding 27: The Trial has helped to or will help to enhance the resilience of LGBTIQ+ communities in the longer-term.

There was strong agreement that Trial will help to enhance the resilience of LGBTIQ+ communities in the longer-term. This builds the finding above that the Trial helped to increase the capacities of LGBTIQ+ communities to support themselves and one another to minimise the risk of suicide. 85% of respondents agreed with the statement below:

Statement: The activities of the Trial have helped to or will likely strengthen the resilience of LGBTIQ+ communities

[n = 34 responses (out of 42 survey respondents)]

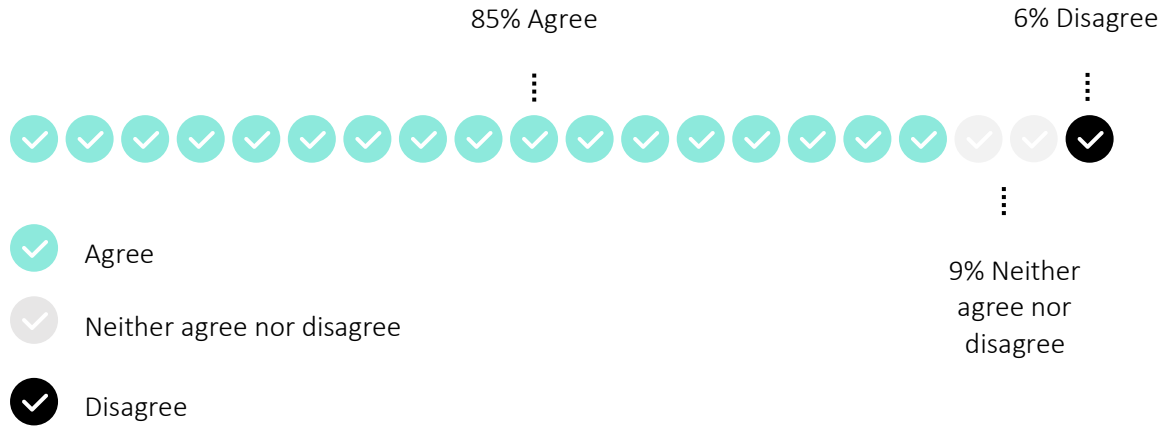


Figure 41 - Extent of agreement with "The activities of the Trial have helped to or will likely strengthen the resilience of LGBTIQ+ communities"

Figure 44 provides a summary of the specific interventions that have contributed to this outcome. Please refer to the relevant intervention-specific evaluation report for further information.

"I now feel confident to advocate for myself and express my needs, the Aftercare program has helped me to be more confident in that regard and call out people and health professionals if I have to. I definitely feel more comfortable to do that" – Intervention beneficiary

"I have learnt to ask for help if I feel suicidal or depressed. There is no shame in reaching out." - Intervention beneficiary

"It's helped me gain back a little confidence in what's available tbh… like if this great program exists maybe there is other help out there for me" - Intervention beneficiary

Longer-term outcome: Self-harm and suicidality

Finding 28: The Trial will lead to lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities in the longer-term

67% of survey respondents agreed that the activities of the Trial will likely lead to lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities.

Statement: The activities of the Trial have led or will likely lead to lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities

[n = 27 responses (out of 42 survey respondents)]

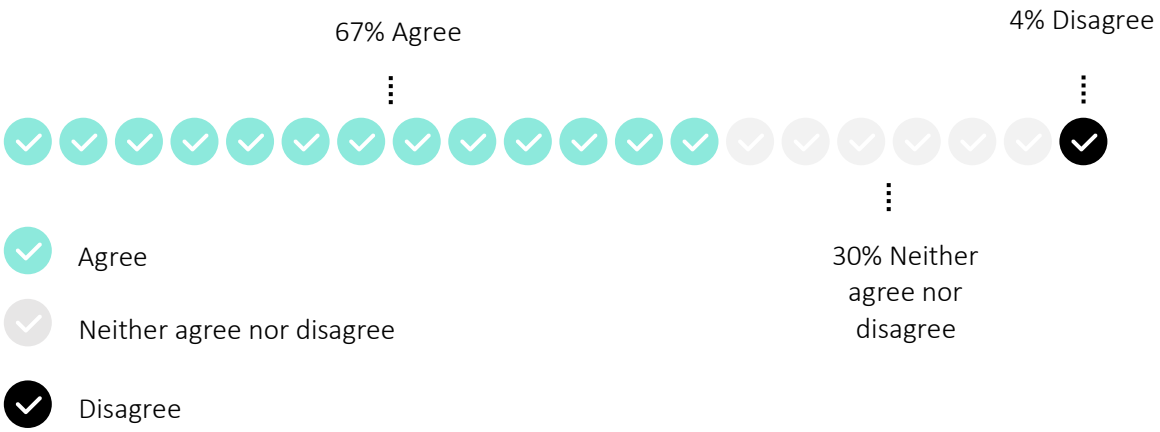


Figure 42 - Extent of agreement with "The activities of the Trial have led or will likely lead to lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities"

"I did have suicidal ideation but that's completely gone now, so I feel like it's made such a big difference. I've finished the Program officially but am going to continue seeing the psychologist because I've found it so beneficial" – Intervention beneficiary

"This Program probably saved my life and I really hope it continues to receive funding and support." – Intervention beneficiary

It is worth highlighting the significantly higher proportion of survey respondents that were neutral compared to the proportion of survey respondents that disagreed with the statement above. When explored further, it was identified that the neutral responses were a reflection of a lack of information to form a definitive view on the statement below, and a sense that it was 'too early to tell', rather than a lack of confidence in the activities of the Trial.

"It is hard to say what the broader impact on community these initiatives has or the long term affects." – Commissioned organisation

“A number of these outcomes are years in the making, it's unlikely we will see the impacts until much later down the track.” – Commissioned organisation

“It is hard to say what the broader impact on community these initiatives has or the long term affects.” – Taskforce member

Figure 44 provides a summary of the specific interventions that have contributed to this outcome. Please refer to the relevant intervention-specific evaluation report for further information.

9.4 Summary of outcomes

The Trial has been able to achieve a number of significant outcomes. These are summarised in the two tables below

Figure 43 depicts each of the outcomes achieved and the extent of available supporting evidence, noting that supporting evidence is both quantitative (i.e. through the Overall Trial Survey) and qualitative in nature (i.e. through the interviews conducted with Taskforce members, NWMPHN and commissioned organisations; and from the findings from the intervention-specific evaluation). It also demonstrates how the outcomes achieved align against Trial Framework that was used to inform the design of the Trial

Outcome		Extent of supporting evidence	Alignment against Trial Framework				
			Individual	Community	LGBTIQ+ Communities	Service System	Society
Short-term	Deeper understanding of the needs of LGBTIQ+ communities				X		
	Deeper understanding of effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities					X	
	Increased the awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities (including LGBTIQ+ specific and mainstream services)		X				
	Stronger sense of community connection (i.e. relationships with other people who are LGBTIQ+ and sense of belonging to the LGBTIQ+ community) among people who are LGBTIQ+				X		
	Stronger partnerships between organisations that support LGBTIQ+ communities.					X	
	Increased capacity of the service system to provide effective and safe suicide prevention,					X	

	intervention and postvention supports for LGBTIQ+ communities						
	Increased capacity of LGBTIQ+ communities to respond more effectively to suicide (i.e. by supporting themselves or each other)				X		
	Increased capacity of the general community to respond more effectively to suicide			X			
	Increased capacity of services providers (including mainstream providers and LGBTIQ+ specific service providers) to deliver services and supports that are safe and inclusive for people who are LGBTIQ+					X	
Longer-term	Reduced stigma against LGBTIQ+ communities						X
	Increased resilience of LGBTIQ+ communities					X	
	Lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities		X				

Higher level of supporting evidence of outcome

Lower level of supporting evidence of outcome

Alignment with Trial Framework X

Figure 43 - Alignment of outcomes against Trial Framework

Figure 44 depicts how each of the interventions contributed to the different outcomes

Outcome		Interventions							
		Aftercare	LGBTIQA+ Mentoring Projects	Affirmative Practice training	LGBTIQA+ Suicide Postvention Response Plan	Start, LGBTIQ+ safeTALK and LGBTIQ+ ASIST	Lean on Me research	Speaking Up Speaks Volume Campaign	Wellness grants
Short-term	Deeper understanding of the needs of LGBTIQ+ communities	X	X	X	X	X	X	X	X
	Deeper understanding of effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities	X	X	X	X	X	X		X
	Increased the awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities (including LGBTIQ+ specific and mainstream services)	X	X	X		X		X	X
	Stronger sense of community connection (i.e. relationships with other	X	X						X

	people who are LGBTIQ+ and sense of belonging to the LGBTIQ+ community) among people who are LGBTIQ+								
	Stronger partnerships between organisations that support LGBTIQ+ communities.	X	X	X	X				
	Increased capacity of the service system to provide effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ communities	X	X	X	X	X	X		
	Increased capacity of LGBTIQ+ communities to respond more effectively to suicide (i.e. by supporting themselves or each other)		X		X	X	X		X
	Increased capacity of the general community to respond more effectively to suicide					X		X	
	Increased capacity of services providers (including mainstream providers and LGBTIQ+ specific service providers) to deliver services and supports that are safe and			X		X			X

	inclusive for people who are LGBTIQ+								
Longer-term	Reduced stigma against LGBTIQ+ communities		X					X	X
	Increased resilience of LGBTIQ+ communities	X	X				X		X
	Lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities	X	X	X	X	X	X	X	X

Legend

Contribution towards outcome X

Figure 44 - Contribution of each intervention to the Trial outcomes

9.5 Key themes

Across the Trial there were critical themes that enabled/supported the outcomes identified in Figure 43 and Figure 44. These *enabling themes* are discussed and explored further below:

1. Community-specific – There was a strong recognition that mainstream suicide prevention models weren't appropriate for the people who are LGBTIQ+. This led to the development of the Trial Framework which drew on leading practice and evidence in suicide prevention and the needs and nuances of LGBTIQ+ communities to inform the specific interventions that made up the Trial. This community-specific approach ensured that the Trial was safe and fit-for-purpose for LGBTIQ+ communities.

2. Co-design – The community-specific approach identified above was further complemented by a co-design approach adopted in the design of the Trial, where people who are LGBTIQ+ and people with a lived experience of mental ill-health and/or suicide were engaged and empowered to drive the design of the Trial. Noting that the co-design process adopted by NWMPHN to work with the Taskforce to design the Trial was not without flaws (described below), on balance it was identified to have been a significant contributor to the design and hence outcomes of the Trial.

3. Involving peers in service delivery (Noting that 'peers' in this instance refers to individuals that share a similar background. This could be for example, people who are LGBTIQ+ delivering services to other people who are LGBTIQ+; or someone who has a lived experience of suicide supporting someone who has recently experienced suicidal ideation) - There were numerous examples of how involving peers led to a greater sense of safety, contributing to a conducive environment for service, training and information to be delivered in an effective manner. By having a lived experience and where appropriate, sharing this lived experience openly, peers were able to empathise with the people that they are working with and build trust more effectively. An example of where this was particularly successful in the Trial was the incorporation of Peer Practitioners (i.e. LGBTIQ+ individuals who had a lived experience of mental ill-health and suicide) in the delivery of the Aftercare service. Clients of the service identified that the Peer Practitioners helped to foster a safe and affirming space for them to seek help. They also created a reciprocal environment, where Peer Practitioners were supporting clients and vice versa. This created a mutually beneficial relationship, that is different to what clients would experience with a clinician or support worker, further reinforcing the sense of safety that clients feel. This also helped to minimise the sense of guilt that clients sometimes feel when seeking help.

   "It has been so affirming to be able to speak with a peer who understands exactly what I am going through" – Client of Aftercare

   "Talking with my peer worker was unique, I straight away felt like they understood, it was a closer person than a therapist" - Client of Aftercare

4. Collaborative relationship between commissioning agent and commissioned organisations – The relationships that the NWMPHN project team established with the commissioned organisations was identified as a critical enabler behind the success of the Trial. This led to

effective collaboration between both NWMPHN and each of the service providers, allowing both parties to collectively address unexpected challenges/issues that arose during the Trial. A prime example of this (as described above) was during the early stages of the COVID-19 pandemic when there was the option of transitioning the delivery of LGBTIQ+ safeTALK and LGBTIQ+ ASIST suicide prevention training programs online. This was discussed between LivingWorks and NWMPHN and an agreement was made to wait until face-to-face training could resume as delivering both trainings virtually would have detracted from the experience and learning outcomes of participants. Instead, NWMPHN agreed to reallocating some of the resources to commission the delivery of the online LivingWorks Start training during the COVID-19 lockdown that were happening across Victoria. This allowed LivingWorks to maintain the integrity of the LGBTIQ+ safeTALK and LGBTIQ+ ASIST (which received very positive feedback) whilst at the same time addressing the increased need for suicide prevention support in the LGBTIQ+ communities during the COVID-19 lockdowns.

"It always felt like a genuine partnership" – LivingWorks staff

"We were never pushed to compromise the quality of the training at any point. It was very nourishing to see that from a funder." – LivingWorks staff

5. Commissioning community-controlled organisations – When working with priority population groups, there are significant benefits in commissioning community-controlled organisations to deliver programs/services back into their own community:
    - Community-controlled organisations already have a deep understanding of the needs and nuances of their community, allowing them to hit the ground running upon commencement of the service.
    - They are also not only accountable to their funders but also to their community (as members of the community are often involved in the governance and leadership of the organisation). This added layer of accountability will help to ensure that programs/services are delivered to a high standard.
    - Community-controlled organisations are often already recognised and trusted by members of their own community, with strong networks in communities that are often hard-to-reach. This is critical in areas where there is a distrust of mainstream services (e.g. for LGBTIQ+ and Aboriginal and Torres Strait Islander communities).

The value of engaging community-controlled organisations was demonstrated through the development of the LGBTIQA+ Suicide Postvention Response Plan by Switchboard. The response plan was highlighted to have effectively captured the unique needs and context of LGBTIQ+ communities. In addition, being associated with Switchboard was also identified to have significantly enhanced the credibility of the document.

"We're not just doing it for ourselves as Switchboard. We're doing it for the community. It's not about making something that makes us look good, but creating a useful resources for someone who goes through this" – Switchboard staff

> *"The fact that the plan has been developed by Switchboard has given it a lot of credibility, a community-controlled organisation that has a lot of experience and expertise in mental health and suicide prevention and also has its own lived experience through the death of Ingrid Zang." – Recipient of the LGBTIA+ Suicide Postvention Response Plan*

On the other hand, there were also themes that limited the outcomes achieved or made it more challenging for them to be realised during the course of the Trial. These *limiting themes* are discussed and explored further below:

1. Co-design – Despite highlighting co-design as strength of the Trial, there is still significant room to improve the way people with a lived experience are engaged in the process. These include:
    - *Proactively addressing potential power imbalances* – There wasn't sufficient recognition of the different forms that power can come in (e.g. those with and without a lived experience, social power and privilege and positional power) and hence a lack of proactive efforts to address these imbalances in power throughout the co-design process of the Trial. This limited the contribution that certain individuals felt comfortable making during discussions.
    - *Intersectionality* – Designing the Trial to target LGBTIQ+ communities allowed the interventions to be nuanced and specific to the needs of people who are LGBTIQ+. However, targeting LGBTIQ+ communities does not mean that the Trial only needs to take into consideration a person's sexual orientation, gender identity and intersex status. Other elements of a person's identity such as culture, ethnicity, age, faith, socioeconomic status etc are also critical considerations that should inform the way programs/services are designed and delivered. This was highlighted as a key gap in the Trial and across a number of the interventions. For example, it was identified that the membership of the Taskforce would have benefited from a greater diversity of intersecting identities.

2. Staff safety – There was a significant focus on ensuring that programs were culturally appropriate and safe for the participants and clients of the interventions that were part of the Trial. The focus on safety for staff working for the different commissioned organisations was less apparent during the Trial and there were a few instances where this impacted their experience and wellbeing. This typically occurred in situations where there were LGBTIQ+ individuals working within a mainstream organisation. Two examples of where there was a lack of cultural safety for staff are:

    - *Aftercare (Mind Australia)* - Program staff highlighted that there was a lack of cultural safety initially within the broader organisation when the program started. Considering the complexity of the work required, this created additional stress for program staff who were not only expected to work with complex clients and but also to operate within a working environment where they didn't feel fully supported as LGBTIQ+ individuals.

    > *"We had to fight tooth and nail to get pronouns in our signatures" – Mind Australia staff*

> *"I felt like I had to do LGBTIQ+ education for folks there who didn't know nuances of certain things, that was a side part of the program that we hadn't anticipated at the start" - Mind Australia staff*

- *Start, LGBTIQ+ safeTALK and LGBTIQ+ ASIST (LivingWorks)* - The facilitators of the adaptation process to adapt the standard ASIST training for the LGBTIQ+ communities weren't familiar with the needs and nuances of LGBTIQ+ communities. This meant that the individuals who participated in the adaptation process did not feel completely safe to engage, which adversely impacted their experience.

> *"[The facilitators] that delivered the [co-design workshop] weren't LGBTIQ+ and meant that participants were a bit hesitant with participating in the training." – Trainers engaged in the adaptation of ASIST*

> *"[The facilitators] that delivered [the training] didn't recognise the disconnect and that the content was 'so straight"– Trainers engaged in the adaptation of ASIST*

Whilst there is value in building the capacity of mainstream organisations to better support people who are LGBTIQ+ (by commissioning them to deliver a program/service to LGBTIQ+ communities), care needs to be taken to ensure that these organisations have the understanding and capability to provide a safe and inclusive environment for LGBTIQ+ staff who may be employed/engaged in the delivery of programs/services to LGBTIQ+ communities.

3. Nature of trials – Trials (i.e. time limited activities) are useful to test and explore innovative programs and new ways of doing things. A number of new approaches were developed through this Trial, such as the development of a LGBTIQ+ - specific aftercare, and the creation of LGBTIQ+-specific suicide prevention training (i.e. LGBTIQ+ safeTALK and LGBTIQ+ ASIST). However, there are also significant drawbacks with this approach (and Trials more generally):
    - The establishment, and winding down of, programs/services creates further changes and uncertainty in terms of the available supports for people who are LGBTIQ+, making it difficult for individuals to navigate an already complex service system; and

    - Building trust within LGBTIQ+ communities takes significant time and resources. Terminating specific programs/services once this has been established may further reinforce the notion that the service system is not willing to make long-term investment into creating safe and culturally-appropriate services for people who are LGBTQ+, creating higher-levels of disengagement and mistrust towards the broader service system.

> *"So many pilot programs are able to have a really big impact and build momentum only to lose funding before being able to establish themselves as a reliable support that isn't going to leave clients hanging." – Referrer to the Aftercare program*

> *"It is such a struggle for the sector. You're given this (tender) and you have to work within those specifications, and then you jump onto another tender. This makes it untenable for the main thing that we do which is to support people" – drummond street staff*

These drawbacks will need to be actively considered in the design and implementation of future Trials for LGBTIQ+ communities and the general population.

Note: Noting the constraints around trials in general, it should be recognised that NWMPHN made a proactive attempt to ensure that the benefits of the Trial would be sustainable beyond its lifespan. This included:

- The development of the LGBTIQA+ Suicide Postvention Response Plan by Switchboard (which can continue to be used post the Trial);
- The Lean on Me research by ARCSHS (which can continue to be used post the Trial)
- The creation of LGBTIQ+ safeTALK and LGBTIQ+ ASIST trainings (which can continue to be delivered post the Trial);
- The training of qualified LGBTIQ+ safeTALK and LGBTIQ+ ASIST trainers who can deliver the training;
- The creation of an LGBTIQ+ Affirmative Practice training module which has been disseminated to a number of organisations to be used internally;
- The training of trainers within organisation to continue delivering the LGBTIQ+ Affirmative Practice training; and
- The development of program manuals that document the approach and learnings for the following interventions (i) Aftercare; (ii) LGBTIQA+ Mentoring Projects; (iii) Affirmative Practice. These will be shared with other PHNs, funders, community organisations and service providers to enable other organisations to establish a similar intervention

EVALUATION RECOMMENDATIONS

RECOMMENDATIONS

NWMPHN, along with other PHNs, operates at the intersect of the funding and policy reform environment and the local service system. Operating within these two domains, NWMPHN plays the following three, key roles (as depicted in the diagram below):

- Advocacy – Amplifying voices from the local community and service system to inform new policy and funding reforms;
- Commissioning – Identifying service gaps and needs in the community, and procuring services and programs to address them; and
- System enabler – Strengthening the capacity of the service system and its constituents.

As a result, the recommendations for this evaluation are categorised into these three roles.

Note: It is understood that the roles identified above are not mutually exclusive, meaning that there are instances where an activity may fit under multiple roles. Because of this, the roles are intended to provide a frame in which to understand how the recommendations from the evaluation can help to inform the work of NWMPHN moving forward.

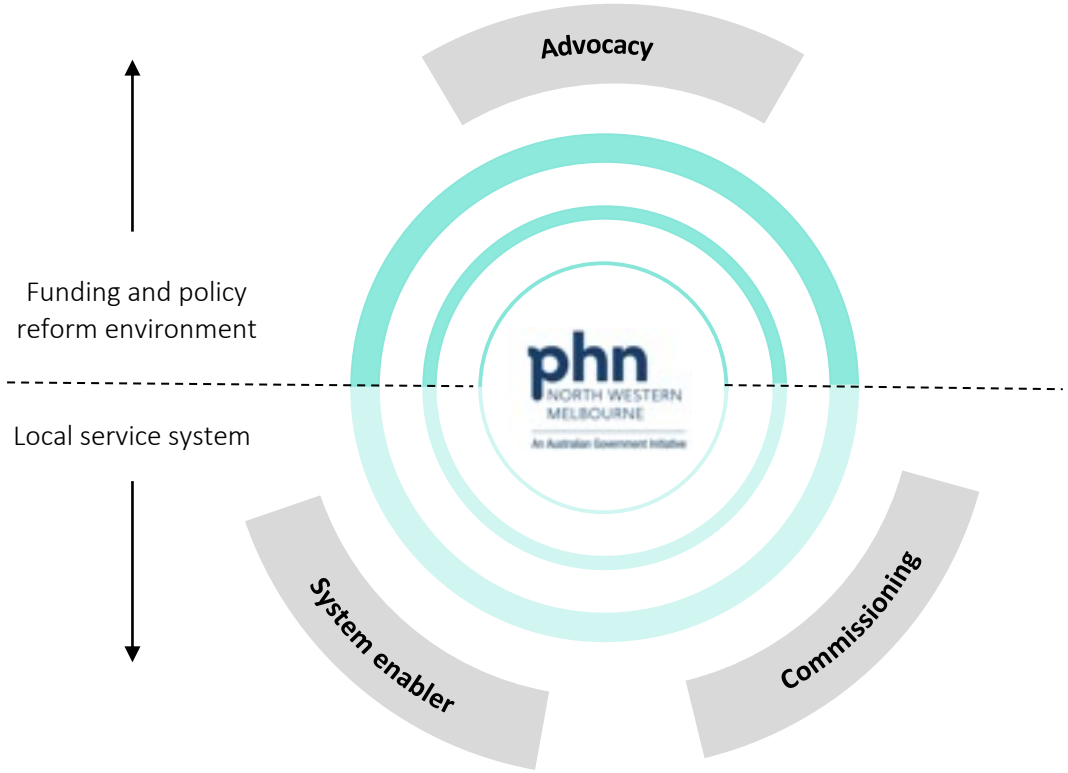


Figure 45 - Role of NWMPHN across the funding and policy context and local service system

Advocacy

Recommendation 1: Advocate for greater support for LGBTIQ+ communities across all levels of government

This Trial was able to address some of the significant unmet needs that exists among LGBTIQ+ communities due to the lack of safe and culturally appropriate mental health and suicide prevention services. The nature of Trial however means that the interventions are time-limited and that LGBTIQ+ communities will eventually lose or, in some instances, have already lost access to the supports that were made available during the Trial.

The limitations of this Trial relating to timeframe, geography and funding also means that a number of the systemic issues that exist in the health system (e.g. discrimination towards LGBTIQ+ people, lack of capability to safely and effectively support LGBTIQ+ people) have not been permanently addressed (notwithstanding the fact that many of these issues have been addressed throughout the Trial).

For this reason, it will be important for NWMPHN to continue advocating across all levels of Government and amongst other PHNs to collectively prioritise the needs of LGBTIQ+ communities across Victoria and Australia. In doing so, the focus of this advocacy should prioritise the delivery of sustainable solutions that are designed to address the systemic barriers and challenges that individuals from this community face.

Recommendation 2: Advocate for longer-term funding structures

A key challenge of the Trial was identified to be its temporary and time-limited nature (as discussed as one of the *limiting themes* in Section 9.3 above). As discussed in Section 9.3, time-limited funding can:

- Pose a significant risk to communities (particularly when there is already a lack of appropriate services);
- Create further uncertainty and challenges in navigating an already complex service systems; and
- Reinforce the notion that the service system is not 'willing to invest' in a particular community.

Recognising that funding parameters are often determined by the Commonwealth Government, NWMPHN should play an active role in sharing the learnings from the Trial (particularly around the challenges and risks of short-term program funding for priority population groups such as LGBTIQ+ communities). This should be done with the intention of advocating for longer-term funding arrangements for activities

Practically, if future trials were to be conducted, it would be useful at the outset to commit to the implementation of a longer-term service/program so that deeper relationships and enduring outcomes can be built and achieved with the community.

Commissioning

Recommendation 3: Continue to prioritise supporting LGBTIQ+ communities

Extending on Recommendation 1, and recognising the unmet needs that still exist in LGBTIQ+ communities, it will be critical that NWMPHN draws on the learnings from the Trial to enable it to prioritise LGBTIQ+ communities in future commissioning efforts.

Recommendation 4: Embed co-design across all stages of the commissioning process

The Trial was designed using a co-design process with the Taskforce, which was demonstrated to effectively meet the needs of LGBTIQ+ communities in the North West of Melbourne (as demonstrated by the findings from this evaluation). This insight not only reinforces the efficacy of co-design as a concept, but also recognises the importance of involving the relevant beneficiaries (in this case, through the involvement of the Taskforce) as early as possible in the commissioning process.

When co-designing in the future, it is also vital that NWMPHN continues to prioritise genuine and meaningful involvement of beneficiaries (i.e. representatives from the communities that will be the focus of commissioned services). This should be done regularly throughout the co-design process, ensuring it is meaningful.

In addition to ensuring that these stakeholders are embedded in the commissioning process (rather than consulted occasionally), it is important that potential power imbalances between different stakeholders involved in the co-design process are proactively addressed (which was identified as a gap in this Trial). This could involve explicitly calling out the power imbalances that exist and proactively providing opportunities to individuals who might be impacted by these power imbalances to contribute to discussions (this might involve facilitating different forums or providing multiple channels for engagement). Doing so will ensure that individuals are able to participate and contribute more effectively during the co-design process.

Recommendation 5: Proactively adopt an intersectional lens to service/program design and implementation

A key strength of the Trial was its focus on the unique and nuanced needs of LGBTIQ+ communities, including the recognition that mainstream suicide prevention models and frameworks (e.g. BDI Lifespan Model) are not appropriate in these instances. However, the Trial could have better recognised and considered the intersecting identities (in addition to an individual's gender identity, sexual orientation and intersex status) that exist in LGBTIQ+ communities. This was identified to be a gap in the composition of the Taskforce and some of the interventions that formed part of the Trial.

Moving forward, NWMPHN should make a concerted effort to understand the presence of intersecting identities and, having done so, ensure that these are considered in the design and implementation of commissioned services/programs, particularly when supporting priority population groups. Where this is not possible, it should be acknowledged and communicated upfront as a key limitation.

Recommendation 6: Prioritise community-controlled organisations in future commissioning efforts

Throughout the Trial, community-controlled organisations brought a number of unique strengths that may not exist (or at least exist to a lesser extent) in mainstream organisations. These strengths include:

1. Having an existing understanding of the needs and nuances of their community;
2. Being trusted and recognised by their community;
3. Having established networks and relationships within their community that can be leveraged to engage with communities that are often hard-to-reach and have a mistrust towards mainstream services; and
4. Being committed to delivering positive outcomes and often willing to go above and beyond the formal contractual obligations to support their community.

NWMPHN should actively recognise the strengths of community-controlled organisations identified above in future commissioning efforts, particularly among priority population groups (such as Aboriginal and Torres Strait Islanders, LGBTIQ+ communities and multicultural groups). Practically, this may involve requiring that any activity that is commissioned be done in collaboration with a community-controlled organisation (i.e. via a partnership model), or potentially that the entire program of works is co-managed by a community-controlled organisation. By taking such proactive steps to recognise the inherent value of community-controlled organisations, NWMPHN would be supporting the self-determination and empowerment of these communities.

Recommendation 7: Define a set of guiding principles to inform future commissioned services/programs for LGBTIQ+ communities

This evaluation has identified a range of critical factors relevant to the design and delivery of LGBTIQ+ services. These factors (which are captured below) should be documented in the form of a set of guiding principles and used to inform all work that the NWMPHN undertakes with LGBTIQ+ communities. Doing so will ensure a common approach to working that will foster greater collaboration across the service system (particularly with community-controlled organisations); and ensure consistency and a minimum standard across commissioned services/programs.

The guiding principles for working with LGBTIQ+ communities are set out below (noting that they are not meant to be exhaustive; rather, they are intended to provide NWMPHN with a preliminary set of principles based on the learnings from this evaluation that can be further refined over time):

1. *Co*-design – Embedding people who are LGBTIQ+ with a lived experience (of mental ill-health, suicide etc) in the identification of service gaps and community need; and actively involving them in the solution design process
2. *Community-led* – Ensuring that people who are LGBTIQ+ or LGBTIQ+ community-controlled organisations play a governing role in the delivery of services/programs;
3. *Lived experience* – Ensuring that people with lived experience (e.g. lived experience of mental ill-health or suicide) are represented in the delivery of services/programs to LGBTIQ+ communities;
4. *Intersectionality* – Acknowledging and reflecting the needs of intersecting elements of an individual's identity when working with LGBTIQ+ communities (in addition to a person's gender identity, sexual orientation and intersex status);

5. *Safety* - Prioritising the safety of LGBTIQ+ communities and also ensuring that the organisations that are commissioned to deliver services/programs to LGBTIQ+ communities are safe and inclusive for LGBTIQ+ people to work at;
6. *Relational* – Recognising that trust and existing relationships play a critical role in the successful engagement of LGBTIQ+ communities. This means that any work proposed with LGBTIQ+ communities must account for this relational aspect in the design and delivery of the work.
7. *Continuity of thinking* – Recognising that LGBTIQ+ communities are over-consulted, it is critical that when engaging or consulting with members from this community that existing information and data is leveraged and new insights/learnings effectively captured. Doing so will support the feeling that individuals from these communities have been heard and their opinions (which have previously been shared) are valued. It will also add to the existing evidence-base on how to work safely and effectively with people who are LGBTIQ+.

Recommendation 8: Empower commissioned organisations and build collaborative relationships

The relationships that were established between NWMPHN and the commissioned organisations during the Trial were instrumental in enabling the Trial to deliver on the outcomes achieved. This genuine and collaborative approach, which was underpinned by mutual trust and respect, should be a model that underpins how NWMPHN engages with all its commissioned organisations moving forward.

Recommendation 9: Strengthen approach to project management

Maintaining continuity of thinking was identified as a challenge during the Trial due to turnover in NWMPHN staff and Taskforce members. Robust project management approaches would be helpful in mitigating the risks with changes in key project personnel in the future and will help to ensure that there is a clear narrative/strategy that underpins the project in the long-term. This will include (but not be limited to) initiatives such as:

- More comprehensive project documentation and record keeping
- More proactive risk identification and mitigation
- Clearer handover processes between staff where there is turnover

System enabler

Recommendation 10: Invest to build capacity at the system and organisational level

Future commissioning efforts should include an active and explicit focus and intended outcome of building the capacity of (i) the LGBTIQ+ service system and (ii) organisations that work with LGBTIQ+ communities. Doing so will help to enhance the sustainability of outcomes and benefits derived from a particular service/program beyond its funding duration.

- *System-level*

  A key outcome of the Trial was the partnerships that were established between organisations that support LGBTIQ+ communities. The benefit of these partnerships was that they enhanced the overall capacity of the service system through greater collaboration and knowledge sharing between organisations that work in a similar space. There is an

opportunity for NWMPHN to continue to cultivate these partnerships in order to enable a more integrated service system that can work collaboratively to support LGBTIQ+ communities.

- *Organisational-level*

  An opportunity exists for NWMPHN to lend its expertise and organisational infrastructure to build the capacity of commissioned organisations to deliver activities in an efficient and effective manner. This is particularly the case for smaller and community-controlled organisations.

  Supporting organisational capacity has two primary benefits. The first is that by doing so it would benefit organisations to deliver activities in a more effective and efficient manner. Second, it would enable a greater diversity of (smaller and less-resourced) organisations to participate in commissioning opportunities more readily in the future. For example, the Wellbeing Grants engaged a number of smaller LGBTIQ+ community-controlled organisations. Some of these organisations, because of their size, demonstrated capability gaps in their ability to deliver against agreed objectives and would have benefitted from any extra capacity and expertise that NWMPHN or the Taskforce could provide.

Recommendation 11: Embed evaluation in services/programs earlier on

A key area for improvement of the Trial was identified to be the delay in program evaluation. Moving forward, this needs to be integrated into the design and delivery of services/programs from the outset to better enable the gathering of robust data and information. This would also enable a more participatory approach to evaluation, with the output from this work progressively informing the refinement of Trial activities (rather than only identifying potential opportunities for enhancement at the end of the Trial).

Recommendation 12: Proactively share learnings from this Trial

The learnings from this Trial have the potential to benefit a range of other stakeholders – from PHNs considering how they may commission services to support their local LGBTIQ+ communities; to informing how other teams within NWMPHN should approach co-designing in the future; to supporting State and Commonwealth Government to understand effective suicide prevention initiatives for LGBTIQ+ communities.

NWMPHN should readily engage with these stakeholders to share and disseminate the knowledge gained, ensuring that future activities of a similar nature can build on the significant effort that went into the design, implementation and evaluation of this Trial.

APPENDICES

APPENDIX A - EVALUATION SCOPE AND METHODOLOGY

Evaluation questions

The agreed evaluation questions that form the focus of this evaluation are identified below:

- To what extent was the Trial designed effectively?
- To what extent was the Trial implemented effectively?
- To what extent did the Trial achieve its intended outcomes/ objectives?

Data gathering

Approach

To support this evaluation, Impact Co. undertook the following data gathering activities to address each of the evaluation questions outlined previously.

Approach	Notes	Evaluation question		
		Q1	Q2	Q3
Survey of all key stakeholders of the Trial i.e. commissioned organisations, Taskforce members and NWMPHN staff	The survey was sent to 54 individuals and received responses from 42 individuals, representing a response rate of 78%.	X	X	X
Semi-structured interviews	Targeted interviews were then conducted with NWMPHN and 6 other representatives from those surveyed.	X	X	X
Intervention-specific evaluation	The findings from the detailed evaluation of each of the 8 interventions that made up the Trial were also leveraged to inform the evaluation of the Trial.	X	X	X

Note: 'X' indicates the data gathering approaches that seeks to address the respective evaluation questions

The program logic on the following page was developed in the establishment of the Trial and describes the potential long-term, medium-term and short-term impacts and outcomes that Program could achieve. It identifies the corresponding outputs, activities and inputs of the Program and provides the framework that underpins the design of this evaluation.

Timeframe

The timeframe of the data gathering occurred between Jan 2021 and June 2021

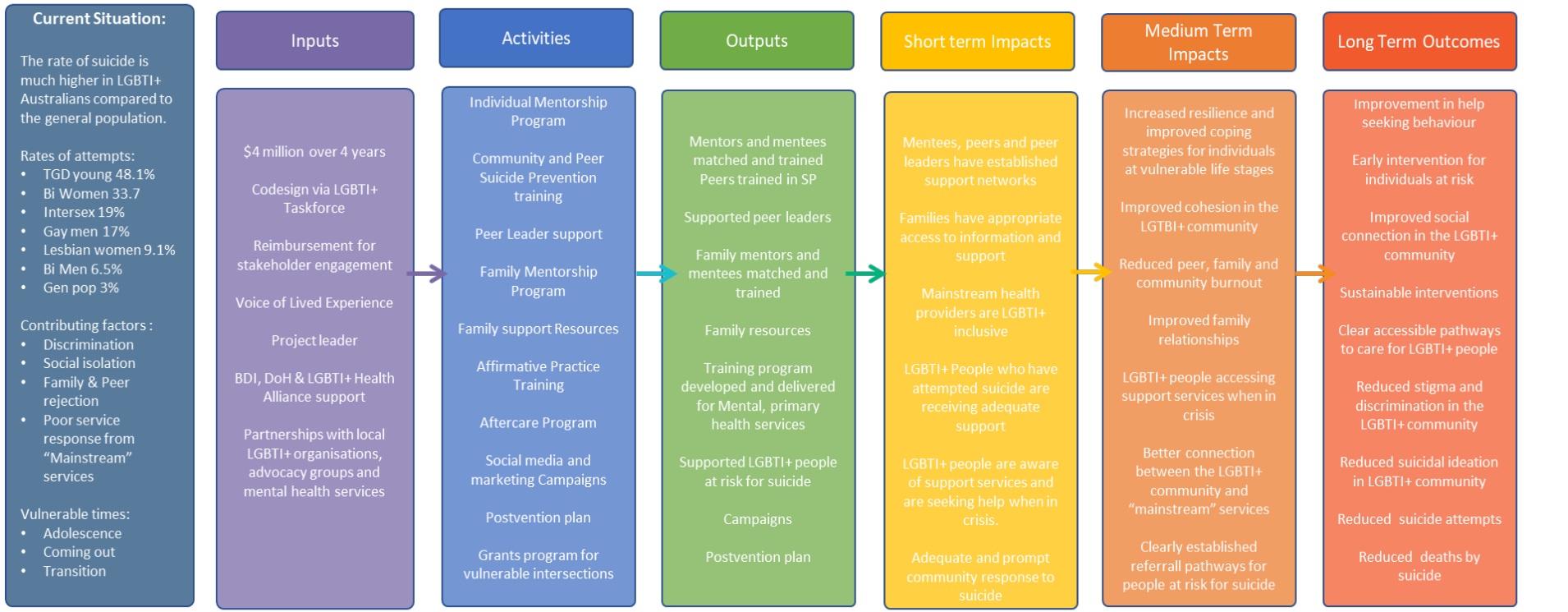
IMPACT CO.

LGBTI+ Suicide Prevention Trial

Aim: Reduce suicidality in the LGBTI+ community in North Western Melbourne; including reducing suicidal ideation, suicide attempts and deaths by suicide.

Objectives:

1. Understand and address the factors that contribute to suicide in the LGBTI+ community
2. Co-design and implement a systems-based framework for suicide prevention in the LGBTI+ community using multiple interventions simultaneously.
3. To understand what works for suicide prevention for the LGBTI+ community and to contribute to the currently lacking evidence base for this high-risk population.



External factors: HOPE trials; LHN statement of priorities; Place-based Suicide prevention trials; State Government election; LGBTI+ family safety initiatives; High demand and burnout in sector; LGBTI+ Homelessness initiatives; Commitment from broader sector to trial

Data analysis

All interviews were recorded and transcribed where necessary. A thematic framework was developed using inductive analysis to identify evaluation findings.

Insight validation

The evaluation findings were validated with NWMPHN via a series of validation workshops. A draft copy of this evaluation report was then circulated to NWMPHN for their review and feedback before being finalised.

APPENDIX B – OVERALL TRIAL SURVEY QUESTIONS

Background

1. What is your involvement with the Trial?
    a. Part of the Taskforce - As a service provider representative
    b. Part of the Taskforce - As a lived experience representative
    c. Part of NWMPHN
    d. Part of a service provider that was funded through the Trial
    e. Other_____

2. What is the length of your involvement with the Trial?
    a. Less than 12 months
    b. Between 12 month and 24 months
    c. More than 24 months

Design

Instructions: Answer what you feel comfortable answering. Where you don't feel comfortable answering a questions, please select "Don't know"

<u>To what extent to do you agree with the following statements [Strongly Disagree <> Strongly Agree or Don't Know]:</u>

Taskforce composition

3. The right people (i.e. with the relevant expertise and experience) were involved in the Taskforce to inform the design of the Trial
4. There was sufficient diversity (e.g. sexual identity, gender identity, cultural background etc) in the composition of the Taskforce
5. Everyone on the Taskforce had an equal voice (i.e. everyone's input was equally considered and respected) and was able to contribute in an equitable manner to the design of the Trial

Design inputs

6. The design of Trial effectively takes into consideration the needs of LGBTIQ+ communities in the North West of Melbourne
7. The design of Trial effectively takes into consideration the state of the mental health and suicide prevention service system in the North West of Melbourne (i.e. the Trial takes into consideration the strengths and gaps of the mental health and suicide prevention service system in the North West of Melbourne)
8. The design of the Trial is adequately driven by people who are LGBTIQ+
9. The design of the Trial is adequately driven by people with a lived experience of mental ill-health and suicide

10. The design of the Trial is adequately informed by research and leading practice
11. There are no gaps in the design of the Trial

Open-ended

12. [OPEN ENDED] Any other comments on the design of the Trial?

Implementation

Instructions: Answer what you feel comfortable answering. Where you don't feel comfortable answering a questions, please select "Don't know"

To what extent to do you agree with the following statements [Strongly Disagree <> Strongly Agree or Don't Know]:

Common agenda

13. There was a shared understanding of the objectives and desired outcomes for the Trial
14. There was clarity around the role of the Taskforce to support the outcomes for the Trial

Backbone infrastructure

15. The activities implemented during the Trial were effectively coordinated
16. NWMPHN worked in a collaborative manner with the Taskforce
17. NWMPHN worked in a collaborative manner with the funded organisations (i.e. organisation that received funding as part of the Trial)

Mutually reinforcing activities

18. The activities implemented as part of the Trial were aligned to the Trial's objectives and desired outcomes
19. The activities implemented as part of the Trial were complementary to one another
20. There was effective collaboration and integration between the interventions and activities of the Trial

Shared measurement and accountability

21. *The objectives and desired outcomes for the Trial were measured using clear success measures*

22. The funded organisations (i.e. organisation that received funding as part of the Trial) were effectively held to accountable to deliver on their contracted obligations during the Trial
23. NWMPHN's approach to monitoring and managing the progress of funded activities was effective

Continuous communication

24. There was effective communication throughout the Trial
25. There was effective knowledge sharing throughout the Trial

Open-ended

26. [OPEN ENDED] Any other comments on the implementation of the Trial?

Outcome

Instructions: Answer what you feel comfortable answering. Where you don't feel comfortable answering a questions, please select "Don't know"

To what extent to do you agree with the following statements [Strongly Disagree <> Strongly Agree or Don't Know]:

Overall

27. The Trial effectively met the needs of the LGBTIQ+ communities and suicide prevention service system in the North West of Melbourne

Knowledge/awareness

28. The activities of the Trial have led to a deeper understanding of the needs of LGBTIQ+ communities
29. The activities of the Trial have led to a deeper understanding of effective and safe suicide prevention, intervention and postvention supports for the LGBTIQ+ community
30. The activities of the Trial have helped to increase the awareness of available and appropriate support services among people who are LGBTIQ+ and service providers who work with LGBTIQ+ communities (including LGBTIQ-specific and mainstream services)

Relationships

31. The activities of the Trial have helped to strengthen the sense of community connection (i.e. relationships with other people who are LGBTIQ+, stronger sense of belonging to the LGBTIQ+ community) among people who are LGBTIQ+
32. The activities of the Trial have helped to strengthen partnerships between organisations that support LGBTIQ+ communities.

Capacity/capability

33. The activities of the Trial have helped to increase the capacity of the service system to provide effective and safe suicide prevention, intervention and postvention supports for LGBTIQ+ community
34. The activities of the Trial have helped to increase the capacity of LGBTIQ+ communities to respond more effectively to suicide
35. The activities of the Trial have helped to increase the capacity of the general community to respond more effectively to suicide
36. The activities of the Trial have helped to increase the capability of services providers (including mainstream providers and LGBTIQ+ community controlled organisations) to deliver services and supports that are safe and inclusive for people who are LGBTIQ+

Long-term health and wellbeing

37. The activities of the Trial have helped to or will likely reduce stigma against LGBTIQ+ communities
38. The activities of the Trial have helped to or will likely strengthen the resilience of LGBTIQ+ communities
39. The activities of the Trial have led or will likely lead to lower rates of self-harm, suicide attempts and deaths by suicide within LGBTIQ+ communities

Open-ended

40. [OPEN ENDED] Any other comments on the outcomes achieved through the Trial?

APPENDIX B – INTERVIEW QUESTIONS

Overview:

1. When did you join the Taskforce
    a. How did you find out about it
2. What is your role in the Taskforce?
    a. Was there any orientation to the taskforce?

Outcomes:

1. What do you think are the key outcomes achieved by the Taskforce?
    a. System level
    b. Organisation level
    c. Individual level
2. What do you think of the design of the LGBTIQ suicide prevention trial?
    a. Do you think the trial design effectively meets the needs of the local LGBTIQ community?
    b. What are the key strengths of the trial?
    c. Are there any gaps in the design of the trial? If so, what are they?
3. How enduring do you think are the outcomes that have been achieved by the Taskforce?

Process:

1. What do you think were the key activities of the Taskforce?
    a. What was the process adopted by the Taskforce to determine the design of the trial?
    b. What is your understanding of co-design? Do you think that a co-designed approach was adopted by the Taskforce in designing the trials?
    c. Did you feel you were able to contribute to decisions around how the trials were designed?
2. How do you think the Taskforce performed in conducting its key activities?
    a. What have been some of the challenges encountered?
    b. What do you think has worked well so far?
    c. What could be improved?
3. Is there anything that you would do differently if you had the opportunity to restart the process?
4. Can you think of any factors outside the program that might have influenced how the activity was put into action (or implemented)? Do you think that that might have influenced the changes that you have seen?
5. Did you feel your input was valued and your thoughts taken into consideration? Were you able to speak openly and honestly about the topics discussed?