LA TROBE UNIVERSITY

Shane Worrell
Andrea Waling
Joel Anderson
Jackson Fairchild
Anthony Lyons
Christopher A. Pepping
Adam Bourne

August 2021

Australian Research Centre
in Sex, Health and Society

Lean on Me: Exploring Suicide Prevention and Mental Health-Related Peer Support in Melbourne's LGBTQ Communities

latrobe.edu.au/arcshs

Australian Research Centre
in Sex, Health and Society

Copies of this report or any other publications from this project may be obtained by contacting:

Australian Research Centre in Sex, Health and Society (ARCSHS)
Building NR6
La Trobe University, Victoria 3086
Australia

T (03) 9479 8700

E arcshs@latrobe.edu.au

latrobe.edu.au/arcshs

Lean on Me: Exploring Suicide Prevention and Mental Health-Related Peer Support in Melbourne's LGBTQ Communities

Suggested citation:

Worrell S, Waling A, Anderson J, Fairchild J, Lyons A, Pepping C, Bourne A (2021) *Lean on Me: Exploring Suicide Prevention and Mental Health-Related Peer Support in Melbourne's LGBTQ Communities.* Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

DOI: 10.26181/60ac728cdb7ef

ISBN: 978-0-6450256-9-9

Report design: Elinor McDonald

Lean on Me: Exploring Suicide Prevention and Mental Health-Related Peer Support in Melbourne's LGBTQ Communities

Shane Worrell[1]

Andrea Waling[1]

Joel Anderson[1]

Jackson Fairchild[1]

Anthony Lyons[1]

Christopher A. Pepping[2]

Adam Bourne[1]

August 2021

1 Australian Research Centre in Sex, Health and Society, La Trobe University
2 Department of Psychology and Counselling, La Trobe University

Contents

About this report

Lean on Me: Exploring Suicide Prevention and Mental Health-Related Peer Support in Melbourne's LGBTQ Communities **examines the experiences of people who help others during a mental health crisis. Drawing on data from 25 interviews and a survey of more than 300 people, this report focuses specifically on how LGBTQ people who provide peer support are impacted by doing so.**

Lean on Me demonstrates that burnout is a common negative impact of suicide prevention and mental health-related peer support in an LGBTQ context. This report explores the genesis of such burnout, considering how and why the need for peer support is so great within LGBTQ communities in Melbourne.

The findings chapters of this report explore the context in which peer-support roles are performed, the pressures community members face when being leant on and the ways in which those experiencing burnout from providing support seek to mitigate its impacts. We highlight the need for people performing peer-support roles to themselves be helped, to prevent burnout and to make support roles more sustainable. Thus, *Lean on Me* makes recommendations about how those being leant on can be better supported in roles that are meaningful to them – and even a matter of life and death for their fellow community members.

Acknowledgements

We thank everyone who made this report possible. A big thank-you especially goes to the 25 people who offered their time to be interviewed and the more than 300 people who took part in the survey.

We express our gratitude to members of the Community Advisory Board for their involvement. Our sincere thanks go to the following people for providing valuable input and feedback at various stages of the research process:

Rei Alphonso (Flat Out)

Amelia Arnold (Thorne Harbour Health)

Anne-lise Ah-fat (Undercurrent Victoria)

Anna Bernasochi (Switchboard)

Daniel Bryen (Thorne Harbour Health)

Kian Hall

Eliza Hovey (Beyond Blue)

Ray Jackson (Beyond Blue)

Jo Read (North Western Melbourne Primary Health Network)

Sara Strachan (Zoe Belle Gender Collective)

Thanks to the funder of the study, North Western Melbourne Primary Health Network (NWMPHN), for its commitment to this important research topic and for making this report possible. We thank the LGBTIQ Taskforce – which provides the National Suicide Prevention Trial (NSPT) advice on behalf of the LGBTIQ community – for identifying this key, and incredibly important gap, in the evidence base.

Thanks to Gene Lim for providing invaluable assistance during the promotion stage of the survey.

We also acknowledge all community members who provide vital peer support to others despite the significant challenges they face in doing so.

Funding

Lean on Me received generous support from North Western Melbourne Primary Health Network (NWMPHN) through the Australian Government's National Suicide Prevention Trial.

phn
NORTH WESTERN MELBOURNE
An Australian Government Initiative

Terminology

We use the term LGBTQ throughout this report to refer to study participants who identity as lesbian, gay, bisexual, trans or queer. Although this study promoted itself as an LGBTIQ study during the survey recruitment phase, only four of 326 survey respondents and none of the 25 people who were interviewed identified as having an intersex variation/s. Despite our efforts to be as inclusive as possible, this study cannot claim to be representative of intersex people or communities. To do so would be inaccurate and misrepresent people with intersex variation/s. We do, however, sometimes use the term 'LGBTIQ' or 'LGBTI' when referring to broader research that is inclusive of intersex people or communities. One of the 25 people interviewed for this study identified as asexual. Similarly, this report cannot claim to be representative of asexual people or communities. Therefore, asexual is not included as part of the acronym we use to describe participants collectively.

Where possible, we keep participants' own terminology used to describe their identities, community or communities. This also occasionally applies to our discussion of community organisations' use of terms, including 'LGBTI'.

Executive summary

About the *Lean on Me* study

Many LGBTQ community members in Melbourne provide suicide prevention and other mental health-related support to peers. This peer support is vital and can be a last resort for those who receive it. In being there to be leant on, community members save lives. Many also experience negative impacts: on their own mental health, their relationships, their employment and their studies.

'Peer support' has various meanings, including in the context of mental health services. We use the term to refer broadly to informal mental health support that LGBTQ people provide peers outside service settings.

Lean on Me explores why such suicide prevention and mental health-related peer support is provided in LGBTQ communities in Melbourne, how it is delivered and what impacts – positive and negative – it has on the people who perform it. We recommend a series of actions be taken to ensure peer-support work is sustainable.

Key findings in this report are that suicide prevention and mental-health peer support:

- Can literally save lives
- Can lead to significant burnout for those who provide it
- Can negatively affect the employment, education and relationships of those who provide it
- Can be a long-term commitment for those who provide it
- Is often a response to exceptionally high levels of mental ill health in LGBTQ communities
- Is often a response to inadequate mental health services for LGBTQ communities
- Is meaningful for those who provide it

Methods

This study draws from data collected in qualitative interviews with 25 people, aged 23 to 79, living in metropolitan Melbourne, Australia, and identifying as LGBTQ. Interviews explored:

- Experiences of providing suicide prevention and mental health-related peer support
- Positive and negative impacts of performing support roles, including on participants' mental health
- How participants dealt with the challenges of peer support, including burnout
- Support participants drew on or would like to draw on when dealing with the challenges of their peer-support roles

Participants were sourced from a quantitative survey of 326 people run in conjunction with this study. The *Lean on Me* survey also focused on suicide prevention and other mental health-related peer support provided by members of LGBTQ communities in Melbourne.

Results

Lean on Me demonstrates that suicide prevention and mental health-related peer support is extensive and vital in LGBTQ communities in Melbourne. Such peer support involves a person being there for a friend, partner, colleague or even stranger during a mental health crisis, including when they are suicidal.

This report shows that peer support can help someone choose life over death. It can help people regain control of their lives and start on a path to better social and emotional wellbeing. The following quotation demonstrates how crucial peer support is:

> *I've had people come up to me years after the fact and during coffee turn around and say, 'Do you realise that I'm only alive today because of what you did at so-and-so event?' and I'm like, 'What are you talking about?' and they're like, 'That week, I was literally debating committing suicide. I was getting my affairs in order and everything like that and then I went to one of the events and you actually sat down and spoke to me like a human being and I wasn't used to that. I wasn't expecting that.' I'm like, 'Well, that's just being human.' (Robbie, cisgender man)*

Peer support occurs in the context of exceptionally high levels of mental ill health in LGBTQ communities; widespread experiences of trauma; and complex, often uneasy relationships with health and mental health services. Peer support is often provided in situations of precariousness – not just for the person being helped, but also for those providing the support. As one participant said:

> *Everyone's mental health is a house of cards built on everyone else's house of cards. It's like one of those Escher drawings where there's hands that are all holding each other but none of them are actually supported by anything other than each other. (Kristen, trans woman)*

Being there to be leant on is not only a response to mental ill health in LGBTQ communities, but also a mental health system that is not adequately inclusive of LGBTQ populations.

This report shows that community members who support peers have been exposed, often frequently, to suicidality, suicide attempts and the grief associated with losing someone to suicide. One participant explained that they had been in dozens of situations in which they supported someone who was suicidal. They said:

> *I wouldn't be able to count, to be honest … it would be over 50. How many people? Probably, say, between … five and 10. There's a couple of particular people that I have done it for quite a lot over the last few years. (Drew, trans)*

Burnout can have a significant impact on a person who performs a peer-support role. Participants in this study provided support to their peers informally in their own time, in ways that often affected their own wellbeing, relationships, employment and studies. For many, providing this support was meaningful and vital – but often unsustainable.

Being leant on: peer-support roles in LGBTQ communities

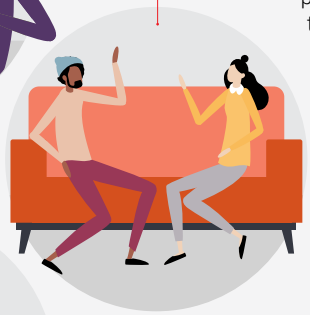
Lean on Me demonstrates that suicide prevention and mental health-related peer support takes numerous forms and is performed in many different contexts. It is important, however, to emphasise the common threads that are visible in participants' support roles.

We propose a typology of peer support that outlines six recognisable roles drawn from participants' experiences. This typology emphasises the distinct characteristics of these role types and the challenges they bring. It allows us to identify specific challenges associated with a peer-support role and provide recommendations aimed at addressing them. Below is a summary of each role and what key challenges someone performing them faces.

THE SAFE FRIEND

Summary: A trusted friend leant on in times of crisis. Known for being non-judgmental, empathetic and approachable. Can end up being 'on-call' for those in need

Challenges: Interruptions to work, education and leisure time. May find it difficult to step back if distress is ongoing and little progress is being made. Can find it hard to define boundaries



THE HOUSEMATE

Summary: Provides support to a non-partner with whom they live. Can be thrust suddenly into a peer-support role, due to their physical proximity to a person who is distressed

Challenges: May find it difficult to draw boundaries in the home and separate the roles of a carer, housemate and friend. Role found to intensify during COVID-19-related enforced lockdowns

THE PEER LEADER

Summary: A prominent person within a community support or friendship group setting. Considered confident, strong and trustworthy. Often approached by strangers or 'friends of friends' for help

Challenges: Can struggle with the volume of requests to support others. May find themselves 'always on' when providing support in community settings or online group chats. Might feel a need to help everyone else while struggling to find their own support

THE HELP WORKER

Summary: Works in a job in which they help people, at least some of whom are LGBTQ. Often called on to use their expertise in a non-work setting to help those around them

Challenges: Faces the risk of working the 'double shift' – providing support to others at work and in their personal life. Might overwork themselves in both settings to help

THE PARTNER

Summary: There for a partner or partners with whom they may or may not live. They provide important emotional and mental health support, especially around issues of trauma

Challenges: May undervalue the support they provide, deeming it 'just part of being in a relationship'. They can become more of a carer than a partner, resulting in their own needs not being met

THE FRIENDSHIP CIRCLE

Summary: A group of friends who rally around s omeone in distress, including while they are suicidal or after an attempt

Challenges: A huge commitment of time and energy communicating with a group of friends. While care can be shared among a group, openness may mean members end up supporting multiple people

Participants' collective experiences have informed the conceptualisation of each role. These articulations might be familiar to other people in LGBTQ communities who perform similar work. Community members might find it helpful to identify with a role in this typology and consider how recommendations to address the key challenges outlined might benefit them. This typology is not intended to be prescriptive. Rather, we present findings in a way that we hope demonstrates that individual experiences of peer support have common threads, both across this study and more broadly.

Readers might recognise themselves as having adopted or resisted one or more of these peer-support roles at various stages of their life. Our hope is that this typology provides an accessible way of understanding different peer-support roles, their challenges and what might be done to mitigate their negative impacts.

Burnout and other impacts on those providing peer support

Interviews with participants in this study show that peer support has significant impacts on those who provide it. One of these impacts is burnout, defined as a 'prolonged response to chronic emotional and interpersonal stressors' (Maslach et al., 2001, p. 397). Three dimensions characterise burnout: exhaustion, cynicism and inefficacy. Among participants in this study, burnout is common, leading in some cases to mental ill health. One participant described their experience, saying:

> *It does force me to reassess the support I offer people, because there's only so much of me, and I am a finite resource … If something like that has happened, I'll tell the other people I care for in my life … 'You will have to go elsewhere, because I am depleted.' (Ingrid, cisgender woman)*

Peer-support roles can be overwhelming. In the case of participants in *Lean on Me*, people being leant on have often turned to others – personal networks and professionals – for support with their own mental health. They have engaged in self-care routines and enjoyed some community and societal support to perform their peer roles. This study also shows, however, that boundaries – between a carer and the peer they help – can be difficult to set.

> *I feel like to withdraw would further derail her, so I feel like I don't know. I'm not confident in managing that boundary. (Jayden, gender diverse)*

Impacts of peer support have also been positive. Not only is peer support vital for those who receive it, people who perform peer-support roles find meaning in their experience. Peer support is an important first response during a mental health crisis, but it also helps build resilience and strength in individuals and leads to better personal, professional and health outcomes in communities. These positive, invaluable contributions to LGBTQ communities, therefore, should be harnessed – but to do this, peer support roles must first be made sustainable.

How LGBTQ peers providing support can be helped

Melbourne's LGBTQ communities should not be in a situation where mental ill health and suicidality are so common nor where the responsibility for so much suicide prevention and mental-health crisis support falls on peers. Rather, community organisations, health services and mental health professionals should be adequately equipped and funded to absorb this demand.

To help achieve better outcomes for those providing vital peer support in LGBTQ communities, we make six recommendations. We emphasise the importance of a collective commitment from various levels of government, public health networks and community organisations to help achieve better mental health outcomes for LGBTQ communities.

We acknowledge that the effects of COVID-19 have placed considerable strain on the provision of health and mental health right across society, stretching some providers to their limit. Therefore, we urge a response proportionate to both the current public health situation and the state of mental ill health and peer-support provision in LGBTIQ communities as highlighted in this report.

Calls for funding in the below recommendations are directed at all those with a capacity to enhance support. This includes, but is not limited to, state and territory governments, the federal government, Primary Health Networks (PHNs), non-governmental organisations (NGOs) and philanthropic enterprises.

Key recommendations

Our recommendations are driven by:

- The need to help people in peer-support roles in ways that promote better outcomes for both them and the person/s they are helping
- The need for structural changes that better support those experiencing mental ill health, thus making them less reliant on peers

Our recommendations are as follows:

1. **Develop a set of guiding principles to support LGBTQ communities in providing care to people experiencing both chronic and acute mental-health crisis**

We anticipate that this will include consideration of boundaries, role definition, self-care and other challenges. We see these core principles being delivered through training and resources for community members.

2. **Raise awareness of and further resource telephone support lines or web-chat services for people in peer-support roles**

We envisage this as multiple helpline or web-chat services that provide immediate advice to peers on issues such as risk management, crisis and carer support. The existing Rainbow Door service, run by Switchboard Victoria, should be further resourced and promoted more widely to ensure accessibility and uptake.

3. **Help peers better respond to active suicidal ideation and to recognise burnout**

Many participants in this study were supporting peers to prevent suicide without training of any kind. There was, however, considerable interest in such training, particularly in the form of ASIST (Applied Suicide Intervention Skills Training). More training needs to be made available to those with the capacity and willingness to undertake it and should be delivered in a culturally safe and LGBTQ affirming manner.

4. **Develop safe suicide-prevention referral pathways**

At a structural level, it is essential that safe and LGBTQ-affirming referral pathways exist that facilitate timely intervention for people experiencing suicidal ideation. These pathways should include peer-led programs in both LGBTQ-controlled organisations and accredited and culturally safe mental health organisations.

5. Develop a broader action plan for responding to suicidality in LGBTQ communities

We call for a broad action plan that supports the need to reduce suicidal ideation and mental ill health in LGBTQ communities and responds to its impacts in more focused and structural ways. Such a plan should speak to the service and policy revision that is required across all sections of the mental health system, including early intervention, acute care and suicide prevention as well as including both mainstream and LGBTQ-specific service provision.

6. Undertake further research that examines the experiences of those being cared for

More needs to be understood about the people being helped – the ones turning to a peer when experiencing mental ill health. A deeper understanding is needed of the nature of LGBTQ community members' mental health experiences, the forces that shape their health service engagement and the nuance of their experience that helps to determine whether it is safe, affirming and effective. Research is also required to assess the competency of mental health service providers to meet the needs of the LGBTQ community in a culturally safe and affirming manner. Further to this, we must acknowledge that no single study can hope to understand and reflect the diverse needs of the entire LGBTQ population. There is a need for nuanced and culturally sensitive research into the specific needs of intersecting communities.

Development of *Lean on Me*

Lean on Me was commissioned by the North Western Melbourne Primary Health Network as part of the National Suicide Prevention Trial (NSPT). The concept for the study emerged from the LGBTIQ Taskforce that provides the NSPT invaluable advice, direction and governance support on behalf of the LGBTIQ community. The LGBTIQ Taskforce identified the limited evidence base articulating how mental wellbeing is shaped in the LGBTIQ community and how these identified needs can be supported. *Lean on Me* was designed in collaboration with a Community Advisory Board comprising key stakeholders and experts from the mental health and LGBTIQ wellbeing sector.

1. **Background**

1.1 Mental health and suicidality among LGBTQ communities

Research from both Australia and comparable settings overseas documents significantly higher levels of mental ill health among lesbian, gay, bisexual, transgender and other queer identifying (LGBTQ) people when compared to those who are heterosexual and/or cisgender (King et al., 2008). This is evident in higher rates of psychological distress, anxiety and depression (Ritter et al., 2012). While rates of mental ill health are high across the entire LGBTIQ population, research has shown that trans and gender diverse (TGD) people experience substantially worse mental health outcomes than their cisgender counterparts (Geist et al., 2019; Crissman et al., 2019). Research conducted in other countries suggests that TGD people are more likely to contemplate suicide and are estimated to be 11 times more likely to die by suicide than the general population (Grey & Janus, 2018). Significantly poorer mental health is also observed among people who identify as bisexual or pansexual. A recently published study of more than 2600 bisexual people in Australia found that 58.8% of participants reported high or very high levels of psychological distress (Taylor et al., 2019), in comparison to 11.7% of the general population (ABS, 2017). There is limited data pertaining to the mental health of people with an intersex variation, although the psychological impact of unnecessary medical intervention and threatened bodily autonomy has been widely documented (Victorian DHHS 2018).

In no jurisdiction in Australia does the coroner collect information relating to sexuality, and data pertaining to gender is only binary in nature. This removes the possibility of clearly establishing how many LGBTIQ people die by suicide each year. However, recently published data from the US indicates that, between 2013 and 2015, LGBTIQ young people aged 12-29 accounted for 24% of all people nationally who died by suicide (Ream, 2019). This is more than seven times the estimated proportion of the population who are LGBTIQ in the US. A large survey of LGBTQA+ young people in Australia, aged 14-21, found that one-in-four (25.6%) had attempted suicide, including one-in-ten (11%) who did so in the previous 12 months, an experience that was significantly higher among TGD participants (Hill et al., 2021). A similarly large survey of LGBTIQ adults (Hill et al., 2020) found that 30.3% had attempted suicide at some point in their lives, which compares to a rate of attempted suicide within the general population of about 3.2% across the life course (Johnston et al., 2009).

This experience of mental ill health and elevated rates of suicidality need to be understood in the context of broader social and cultural forces. LGBTIQ people are often challenged by significant levels of stigma and marginalisation (Perales, 2019; McKay, 2011). While important legislative advances have been made in some areas, such as the implementation of marriage equality in Australia and the ability for birth certificates to reflect gender identity in some states (such as Victoria), additional challenges remain. This is particularly the case for trans and gender diverse individuals, many of whom still struggle to access gender affirming therapies (Waling et al., 2019; Heyes & Latham, 2018), and for people with an intersex variation, who still face unacceptable discrimination in healthcare settings and a loss of bodily autonomy (Carpenter, 2016).

1.2 Support mechanisms within LGBTQ communities

Access to, and experience of, supportive and affirming mental health support among LGBTIQ people has historically been mixed. A large, national study conducted by ARCSHS in 2019 found that more than a third (34.8%) of LGBTIQ respondents had used a mainstream mental health service of some kind in the previous 12 months (including face-to-face services); however, the study also found that 43% did not feel that their gender identity, and 28.1% their sexuality, was respected by the healthcare providers in this context. A further study conducted by this investigator team in 2018 identified that among 472 LGBTIQ people who had personal experience of a mental health crisis, only 29% sought help from a dedicated telephone crisis support service at this time (Waling et al., 2019). Concerns for, or prior experience of, discrimination or poor-quality care were significant factors in people choosing not to access crisis-support services (Lim et al., 2021a; 2021b).

There exist at least three strata of individuals who provide mental health crisis or suicide prevention-related support within LGBTIQ communities. The first comprises formally trained professionals working within psycho-therapeutic roles, either in clinical settings or within community-based organisations. Such individuals typically have access to supervision that includes personal psychological support to help deal with what can at times be an emotionally labour-intensive role. The second stratum comprises individuals who volunteer with organisations whose goal is to support the mental health and wellbeing of LGBTIQ communities. Such individuals receive training in support of their role, including counselling and peer-support techniques, but do not as a matter of course have formal training, such as that which permits membership of professional societies for counselling, psychology or psychiatry.

The third stratum of individuals are those who provide informal suicide prevention and mental health-related support within their communities but are not necessarily connected to professional services or LGBTIQ organisations, either as a staff member or volunteer. In some instances, but not all, they may be part of online communities or social media groups that aim to promote mental health and prevent deaths by suicide. Key stakeholder interviews and formative intervention development workshops conducted by the North Western Melbourne Primary Health Network (NWMPHN) identified that this stratum of individuals likely plays a key role in providing support to LGBTIQ peers during mental health crises or when they are considering, or have attempted, suicide. However, this can present a range of challenges, including a significant cognitive burden borne by those individuals. While this specific topic has not, to the best of our knowledge, been studied with this population before, research among LGBTIQ human rights activists indicates that those involved can

experience burnout, compassion fatigue and, in some cases suicidal ideation (Vaccaro & Mena, 2011). A need to better understand this third stratum of people who offer support provides the rationale for this study.

1.3 Research questions

This study is a response to a gap in the literature relating to the crisis support provision that occurs outside professional health and mental health services settings. This study specifically focuses on how peers and community leaders in LGBTQ communities in Melbourne provide suicide prevention and mental health-related peer support.

Burnout has been defined as a 'prolonged response to chronic emotional and interpersonal stressors' (Maslach et al., 2001, p. 397). Three dimensions characterise it: exhaustion, cynicism and inefficacy (Maslach et al., 2001). Burnout was conceptualised in the 1970s in relation to the negative impacts of employment (Freudenberger 1974). Exploration of burnout has expanded significantly in the decades since to other forms of labour, including informal work and support roles in queer spaces (see Vaccaro & Mena 2011). People in helping professions are 'more susceptible to burnout because of the emotional work and level of emotional exhaustion experienced on a consistent basis' (Viehl et al. 2018, p. 52). This report considers how those performing informal peer-support roles might also experience emotional exhaustion on a consistent basis.

Given the shortcomings of existing literature, and a need to understand how peers could best be supported to provide mental health crisis support (including in the context of suicide prevention interventions that may be considered at a later date), this study asks three key questions:

Research question 1: What is the nature of suicide prevention and mental health-related support provided by peers or 'community leaders' within LGBTQ communities?

Research question 2: What is their lived experience of providing this support, including any experience of emotional labour, burnout or cognitive burden and how can they as individuals be supported to reduce or manage this?

Research question 3: How can peers or community leaders be supported in their roles in terms of identifying, responding and referring at times of mental health crisis?

This research is utilisation focussed and is principally designed to gain knowledge from the lived experience of those who provide suicide prevention and mental health-related peer support in LGBTQ communities and to make recommendations on how to improve support for people in such roles in the future.

While the focus of the study is understanding how peers or community leaders have fulfilled a role in providing suicide prevention and mental health-related peer support, an opportunity emerged during the research phase to also explore how LGBTQ community members supported each other during a public health crisis – the COVID-19 pandemic. Some of these results are included in this report.

2. **Methods**

As outlined in the Background section, suicide prevention and mental health-related peer support is provided in various ways by numerous actors in LGBTQ communities.

It is likely, therefore, that the longevity, frequency and impact of such support also vary markedly. In this context, some individuals more than others will find themselves providing informal peer support to people around them and, consequently, be more exposed to the challenges that come with this, including higher levels of emotional labour and burnout.

It is a challenge, however, to identify exactly who in LGBTQ communities is providing such support or is considered a 'leader' when it comes to being there for others. *Lean on Me*, therefore, took a two-phase approach. Phase 1 was quantitative, consisting of a survey in which more than 300 people participated. This identified the breadth and nature of suicide prevention and mental health-related peer support. Phase 2 then centred on semi-structured in-depth interviews with 25 people, all of whom had taken part in the survey. This more-focussed qualitative study explored the lived experience of people providing suicide prevention and mental health-related peer support in LGBTQ communities in Melbourne.

Research with LGBTIQ communities requires careful consideration and engagement. Historically, LGBTIQ communities have often been subject to data collection and dissemination practices that have caused harm (Roffee & Waling, 2017). Additionally, LGBTIQ research can often subsume gender within sexuality, rendering invisible the unique experiences of trans and gender diverse (TGD) people (Vincent, 2018), as well as people with non-monosexualities, for example, bisexuality or pansexuality (Taylor et al., 2020). It was important, therefore, that this study underwent ethics approval from the institution hosting the research and key community organisations that provide an ethics review or community endorsement. The result of this process was the La Trobe University Human Research Ethics Committee granting ethical approval for this study (HEC20369) and Thorne Harbour Health, a leading community-controlled health organisation for LGBTI communities in Victoria, endorsing it via its Community Research Endorsement Panel (THH/CREP 20-015).

Due to the sensitive nature of this study's subject matter, the research team developed a participant support protocol, designed specifically with the participants' wellbeing in mind. The protocol provided researchers with clear steps to take in the event of a participant becoming distressed during or after an interview. This was of particular concern to researchers due to participants being subject to COVID-19-related lockdowns and associated social-distancing measures during the interview phase. Most of the study was conducted during periods of COVID-19-related restrictions enforced by the Victorian state government. The support protocol, which included facilitated access to paid, professional mental health support (when required), was part of the approved ethics application.

ARCSHS is firmly committed to ensuring affected communities are meaningfully involved in LGBTQ-focused research. Therefore, a Community Advisory Board, consisting of representatives of LGBTQ organisations, mental health and suicide-prevention organisations, the NWMPHN, ARCSHS and community members with lived experience of suicidality, was formed prior to the project commencing. The names and affiliations of these advisory board members appear in the Acknowledgements section. The Community Advisory Board met several times throughout the research process, being updated on both Phase 1 and Phase 2 of the study and members providing their feedback to the research team. We now discuss these two phases in more detail.

2.1 Phase 1: Survey

2.1.1 Eligibility

A survey was developed as part of the first phase of this research, with the aim of learning more about the nature and diversity of suicide prevention and mental health-related peer support provided within LGBTIQ communities in Melbourne. To be eligible to take part in the survey, participants had to:

- Be aged 18 years or over
- Identify as LGBTIQ
- Live in metropolitan Melbourne

The NWMPHN's catchment region includes large parts of northern, western and central Melbourne. Including the whole of metropolitan Melbourne in this study reflected that the NWMPHN's sphere of influence likely extends beyond its boundaries, not least of all due to the movement of people across these boundaries for work, education, social and health reasons.

2.1.2 Recruitment

The survey was hosted online from October to November 2020. It was promoted through paid social media advertisements, social media accounts and the professional networks of researchers, community organisations and Community Advisory Board members. The survey was also promoted through an extensive database held by ARCSHS of LGBTIQ adults living in Victoria who participated in a 2019 survey and indicated a willingness to engage in future research relating to LGBTIQ communities. Respondents clicked into the survey, answered screening questions and completed the survey anonymously.

2.1.3 Content of survey

Respondents were asked to provide demographic details and describe their experiences of providing peer support. Questions focused on:

- Who they had supported, for how long and for what reason/s
- Their perceptions of the support they provided
- The extent to which they were supported and valued in their peer role/s
- Mental health training, if any, they had undertaken
- Their psychological wellbeing

2.1.4 Analysis

In addition to providing valuable information about the breadth of suicide prevention and mental health-related peer support occurring among LGBTQ communities, the survey helped identify and recruit people for Phase 2. Respondents with relevant experiences of providing peer support were asked whether they would be interested in being interviewed.

2.2 Phase 2: In-depth interviews

Twenty-five LGBTQ adults in metropolitan Melbourne were interviewed as part of Phase 2. They were purposively sampled from the list of those survey respondents who indicated a willingness to take part in an interview and provided their contact details. Sampling sought to capture various experiences and diversity in terms of gender, sexuality and age.

2.2.1 Eligibility

Like the survey, Phase 2 required participants to:

- Be aged 18 years or over
- Identify as LGBTIQ
- Live in metropolitan Melbourne

Participants were also required to have experience of providing mental health-related peer support within their communities.

2.2.2 Contact

Potential interviewees had identified in the survey experiences of losing someone to suicide, supporting someone after a suicide attempt, being concerned about someone ending their life by suicide and various other issues related to mental ill health. Those with suicide-related peer support experience were prioritised for an interview. Potential interviewees were contacted either by telephone or email, using contact details they had provided. All gave informed consent prior to commencement of the interview.

2.2.3 Content of interviews

Due to Victorian state government-enforced COVID-19 pandemic restrictions, no interviews were conducted in person. Instead, participants were interviewed using Zoom, where only the audio was recorded for transcription. Interviews were conducted from October to December 2020. Participants were informed they were free to respond to questions in as much or as little detail as they wanted and terminate the interview if they did not feel comfortable. Interviews generally ran for between one and two hours.

Questions focused on:

- Participants' connection to LGBTIQ communities and their perceptions of mental health therein
- Participants' experiences of providing mental health support to peers, including how, where and why this occurred
- The evolution of participants' experience of providing mental health support to peers
- How supporting peers impacted on participants
- The kinds of support participants might want or need in response to those impacts

2.2.4 Analysis

Audio of the interviews was digitally recorded and transcribed. Participants' names and other identifying data were removed from transcripts. Participants had the opportunity to review the transcript of their interview. Data was coded within NVivo, a qualitative data-analysis support package, and subject to a rigorous thematic analysis (Braun & Clarke, 2006) that enabled themes to be drawn from the raw data in ways that addressed the research questions. The constant comparative method (Kolb, 2012) was used to continually code and analyse the data, allowing concepts to be refined as new insights emerged.

3. **Overview of key findings**

This report demonstrates findings from the online survey and qualitative interviews phases of *Lean on Me*. Before discussing the key findings in detail in the next few chapters, we provide here an overview of both phases of the project.

3.1 Phase 1

Of 326 people who completed the survey, 114 identified as cisgender female, 101 as cisgender male and 109 as transgender and gender diverse. Respondents identified with one or more sexual identities, including gay (85 respondents), queer (79), bisexual (67), lesbian (53), pansexual, asexual and polysexual. Most respondents (258) were born in Australia. Eight respondents identified as Aboriginal and one as Torres Strait Islander. The sample was highly educated, with 97 respondents reporting a postgraduate degree, 24 a graduate diploma/certificate and 109 a bachelor's degree as their highest level of education attained.

3.2 Phase 2

The 25 participants interviewed for this report ranged in age from 23 to 79. Most were under 40. Seven participants were aged in their twenties, 13 in their thirties, three in their forties, one in their fifties and one in their seventies. Gender and sexual identities were diverse (See Table 1). Seven participants identified as cisgender men, six as cisgender women and 12 as trans and gender diverse (including participants who identified as one or more of trans, trans man, trans woman, genderqueer, genderqueer man, genderqueer woman, nonbinary and gender diverse). Participants identified with one or more sexual identities. These included gay (4), lesbian (1), bisexual (4), polysexual (1) and queer (5). Ten participants used multiple terms to describe their sexual identity, including queer, pansexual, bisexual, gay, lesbian and asexual. Four participants were born overseas and a further six were from culturally diverse backgrounds. None identified as Aboriginal or Torres Strait Islander.

The survey results provide important insight into the prevalence and nature of suicide prevention and mental health-related peer support in Melbourne's LGBTQ communities.

KEY FINDINGS INCLUDE:

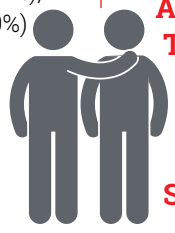
295
OUT OF 326 (90.5%) PEOPLE
HAD PROVIDED MENTAL HEALTH SUPPORT TO PEERS IN THE PREVIOUS TWO YEARS

ABOUT 60% OF RESPONDENTS
HAD PROVIDED MENTAL HEALTH SUPPORT FOR A PERIOD OF FIVE YEARS OR LONGER

83%
OF RESPONDENTS HAD HELPED A CLOSE FRIEND,
WHILE HELPING A PARTNER (41%), A COLLEAGUE (31%), A STRANGER (29%) AND A FAMILY MEMBER (17%) WERE ALSO COMMON

MOST RESPONDENTS HAD HELPED SOMEONE WITH DEPRESSION (82%) AND ANXIETY (81%), WHILE

56%
HAD SUPPORTED A PERSON WHOM THEY WERE CONCERNED MIGHT ATTEMPT SUICIDE



These quantitative findings complement the qualitative findings in this report. The survey data is used at various points to illustrate situations in which a participant's story – however unique – is reflective of broader experiences in LGBTQ communities.

Table 1. Demographic characteristics of interview participants

	n
Assigned sex at birth	
Female	15
Male	10
Age	
18-29	7
30-39	13
40-49	3
50-59	1
60+	1
Sexual identity	
Queer	5
Gay	4
Lesbian	1
Bisexual	3
Polysexual	1
Prefers not to answer	1
Uses multiple terms	10
Gender identity	
Cisgender man	7
Cisgender woman	6
Trans and gender diverse	12

The key findings in the chapters that follow are framed in terms of the main issues we sought to understand about the provision of suicide prevention and mental-health peer support in LGBTQ communities in Melbourne. These were:

- Why does it occur?
- How is it provided?
- What are its impacts on those providing it?

Key findings emerging from the qualitative interviews are that suicide prevention and mental-health peer support:

- Can lead to significant burnout for those who provide it
- Can negatively affect the employment, education and relationships of those who provide it
- Can represent a long-term commitment for those who provide it
- Is often a response to exceptionally high levels of mental ill health in LGBTQ communities
- Is often a response to inadequate mental health services for LGBTQ communities
- Provides meaning for those who engage in it
- Can literally save people's lives
- Comes in many forms

We attempt to explain these many forms through a typology of suicide prevention and mental-health peer support that emphasises these roles:

- The Safe Friend
- The Peer Leader
- The Partner
- The Housemate
- The Help Worker
- The Friendship Circle

Each role has distinctive features and challenges. Discussion of these roles leads us to our recommendations chapter in which we highlight how challenges of providing peer support might be addressed. Recommendations centre on the need to mitigate the risk of burnout and other negative impacts on the lives of those providing peer support. They are also designed to help make peer support a more sustainable practice.

Participants' direct quotations are used throughout these three findings chapters to drive the discussion. In some instances, responses have been edited for clarity. Each quotation is accompanied by details that provide demographic context about the participants while ensuring their privacy. Unless individual gender and/or sexual identities are specified, findings in the following chapters are discussed in relation to any or all LGBTQ identities represented in this report. The same is true for those of diverse cultural backgrounds. However, every effort has been made to ensure that rare or unique experiences are demonstrated as such.

4. The need for peer support

This first findings chapter explores the context in which LGBTQ community members in Melbourne support peers who experience a mental health crisis, which can include suicidal ideation.

Drawing from the 25 interviews, we demonstrate that factors contributing to people leaning on others, or being leant on themselves, include open dialogue about mental ill health, shared and pervasive experiences of trauma and discrimination, and empathy for fellow community members. This provides context for later findings chapters, in which we consider the positive and negative impacts of peer support for community members being leant on.

4.1 Turning to others in times of need

To understand why people in LGBTQ communities in Melbourne lean on others, three main themes are explored first:

- Perceptions of mental ill health being widespread
- A culture of openness, solidarity and support around issues of mental health
- Experiences of accessing or avoiding mental health services

4.1.1 Widespread mental ill health and suicidality

Participants generally considered the state of mental health in their LGBTQ communities to be poor. 'Terrible', 'dire' and a 'major problem' were ways of describing the prevalence of depression, anxiety and other mental health issues in social circles. As one participant explained:

> *The vast majority of the people I know have mental health issues, mental health concerns … I'd be hard pressed to think of someone I know who hasn't had mental health concerns. (Frankie, genderqueer)*

These perceptions are largely consistent with broader literature showing that rates of mental ill health are exceptionally higher in LGBTQ communities than the general population (King et al., 2008). Experiences of trauma – including being rejected by family or discriminated against – had shaped the lives of participants and others in their communities. Some participants spoke of suicidality, depression and anxiety being more frequent and more acute among trans and gender diverse people and/or people with non-monosexualities such as bisexuality and pansexuality. As one participant explained:

> *I don't think I've met a single trans person who has never experienced mental health issues. I think we've all had the experience of anxiety and depression. Most of us have self-harmed [and] so many people have attempted suicide at least once. (James, trans man)*

Some participants were positive about the progress made in recent years as society had become more accepting of LGBTQ communities.

4.1.2 Openness about mental health in LGBTQ communities

Mental health was spoken about openly and meaningfully in participants' communities. Some described this openness about mental health as a necessity. One participant said such discussions about community members' mental health were often driven by urgency:

> *There's no time to fuck around because in our community, it is life and death sometimes … Without your support, you know, who are we really? Where would we be? Yeah, I just think there's less bullshit because it's just you don't have the same … capacity or space or time to have a façade. (Kerry, non-binary)*

Some participants spoke of mental ill health being minimised, both by oneself and others, in communities where to struggle was considered a given. Despite such concerns, many participants viewed fellow community members as largely supportive. High levels of mental ill health meant many people needed support. Openness and supportiveness about mental ill health seems conducive to the provision of peer support. Opportunities existed, therefore, for people to turn to each other.

4.1.3 Experiences of mental health services

It is useful to consider this need for mental health support in the context of how LGBTQ community members interact with mental health services in times of distress and crisis. Community members were willing to engage with services they considered helpful. Some, however, discovered that a health professional they were dealing with was ignorant of the health concerns of LGBTQ people or dismissive of their gender and/or sexual identities. They sought, therefore, to avoid situations in which they would be exposed again to such mistreatment.

I don't think I've met a single trans person who has never experienced mental health issues. I think we've all had the experience of anxiety and depression. Most of us have self-harmed [and] so many people have attempted suicide at least once.

JAMES, TRANS MAN

Some participants described how community members were often wary of crisis assessment and treatment (CAT) teams, hospitals and police. They were aware of experiences of discrimination and physical violence that had occurred when people in LGBTQ communities had called on emergency services for help. One participant spoke of discrimination in a hospital setting, saying:

> *There's been discrimination from doctors who might be the only people who can provide mental health assessments … Certainly, I talk to people who just refuse to go back to a hospital because of how they were treated because of their gender identity, or because a partner wasn't allowed in. (Devon, trans)*

In such contexts, leaning on a peer was often important, if not essential. As one participant said:

> *I think the vast majority of the people I know turn to their personal networks … Friends end up doing a lot of the work, which like isn't good or bad, it's just the reality of it. (Pat, non-binary)*

4.2 Motivations for providing peer support

Having established a context in which people might seek to lean on others in their community, we now explore why peers provide such support. Participants reported having been 'go-to' persons for partners, friends, colleagues and strangers who were significantly distressed, sometimes to the point of attempting suicide.

4.2.1 'Carer' personalities

Some participants said they felt an innate need to help others. Contributing to this were some participants' perceptions and descriptions of themselves as 'natural' carers. They spoke about empathy, their desire to be available when people needed to talk, and the importance of being non-judgmental. It was not just 'caring' personalities that some participants described but 'carer' personalities. This quotation captures such a sentiment:

> *I remember when I was very young, maybe like 7 or 8, I had this really intense realisation around my privilege and how very lucky I am, really, and how there's so many people that have much less than I do … And I feel like that was the beginning of knowing that I'm very empathetic and that a lot of people aren't, and that's just how people are; there's nothing right or wrong about it. I've always had a lot of insight, I feel. (Alex, gender diverse)*

Social justice was a way for some participants to make a meaningful difference to society, through focus on issues affecting LGBTQ, Indigenous and refugee populations. Activism sometimes crossed over into mental health peer support. Some participants talked about these interests inspiring them to pursue a career in the mental health field.

4.2.2 Personal experiences and empathy as catalysts for supporting others

Participants' own experiences, which included trauma and other mental ill health, also shaped their carer personalities.

> *I had quite a number of traumatic experiences myself as a child and have worked through those with various different support networks. When it became apparent to me that it was possible to work through trauma, then obviously my quest became to help other people do the same. (Luke, cisgender man)*

Often, participants' own mental health journeys were complex. Some had experienced bipolar disorder, depression, anxiety, eating disorders, posttraumatic stress disorder and suicidal ideation. Several participants had a disability or neurodiversity. Experiences of mental ill health were sometimes participants' motivation to provide peer support; they wanted to help others, perhaps in ways that they had not been helped themselves. Experiences of trauma were often motivators for participants to reach out to others.

4.2.3 Becoming a 'go-to person'

Some participants made themselves known to peers as someone who could help, including through community leadership or activist roles they played in their LGBTQ communities. For others, it was by being open about their own mental health with friends. As one participant recounted:

> *The more open I am about it, the more I open up to other people to share back with me. I firmly believe a problem shared is a problem halved … I talk to every single friend that I have about my mental health. (Anastasia, cisgender woman)*

Sometimes a participant came to be leant on because they were one of only a few options, or even the last resort, for someone. The mental health challenges in their community were such that no one else had the capacity or headspace to take on a peer-support role. One participant described such a situation, saying:

> *I felt a little bit helpless in some regard but also with a responsibility because I was one of the few stable people in his immediate sphere of friends and family. I felt that obligation to be the one to try to intervene in some way and to keep being there and supporting. (Gabriel, cisgender man)*

4.2.4 Isolation and COVID-19

The social impacts of COVID-19 were pronounced in Melbourne, which was subject to two significant lockdowns during 2020. Enforced confinement at home for long periods resulted in many social activities in LGBTQ communities being postponed or shifting online. This is significant given that a large body of research (Sherman et al., 2020) indicates that connection to community is one of the most reliable predictors of health and wellbeing among LGBTQ populations, in relation to all manner of health domains.

Loss of employment during the pandemic caused significant stress for people in participants' networks. Lockdowns, for some, meant extended time around housemates who were struggling. For many who lived alone, periods of prolonged isolation were challenging. Other issues included young people having to return to live with family who were not accepting of their identity; pre-existing mental ill health being minimised in a climate where everyone was seen as 'doing it tough'; fears of hospitalisation; and increases in intimate-partner violence. Participants spoke of mental ill health increasing during lockdowns. As one participant said:

> *I haven't really experienced so many people struggling with mental illness in my life before this year. At least 75% of the people that I know. (Karl, cisgender man)*

4.3 Summary

Widespread mental health concerns, including suicidality, depression and anxiety, combined with difficulties accessing suitable mental health services and treatment, provide conditions in which LGBTQ community members might seek help from peers. Participants in this study are people providing such support. Their engagement has been spurred, in part, by their self-perceptions of themselves as carers, their own experiences of mental health and their being regarded by others as approachable and empathetic. Their motivations to help, and the demand upon them, seem only to have grown with COVID-19.

This chapter has demonstrated that a considerable need for peer support exists in LGBTQ communities in Melbourne. Even with the willingness of community members to provide it, the provision of peer support is not straightforward or seamless, let alone adequate or sustainable. As the next chapters demonstrate, peer support is delivered in myriad ways in LGBTQ communities. The impacts – positive and negative – of providing this support are also diverse.

The more open I am about it, the more I open up to other people to share back with me. I firmly believe a problem shared is a problem halved … I talk to every single friend that I have about my mental health.

ANASTASIA, CISGENDER WOMAN

5. The nature and mechanisms of peer support

A mental health crisis is a significant event, not just for the person experiencing it but also for the person or persons they lean on for support. This chapter focuses on the broad range of situations in which LGBTQ community members are called on to provide suicide prevention and mental health-related support to others.

Featuring prominently in accounts of peer support in this chapter are stories of participants helping people who are suicidal; in such instances, people act with urgency, literally as a matter of life or death. This chapter also demonstrates that such scenarios form only one part of a much broader range of suicide prevention and mental health-related peer support provision. Situations can vary in terms of their urgency, frequency and longevity while being hugely significant for both the people needing support and those providing it.

Many participants interviewed for this study have supported someone who has either attempted suicide or felt suicidal. They have been there for people experiencing depression and anxiety or dealing with the impacts of violence and discrimination. Many participants have helped multiple people – from partners and close friends, to colleagues and strangers – in a range of home, work, social and community settings. They have been there for someone as a one-off event or continually over a period of years. Those interviewed have been leant on in person – as an individual or in a community group setting – or more figuratively in an online space. This chapter explores these experiences before presenting a typology of peer-support roles that explain the different ways that help is provided. Finally, the frequency and intensity of exposure to other people's suicidality is explored as a recognisable aspect of many peer-support roles.

5.1 Mechanisms of peer support

The *Lean on Me* survey found that of 326 respondents, 60% (n = 174) had been helping peers for more than five years; 20% (n = 57) for 1-2 years and 7% (n = 21) for less than a year. The survey also found that 83% (n = 269) helped close friends, 31% (n = 102) helped colleagues, 41% (n = 134) helped partners and 29% (n = 94) helped people they did not know, including through online support groups.

Some 82% of respondents (n = 266) had helped somebody deal with anxiety, 80% (n = 261) with depression, 56% (n = 182) with suicidal thoughts and 55% (n = 180) with work-related stress, Furthermore, some 52% (n = 170) had helped with the effects of stigma and/or discrimination, 38% (n = 124) with concerns about self-harming, 35% (n = 115) with the effects of violence and/or abuse and 20% (n = 65) with concerns about attempting suicide.

This section builds on these survey data by using participants' stories from the interviews to illustrate how they have provided peer support and the settings in which this has occurred. This is explored by considering the provision of peer support in three main ways: that which occurs in person (primarily one-to-one support), online and in a community group setting (either in person or online). The aim of this approach is to consider in more detail the complex ways in which peer support is provided and transcends only literal notions of 'leaning on' someone. Understanding the modalities of peer support is an essential part of seeking to help people in such roles. This approach, however, does not assert that peer support is provided only in one of three ways. Indeed, support can be provided through a combination of in-person, online and community group interactions and practices.

5.1.1 Literally being there for someone

'Being there' for others took many forms for participants. Being physically present for someone who was experiencing a mental health crisis, especially when the situation was acute, was important to many. The ability to get there for someone – even being 'on-call' in emergency situations – was central to some participants' sense of what their role was. 'Being there' was more straightforward for some than it was for others: some participants provided support for a live-in partner or a housemate, while others supported colleagues or strangers whose homes they might not ever have visited.

Peer support provided in person, one-to-one, involved a range of emotional, physical and practical assistance, depending on the situation. Simply being there was enough in some situations, while other times, participants were called on to take a much more active role. Many situations demanded multi-faceted responses. One participant said:

> *So, that can be staying with somebody if they can't be alone, that could be coming and visiting them and bringing them food if they're too depressed to get out of bed … it can be talking, it can be hugging, it can be physical help around the home. (Sabrina, cisgender woman)*

Talking openly about a person's suicidality, depression or anxiety occurred in many situations, while at other times, support centred more on physically embracing someone or preparing their food and delivering their medication. Emergency situations sometimes meant participants were required to call an ambulance, a CAT team or the police.

> *It can be calling the ambulance, taking them to the hospital, visiting them within the inpatient clinic, going to appointments with them with any sort of mental health professional … if they need me to advocate for them or support them to advocate on their behalf, being that person. So, I guess a whole range of things. (Alex, gender diverse)*

5.1.2 Providing care from afar

Relationships maintained over distance are a feature of a digitally connected, globalised 21st-century world. Likewise, suicide prevention and mental health-related peer support is something that is increasingly provided over distance.

For participants in this study, such support was provided primarily by way of the internet and smartphones. This ranged from urgent support for someone considering suicide, to simple messages that served as less urgent welfare checks. Digital communication was particularly important when a participant lived considerable distance from a peer who needed support or when they needed to urgently help a person whose location they could not immediately reach.

Support was provided using voice calls, video calls, and text or other instant-messaging applications. Participants sometimes sought additional help if the situation was serious enough. As one participant explained:

> *It might just be a simple text message or an email. It might be giving them some advice or support if they ask for it, it might be referring them on. So, if there's an organisation or a service that I feel … might be helpful, then I'll refer them to that. (Alex, gender diverse)*

Some observed that it was tiring or unhelpful to always talk through problems in search of a solution. Memes and other media items – among them 'cat videos' – were sometimes described as tools to help calm someone down or get their mind off their worries. Social media feeds allowed participants to observe the welfare of others. Some participants spoke of posts about suicide prompting them to reach out to a peer privately. One participant explained a situation in which a friend in another state of Australia was 'melting down on Facebook':

> *I just happened to have turned on Facebook right at that moment – and I kept him talking … eventually, his mum drove over and when she got there he was in a really bad state; he was suicidal. (Zoe, cisgender woman)*

The COVID-19 pandemic, its associated physical-distancing measures and enforced lockdowns only increased the importance of online communication as a means of providing peer support.

5.1.3 Support in a community group setting

Community group peer support featured in some participants' care practices. These participants talked about their involvement in LGBTQ community groups, including in a leadership capacity. Group gatherings provided people with supportive settings in which to express themselves. Such environments led to group members expressing vulnerability and distress when it came to matters of coming out, gender transitions and receiving a positive HIV diagnosis, among other significant life events. People in leadership roles were approached by new members of a group – strangers, effectively – who sought to talk about intense and distressing situations in more private, one-to-one settings. Some participants actively took leadership roles in community group settings, making them more likely to be approached by people needing support. Others, however, were drawn into a support role more gradually. As one participant explained:

> *It's just one of those things that when you're going along to support and then you're going along as a long-term member, people look up to you as someone who can provide that support and friendship and guidance, and then it just sort of flows from that. (Ingrid, cisgender woman)*

Community group support was also provided online. Some participants were part of private group chats involving multiple people who shared problems and sought advice. Leaders among the groups would provide support to those seeking it. One of these groups consisted of people who, prior to COVID-19, were generally in the same space in the offline world. During the lockdowns of 2020, their online spaces became more important to their staying connected to each other and feeling supported. One participant had a leadership role in this group. Their experiences included providing support to young adults living with family during lockdown. They said:

> *We have a [group member] who's … not out to their parents and now they're stuck at home with their parents constantly … There's nowhere that they can go that's affirming of their gender or their sexuality because they're at home constantly and that's a really big stressor to them. They've got a bunch of other stressors in their life as well but that's a really big thing for them, and so just having somewhere where they can vent about that has been really big for them. (Taylor, gender diverse)*

In providing support in the above ways, participants tended to assume distinct care roles. These roles are explored more in the next section.

5.2 A typology of peer-support roles

Participants' identities, experiences and social networks were unique to them. So, too, were their experiences of suicide prevention and mental health-related peer support. This support was provided to different people, in different locations and at different life stages. Although no two participants' experiences could be described as exactly alike, significant similarities between experiences of peer-support provision can be observed. In this section, we draw from participants' experiences to consider how suicide prevention and mental health-related peer support can be viewed as a collection of support roles that, although performed by individuals, share distinctive characteristics.

We outline a typology of peer-support roles visible in the data, developed as composites of different participants' experiences. These roles recognise how varied peer support can be in terms of the social and cultural contexts in which it is provided. This typology also emphasises the distinct characteristics of these role types and the challenges they bring. It is important to emphasise the common threads that are visible in participants' support roles. Doing so allows us to identify specific challenges associated with a peer-support role and – later in this report – provide recommendations aimed at addressing them. Right is a summary of each role and what key challenges someone performing them faces.

Table 2. A typology of peer support

Role	Summary	Key Challenges
The Safe Friend 	A trusted friend leant on in times of crisis. Known for being non-judgmental, especially empathetic and, therefore, approachable. May actively make themselves known as someone who can help. Can end up being 'on-call' for those in need.	Interruptions to work, education and leisure time. May find it difficult to step back if distress is ongoing and little progress is being made. Can find it challenging to define boundaries and separate the roles of friend and carer.
The Peer Leader 	A prominent person within a community support or friendship group setting. Considered confident, strong and trustworthy, especially if they have also experienced similar mental health challenges. Often approached by strangers or 'friends of friends' for help.	Can struggle with the volume of requests to support others. May find themselves 'always on' when providing support in community settings or in online group chats. Might feel a need to help everyone else while struggling to find their own support. Can find it difficult to step back.
The Partner 	There for a partner or partners with whom they may or may not live. As an intimate, they provide important emotional and mental health support to their partner/s, especially around issues of trauma.	May undervalue the support they provide and the toll that it takes on them, deeming it 'just part of being in a relationship'. They can become more of a carer than a partner, resulting in their own needs not being met.
The Housemate 	Provides support to a non-partner with whom they live. Can be thrust suddenly into a peer-support role, due to their physical proximity to a person who is distressed. Might not necessarily be emotionally close to the person they help.	May find it difficult to draw boundaries in the home and separate the roles of a carer, housemate and friend. Role found to intensify during COVID-19-related enforced lockdowns.
The Help Worker 	Works in a job in which they help people, at least some of whom are LGBTQ. Often called on to use their expertise in a non-work setting to help those around them.	Faces the risk of working the 'double shift' – providing support to others at work and in their personal life. Might overwork themselves in both settings to help.
The Friendship Circle 	A group of friends who rally around someone in distress, including while they are suicidal or after an attempt. They provide a range of emotional and practical support, including through development of a roster.	A huge commitment of time and energy communicating with a group of friends. While care can be shared among a group, openness may mean members end up supporting multiple people.

These roles do not encapsulate any one participant's complete experience. No participant is presented as a neat case study of, for example, a Peer Leader, or the perfect embodiment of any other role. Instead, participants' collective experiences have informed the conceptualisation of each role. These articulations might be familiar to other people in LGBTQ communities who perform similar work. Community members might find it helpful to identify with a role in this typology and consider how recommendations to address the key challenges outlined might benefit them. This typology is not intended to be prescriptive – we are not suggesting that someone must fit into this model. Instead, we present findings in a way that we hope demonstrates that people's individual experiences of peer support have common threads, both across this study and more broadly.

Furthermore, we are not suggesting that anyone should seek to identify with only one category. Although each composite represents a distinct type of peer-support role, the experiences of individual participants in this study often traversed multiple roles. Participants who took part in the study – and readers who provide peer support themselves – might identify as fulfilling, or having fulfilled, multiple or even all roles featured in this typology. The temporality of the peer support experience is also worth emphasising. Readers might recognise themselves as having adopted or resisted one or more of these peer-support roles at various stages of their life. Our hope is that this typology provides an accessible way of understanding different peer-support roles, their challenges and what might be done to mitigate their negative impacts. Each role is now discussed in more detail.

5.2.1 The Safe Friend

The first peer support role we focus on is the Safe Friend. This is someone who stands out as available to be leant on during times of crisis. A Safe Friend is often known for their empathy, non-judgmental nature and willingness to listen. For these reasons, they might be considered more approachable than other people in a social, community or professional setting.

> *Friends would say to me that they feel like they can kind of tell me anything and I'll always react in a supportive or non-judgmental way. (Anastasia, cisgender woman)*

A Safe Friend's peer-support responsibilities range from comforting someone who is feeling anxious, to responding in the middle of the night when someone is contemplating suicide. A Safe Friend offers emotional, practical and sometimes financial support, in ways that might require significant commitments of their time and energy. One participant described the variety of situations in which a Safe Friend steps up to support those around them in this way:

> *The more minor crises, like people getting drunk, getting distressed, having some sort of crisis … sitting with people during instances where they've self-harmed, where they're considering suicide, where they have attempted suicide. (Sabrina, cisgender woman)*

A Safe Friend is often there at crucial moments, to the extent that they might think of themselves as 'on-call'. In some cases, they might be there in small but significant ways for dozens of friends and associates, while remaining focused on one or several people in acute situations. This participant's experiences demonstrate how a Safe Friend might rationalise such a situation:

> *There's certainly one or two people – maybe even three or four – that I would be on call 24/7 for, and I want it that way … If it was like a suicidal crisis, yeah, 100% on call. (Alex, gender diverse)*

A Safe Friend might identify as a 'natural' carer or have had lifelong experiences of providing support that leads them to think of their performance in the role as 'second nature'. As highlighted earlier, a Safe Friend might be the only person in a social circle with the capacity or headspace to be leant on.

The peer support they provide is often consistent with their broader views of society that emphasise the importance of helping marginalised peoples. They ask questions that build trust, helping them gain access to someone's inner world. A Safe Friend's role, as they see it, is to be there to provide support in any way they can. Their role is meaningful to them, helping shape their identity.

> *I make it really clear that I am someone that they can go to … I try to be as open and empathetic and non-judgmental and reassuring and all those things as possible. (Kelly, cisgender woman)*

Others notice such things, too:

> *Everyone's good at certain things and not good at other things; there's nothing wrong with that. I'm just good at the mental health stuff … People have told me that again and again. (Alex, gender diverse)*

Among a Safe Friend's challenges are creating boundaries between their peer-support role and other parts of their life, notably their work and study commitments. Complicating this at times is that a Safe Friend might want to be there for someone even if it is detrimental to their own mental health. Burnout occurs over time if the mental health concerns of those they are helping exacerbate or appear to be unresolvable.

> *Often when you're rushing to help someone who's struggling with mental health, it affects your own mental health … I'm likely to feel depleted energy wise. (Devon, trans)*

5.2.2 The Peer Leader

The second peer-support role is the Peer Leader. Such a person is often a role model and a 'rock' for others in their community. A Peer Leader might be found in a voluntary role formally affiliated with an LGBTIQ community-controlled organisation. Alternatively, they might be a leader in more informal ways among a group of friends. They might be considered someone who has experienced similar challenges to those who seek their support or advice. Often, they are admired for their strength and confidence.

A Peer Leader is leant on in a range of situations. They help peers, including people they meet for the first time,

deal with issues around their gender transition, coming out, family conflict, medical diagnoses, family violence, substance abuse or housing situation, among others. A Peer Leader might provide support in a group setting at organised times. As one participant described:

> *People that have been with the group the longest tend to be the people that everyone will kind of gravitate towards to talk about their problems. (James, trans man)*

As they become more involved in their role – and more recognisable to their community – their peer support responsibilities might expand to include helping individuals at any time:

> *It's hard to put an exact amount of time on it because things like the chats are on all the time. It just kind of pings and then I'll answer it for a little while and then I'll stop talking on it and then I'll go back to it. It does seep into other parts of my life. I do definitely find myself thinking about it and thinking about people and their worries. (Taylor, gender diverse)*

Support that a Peer Leader provides might increase in frequency and intensity over time. In particularly acute situations, they might be called on to support someone experiencing suicidal ideation. Support can be straightforward or more complex and urgent in nature. This can present a challenge to a Peer Leader. As one participant explained:

> *I think it is a lot about … sticking to listening and empathy a lot of the time, trying to refer people onto services that we know we can trust, even though they can often be so booked out … But sometimes it can be calming people who are very distressed and have huge anxiety issues, and [you] get to a point of 'Well, it's sort of getting to extreme suicidal thoughts just bordering into having a plan.' (Michelle, trans woman)*

A Peer Leader might start out in their role seeking to provide the kind of peer support they wished they had as a young person. Alternatively, they might seek to 'pay forward' the generous support they did receive by being there for an emerging generation. A Peer Leader might have an interest in social work or psychology and may have studied these topics or worked in these fields. It is not unusual, however, for a Peer Leader to have had little formal training in mental health beyond undertaking Mental Health First Aid. More than 28% of the survey respondents reported helping someone they did not know. A Peer Leader, therefore, often does not know the full impact of the support they provide. They might not even know exactly what they are helping with. One participant described such a situation, saying:

> *There are always a few people who will sort of think, 'Oh well, I'll ring … and find out how he is.' And then they raise the issue. And probably when you put the phone down you think, 'Well, what was all that about?' But it is something. (William, cisgender man)*

Sometimes, the importance of a Peer Leader's support, however brief, might be made known to them years later. One participant described an especially profound experience of this, recounting:

> *I've had people come up to me years after the fact and during coffee turn around and say, 'Do you realise that I'm only alive today because of what you did at so-and-so event?' and I'm like, 'What are you talking about?' and they're like, 'That week, I was literally debating committing suicide. I was getting my affairs in order and everything like that and then I went to one of the events and you actually sat down and spoke to me like a human being and I wasn't used to that. I wasn't expecting that.' I'm like, 'Well, that's just being human.' (Robbie, cisgender man)*

5.2.3 The Partner

Suicide prevention and mental health-related peer support occurs often in intimate relationships. This makes the Partner an important role in this typology. A Partner might provide similar support to that of other roles in this typology – except it is in the context of a loving relationship with a partner or partners. (At least one participant in this study identified as polyamorous.) Depending on the dynamic of the relationship, a Partner's own emotional wellbeing, finances and housing situation might be significantly more affected by the person they are helping when compared with other roles in this typology. For example, one participant described how their experiences of being a Partner impacted on their wellbeing:

> *At the time, my partner had some serious mental health issues, my mental health wasn't good as a result of trying to support them every day and then my friend going through that as well – I just felt completely emotionally drained for a month afterwards. (Anastasia, cisgender woman)*

A Partner provides proximate and distant support, depending on their living arrangements. In doing so, they might be confronted with situations in which the person or people closest to them are suicidal. Their intimate status with another person provides a more direct access to their inner world, meaning a Partner often finds themselves providing support around depression and anxiety. Shared lived experiences might also prompt more open discussions about trauma, stigma and discrimination related to sexual and/or gender identity. A Partner might also help a loved one deal with issues of work-related stress, substance abuse, hospitalisation or imprisonment. A Partner is sometimes vulnerable to domestic violence and gaslighting in relationships in which they provide support.

Being both physically and emotionally closest can result in a Partner becoming the sole carer of a vulnerable person, including when that person has been rejected by their family of origin. As one participant described, this can have a significant impact on a Partner, especially if they are a young person without much peer-support experience:

> *My partner at the time was having thoughts of suicide … I was just trying to get to her because she was just again dealing with family that weren't accepting, didn't know how to deal with it. (Devon, trans)*

I was studying and working in mental health and then I was also supporting someone quite frequently. They were pretty unwell, and I got really burnt out. I'm still kind of recovering from that whole thing.

ALEX, GENDER DIVERSE

Of the 326 people surveyed for this study, more than 40% reported providing peer support to a partner. The 25 participants subsequently interviewed, however, tended to talk more about helping people who were not their partners, though some did share stories of helping a partner who was considering suicide. This raises the question of whether peer support is considered simply part of being in a relationship and, if so, whether such support provided by a partner is taken for granted, even devalued, when compared with support provided to friends, colleagues and strangers.

5.2.4 The Housemate

A significant portion of the peer-support load in LGBTQ communities falls on people who are literally 'there', proximate to a person in crisis. Those physically closest to someone experiencing a mental crisis can find themselves thrust into the role of a carer. This can be the experience of the Housemate, the fourth peer-support role in this typology.

> *I think a lot of the times you turn to whoever is closest that you trust, like physically closest, usually. So, if you have housemates that you're friends with. (Declan, cisgender man)*

A Housemate plays a crucial and challenging role. They are there for immediate support, often having a window into the social and emotional wellbeing of someone they live with that might not be accessible to others in that person's networks. A Housemate's peer support is striking in how wide-ranging it can be. Proximity makes possible (but does not guarantee) the provision of practical, physical and emotional support. It also provides conditions for peer support to potentially develop into full-time care, especially during enforced lockdowns. Indeed, the Housemate represents a type of peer support that became more prominent among LGBTQ communities in Melbourne during lockdowns enforced in 2020 as a response to the COVID-19 pandemic.

A Housemate can find boundaries difficult to draw. This can be particularly so when the demands of supporting someone begin to conflict with expectations of what a friendship should be or what responsibilities housemates are meant to share. One participant's experiences of supporting a friend and housemate demonstrate the challenges of providing proximate support:

> *It's a lot harder to draw those boundaries because we're friends but we're also housemates but I'm also acting as your carer and I'm also loaning you a lot of money and I'm also driving you to appointments and keeping track of your meds and things like that. So, yeah, in practice a lot harder than knowing that, in theory, this is what I can help you with, but you need to try and do this by yourself. Yeah, so it's been really difficult finding that balance. (Kelly, cisgender woman)*

A Housemate is often aged in their twenties. They might be single and more likely to be living with friends or other non-partners. Their previous experience of providing peer support and drawing relevant boundaries between that support and other parts of their life might be limited. Much of what has been described about a Housemate may also apply to a Partner. One important difference, however, is that a Housemate may not necessarily share any emotional connection with the person they are helping (at least to begin with). Being drawn into an acute situation suddenly is something that the Housemate appears more vulnerable to. Even when a Housemate is aware of another person's mental ill health, being physically proximate means a Housemate might find themselves dealing with an emergency without warning. One participant described waking in the middle of the night to an unfolding crisis:

> *My friend tried to kill himself, went to this other friend and told them, and their reaction was horrific, very, very volatile, very, very angry … kind of like, 'If you're not going to do all these things to help yourself immediately, get out, get out of my room.' And obviously the consequence of that if I hadn't have woken up to the sound of him crying, could've been that he goes to his room and he tries to kill himself again. (Sabrina, cisgender woman)*

A Housemate is not a homogenous figure in LGBTQ communities. Experiences of being a Housemate can vary in ways that sometimes correlate with sexual and/or gender identity. Being a Housemate in a trans and gender diverse context are experiences particularly worth focusing on. The idea that share houses can become short-term (and perhaps even last resort) refuges for trans people featured occasionally in discussions. This is consistent with research that reveals the extent to which transgender populations experience precarious housing situations and face discrimination based on their identity (Hill et al., 2020; Hill et al. 2021). A Housemate, in this context, might provide support for people staying with them on a temporary basis. One participant described their experiences of shared accommodation, saying:

> *With social groups of usually quite traumatised, quite vulnerable people … relationships often get very co-dependent … Everyone kind of does [become a go-to person]. I've described mental health in the kind of social groups I was in at that point*

as like everyone's mental health is a house of cards built on everyone else's house of cards. (Kristen, trans woman)

5.2.5 The Help Worker

The Help Worker, the fifth peer-support role in this typology, is someone likely to be employed in a helping profession, particularly one related to mental health, including that of LGBTQ people. The broader health, family violence and housing sectors are also sites of employment. Someone in a role that supports the social and emotional wellbeing of colleagues in a more corporate setting might also be considered a Help Worker. To those experiencing mental ill health, this peer is not only approachable and caring but also brings expertise and professionalism to their support role.

Being identifiably LGBTQ in a work setting in which help is provided can mean being called on to assist fellow community members at a higher volume than is asked of non-LGBTQ colleagues. Or there might exist a desire within the Help Worker themselves to take on the mantel of supporting fellow community members.

It's almost like sometimes going above and beyond saying, 'I'll give you a call back to send you the links that you need', or 'I will ring around some of the groups for you to make sure you're linked in and you're not experiencing this bouncing around all the telephone services'. (Devon, trans)

Because a Help Worker is known to friends as possessing professional expertise and caring qualities, they are often called upon to help people outside of work. Requests come from not only people in their social circles but also beyond them. A 'friend of a friend' might have been told of ways in which they can help. A Help Worker is seemingly an ideal person to lean on during times of crisis. This can be to their own detriment – they might find it difficult to get a break from helping. One participant described their experiences of trying to switch off from other people's needs and seek support for their own. They said:

I was studying and working in mental health and then I was also supporting someone quite frequently. They were pretty unwell, and I got really burnt out. I'm still kind of recovering from that whole thing. (Alex, gender diverse)

The lack of a divide between help work and home is particularly challenging for a Help Worker during enforced lockdowns. This is especially the case for those working from home in a suicide and mental health support role while helping a partner. One participant described experiencing a situation in which they were 'talking about mental health and suicide at work and dealing with exactly the same thing at home'.

A Help Worker might also be considered in terms of support they provide LGBTQ colleagues. In this sense, it is not necessarily the field in which they are employed that matters but their willingness to help a colleague who also identifies as LGBTQ. Some examples of this type of support, perhaps better defined as 'help at work' rather than 'help work', was evident in participants' discussion. This might be more prevalent a peer-support role than this study captures, even warranting its own type – The Colleague – in future conceptualisations of this typology.

5.2.6 The Friendship Circle

To share the emotional load is really important … we all kind of do it together and I think, as well, it helps that person who is being supported benefit from having multiple supports. I think it just makes all the difference. (Kerry, non-binary)

The final peer-support role we propose is one made up of multiple people. Openness about mental health in LGBTQ communities can lead to peer support being provided during times of crisis. This includes not only one-to-one support, but also collaborative support offered to someone by a Friendship Circle.

Most of the people I know who have major issues or … really worrying breakdowns and so on would be turning to a group of friends. Not a large group of friends but a group of friends. (Frankie, genderqueer)

Being a collective role, a Friendship Circle is the exception in this otherwise individualised framework. The significance of the peer support provided within a Friendship Circle, however, justifies its inclusion. A Friendship Circle consists of individuals who may bring to their work aspects, if not direct experiences, of the roles that make up the rest of this typology.

The type of peer support offered by a Friendship Circle might be especially strong and co-ordinated when someone experiences suicidality or after a suicide attempt. In such times, a Friendship Circle can form around a person in acute need, either at their own request or upon initiation by the group.

In my experience, it's fairly common. I think, particularly, if someone posts on social media something that suggests they're at risk, you know – it could be a goodbye note or just something that seems a bit off and then someone will kind of comment, reach out to people and naturally a mini-network or support group forms. Certainly, within my communities that's really normal. (Drew, trans)

Members of a Friendship Circle recognise each other as being open to, and capable of, providing crisis support. They view each other as empathetic to an individual's mental health issues, perhaps because they themselves have experienced mental health challenges or crises in the past. Some members might consider peer support as something that needs to be shared for it to be sustainable.

Sometimes we can't be everything we want to be to our friend. Sometimes people find the things they need in multiple people … They're often the folks that provide the best bloody support because they've walked it, particularly with suicidality. (Kerry, non-binary)

Care responsibilities might be shared among members of a Friendship Circle much like a roster system, the logistics facilitated through private

group discussions on social media. The recipient of peer support might also change. An example of this would be a situation in which a person being supported, over time, begins helping one of their carers to deal with their own mental health challenges. Although such reciprocity creates solidarity, some members of a Friendship Circle may not find the support they need when they experience mental ill health.

5.3 Exposure to suicidality

The typology of suicide prevention and mental health-related peer-support roles presented in this chapter demonstrates a variety of situations in which care is provided. The severity of these situations also varies – for example, people intervene when someone is attempting suicide or are there to be leant on when someone needs to debrief about a stressful situation at work. There are, however, important similarities between peer-support roles in the above typology. These can be better understood through a focus on the most severe situations of peer support, ones in which suicidality is present.

Many, though not all, participants in this study had been exposed to suicidality while providing support, regardless of which role or roles in the peer-support typology they performed. This direct experience was often part of a broader social exposure to suicidality, which included the loss of friends, former partners and family to suicide, and knowledge of the loss of community members in extended networks. These experiences are explored in this section.

5.3.1 Crisis situations and interventions

Suicide-prevention peer support featured heavily in participants' accounts of helping others. A number of participants spoke of supporting someone who had attempted suicide. They discussed being there for a person in an emergency where the threat of suicide was immediate. Participants also shared stories of their caring for – and perhaps living with – someone who was experiencing suicidal ideation over a longer period. Support was often complex, provided over a number of years. For some participants, these situations mirrored their own past experiences of mental ill health.

Thus, the cumulative effect on participants was significant. One participant outlined their experiences of being there for others, saying:

> *I have had some ex-partners attempt – thank God I didn't lose them. I have had friends attempt … I don't know if I could put an exact number on that but maybe … out of suicidal ideation and attempts, maybe about 20 people and I've lost two. (Kerry, non-binary)*

What is striking in the above account is the volume of peer-support situations involving the risk of suicide. Another participant, who was part of a trans and gender diverse community, estimated they had been in dozens of peer-support situations in which persons they knew were at immediate risk of suicide. They explained:

> *I wouldn't be able to count, to be honest … loads and loads of times – yeah, it would be over 50. How many people? Probably, say, between … five and 10. There's a couple of particular people that I have done it for quite a lot over the last few years. (Drew, trans)*

Another participant described supporting about 20 people. This included actively trying to stop people from attempting suicide and being there for others who had attempted before. The participant had lost two people to suicide: a former partner and a friend whom they had supported more than a decade earlier when they were experiencing suicidal ideation. The participant said:

> *It saddened me greatly. I mean, at least with the friend who I had helped or at least I helped them for a while, they got [extra time] – and they had some fun and some good times in that. It's not a reasonable regret but they didn't know that they could ask for help. I mean they did know that they could ask for help but, yeah, in that moment, they didn't. (Frankie, genderqueer)*

This participant's first experience of helping someone in crisis had occurred in their late teens. It had involved calling a CAT team, which was a 'terrifying' experience in which they felt helpless. Dealing with authorities and support services in situations like this provided further challenges for participants.

5.3.2 Losing someone close to suicide

Some participants had lost a person close to them to suicide. This included family members, friends and former partners. Loss was experienced both inside and outside of participants' LGBTQ communities. For some, losing a person to suicide had occurred when they were teenagers and still at school. Others were grieving for someone they had grown apart from or lost contact with over time.

The profound impact of their loss had motivated some participants to want to be there to help others during times of distress. One participant described their loss and how it prompted them to act to ensure others they encountered were safe:

> *I've kind of gotten to a point of thinking about it like I recognise that I don't think … there was anything I could have done to stop that from happening, but now if it is within my power to stop someone from taking their life, I will do anything to stop that. (James, trans man)*

For other participants, the fear of losing someone they were helping loomed large – to the extent that they found it difficult to believe they had not yet lost a person around them. Two participants explained how they felt relatively fortunate to be in such a situation:

> *No, I have no idea how I haven't [lost someone]. I have no idea how I haven't, but I haven't. Bloody lucky. (Sabrina, cisgender woman)*

> *I absolutely count myself so lucky. I don't know how or why but I'm very, very aware that that's a massive possibility. (Alex, gender diverse)*

Not all participants who had lost someone to suicide felt in a place where they could talk in detail about their experiences. As such, accounts of dealing with loss in this report demonstrate the presence of suicide-

I think there's this kind of ambient grief – it's like all these little Venn diagrams of people in their social circles and people who are affected by their death and when they start to overlap, it gets particularly difficult.

DREW, TRANS

related grief and trauma in participants' lives – but they do not by any means capture the full extent of their impacts.

5.3.3 Broader impacts of suicide in LGBTQ communities

Many participants had been impacted by the suicide of a person or persons in their extended social circles or communities. Awareness of a 'friend of a friend' who had taken their life often deeply affected participants. One said:

> *In my direct group of friends, I haven't known anyone who has suicided, but in the next ring of people, there's been a couple of people who have killed themselves over the last few years. Yeah, I mean, it's so awful and seeing the way that it impacts the people around me just sucks – sucks. (Pat, non-binary)*

Another participant described this type of loss in trans and gender diverse communities as frequent and its impacts pronounced. The result, they said, was the experience of an 'ambient' type of grief. They explained:

> *I think there's this kind of ambient grief – it's like all these little Venn diagrams of people in their social circles and people who are affected by their death and when they start to overlap, it gets particularly difficult. (Drew, trans)*

Another participant drew a link between this type of grief and the sense of solidarity that had developed as a response to the prevalence of mental ill health in transgender communities. They explained:

> *The length, depth and breadth of the mental health issues, particularly in the trans community, are huge. And the people are close – whether they're friends, colleagues, whatever – it's really, really difficult and particularly when we are a community, or communities being … where we have lost people and … in one sense there is this person to whom we were connected and yet they didn't feel they could reach out to anyone; it's incredibly hard. (Michelle, trans woman)*

Participants sometimes recognised how peripheral loss affected their approach to supporting someone close to them. Experiences of this, however, varied from more focused concern, to passing thoughts. One participant described their way of processing this type of grief, saying:

> *I think it's very much a cautionary tale in the sense that, obviously, if you knew these people were contemplating suicide, you would have intervened, and so now that you're with this friend who just said something that's a little bit off – should I ask them if they're feeling suicidal or should I just leave it? … I should definitely ask because, maybe, this could have been the difference in previous people suiciding. (Declan, cisgender man)*

5.4 Summary

Suicide prevention and mental health-related peer support is provided in many ways in LGBTQ communities in Melbourne. This chapter has demonstrated that community members who help others do so in person, over distance using technology and in the context of community group settings. Peer support varies further depending on who is helping and what their relationship is with the person in need of support. This chapter has argued that it is useful to consider these varied experiences of providing peer support in terms of a typology of roles.

Drawing on the experiences of participants in this study, we have identified six peer-support roles prominent in LGBTQ communities: the Safe Friend, the Peer Leader, the Partner, the Housemate, the Help Worker and the Friendship Circle. The typology that these peer-support roles form is designed to do three things: first, highlight how diverse peer support is; second, provide an accessible way for the broader community to understand peer support in LGBTQ communities; and third, acknowledge the similar work that people in these roles, both participants and anyone reading this report, perform.

In the case of this study, performing peer-support roles has exposed participants to situations in which another person has been suicidal or attempted suicide. This chapter has demonstrated that such situations can be frequent, involve multiple people in severe distress and occur over a period of years. Some participants have also dealt with the grief of losing someone close to them to suicide and/or the 'ambient' grief of dealing with the suicide of someone in their wider community. These experiences have significant impacts – including burnout – on those providing peer support. These impacts, and the strategies participants use to mitigate them, are the focus of the next chapter.

6. The impacts of being leant on

Providing suicide prevention and mental health-related peer support is a significant undertaking.

As this report has already demonstrated, a person who performs a peer-support role in an LGBTQ community does so in a context of exceptionally high incidence of mental ill health and lived experiences of trauma and discrimination. By being leant on, they might be exposed to suicidality and experience the loss of someone to suicide. They, too, might experience some of the same challenges overwhelming the people they are supporting. It is important, therefore, to consider the impacts of peer support on those who provide it.

This chapter demonstrates that suicide prevention and mental health-related peer support has numerous impacts – positive and negative – on those providing it. The severity of the situations in which someone performing a peer-support role finds themselves, whether by choice or by chance, can have considerable impact on their own wellbeing. If situations are not managed or adequate boundaries drawn, a person performing a peer-support role can experience burnout and other effects of mental ill health. Negative impacts on a person's relationships, finances and careers might also be felt. Peer support undoubtedly has positive impacts as well. From helping someone literally choose life over death, to finding meaning and identity through being a carer, being leant on can be highly rewarding.

These impacts are explored in this chapter. We approach this in three ways: first, by considering three broad types of peer support impact: the 'cognitive and emotional', 'the logistical' and the 'social' impacts; second, by seeking to understand how burnout is experienced; and, third, by exploring how negative impacts are managed and mitigated.

6.1 Types of impacts

In this section, the impacts of peer support are separated into three broad categories. The first category, the 'cognitive and emotional', represents the impacts on an individual's inner self, essentially how peer support experiences affect how a person thinks and feels. This is considered mainly in terms of participants' sense of their own wellbeing and mental health. The second category, 'the logistical', relates to the impacts of providing peer support on a person's ability to fulfil their everyday commitments such as going to work and keeping up with their studies. It also focuses on the financial implications of supporting someone. The third category, 'the social', centres on the impacts of peer support on the maintenance of relationships and friendships. Although the negative impacts provide much of the focus, positive impacts are also considered. It must be acknowledged that impacts contained within these three categories often overlap.

6.1.1 Cognitive and emotional

Peer-support work can significantly affect the thoughts and feelings of the person undertaking it. Support roles can be intense, confusing and scary. Being there for someone, especially if they are considering or attempting suicide, can leave a peer feeling helpless and ill-equipped to deal with the situation. This is particularly so the first time a person experiences such an event. Questions about whether the support they provide is adequate; at what point to involve emergency services; and how and when to step back can take a huge toll on a person providing support.

The pressure to help can amplify in a person's mind if they feel as though they are the only option or the 'last resort' for a peer in crisis. One participant, who otherwise felt relatively unaffected by their experience of providing peer support, explained how being a rare 'stable' person in another person's life created a sense of 'obligation' to always be there for them:

> *It didn't bring me down … [but] I remember there was a lot of second guessing about the support I was giving and whether it was the right type of support. (Gabriel, cisgender man)*

Some participants' experiences show how a peer-support situation, especially if it is ongoing rather than confined to a single event, can pervade the thoughts of a person being leant on. This can be difficult to manage, including if someone helping has themselves experienced trauma or mental ill health in the past or continues to do so. One participant explained the effect of a friend's mental ill health on their own thoughts and emotions:

> *I feel like my friend … just triggers a lot of things for me … I feel anxious that she'll die … I'm worried about her most of the time, like she's in a constant set of crises and she's not very in touch with her experience. And, yeah, I know that's my problem – like I don't need to worry about her. But I do. (Jayden, gender diverse)*

Some participants reported feeling drained, stretched to their capacity and disappointed that they could not offer more help to a peer. On the other hand, many also experienced positive cognitive and emotional impacts. For some, a sense of reward, honour, meaning and community (if support was provided collaboratively) often came from being leant on. As one participant explained:

> *I think some of the rewards are it feels meaningful … [it's] kind of an honour if you're there with someone when they're at their worst or what they think is their worst. That's a big one and I think that's the core of life; it doesn't have to be all of what life is, but I think for those that we love, we show up. (Kerry, non-binary)*

For some participants, showing up was also about their own desire to feel needed – and being leant on was a way of knowing they were.

> *I enjoy feeling needed; it gives me a purpose, so it serves me in a way, but also what I get is connection. So, connection for me is being with people in a whole range of their emotions and experiences, getting to know them, sharing … who they are as a human being, and that can be a stranger who I'm only there for in the moment, and/or friendships and family relationships. (Devon, trans)*

In this sense, peer support has a positive impact on both the supporter and the supported. Some participants, however, questioned whether a desire to feel needed through peer support was always as positive as it might appear, even suggesting it might lead to complicated outcomes. Addressing this, one participant said:

> *It's almost like controlling and gross. It's like, 'Why can't I make this person better?' Because you want to – you want to – but … that's on that person, that's their choice. It's not even about you in that way – and to make it about you in that way is the shadow side of self for me. (Kerry, non-binary)*

6.1.2 Logistical challenges

A person who performs a peer-support role often sacrifices a lot of their time to help. Situations in which a person supports a friend, partner, colleague or stranger can arise unexpectedly. Even when help is more predictable in terms of when it needs to be provided – for example, in situations where a person offers to help, or two people schedule a time to talk – it can still be very time-consuming. Someone fulfilling a peer-support role can find themselves sacrificing leisure time, losing sleep, missing or underperforming at work and falling behind in their studies. For many participants in this study, these impacts were ultimately manageable – they had found ways of negotiating them. These impacts are, however, negative in the sense they had the potential to be much more serious for some people than others – and were not ideal for anyone.

Peer support was not only demanding in the sense that participants spent many hours being there with others, helping them through crises, but also because such situations used up a lot of energy. This was sometimes compounded if a participant was themselves experiencing illness, disability or mental health concerns. As one participant described:

> *I have assisted someone who was having suicidal thoughts at 2:30 in the morning, which was difficult for me in that sleep is obviously important to someone with my own ongoing mental health issues. (Michelle, trans woman)*

Participants reported experiencing burnout and exhaustion from their support roles, which affected their focus at work. In more serious situations, participants missed work to help a person close to them. One participant described taking time off to be there for a housemate who was suicidal. Depending on how open-minded and supportive their managers and colleagues were, participants were often not able to disclose details of their peer-support roles to others. One participant, however, explained their experience of working in a relatively supportive environment, saying:

> *Thankfully, with work I've never been cautioned; however, I have called in sick because my mental health has gone downhill or because I've been giving too much of myself to help someone else. So, a lot of days lost with work, but my work is very understanding. (Devon, trans)*

Another participant detailed how disguising the effects of a peer-support role as the consequences of a medical condition was the only way of dealing with their situation:

> *I used to have a lot of casual jobs and sometimes it was kind of – very rarely did I pull out of a shift – but it would be 'I have exhausted myself. I have a medical condition. Therefore, I have to leave the shift early.' (Jenny, cisgender woman)*

Participants' study commitments were also sometimes affected by their peer-support roles. Some juggled tertiary studies with their roles in ways that were manageable – barely. One participant spoke of the challenges of negotiating their situation:

> *It's definitely made it harder, a lot harder in my studies, the level of stress that I was dealing with. Like you said, doing the 2am crisis management when you've got an assessment the next day or whatever, that's really hard. (Drew, trans)*

Not all scenarios in which studies and peer-support roles clashed, however, were sustainable. One participant withdrew from study due to mental ill health exacerbated by the stress of being there regularly for someone experiencing suicidal ideation. Another detailed the negative impact their peer-support role had on their studies during Year 12, the final year of secondary school.

Logistical impacts of providing peer support were sometimes more directly financial. Some participants found themselves in situations where they were supporting a partner or housemate, a person with whom they shared financial responsibilities. These situations became complicated when the mental ill health of the person being helped affected their ability to pay their share of something, including rent. One participant, who had helped a former partner while they were together, spoke of paying for their sessions with a psychologist and clearing some of their debts, while also supporting them emotionally. Another had grappled with the question of whether to ask a housemate – whom they were caring for – to repay money. 'Overly helpful' was how another participant described their past approach to helping someone who had no money – and whom they eventually realised was taking advantage of them.

It might seem unusual in one sense to consider logistical impacts in terms of positive outcomes. After all, people are not engaging in peer support for financial or educational gain. It can be said, however, that positive logistical outcomes of peer support include that it often brought some stability to the lives of those being helped (and by extension, those helping); and it provided inspiration to some participants to undertake formal education and seek employment in mental health and LGBTQ-focused sectors.

6.1.3 Social impacts

Peer-support situations are often complex, stressful, intense and disenfranchising for those being leant on. The nature of such situations, therefore, can impact upon a person's relationships with people in their wider social circles. The experiences of participants in this study reveal that the negative impacts of peer support can affect a carer's relationship with partners, family, friends

and community in various ways. This part explores some examples of how these relationships are affected.

The social impacts of peer support can be considered in relation to a partner in two main ways. First, there are situations where a person is providing peer support to their partner. In such cases, peer support might significantly help the person and the relationship itself. On the other hand, it might create a situation where a person providing support does not have their needs met, either emotionally or socially. Their time might be spent more on helping their partner than engaging in other activities as partners.

Second, situations might occur when a person is providing peer support to someone who is not their partner. Such support might come at the expense of spending time with their partner/s and developing the relationship/s. One participant explained:

> *If I do have to spend an ample amount of time with a struggling friend … it impacts on my relationship and it's obviously eating away at the time I could be spending with my partner. There's that sort of tension every now and then. (Gabriel, cisgender man)*

Peer support might also impact upon a carer's relationship with family members who might not understand the intensity of the situation that the person is in. In such a situation, family members – even those supportive of a person's LGBTQ identity – might not understand why their loved one is prioritising friends over them. Similar dynamics can occur in friendship groups, when the needs of one person become urgent and tending to them comes at the expense of a carer's other plans with friends. One participant described this as having to 'triage your own friends'. They explained a thought process that drives this, saying:

> *OK, this person is literally in absolute crisis. My other friend is doing it really hard, but unfortunately, I can't help them at the moment because I've got this other person in crisis that I want to support. (Drew, trans)*

Being in relatively small, close-knit LGBTQ communities meant some participants providing peer support experienced issues around privacy. Having to be careful who they spoke to or being able to get support only from the person they were helping were some participants' experience. One participant described how small their community could seem in such moments:

> *You can't even anonymously be like, 'Oh, one of my friends … has been stealing prescription pills from the pharmacy and they have a substance abuse problem.' It's like everyone will know which friend you're talking about. You can't be anonymous, and you can't seek support in that way, without sharing somebody else's business. (Jenny, cisgender woman)*

If I do have to spend an ample amount of time with a struggling friend … it impacts on my relationship and it's obviously eating away at the time I could be spending with my partner. There's that sort of tension every now and then.

GABRIEL, CISGENDER MAN

6.2 Burnout and boundaries

The negative impacts of providing peer support, outlined in the previous section, contributed to many participants experiencing the effects of burnout. This indicates the commitments participants made to supporting their peers, often over a period of years or even decades. Burnout is a 'prolonged response to chronic emotional and interpersonal stressors' (Maslach et al., 2001, p. 397). Three dimensions characterise it: exhaustion, cynicism and inefficacy (Maslach et al., 2001). Differences exist between simple burnout and compassion fatigue. Burnout has been described as 'gradual and cumulative, while [compassion fatigue] has a faster onset of symptoms and may result from the exposure to a single traumatic event' (Rossi et al. 2012, p. 934).

Participants in this study mostly described negative impacts as arising from the cumulative effect of helping a person or persons. The term 'burnout' was used more frequently than 'compassion fatigue' to describe

situations in which participants felt exhausted and had sought to step back from their situations. We have, therefore, focused more on burnout for two reasons: first, experiences of it are apparent in the data; and second, some participants themselves identified with the term when describing their experiences. By doing this, however, we are not discounting traumatic single events that might have contributed to some participants experiencing compassion fatigue.

Before considering how providing peer support in crisis situations led to burnout, it is important to consider the evolution of the peer-support process for those being leant on. It is useful, also, to recognise the evolution of the peer-support provider. In many cases, this evolution was from a teenager or young adult leant on for the first time, to a mature adult with the wisdom gained from many different experiences of providing support to others.

6.2.1 The evolution of peer support

Peer support was an evolving experience for many participants, often occurring over many years. Even if one experience stood out above all others as particularly intense or profound, it was usually one of many times a participant had been leant on during their adult life. For some, peer support had its genesis not in adulthood but childhood or adolescence, when family members or school friends were experiencing physical or mental ill health and they were thrust into caring roles. For others, young adulthood was the site of their first experience of a peer-support role.

At the time of being interviewed, participants were aged between 23 and 79. The time that had elapsed since each of their first experience of peer support, therefore, varied significantly. Even so, most participants' first peer-support experience was distant enough in their past for them to be able to identify personal and professional growth that had occurred since. This had allowed (or would allow) them to provide subsequent peer support that they believed was more informed, of a greater quality, and more conducive to the maintenance of their own mental health.

Participants often spoke of their early experiences of peer support as quite raw; many considered themselves underprepared for the gravity of the situations they had faced. This was despite emerging perceptions of themselves as natural carers or Safe Friends. One participant reflected on this, saying:

> *I've just always been that person. I probably didn't do a very good job of supporting people when I was younger, and it's only been in the last [few] years that I've actually gained any sort of professional knowledge. So, I was definitely doing this always anyway, but now I just know the right language, know to listen rather than talk as much as I might have. You know, know the supports to offer. (Alex, gender diverse)*

Experience in a peer-support role helped participants' confidence grow. Mental health training, study and professional development were also factors in participants evolving to feel more comfortable being leant on. A participant's own personal growth also contributed to changes in how they provided support. Growing older often meant acquiring wisdom, refining worldviews, and reconsidering how one interacted with others. This evolution within a person helped shape their approach to peer support. As one participant explained:

> *I've changed, so I'm going to assume my approach has changed. I'm probably less blunt than I was previously, a little less black and white … I'd say as my experience of the world has grown, yes, my viewpoint and ways I would go to help people has changed. (Robbie, cisgender man)*

Being more financially stable, established in a career and emotionally grounded – factors that also came with age – also provided participants with more confidence in challenging situations. This included being better able to assess the severity of a crisis and to provide support accordingly. One participant said:

> *As I got kind of older and wiser, I was better able to identify … when a friend was in crisis. There are probably times when I was younger when, if I could look back now, I would have helped. Whereas, because I didn't have the language or the knowledge then, I just didn't get involved. I think I have learnt to pace myself a little bit. But there's a grey area between pacing your involvement and kind of developing that crusty burnt-out outer shell. (Drew, trans)*

This 'grey area' underscores the uncertainty that comes with providing peer support, even as a person becomes stronger and wiser in their role. Peer-support roles and processes evolve over time, shaped by the growth of the individual and changes in their circumstances and the world around them. These might be considered part of a natural trajectory that occurs in response to a level of peer support that is manageable for an individual. When peer support becomes unmanageable, however, burnout is a possible or even likely outcome. This type of trajectory is explored now.

6.2.2 Feeling the effects of burnout

Providing suicide prevention and mental health-related peer support pushed some people to the limit. Participants described themselves as 'burnt out', 'drained', 'depleted', 'exhausted' and/or other similar terms. The stress of a crisis, the ongoing fatigue of what might seem like an unresolvable situation and a participants' own work, study and relationship responsibilities contributed to such feelings. While some participants had themselves experienced suicidality and/or attempted suicide in the past, no participants spoke about such experiences as a direct result of their peer-support roles.

Participants described the sometimes-unrelenting nature of peer support when it was provided to a partner with whom they lived or housemates during the COVID-19-related lockdowns of 2020 in Melbourne. The volume of people helped often contributed to participants in a Peer Leader role burning out, including in terms of instant messages and other smartphone technology contributing to an 'always-on' culture of peer-support

provision. A number of trans and gender diverse participants had experienced burnout after multiple experiences of helping someone who was suicidal through a crisis. The intensity of Housemate roles, especially for young trans people or participants helping young trans people, were also present in some stories of burnout.

Many participants were consciously aware of the impacts peer support had on them, especially if those impacts included burnout. Some participants were experiencing burnout at the time of being interviewed, while others talked about it as something they had dealt with or overcome. For some, it had only become apparent sometime later that what they had experienced was burnout. As one participant described:

> *I have in the past felt like I've completely burned out from doing it, that I've just been unable to cope with an additional request. I have felt just so tired of it all that I'd really just like to run away to the hills and hide in a cave. So, it's that combination of being exhausted and completely drained of all emotional capacity to just give anymore. Which I know is classic burnout. I know that now. I didn't know that then. (Ingrid, cisgender woman)*

Work situations came with the benefit of a specific framework for responding to people experiencing suicidality and other crises. This provided some comfort to participants faced with emergencies. As one participant detailed:

> *Through work, I've dealt with a good few and very difficult mental health cases, where we've had calls from people saying that they are going to attempt suicide … I think it's very different when it's work to your personal life … I've been through it a number of times. No one's actually gone through with it, which is a huge relief, but I know the process to follow from a work perspective, which is pretty clear. (Anastasia, cisgender woman)*

For those whose professional and personal lives both involved issues of mental health and/or peer support, a feeling of being overwhelmed and unable to switch off could quickly take hold. Describing their experiences of this, one participant said:

> *I was taking on so much stress, I was so anxious all the time … I just needed to sleep 24 hours. I was just exhausted; it didn't matter how much time I had off work, I wasn't able to regain anything. So, even though it wasn't directly affected by an individual person, it was the cumulative effect. (Devon, trans)*

Feelings of burnout were sometimes heightened if participants did not feel as though they had go-to people of their own to lean on. One participant said:

> *I was studying and working in mental health at the time, and also trying to support my family members whilst another family member was quite unwell. So, it was just very, very overwhelming, because I didn't particularly have anyone who was able to be there for me in the way that I was there for other people. (Alex, gender diverse)*

This was particularly evident among participants performing a Peer Leader role. In this context, one participant talked about burnout as something of an inevitability; people in leadership roles, the participant said, gave their all to help others until they were exhausted, at which point they tended to withdraw from the community altogether. In some cases, the enforced COVID-19-related lockdowns of 2020 provided an opportunity for some participants to step back from their community roles and focus primarily on their own wellbeing.

Participants spoke of being pushed to their limit but remaining in their support role anyway. Their empathy depleted and their resilience broken, they began noticing themselves becoming less tolerant of other people's struggles. One participant described the effects that burnout 'off and on over the last few years' had on them, saying:

> *That kind of compassion fatigue is really hard. I certainly notice myself being a little bit less tolerant or being less able to take on other people's emotions after having been one of the go-to people for support for a couple of years there. Yeah, it's really affected my ability to actually be able to talk to people I care about about their mental health because I find myself kind of putting up walls pre-emptively. (Drew, trans)*

Another participant described a situation in which a person they knew was suicidal on multiple occasions. Ultimately, it became too much for the participant to deal with and they sought to withdraw from the situation:

> *Oh absolutely, it was bloody awful … yeah, it was extremely draining … It was draining, and ultimately, I adopted the attitude, 'Well, you know, stuff it. If that's what you want to do, do it.' (William, cisgender man)*

Some participants who had been pushed to their limit found support in those around them. As detailed earlier, openness about mental health, awareness of the struggles of fellow community members and solidarity meant that some participants were fortunate enough to be surrounded by people who understood the pressure they were under and the limitations of their caring capacity. One participant's experiences of burnout encapsulate this particularly well:

> *It does force me to reassess the support I offer people, because there's only so much of me, and I am a finite resource … If something like that has happened, I'll tell the other people I care for in my life that that has happened, because then I'm like, 'I basically am going to not be able to provide the care that you may like. You will have to go elsewhere, because I am depleted.' (Ingrid, cisgender woman)*

On the other hand, the impacts of peer support and its associated burnout were too much for some friendships and relationships to survive. One participant described the strain of intervening multiple times when someone they knew was suicidal:

> *Caring for someone really intensively usually has rebound effects on the carers' own mental health –*

particularly when it's in this kind of informal way and there aren't really clear boundaries. I had to disengage from doing that because it was wrecking me. (Kristen, trans woman)

The sense that boundaries could be difficult to draw, suggested above, was a recurring theme in the interviews. The ability for a participant to create boundaries – between themselves and the people they were helping – appeared a helpful way of preventing or managing burnout. Having supportive partners, friends and family also helped in such situations. For some, the forging of boundaries did not always occur until after a participant had experienced burnout. Participants' reasons for creating such boundaries, and the effects of doing so, are explored in the next part of this section.

6.2.3 Setting boundaries and stepping back

I think I've learnt from mistakes – so, whether I've maybe given too much of myself and then I start sinking, which happened a lot more when I was younger, and also I think just being such a helicopter mate. (Kerry, non-binary)

Many participants considered boundaries between themselves and their support roles important to their wellbeing and the sustainability of the peer support they provided. Many who experienced burnout had, at some stage, felt consumed by a support role that was overwhelming yet vital to the wellbeing, and even survival, of a partner, friend or community member. Participants had drawn meaning from their roles but sometimes found them unsustainable; without adequate boundaries, the stress of their roles seeped into other parts of their life, affecting other relationships, their employment, studies and sleep. Their own wellbeing suffered from their not being able to draw boundaries and step back.

It is reasonable to suggest that the prevalence of mental ill health in LGBTQ communities exacerbated the difficulties some participants had in setting boundaries. The openness and support participants found in LGBTQ communities helped them deal with challenges related to mental health, stigma and discrimination. When support situations within their communities became too overwhelming, however, some participants found they had no place to go. One described the isolation that peer support could bring:

My support system is the system I'm supporting, so you see the problem … I mean, a time I was just so overwhelmed and just stressed and I was just crying, and the only person I could go to was the person who was the cause behind it. So, I didn't tell them anything, it was just like, 'Can I have a hug?' (Jenny, cisgender woman)

Most participants who reported such experiences had learned from them. A feature of this learning was recognising the importance of establishing boundaries: between themselves and those they helped; between themselves and their support roles; and between their experiences of peer support and their relationships with other people they were not helping. This was not an easy process. Participants had to reconcile their willingness – even their need – to help others with the fact that doing so unconditionally might come at the expense of their own wellbeing. One participant described this challenge, saying:

The biggest issue that I struggle with and that I am still trying to work through at this present moment – I probably will for the rest of my life – is how do I then wean those people off me? One of my insecurities is that people aren't going to like me or need me, so that's a big thing. When I get an opportunity to prove to myself that somebody needs me, I'm going to want to take it. (Luke, cisgender man)

As well as wanting to help and be needed, some participants felt obliged to be there for others. Feelings of guilt and doubt arose for some people who tried to step back. In practice, not everyone found the process of setting boundaries possible. As one participant said when describing a friend whom they had supported:

I feel like to withdraw would further derail her, so I feel like I don't know. I'm not confident in managing that boundary. (Jayden, gender diverse)

Sometimes the thought of boundary making came with fears of losing the person. This was particularly acute for one participant who was supporting a partner:

It's incredibly difficult. Incredibly difficult because you have the assumption that if you create the boundaries then you're going to lose them. And it's a constant battle/ reminder in your head that that shouldn't be stopping you from creating those boundaries because by creating those boundaries you're absolutely helping them. (Luke, cisgender man)

For trans community members in particular, concerns about not only losing a person but also losing a sense of community made the process of drawing boundaries particularly challenging. An experience of marginalisation, beyond what other LGBTQ communities might have felt, meant some trans and gender diverse participants were especially looking out for fellow community members. One participant explained this, saying:

It's not only just that you should [help someone] because they're a person and people should look out for each other, but they're one of your own and that's a particularly difficult feeling. As a trans person, I rely on there being other trans people around me to have a community. So, looking after [others] is also part of your own survival, and that makes it harder to have boundaries sometimes. (Drew, trans)

Some other participants had little hesitation in drawing a boundary, feeling more comfortable with putting their own wellbeing first. In some situations, the person needing support expected the participant to be there. As some participants' stories revealed, this was not always a healthy dynamic; in some instances, in fact, it created dependency. One participant described such a situation, saying:

I was trying to be there for them and be a good partner, and provide them as much support as I could … I didn't feel like they were doing anything for themselves; a lot of that reliance was coming on to me, so I felt like then I was enabling it … Sometimes when you step back or put in a boundary … you [get] a bigger reaction from them. (Lisa, cisgender woman)

Experience brought more knowledge of the importance of boundaries and even greater confidence in drawing them. This sometimes came in the form of a participant explaining to someone what the boundaries were (perhaps expressed in terms of when they were available to meet, talk or respond to a message); turning off their phone at certain times (usually overnight or while at work); or ending a friendship or relationship if it was particularly unhealthy for them. One participant described how a difficult experience of distancing themselves from someone helped them realise the importance of creating healthy boundaries. Of the first part of that experience they said:

I don't at all regret that decision – that was absolutely the necessary and correct decision, but it still is kind of miserable that my only option in that situation was just leave [them] to suffer. (Kristen, trans woman)

This experience made the participant realise the importance of establishing boundaries before it got to the point of severing contact with someone:

I feel if a similar situation happened now … I would never let it get that bad – at least for me. I would have enforced boundaries sooner, had a conversation about boundaries … inevitably, it's going to take energy to care for someone in a crisis situation, but I try to make sure I am not doing that if that takes more energy than I have. (Kristen, trans woman)

Other participants had developed their own approaches to ensuring boundaries were clear – and respected. One said:

I've definitely learnt where I have the right to my own health. I guess when I was younger, I was a bit more idealistic and I'd be willing to give more of my time and my effort and my energy to basically anyone whereas now there are certain boundaries. (Robbie, cisgender man)

For others, drawing boundaries was very much a work-in-progress. Stepping back altogether was perhaps neither an option nor something they had considered. They remained in a peer-support role that was too demanding. This was the experience of some Peer Leaders who found themselves fielding calls from 'friends of friends' who received a recommendation to contact them when they needed someone to talk to.

On the other hand, some performing Peer Leader and Help Worker roles were better prepared than others for the boundary work required of a peer who provided support. Some participants in these situations spoke of the idea of boundaries being built into their practices when volunteering with professional organisations, specifically as a way of preventing burnout.

The one really important thing I've got out of that is knowing where my boundaries are and how to enforce them without feeling like you're failing someone. (Declan, cisgender man)

This was sometimes easier in theory than in practice, especially when someone sought to bring these principles to a situation in their personal lives. One participant talked about this with reference to helping a housemate:

It's not best practice to insert yourself fully into someone's life and give them all the support. You know, what happens if you can't do it anymore? What happens if that's not sustainable basically because you'll burn out? And I know that – but in practice it's just really, really difficult sometimes to draw those boundaries. (Kelly, cisgender woman)

These complex situations demonstrate the challenges of boundary making in peer-support situations. Some participants were able to establish boundaries that improved their peer-support provision and thus improved their own wellbeing. Others found it more difficult. All participants also had other self-support strategies to protect their wellbeing. These are explored in the next section.

6.3 Managing and mitigating negative impacts

Drawing boundaries, though difficult, was often part of a wider system of self-care for those providing peer support. Not all self-care, however, came in response to burnout. Some participants, after all, were not burned out. All participants had their own way of tending to their wellbeing in the context of their support roles. For some, it was, by necessity, a pressing concern – they had reached a tipping point and needed to act to help themselves. For others, a proactive rather than reactive approach helped insulate them against burnout or breakdown. Peer support, for some, was a relatively manageable experience and the self-care they engaged in was linked more to their broader experiences and routines.

This section details some of the self-care practices of participants. It considers the activities in which they engaged to help their wellbeing, which may have suffered due to the negative impacts of providing peer support. It also considers what support options exist to help participants perform and continue in their peer-support roles. This is explored in terms of participants' own perceptions of what worked for them and what more could be done to ensure they are better supported. Central to this is the role that government, health services and community organisations could play in helping prevent burnout among peer-support providers in LGBTQ communities and, thus, make their roles more sustainable.

6.3.1 Practicing self-care

Participants' self-care practices supported their wellbeing, which may have been negatively impacted by peer-support roles. These practices took numerous forms, reflecting participants' various networks, interests and peer-support situations. Broad patterns of self-care among participants, however, are identifiable. Participants' self-care practices could be described as fitting into three main categories: drawing

Often my own mental health appointments with my own mental health professional end up being debriefing from some of these situations, rather than being ways that I can strengthen my capacity in a longer term, or deal with other issues in my life.

MICHELLE, TRANS WOMAN

boundaries (already discussed above); leaning on others, which included seeking support from people they know and accessing mental health services; and participating in leisure activities. The focus of this part is the second and third of these categories.

For some participants, leaning on people in their social networks was vital to their wellbeing. They sought support from people close to them who were open to talking about mental health and sympathetic to their situations. This is reflected in previous discussion in this report, including in terms of a Friendship Circle, in which the focus of care can regularly shift to the person most in need of it. Participants also spoke of reconfiguring social networks and friendship circles to avoid one-sided or 'toxic' relationships. Often, support systems were multi-faceted. Although at times complex, they provided options for a participant seeking help. As one participant described:

> *I wouldn't say my family is supportive, but they would be supportive if I ever became homeless and needed somewhere to stay. I wouldn't go to them for emotional support … I find my friendship group really good, and then I have other friends outside of that group and then the community more broadly where … I might not have super close friendships with someone, but I feel like they would support me if I needed it. (Jayden, gender diverse)*

A combination of leaning on friends and seeking professional mental health support was the experience of some participants. As one explained:

> *I've got really amazing people around me and I've got a really comprehensive health care network of like a psychiatrist [and] GP, that are really, really good. (Pat, non-binary)*

Many participants described having talked to a professional – often a psychologist, counsellor or general practitioner – about their mental health. For some, this had long been part of their routine, even dating back to their childhood. Some talked about therapy as something they would access even more if it were more affordable. In some cases, participants said they used their therapy sessions to talk about the peer support they provided. One such participant said:

> *Often my own mental health appointments with my own mental health professional end up being debriefing from some of these situations, rather than being ways that I can strengthen my capacity in a longer term, or deal with other issues in my life. (Michelle, trans woman)*

It was important to many participants that professionals they engaged with were at least knowledgeable about and respectful towards LGBTQ clients and their concerns. Gaining access to such professionals could be challenging, as one participant explained:

> *It's a bit tricky, I think … just trying to find LGBTI-friendly professionals without a huge wait list because we all need that support and it's quite difficult, so it has been off and on, but it does happen. (Drew, trans)*

Some participants also spoke about mental health plans and described taking medication for anxiety and depression.

Participants engaged in many activities that helped maintain or regain a sense of wellbeing. These included meditation and mindfulness practices; exercise; and artistic and creative pursuits, ranging from graphic design and photography, to writing and composing music. Various social activities, from nightclubbing to journaling as part of an online support group, were also important to participants and served as opportunities for them to lean on others.

6.3.2 What helps LGBTQ community members in their peer-support roles?

It is important to consider not only the self-care practices that help participants' wellbeing, but also the support that has enabled them to perform and remain in their peer-support roles. Participants talked about such support in two main ways. First, some discussed it in terms of having a caring community with good knowledge of wider support systems. As one participant said:

> *One of the benefits or positive things of the community is how connected people are – there is the intention to support and help each other out. (Jayden, gender diverse)*

Another expressed a similar sentiment, though more specifically in terms of wellbeing, saying:

> *When I spoke to my friends, they were like, 'You need to go and look for these specific supports' and gave me places to reach out to, like specific counsellors' names – and once I accessed those supports, it was a different world. (Anastasia, cisgender woman)*

Second, participants spoke about support to sustain their peer roles in terms of the training they had received. Most notably, Mental Health First Aid and Applied Suicide Intervention Skills Training (ASIST) were identified as particularly helpful for dealing with a crisis. One participant said:

> *Doing Mental Health First Aid training was honestly brilliant because I used to feel a huge personal responsibility for people and I think doing that training gives you that sense of you need to be able to detach yourself in these situations and provide practical support, and if the person's not responding, here are the steps that you take. So, I think even making training like that free or easily accessible to people in the queer community would be really positive. (Anastasia, cisgender woman)*

As touched on at the end of that account, common in discussions of 'what works' was an accompanying emphasis on 'what more needs to be done'. Some participants suggested that community members were filling gaps where professional health services should have been operating. It was clear throughout the interviews that more could be done to support people in peer-support roles. Participants' ideas about what this might look like forms the next part of this section.

6.3.3 How do those in peer-support roles want to be helped?

Participants shared many ideas about what could be done to better support people in peer roles. These ranged from major social reforms to practical on-the-ground training for an individual providing emergency support. Some of these suggestions are explored in this part. This, however, is not an exhaustive list of participants' suggestions.

As explored above, some participants said more LGBTQ community members should be given the opportunity to undertake suicide prevention and mental health-related training:

> *Having more queer and trans people have access to things like Safe Talk or ASIST at low cost would be really, really helpful as well as obviously just employing queer and trans people in mental health services. (Drew, trans)*

Attending such training would be time consuming, one participant suggested, so would likely need the support of more employers and, therefore, more recognition of the importance and commitment of a peer-support role. Organisations such as Switchboard were suggested as possibilities for the delivery of such training in online spaces. Many participants supported the idea of community organisation-led mental health response training and education more broadly. Some acknowledged the limitations that existed in providing that training among communities of already-overworked volunteers and, therefore, called for more funding to support such efforts.

More suicide prevention and mental health-related training would help disperse response skills more widely. The *Lean on Me* survey asked respondents whether they had received training in the provision of mental health support. Of the 326 people surveyed, 27% (104 people) had participated in workshops or training programs related to providing mental health support, 12% (44) had completed a relevant formal qualification and 13% (50) had received relevant workplace training. On the other hand, 118 (31%) had undertaken no such training.

Several participants talked about the idea of forming peer-support networks, in which people could debrief after helping others through crises, sharing experiences and strategies. As two participants explained:

> *A lot of the skills that I've picked up from this have been from other people who do the same kind of*

I don't know many other carers … So, in some hypothetical world if there was a space wherein these people could connect … because I think carers attract people that need the help and you don't often attract other carers because you're not inherently compatible.

MARIA, GENDER DIVERSE

thing, and I wonder if there isn't room for perhaps a more formal way for people who are finding themselves doing this stuff to actually share skills. (Kristen, trans woman)

I don't know many other carers … So, in some hypothetical world if there was a space wherein these people could connect … because I think carers attract people that need the help and you don't often attract other carers because you're not inherently compatible. (Maria, gender diverse)

Formal recognition for carers was also seen as having the potential to make peer-support roles more sustainable for those performing them. One participant described their experiences of performing a role that was largely unacknowledged as care work:

I'd taken on a caring role. That hadn't occurred to me because I wasn't like a parent or I wasn't like a formal carer. It didn't really click that I could actually access some of those services if they existed … So, I think maybe more awareness about what that looks like. I know a lot of other friends with partners or housemates in queer communities who have a lot of complex mental health issues who … have housemates or partners who would technically be carers even though they're not recognised as such. (Kelly, cis woman)

Some participants also suggested that funding for LGBTQ initiatives could be more widely distributed across organisations and communities. More around-the-clock phone services for people in peer-support roles were also proposed as something that would give people an immediate option while helping a peer experiencing a mental-health crisis.

On a broader, societal level, many participants wanted perceptions of mental ill health to change. They wanted health and emergency services to better respect LGBTQ communities, including those needing peer support and those providing it. Some stressed that it was vital for people in peer-support roles to be able to call CAT teams and engage with hospitals and police without discrimination or seeing a situation escalate into violence.

Many called for mental health to be recognised as more of a long-term challenge for individuals and communities. Some participants wanted funding, especially related to counselling and psychology, to reflect this long-term view of mental ill health, suggesting that people dealt with challenges over a period of years rather than through a set number of sessions with a psychologist. Such discussions were relevant to carers themselves, who often remained in peer-support roles over long periods of time. One participant described this in relation to someone they were helping with issues of mental ill health and alcohol use, saying:

I wish somebody could give me the answers to what to do when it's been three years … How do you help somebody with a chronic problem, not just in a crisis? … What happens when things don't change? (Jenny, cisgender woman)

These are participants' main suggestions for supporting people in peer-support roles. They help to inform the recommendations made in the next chapter.

6.4 Summary

The impacts of suicide prevention and mental-health related peer support are highly variable. Each experience of providing peer support brings with it a different set of cognitive and emotional, logistical and social impacts. These impacts, both positive and negative, can be significant for those performing peer-support roles. This chapter demonstrates that the most significant impact – saving someone's life – is positive but that the negative impacts can be numerous and take a substantial toll on those offering support. One of the most significant of these is burnout, which can affect a carer's mental health, professional commitments, finances and relationships. Participants employ various self-care strategies and draw on their own support networks to mitigate the negative impacts of providing peer support. Many people in such roles actively construct boundaries; talk to peers and mental health professionals; and take part in leisure activities focused on finding balance in their life and improving their wellbeing.

Participants' efforts to manage and mitigate the negative impacts of peer support through self-care provide crucial insight. When it comes to being supported, however, helping themselves is only one half of the picture for peer-support carers. The other half is how they might be helped to perform and remain in their peer-support roles. Participants' perceptions of the type of support they need to be able to continue to help their peers – without burning out – featured in the final part of this chapter. Acknowledging these perceptions is a step towards addressing the issue of unsustainable peer-support provision.

7. **Summary and recommendations**

This report's findings demonstrate that suicide prevention and mental-health related peer support is common and vital in LGBTQ communities in Melbourne. It is highly variable both in terms of its delivery and the situations in which it is provided. LGBTQ community members assume various roles when supporting someone experiencing a mental health or personal crisis. These roles include Safe Friends, Peer Leaders, Partners, Housemates, Help Workers and members of Friendship Circles. Each role has their own demands and, thus, each person fulfilling them has their own experience of being leant on.

Performing a peer-support role brings with it the risk of negative impacts. A person providing support can be affected by their experience in numerous ways. As participants' stories in this report demonstrate, many people in peer-support roles experience burnout and struggle to construct boundaries between the support they provide and other parts of their lives. Some participants have been shown to successfully set boundaries, engage in self-care activities, lean on friends for support and talk to mental health professionals to mitigate the impacts of a peer-support role. However, much more can be done to support people in LGBTQ communities who are leant on by peers during times of mental health or personal crisis.

Furthermore, those providing peer support should be better supported to perform and remain in their roles (if they choose to) in ways that are sustainable. This report demonstrates that they are performing vital work. They should, therefore, be shielded as much as possible from the harmful impacts of burnout and empowered to provide peer support in ways that do not impact negatively on aspects of their personal, social and working lives. If peers are not adequately supported, then this may also have implications for those who are depending on them.

Peer support is not support provided in a vacuum; it is part of a bigger context of care in participants' wider family and friendship networks and follows a long tradition of community-led support in LGBTQ contexts. It needs to be better understood. The North Western Melbourne Primary Health Network (NWMPHN), which provided funding for this study, has been part of the Australian government-funded National Suicide Prevention Trial. Beyond programs already developed as part of this trial, this report offers further insight into mental health and suicidality within LGBTQ communities in Melbourne, providing important opportunities for action to be taken to improve outcomes. Content within this report might also be relevant to other LGBTQ communities in urban settings in Australia and elsewhere.

Before making recommendations aimed at providing better support for LGBTQ community members performing peer-support roles, it must be acknowledged that Melbourne's LGBTQ communities should not be in a situation where mental ill health and suicidality are so common nor where the responsibility for so much suicide prevention and mental-health crisis support falls on peers. Rather, community organisations, health services and mental health professionals should be adequately equipped and funded to absorb this demand.

It must also be emphasised that peer support has significant positive impacts both on those providing it and those who are helped. It can literally save lives. It can help people regain control and begin on a path to better mental health. Not only is peer support vital for those who receive it, people who perform peer-support roles find meaning in their experience. Peer support is an important first response during a mental health crisis, but it also helps build resilience and strength in individuals and leads to better personal, professional and health outcomes in communities.

These positive, invaluable contributions to LGBTQ communities should be harnessed – but to do this, peer support roles must first be made sustainable.

Our recommendations for reform, therefore, take a dual focus, driven by:

- The need to help people in peer-support roles in ways that promote better outcomes for both them and the person/s they are helping
- The need for structural changes that better support those experiencing mental ill health, thus making them less reliant on peers

In making these recommendations, we emphasise the importance of a collective commitment from various levels of government, public health networks and community organisations to help achieve better mental health outcomes for LGBTQ communities. We acknowledge that the effects of COVID-19 have placed considerable strain on the provision of health and mental health right across society, stretching some providers to their limit. In presenting these recommendations, therefore, we urge a response proportionate to both the current public health situation and the state of mental ill health and peer-support provision in LGBTQ communities as highlighted in this report.

Calls for funding in the below recommendations are directed at all those with a capacity to enhance support. This includes, but is not limited to, state and territory governments, the federal government, Primary Health Networks (PHNs), non-governmental organisations (NGOs) and philanthropic enterprises.

1. Develop a set of guiding principles to support LGBTQ communities in providing care to people experiencing both chronic and acute mental-health crisis

We anticipate that this will include, at a minimum, consideration of:

- How to set boundaries
- Role definition
- Self-care
- Vicarious trauma
- How to recognise signs of burnout
- How to ensure the presence of personal support networks
- How to know when to step back and feel empowered to do so
- How to 'do no harm'
- How to recognise, respond to, and refer on cases of mental ill health

We see these core principles being disseminated through different channels, including:

- Training for community members on how to support peers and keep themselves safe, including by identifying the signs of burnout. Such training would also provide opportunities for networking with others who perform similar roles and facilitate mutual support networks
- A series of resources, including professionally designed videos and website materials, produced, hosted and disseminated by LGBTQ-controlled organisations

Where possible, the dissemination of training and resources should involve the leadership of LGBTIQ community members with lived experience of mental health. The typology of peer-support roles developed in this report can help inform the development of training and resources provided to peers and ensure they are targeted, accessible and effective.

2. Raise awareness of and further resource telephone support lines or web-chat services for people in peer-support roles

We envisage this as multiple helpline or web-chat services that provide immediate advice to peers on issues such as risk management, crisis and carer support. The existing Rainbow Door service, run by Switchboard Victoria, should be further resourced and promoted more widely to ensure accessibility and uptake. Such services would offer support for peers on what action to take during a crisis, what ongoing support they may wish to consider providing to someone, and the opportunity to debrief. They could also serve as a source of guidance regarding safe referral points for those in receipt of peer support in acute circumstances. These services should be advertised within the community and sufficiently resourced to cope with demand. The capacity of mainstream helplines should also be increased to ensure peers and extended networks receive the support they seek in a culturally safe manner.

3. Help peers better respond to active suicidal ideation and to recognise burnout

Many participants in this study were supporting peers to prevent suicide without training of any kind. There was, however, considerable interest in such training, particularly in the form of ASIST (Applied Suicide Intervention Skills Training). More training needs to be made available to those with the capacity and willingness to undertake it and should be delivered in a culturally safe and LGBTQ-affirming manner. Individuals providing peer support should not bear the financial cost of such training. The typology of peer-support roles in this report could help guide the development of training and resources.

4. Develop safe suicide-prevention referral pathways

At a structural level, it is essential that safe and LGBTQ-affirming referral pathways exist that facilitate timely intervention for people experiencing suicidal ideation. Such pathways would offer clarity for peers being leant on and for those in need of further support with their mental health. These pathways should include peer-led programs in both LGBTQ-controlled organisations and accredited and culturally safe mental health organisations.

Developing peer-led programs is one way of harnessing the positive aspects of peer support provided in LGBTQ communities. Inspiration for such programs might be found in existing peer-led initiatives, adapted to be culturally safe and LGBTIQ affirming.

5. Develop a broader action plan for responding to suicidality in LGBTQ communities

Reiterating the point that LGBTQ communities should not be carrying the peer-support load that they are, we see the need for broader action to address mental ill health. We recognise the roles that community members play in helping their peers – and advocate for supporting them as much as possible. We also call for a broad action plan that supports the need to reduce suicidal ideation and mental ill health in LGBTQ communities and responds to its impacts in more focused and structural ways. Such a plan should speak to the service and policy revision that is required across all sections of the mental health system, including early intervention, acute care and suicide prevention as well as including both mainstream and LGBTQ-specific service provision. The development and actioning of such a plan would relieve the burden placed on peers, including many of the participants who have contributed to this study.

6. Undertake further research that examines the experiences of those being cared for

- While this report focuses on the important experiences of those who perform peer-support roles, more needs to be understood about the people being helped – the ones turning to a peer when experiencing mental ill health. Findings from recent surveys (such as those noted in chapter 1) provide a global sense of mental health service engagement and whether people feel they have been treated with respect with relation to their gender identity and/or sexuality. However, more needs to be known about the nature of LGBTQ community members' mental health experiences, the forces that shape their health service engagement and the nuance of their experience that helps to determine whether it is safe, affirming and effective. Such research would be an important step towards effecting structural change and would provide the evidence base to ensure that all members of the LGBTQ community feel empowered to access mental health support when required.
- In addition, research is also required to assess the competency of mental health service providers to meet the needs of the LGBTQ community in a culturally safe and affirming manner. This could include examining how mainstream crisis support lines can better help peer supporters and those in need of support, exploring how GPs recognise and refer patients who would benefit from specialist mental health care, and how referral pathways are established to best take account of the unique needs of the LGBTQ community.
- Further to this, we must acknowledge that no single study can hope to understand and reflect the diverse needs of the entire LGBTQ population. There is a need for nuanced and culturally sensitive research into the specific needs of intersecting communities, including those with disability, those from multicultural backgrounds, those living in rural areas and Aboriginal and Torres Strait Islanders, particularly given that quantitative research suggests both exacerbated mental health need and differing patterns of LGBTQ community connection. Noting that this report does not reflect the experiences of people with an intersex variation, we also recommend further peer-led research into the mental health needs and responses within this specific community.

8. **References**

Australian Bureau of Statistics (ABS). (2017). *National health survey: Users' guide*, 2014–15. ABS.

Braun, V., & Clarke V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology. 6*(3), 77-101.

Carpenter, M. (2016). The human rights of intersex people: addressing harmful practices and rhetoric of change. R*eprod Health Matters, 24*(47), 74-84.

Crissman, HP., Stroumsa, D., Kobernik, EK., & Berger, MB. (2019). Gender and frequent mental distress: Comparing transgender and non-transgender individuals' self-rated mental health. *J Womens Health, 28*(2), 143-51.

Freudenberger, H. (1974). Staff burn-out. *Journal of Social Issues, 30*(1), 159-165.

Geist, C., Russell, T., Muns-Aponte, S., Dell, AW., & Mihalopoulos, NL. (2019). Perception of gender and mental health In transgender and cisgender adolescents and young adults. *Journal of Adolescent Health, 64*(2), S106-S7.

Grey, M., & Janus, I. (2018). Improving interactions between transgender and other gender-diverse persons and the healthcare system. *AMSA Journal of Global Health, 12*(2), 18-23.

Heyes, CJ., & Latham, JR. (2018). Trans surgeries and cosmetic surgeries: The politics of analogy. *Transgender Studies Quarterly, 5*(2), 174-89.

Hill, AO., Lyons, A., Jones, J., McGowan, I., Carman, M., Parsons, M., Power, J., Bourne, A (2021). Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia. National report, monograph series number 124. Australian Research Centre in Sex, Health and Society, La Trobe University.

Hill, AO., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. ARCSHS Monograph Series No. 122. Australian Research Centre in Sex, Health and Society, La Trobe University.

Johnston, AK., Pirkis, JE., & Burgess, PM. (2009). Suicidal thoughts and behaviours among Australian adults: Findings from the 2007 National Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry, 43*(7), 635-43.

King, M., Semlyen, J., Tai, SS., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8*(70).

Kolb, SM. (2012). Grounded theory and the constant comparative method: Valid research strategies for educators. Journal of Emerging Trends in Education *Research and Policy Studies, 3*(1), 83-86.

Lim, G., Waling, A., Lyons, A., Pepping, C., & Bourne, A. (2021a). The experiences of lesbian, gay and bisexual people accessing mental health crisis support helplines in Australia. *Psychology and Sexuality.* Online first, https://doi.org/10.1080/19419899.2021.1904274.

Lim, G., Waling, A., Lyons, A., Pepping, C., Brooks, A., & Bourne, A. (2021b). Trans and gender-diverse peoples' experiences of crisis helpline services. *Health and Social Care in the Community.* Online first, DOI: 10.1111/hsc.13333.

Maslach, C., Schaufeli, W., & Leiter, M. (2001). Job burnout. *Annu. Rev. Psychol., 52*, 397–422.

McKay, B. (2011). Lesbian, gay, bisexual, and transgender health issues, disparities, and information resources. *Med Ref Serv Q, 30*(4), 393-401.

Perales, F. (2019). 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, 43*(3), 281-7.

Ream, GL. (2019). 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, 64*(5), 602-7.

Ritter, A., Matthew-Simmons, F., & Carragher, N. Monograph No. 23: *Prevalence of and interventions for mental health and alcohol and other drug problems amongst the gay, lesbian, bisexual and transgender community: A review of the literature.* DPMP Monograph Series. National Drug and Alcohol Research Centre.

Roffee, J., & Waling, A. (2017). Resolving ethical challenges when researching with minority and vulnerable populations: LGBTIQ victims of violence, harassment and bullying. *Research Ethics, 13*(1), 4-22.

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., Curtolo, C., Tansella, M., Thornicroft, G., & Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Res., 200*(2-3), 933-8.

Sherman, ADF., Clark, KD., Robinson, K., Noorani, T., & Poteat, T. (2020). Trans* community connection, health and wellbeing: a systematic review. *LGBT Health, 7*(1), 1-14.

Taylor, J., Power, J., Smith, E., & Rathbone, M. (2019). Bisexual mental health: Findings from the 'Who I Am' study. *Aust J Gen Pract, 48*(3), 138-44.

Taylor, J., Power, J., & Smith, E. (2020). Experiences of bisexual identity, attraction, and behavior and their relationship with mental health findings from the 'Who I Am' study. *J Psychosoc Nurs Ment Health Serv., 58*(3), 28-37.

Vaccaro, A., & Mena, JA. (2011). It's not burnout, it's more: queer college activists of colour and mental health. *Journal of Gay & Lesbian Mental Health, 15*, 339-67.

Victorian Department of Health and Human Services (Victorian DHHS). (2018). *Health and wellbeing of people with intersex variations: information and resource paper.* Victorian Department of Health and Human Services.

Viehl, C., Dispenza, F., Smith, J., Varney, M., Guvensel, K., Suttles, M., McCullough, R., Chang, C., Brack, J., & Kaufmann, J. (2018). How do sexual minority men experience burnout in the mental health field: A grounded theory study. *Journal of Gay & Lesbian Mental Health, 22*(1), 52-70.

Vincent BW. (2018). Studying trans: recommendations for ethical recruitment and collaboration with transgender participants in academic research. *Psychology and Sexuality. 9*(1), 102-16.

Waling, A., Lim, G., Dhalla, S., Lyons, A., & Bourne, A. (2019). *Understanding LGBTI+ Lives in Crisis.* Australian Research Centre in Sex, Health and Society, La Trobe University and Lifeline Australia.

Waling, A., Lyons, A., Alba, B., Barrett, C., Minichiello, V., Hughes, M., Fredriksen-Goldsen, K., Edmonds, S. (2020). Trans Women's Perceptions of Residential Care in Australia. *The British Journal of Social Work, 50*(5), 1304-1323.

9. **Glossary of key terms**

Asexual	Asexuality is the lack of sexual attraction to others, or low or absent interest in or desire for sexual activity. It may be considered the lack of a sexual orientation, or one of the variations thereof, alongside heterosexuality, homosexuality and bisexuality among others.
Bisexual	A person who is sexually and/or emotionally attracted to people of more than one sex. Often this term is shortened to "bi".
Cisgender	Cisgender describes a person whose gender conforms to the dominant social expectations of the sex they were assigned at birth.
Gay	A person whose primary emotional and sexual attraction is toward people of the same sex. The term is most commonly applied to men, although some women use this term.
Gender diverse	A term that encompasses a diversity of gender identities.
Gender identity	In broad terms, it refers to a person's deeply felt sense of being a man or a woman, both, neither, or in between. For example, an individual who has no gender identity or a gender identity that is neutral may refer to themselves as agender or gender free. Some people's gender identity may vary according to where they are and who they are with.
Intersex	Intersex people are born with physical sex characteristics that don't fit medical and social norms for female or male bodies. These include a diverse range of genetic, chromosomal, anatomic and hormonal variations. Intersex is understood as a political, embodied identity, and intersex people can have a range of gender identities and sexual orientations.
LGBTIQ	Lesbian, gay, bisexual, trans and gender diverse and intersex or queer identifying people.
Non-binary	Non-binary refers to a model of the relationships between sex and gender that does not assume a radical division between sex (a person is either male or female but not both or neither) and gender (a person is masculine or feminine but not both or either). People who are non-binary may have sex characteristics that do not fit a binary model of male or female or may express their gender in ways that do not match the dominant social expectations of the sex they were assigned at birth.
Pansexual	Term used to describe people who have romantic, sexual or affectional desire for people of all/ multiple genders and sexes.
Queer	Queer is often used as an umbrella term that includes non-heteronormative gender identities and sexual orientations. The term has also been used as a critique of identity categories that some people experience as restrictive. For some older LGBTI people the term is tied to a history of abuse and may be offensive.
Trans/ transgender	A person whose gender identity or expression is different from that assigned at birth or those who sit outside the gender binary. The terms male-to-female and female-to-male may be used to refer to individuals who are undergoing or have undergone a process of gender affirmation. Transgender and trans* are older terms and may now be seen as less inclusive than trans and gender diverse. Terms that may be used now include trans man/ transmasculine/ transmale, and trans woman/ transfeminine/transfemale among others.

La Trobe University proudly acknowledges the Traditional Custodians of the lands where its campuses are located in Victoria and New South Wales. We recognise that Indigenous Australians have an ongoing connection to the land and value their unique contribution, both to the University and the wider Australian society.

La Trobe University is committed to providing opportunities for Aboriginal and Torres Strait Islander people, both as individuals and communities, through teaching and learning, research and community partnerships across all of our campuses.

The wedge-tailed eagle (Aquila audax) is one of the world's largest.

The Wurundjeri people – traditional owners of the land where ARCSHS is located and where our work is conducted – know the wedge-tailed eagle as Bunjil, the creator spirit of the Kulin Nations.

There is a special synergy between Bunjil and the La Trobe logo of an eagle. The symbolism and significance for both La Trobe and for Aboriginal people challenges us all to 'gamagoen yarrbat' – to soar.

Contact

ARCSHS
Australian Research Centre
in Sex, Health and Society
Building NR6
Bundoora VIC 3086
Australia

General enquiries
T +61 3 9479 8700
E arcshs@latrobe.edu.au

latrobe.edu.au/arcshs

facebook.com/latrobe.arcshs
twitter.com/LTU_Sex_Health