Submission to the Senate Community Affairs References Committee

Inquiry into Suicide in Australia

4 December 2009

International and Australian research consistently shows that suicide, suicide attempts and self-harm rates are significantly higher for lesbian, gay, bisexual, trans[1] and other sex and gender diverse (LGBT) populations when compared with the rates of heterosexual and gender conforming populations – particularly for young people and in Australia, for Indigenous Australians.

At the same time virtually no consideration has been given to this group in Government policy and programs to date. This group must therefore be a priority and its concerns explicitly addressed in suicide prevention and postvention strategies.

The National LGBT Health Alliance welcomes the opportunity to make a submission to the Senate Community Affairs References Committee Inquiry into suicide in Australia. We commend its focus on examining issues that may affect the accuracy of reporting suicide and suicide attempts, and the adequacy of current research programs into suicide prevention.

In this submission we highlight the high incidence of self-harm, suicide attempts and suicide among the Australian LGBT community. It is crucial that strategies flowing from this Inquiry include properly funded measures targeted to LGBT people, so as to curtail the alarmingly disproportionate incidence of suicide among LGBT Australians. This elevated risk of suicide is due to complex factors including mental illness and traumatisation suffered in response to heterosexism[2], homophobia and transphobia[3] – which can lead to social isolation, substance abuse, poverty and homelessness for LGBT people.

The National LGBT Health Alliance has been consulted in the development of the joint submission to the Inquiry lodged by Lifeline Australia, Suicide Prevention Australia, The Inspire Foundation, OzHelp Foundation, The Salvation Army, The Mental Health Council of Australia and The Brain and Mind Institute, University of Sydney. We endorse the recommendations made in relation to LGBT populations.

About the National LGBT Health Alliance

The National LGBT Health Alliance is an alliance of organisations across Australia that provide programs, services and research to improve the health and wellbeing of lesbian, gay, bisexual and transgender and other sexuality, sex and gender diverse (LGBT) people.

Members of the National LGBT Health Alliance share the vision of healthy and resilient LGBT people and communities fully participating in a socially inclusive Australian society. We work on the basis of

[1] The term 'trans' is used here as an umbrella term for people whose internal sense of gender (their gender identity) differs from their birth sex. The term encompasses transsexual, transgender, genderqueer and other identities.
[2] Discrimination in favour of heterosexual and against homosexual and bisexual people.
[3] A fear, ignorance of, and/or prejudice against people who are perceived to be trans or more generally to not conform to mainstream male or female gender norms, often expressed as stereotyping, discrimination, harassment and violence.

a holistic understanding of health and wellbeing, and consider social as well as medical determinants.

The Alliance works on a national level to address systemic issues of disadvantage experienced by people of diverse sexuality, sex and gender in accessing preventative and responsive healthcare from mainstream healthcare providers, as well as gaps in community-specific services. Key areas of work include: advocacy regarding the unacceptably high incidence of violence against LGBT people; the causal relationship between common LGBT health issues and stigmatisation; and the discrimination faced by LGBT people in all areas of life, throughout life.

LGBT suicide rates

Despite the limitations of the data available (discussed below), it is indisputable that LGBT suicide rates are significantly higher than for non-LGBT peers. Australian and international research has revealed rates of self-harm and attempted suicide between 3.5 and 14 times the rate of non-LGBT people.[4] Studies of LGBT Australians, concordant with studies of LGBT populations in other Western countries, consistently report disproportionately high rates of attempted suicide and suicidal ideation:[5] 20% of transgender[6], and 15.7% of lesbian, gay and bisexual[7] people report current feelings of suicidal ideation.

An empirical study investigating general mortality and morbidity among transsexual identified people in the Netherlands revealed that suicide was the leading cause of mortality for transgender people in the population, and that the rate of completed suicides far exceeded that of the general Dutch population.[8] North American studies reveal rates of attempted suicide among transgender people of between 16 and 47 per cent.[9] Evidence obtained from mental health professionals in a United Sates study showed high levels self-harm among transgender patients, including genital mutilation.[10]

There is no Australian data on self-harm or suicide rates among intersex[11] people, however some overseas researchers have begun to address the mental health needs of this population. We know that intersex adults are markedly psychologically distressed, with rates of suicidal tendencies and self-harming behaviour on a level comparable to traumatized non-intersex women, eg those with a history of physical or sexual abuse (Schutzmann et al. 2009). Anecdotal evidence indicates that in Australia suicide is a similarly significant issue for intersex people as it is for trans people. It is likely that both the rates of suicidality and the experiences of some intersex people will resonate with those of transgender people given shared experiences of discrimination on the basis of perceived nonconformity to sex norms. Intersex people are also likely to face specific issues with specific risk factors associated with the violation of bodily integrity and privacy from a young age. We urgently need to develop a robust evidence base on intersex mental health.

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[4] Dyson et al (2003), Bagley & Tremblay (1997); Garafolo et al (1998); Herrell et al (1999); National Institute for Mental Health in England (2007); Nicholas & Howard (1998); Howard et al (2002); Remafedi et al (1998)
[5] For overseas examples see Clements, Nolle et al (2006); Remafedi et al (1998)
[6] Couch et al (2007)
[7] Pitts et al (2006)
[8] Van Kesteran et al (1997)
[9] Bockting et al (2006); Clements-Nolle et al (2001); Kenargy (2005); Leonard (2002); San Francisco Department of Public Health (1999), Whittle et al. (2007)
[10] Ontario Public Health Association (2003)
11 Intersex people are born with any of a number of variations in their sex development that means they do not fully fit current expectations of male or female anatomy or physiology (e.g. they have genitals that are atypical, XXY chromosomes, unusual hormone production levels, etc).

Why the high rates of suicide among LGBT people?

Research shows that many LGBT people who attempt suicide do so while trying to come to terms with their sexuality or gender identity, often before disclosing to anyone. This is particularly so for young people.[12] Family and friends may have been completely unaware that the person had been grappling with issues of sexual, sex or gender identity[13]. Even where a person may have disclosed their sexuality or gender identity issues to family, friends or health professionals, their suicide may be more readily attributed to compounding factors such as depression and homelessness, for example. Further research is needed in this area, with a view to establishing how mainstream services may identify people in this population who are at high risk of suicide.

The impact of discrimination, abuse and isolation

Given that LGBT people are a high risk population in terms of suicide risk, there is a pressing need to develop suicide prevention programs targeted to LGBT people. That being said, it is essential that sexual orientation and gender identity not be pathologised in the process of developing and delivering such targeted programs. The elevated risk of suicide for LGBT people is not due to issues regarding sexuality or gender identity in and of themselves.

The elevated risk is due to complex factors including mental illness and trauma suffered in response to exposure to heterosexism, homophobia and transphobia – all of which are pervasive and cause and contribute to social isolation, mental illness, substance abuse, poverty and homelessness for the victims. As noted by Howard et al. in their 2002 study, sexuality and gender identity "may play a distal or proximal role and interact with numerous other risk factors" that are common risk factors for the general Australian population.[14] Such factors can include previous suicide attempts or self-harm; mental illness; suicide by a friend or relative; isolation; family/relationship stress; harassment, physical or sexual abuse; discrimination; and substance abuse. Harmful use of alcohol and other drugs is a further complicating factor, which in turn increases the risk of mental illness, self-harm and suicide.[15]

These factors are particularly powerful for transgender people, for whom the prevalence of depressive disorders is particularly high[16]. As noted in a NSW study,

> "From crossing gender to social discrimination the everyday experience for many tranys is isolation, family rejection, unemployment and maltreatment by just about everyone from the courts, public servants, the police, and professionals to the average person on the street. For many, far too many as our figures indicate, this leads to loneliness, depression, low self-esteem and poor health. …the inevitable conclusion sinks even lower to incrimination, incarceration, drug addiction and/or suicide."[17]

Respondents in the 2007 Tranznation study of Australian transgender people found that respondents who had experienced a greater number of different types of discrimination were more likely to report being depressed, and 64.4% reported modifying their behaviour due to fear of stigmatisation and discrimination.[18] The same study found that the stigmatisation of trans people is all-pervasive and constant, with participants facing discrimination in all areas of life:

[12] Dyson et al (2003); Hillier & Walsh (1999); Nicholas & Howard (1998)
[13] Bagley & Tremblay (1997); Dyson et al. (2003); Hillier & Walsh (1999); Cole et al. (1997)
[14] Howard et al (2002)
[15] McNair et al (2003)
[16] Pitts et al. (2006); Clements-Nolle et al. (2006)
[17] National Transgender HIV/AIDS Needs Assessment Project (1994). 48.6% of respondents in this study had been sexually assaulted.
[18] Couch at al. (2007)

> "Social forms of stigma and discrimination were the most common, with around half of participants reporting being verbally abused, socially excluded, or having rumours spread about them. A third had been threatened with violence. A similar level had received lesser treatment due to their name or sex on documents, as well as been refused employment or promotion. Almost a quarter had been refused services in other areas, while one in five had been threatened to be 'outed'. Physical attacks were reported by 19% of participants, a similar level reported discrimination from police, and 15% had things thrown at them. Refusal of bank finance was experienced by 15%, while housing had been refused for 12% of participants. Obscene mail and phone calls, and damage of personal property were experienced by 11%." [19]

Health Service Access

LGBT people are frequently not accessing preventative and responsive health care services at all, or are delaying their access to services due to fear of discrimination and stigma. Those who do access services frequently receive ill- or uninformed advice and inappropriate treatment.[20] Some health professionals assume that all their clients are heterosexual, most will not automatically consider the possibility of their client being trans or intersex. LGBT people may fear discrimination or withdrawal of care if they disclose their sexual orientation, their gender identity or their intersex status. [21] Thus LGBT people may have difficulty raising issues related to their sexuality, sex or gender identity even where they believe these issues are directly relevant to their health concern.[22] Given what we know about the relationship between sexuality, sex and gender identity and social isolation, experience of discrimination and resulting distress and mental health problems, the inability of many LGBT people to address these issues in psychosocial, primary health care and mental health services is of particular concern. To ensure effective health care for LGBT people, services must be proactively inclusive of sexual orientation and gender identity issues and demonstrate this to their potential clientele.

Studies also show that most suicide attempts among trans people are made before the person has disengaged in any gender-related treatment, counselling or therapy.[23] Transsexual people face a range of barriers to access to such services, including approval by medical practitioners and the high cost of unsubsidised, medical procedures and hormones. Personal accounts from transsexual people and their clinicians in one US study demonstrate that access to medical interventions to affirm gender of identity often represents, quite literally, a matter of life or death[24]; In January 2008, an Australian trans woman suicided after being rejected for hormone therapy.[25]

A respondent to the Australian Tranznation study noted, somewhat cynically

> "The Financial aspect of Transition has driven many of my Friends to Suicide.... There But for luck go I... But I have the Stockpile of Pills waiting for adequate motivation"[26]

[19] Couch at al. (2007), p.9
[20] Pitts et al. (2006)
[21] Semp (2006)
[22] Huygen (2006)
[23] Cole et al (1997)
[24] Kotula (2002)
[25] Available at www.genderproject.net.au/2008/farewell-to-zoe-belle
[26] Couch et al. (2007), p.36

LGBT Diversity – LGBT People within Other High Risk Populations

It may be stating the obvious but it is important to keep in mind that LGBT people live in all parts of Australia and come from all backgrounds. The nature of that background – personal, socio-economic, cultural and linguistic – can strongly influence how an individual deals with issues of gender and identity, and with stigmatisation and discrimination.

The fact that LGBT people come from diverse socio-economic, cultural, ethnic, and religious backgrounds and that they live, study and work in all parts of Australia – urban, regional, rural and remote - means that mainstream service providers need to take this diversity into account in developing and delivering suicide prevention programs. LGBT people are both a separate group to be targeted; and people within other broad population groups that need to be targeted, namely:

- young people;
- Aboriginal and Torres Strait Islander people;
- Culturally and linguistically diverse and refugee communities;
- older people; and
- people in rural, regional and remote areas.

Young people

For all young people, adolescence is a period of emotional upheaval, with physical and psychosocial development compounding issues inevitably confronted in establishing sexual orientation and/or gender identity, and a positive sense of self[27]. Australian research has shown that between 7% and 11% of young people are attracted to others of their own sex or are unsure of their sexual attraction[28]. The research also shows that same-sex attracted and gender-questioning young people are some of the most vulnerable young people in Australia.

Hiller et al concluded from their Australian survey of the health and wellbeing of same-sex attracted young people, that the high prevalence of family and peer rejection, harassment, and bullying fuelled feelings of isolation, self-loathing and shame – all of which have been shown to substantially increase vulnerability to suicide and self-harm. [29] Specific findings of the study included that:

- over half the respondents had been verbally or physically abused because of their sexuality;
- school was the place where most of that abuse took place; and
- the majority of respondents felt unsafe in many different environments including school, at home and in the community. The levels of violence experienced by same-sex attracted young people increased between 1998 and 2005, escalating in schools particularly.

Aboriginal and Torres Strait Islands people

Health outcomes for Australian Indigenous people are the poorest of any demographic group in Australia across all areas, resulting in average mortality 17 years earlier than the general population. LGBT Aboriginal and Torres Strait Islands people face the same challenges as other Indigenous Australians, with some issues being compounded by their sexual or gender identity.

[27] Di Ceglie & Freedman (1998); Holman & Goldberg (2006); Morrow (2004)
[28] Lindsay et al. (1998); Smith et al. (2003); Smith et al. (2009)
[29] Hillier et al (2005)

In its review of statistics and research for the year 2006/2007, the National Aboriginal and Torres Strait Islander Health Survey found that Aboriginal and Torres Strait Islands people were almost twice as likely to be hospitalised for mental illness and behavioural disorders compared to non-Indigenous counterparts. Death rates for mental and behavioural disorders due to psychoactive drug use were 14 times higher for males between 35 to 44, and 12 times higher for women in that group.[30]

Death rates from intentional self-harm were generally between two and four times higher for Indigenous people in Queensland, Western Australia, South Australia and the Northern Territory in 2001-2005 than for their non-Indigenous counterparts.[31]

Almost no research has been conducted on the specific experiences of LGBT Indigenous Australians so that there is an extremely limited evidence base in relation to their suicidality and self-harm. The Indigenous samples in the research that has been conducted in Australian LGBT populations have tended to be too small to allow comparative analysis. A small number of community-based support services and peer-support groups exist in urban centres, who provide knowledge. The diversity of cultures within Indigenous Australia is reflected in the diversity of experiences of Indigenous LGBT people, although some experiences do appear to be shared.

Indigenous National LGBT Health Alliance stakeholders note that this population is even more likely to be socially isolated than other LGBT people - especially those from rural and remote areas who have often felt pressure to move away from family and cultural support networks in order to openly live as who they are. This often leads to weakening of the social resources represented by family, community and culture, and increased risk behaviour. Mental health, and in particular suicide are consistently raised by our Indigenous members as the most significant issues facing Aboriginal and Torres Strait Islands LGBT people.

> "When making the decision to come out we often feel a sense of isolation and disconnection of country we identify with and the land location we identify our kinship, often resulting in drug and alcohol dependency to suppress feelings connected to the whole 'Coming Out' process. In our home communities we practise our roles as expected in a female or male capacity then fly back to the city where our sexuality is openly accepted and community and support allow us to express and be ourselves in regards to sexuality although discrimination presents many challenges. There is a mental challenge to balance culture ,connection to land and sexuality acceptance within our kinships"[32]

Available evidence confirms that factors known to contribute to suicide risk, such as discrimination, loss of cultural identity and family belonging are particularly high among Indigenous LGBT people. A respondent to the Tranznation study noted:

> "I feel that as Aboriginal and a sistergirl, we face more discrimination and stigma than non-Aboriginal trannies. We have to deal with our own communities attitudes and values, not alone deal with the broader community. I have noticed that living in a large city, I face some form of discrimination at least 3 to 4 times a week." [33]

This means that the risk of suicide for Aboriginal and Torres Strait Islands people who are LGBT is compounded and further increases the already high suicide rates among these communities.[34]

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[30] Australian Indigenous Health*InfoNet*, Summary of Indigenous health, 2009. Available at www.healthinfonet.ecu.eu.au/summary

[31] Australian Indigenous Health*InfoNet*, Summary of Indigenous health, 2009. Available at www.healthinfonet.ecu.eu.au/summary

[32] Indigilez representative, personal communication with the National LGBT Health Alliance

[33] Couch et al (2007), p. 64

[34] More information can be found at www.suicidepreventionaust.org

Culturally and linguistically diverse and refugee communities

Many LGBT people from culturally and linguistically diverse (CALD) backgrounds experience not only the homophobia and heterosexism perpetrated in the broad Australian community, but also racism related to their cultural identity. Some LGBT people from CALD backgrounds, especially young people, can be placed under particular pressure to conform to strong cultural expectations regarding gender and marriage in the face of a mainstream society perceived of as 'other'. This can delay self-identification and/or disclosure of sexuality.

Refugee communities come under particular pressure. Families coping with the impact of persecution in their country of origin may not have the resources to provide support to members who are also coping with issues of sexual orientation or gender identity, and the sense of responsibility to family may be perceived as a conflict with personal fulfilment.

There has been little research in this area but there can be little doubt that such personal turmoil for people seeking to come to terms with their sexuality or gender identity, accompanied by alienation, isolation, and estrangement from family and community, increase rates of mental illness, self-harm and suicide for LGBT people in CALD communities. At the minimum, such pressure to conform can cause self-loathing, which elevates the risk of suicide.[35]

Sometimes the LGBT 'community' that provides social support for many LGBT people both informally and through the provision of targeted health services, fails to be culturally inclusive and can even be another site of racism, creating additional barriers and vulnerability for CALD people. Further research in this area is needed so as to ensure that suicide prevention programs are developed which effectively target LGBT people from CALD communities.

Older people

There has been little research looking at the incidence and causes of suicide among older Australians. Indeed the collection of this data is challenging, in particular when seeking to differentiate according to membership of stigmatised social groups. There is evidence of an increased discussion around the need to research older LGBT suicide and self-harm, however, given the high level of depression experienced by this group.[36] Certainly it is plausible that the prevalence of suicide may be even higher among older LGBT people than among younger LGBT age groups.

Anecdotal reports provided to the National LGBT Health Alliance from professionals working with older LGBT people show that many older people have sought to conform to social expectations as they perceive the consequences of exposing their sexuality or gender identity to be intolerable. The prospect of entering a residential aged care facility is daunting for people who have led contained and isolated personal lives due to the fear of exposure. One researcher has reported that an older lesbian expressed a preference for suicide if faced with nursing home admission. [37]

There is a need for research into this area so that strategies can be developed to address the isolation experienced by many older LGBT people, and enhance their quality of life. There is also a need for organisations to implement anti-depression programs targeted to older LGBT people at ground level. The Beyond Blue program Maturity Blues needs to be operated with targeted LGBT groups of older people as an urgent priority.[38]

Welfare Rights caseworkers advise that the recognition of same-sex de facto relationships under Social Security law from July 2009 has clearly been challenging and confronting for many older people – due to the need to discuss with Centrelink what have until recently been highly personal

[35] Hillier et al (2008)
[36] Suicide Prevention Australia, Position Statement (2009)
[37] Harrison (2004)
[38] http://www.beyondblue.org.au/index.aspx?link_id=101.864#beyondmaturity

issues, and due to the emotional and financial impact of dealing with the reduction or withdrawal of Social Security entitlements[39]. Welfare Rights caseworkers report that the recognition of same-sex relationships for Social Security purposes has been particularly challenging for older men living with HIV and also for other older gay men and lesbians who, due to experiences of stigmatisation in their youth, hold deep-seated fears of discussing their sexuality with a government officer, i.e. Centrelink.

Given the ageing of the Australian population, research is required into the discrimination and invisibility-related issues faced by older LGBT people, taking into account the impact of Federal, state/territory and local government policies that affect income security, retirement planning and aged care. Federal aged care policies currently fail to mention LGBT older people and this serves to reinforce their invisibility, continuing the negative impact of the 'cycle of invisibility' in aged care.[40]

We note that the GLBTI Retirement Association (GRAI) has lodged a submission to the Inquiry, which refers to research it conducted in 2006-2007 on the needs of older and ageing LGBT and intersex people. GRAI's submission highlights the discrimination, fear and social isolation experienced by many older LGBT and intersex people in the Australian community, and the lack of support available.

People in rural, regional and remote Australia

Young people living in rural and remote areas can live in well-founded fear about being outed and rejected in small and/or conservative communities. Geographical isolation, rural culture and limited or lack of access to culturally competent mental health services compound the issues faced by LGBT people.[41] [42]

Treatment services and general support programs for LGBT people in rural and remote areas are often challenged to respond to diverse health issues. Given the current lack of explicit Commonwealth commitment to issues faced by LGBT people, isolated health services can tend to allocate these population groups a low priority, or simply lack the resources to provide adequate service despite the best of intentions.

In addition, in small communities there are particular problems relating to confidentiality and privacy. Strong messages from government regarding privacy laws, the right to confidentiality, would address some of these problems.

Program targeting

Given the prevalence of suicide among LGBT Australians, development of prevention and treatment strategies must be under-pinned by recognition of the extent to which sexuality and gender identity are primary social determinants of health and that these factors are inter-related to broad determinants - including indigenous, ethnic and socio-economic status. Only through such recognition and government leadership, will prevention and treatment programs be developed which can curtail the high incidence of suicide among GLBT people.

As outlined above, research shows that stigmatisation, discrimination and other forms of exclusion experienced by LGBT people have a detrimental impact on health and well-being. Given the prevalence of self-harm, suicidal ideation, suicide attempts and completed suicide among LGBT people, it is essential that health services target prevention and treatment programs carefully so as to enhance access to LGBT people. Without such a focus, suicide prevention strategies will not fulfil the Government's Social Inclusion Agenda in respect of LGBT people. Community programs that

[39] http://www.aph.gov.au/SENATE/COMMITTEE/legcon_ctte/same_sex_general_law_reform/submissions/sublist.htm
[40] Harrison (2001), pp 142-145
[41] Quinn (2003); Edwards (2007)
[42] more information on suicide in rural communities can be found at www.suicidepreventionaust.org

promote peer support and social inclusion are considered to have potential to significantly reduce suicide and self-harm in LGBT communities[43].

It is accepted that a sense of despair and suicidal ideation can flow from a lack of resilience, and that programs focussing on building young people's resilience are effective in reducing the risk of suicide. Research indicates that LGBT people are less likely to be resilient, being less likely to have strong family connections and peer support and less likely to have access to mental health providers who are competent to identify and adequately deal with issues that are unique to LGBT people[44].

There is no doubt that health promotion strategies that foster resilience, self esteem and an attitude of self-care among members of marginalised groups contribute to positive health outcomes. If the suicide rates among LGBT people are to be addressed, health programs and services need to be delivered in a way that is culturally appropriate to LGBT people, by:

- providing LGBT-accessible programs in mainstream services;
- niche marketing;
- providing custom-made services;
- providing LGBT-specific services; and
- utilising the internet

LGBT-accessible programs in mainstream services - As most LGBT people access health services from the mainstream, staff of mainstream services should be knowledgeable and respectful of issues affecting LGBT people generally, and also regarding compounding issues faced by young people, older people, Aboriginal people and Torres Strait Islanders and people from other diverse cultural and linguistic backgrounds. Services must be required to ensure that: staff are properly trained regarding issues of sexuality and gender identity; that there are policies and procedures in place that are inclusive of LGBT people; and that they are able to make referrals to LGBT- specific services/resources where they exist and where referral is desired by the person, and appropriate.

Niche marketing - Mainstream health services, suicide prevention programs and mental health services should be promoted utilising LGBT-specific press, websites, groups and venues as well as mainstream, Indigenous and CALD media, so as to send a clear message that these services are inclusive and welcoming of LGBT people, from all backgrounds. Marketing should explicitly include images and text that 'speak' to LGBT people.

Custom made services- Some mainstream services would be able to readily adapt their service provision such that it is more culturally appropriate to LGBT people. Initiatives could include: running services in a LGBT-friendly setting; employing lesbian, gay, bisexual and transgender workers; and using language, printed resources and examples that LGBT people relate to.

LGBT-specific Services – There will be situations where provision of a LGBT-specific service is required or preferred, particularly for LGBT people whose sense of marginalisation is such that they are unable to disclose personal issues to a health professional or other worker who is perceived to be mainstream, whatever their expertise and sensitivity. LGBT community based services known to be run by and for LGBT people are often most effective for this high-risk group; they have fewer barriers to access and people accessing such a service can be confident of workers' in-depth understanding of the issues at hand.

The Internet It is widely acknowledged that the internet can be a effective tool for engaging and empowering marginalised and traditionally hard-to-reach groups, as barriers that may prevent a

[43] Brown (1999), pp. 28-31
[44] Couch et al (2007); Hillier et al (2005)

person from disclosing issues to an agency are irrelevant.[45] The internet is a particularly effective means of providing young people with information and education regarding sexuality and gender identity. Utilising information web-sites and/or social networks enables a balance between anonymity and intimacy.[46] Internet resources can be a powerful tool for mental health promotion and suicide prevention among LGBT people whose traumatisation, marginalisation and/or fear of disclosure of sexuality and gender identity means that they would otherwise fail to engage with any service despite being at high risk of self-harm or suicide.

Funding

There is very little national or state based funding for addressing general LGBT health needs. One reason for the lack of funding is that LGBT people have until recently been rarely identified in government strategies or policies, and rarely consulted with regarding reform agenda. This is partly because LGBT community organisations have had limited resources to apply to policy advocacy.

Organisations anchored in the LGBT community constitute an appropriate, accessible and skilled resource for identifying LGBT health issues, and for developing socially inclusive mental health promotion and suicide prevention initiatives. Often, however, such organisations are by nature grass-roots and small, and inadequate funding means that opportunities for providing useful input into consultation processes are inevitably lost. By prioritising funding for these organisations and providing long term funding models, their expertise and resources could be more effectively focused on their substantive work of health promotion.

Research/Data Collection

As noted above, despite a growing body of international and Australian research, significant gaps in research evidence available on LGBT people remain. Current Australian data collection does not provide accurate information on demographic factors contributing to risk of suicide and suicide attempts, or on factors contributing to resilience in the face of risk factors such as discrimination.

A significant weakness of not only population-based household surveys but also current administrative data collection mechanisms, such as coronial databases, and suicide research programs is the lack of collection of sexual orientation, sex and gender identity information. We therefore lack both reliable baseline data and suicide mortality statistics for LGBT populations as well as differentiated information on factors contributing to both suicidality and resilience.

There is growing international awareness of the need to better inform policy development regarding prevention and treatment by collecting robust data on sexual orientation and gender identity in probability surveys so as to properly establish risk factors.[47] Significant progress has been made internationally in the collection of robust sexual orientation and gender identity data, resolving methodological issues, such as operationalisation and respondent acceptability. Both overseas and Australian examples of the inclusion of sexual orientation variables in population-based and longitudinal surveys show that robust data collection is feasible.[48] Further investigation of methodological issues relating to the measurement of sex and gender identity and consultation with sex and gender diverse communities is required, but here too promising steps are being taken.[49]

[45] Alexander (2002); Burns et al (2007); Cline & Haynes (2001); Drabble et al (2003)
[46] Hegland & Nelson (2002); Hillier et al (2001)
[47] Noted, for example, by Statistics New Zealand, and the UK Office for National Statistics
[48] for example, both the recent National Drug Household Survey, and the National Survey of Mental Health and Wellbeing included questions on sexual orientation.
[49] Cf. Mitchell & Howarth (2009)

Coronial data bases in particular pose specific challenges in relation to the accuracy of reporting factors associated with suicide. As noted above, unlike other demographic characteristics, sexual orientation and gender identity are seldom readily observable. Research shows suicide attempts among LGBT youth often occur after awareness of same-sex attraction or questioning of gender identity but before disclosure of their sexual orientation to others. Thus, sexual orientation and gender identity may not be known by family and friends at the time of death.[50] For this reason, and because of the continuing stigma associated with LGBT identities, we can assume that while helpful indicators, figures available will continue to be underestimates.

Recommendations

The National LGBT Health Alliance calls on the Government to develop explicit and targeted strategies to address the alarming rates of suicide among LGBT Australians.

As noted above, the Alliance endorses the recommendations made in the joint submission to this Inquiry lodged by Lifeline Australia, Suicide Prevention Australia, The Inspire Foundation, OzHelp Foundation, The Salvation Army, The Mental Health Council of Australia and The Brain and Mind Institute, University of Sydney. We also endorse the recommendations made by Suicide Prevention Australia in its Position Statement on *Suicide and self harm among gay, lesbian, bisexual and transgender communities.*[51] We draw particular attention to the following recommendations made in that statement:

- Heterosexism, homophobia and transphobia must be addressed at the interpersonal, socio-cultural, and institutional levels. The approach needs to be comprehensive, with initiatives ranging from community education campaigns through to legislative measures to remove discrimination.
- The Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) should lead the development of a 'whole of school' approach to address homophobia and transphobia in education settings across Australia. Frameworks such as the Victorian Department of Education and Early Childhood's Supporting Sexual Diversity in Schools be extended to all states and territories in Australia, as should curriculum development, professional and/or pre-service training for teachers to identify and respond to bullying and harassment on the grounds of sexual orientation and/or gender non-conformity, and development of targeted resources through initiatives such as Mind Matters. We note that such an approach should include components specifically aiming at strengthening the resilience of young people
- Greater capacity must be provided for the delivery of services and support services for parents and families dealing with sexuality and gender issues.

In addition, the National LGBT Health Alliance recommends:

Research and development:

- that information regarding sexual orientation, gender identity and sex identity (in relation to intersex conditions) be specifically included in national household surveys;
- that all major population based health research commissioned, funded or conducted by governments or related bodies (e.g. the Australian Institute of Health and Welfare) should routinely collect and report data on sexual orientation and gender identity;

[50] Dyson et al (2003); D'Augelli et al. (1998); Cole et al. (1997)
[51] Suicide Prevention Australia (2009)

- that the Federal Government consult with social researchers regarding issues of sexuality, sex and gender identity, to identify ways of enhancing the collection and reporting of data regarding self-harm, suicide attempts and suicide among lesbian, gay, bisexual, trans, and other sex and gender diverse Australians, and in particular to begin to build an evidence base on the experiences of intersex people;
- that the Federal Government provide funding for immediate and ongoing research to identify and address health issues faced by LGBT people, having particular regard to the Government's Social Inclusion Agenda.

Capacity funding:

- that Federal funding be provided to LGBT community-based organisations to enhance capacity to provide advocacy and support for LGBT people, and to enhance those organisations' capacity to contribute to the development and implementation of inclusive policies and programs;
- that given the success of peer support models in schools (such as Gay Straight Alliances and Diversity Groups), both here and overseas, these be further developed and extended;
- that Federal funding be provided to mainstream services to develop inclusive mental health and suicide prevention outreach services to young people who have disengaged from schooling;
- that funding be provided to mainstream, and community-specific services (e.g., Indigenous or CALD-specific services), to allow ongoing collaboration with specialist LGBT agencies in service provision, and to allow collaborative development and delivery of education and awareness campaigns designed to enhance the access of LGBT people to services

Funding requirements:

- that monitoring and evaluation of program implementation (at the federal, state and local levels) include assessment of how accessible funded programs are to LGBT people accessing services;
- that Commonwealth funding agreements for mainstream organisations require the suicide prevention and counseling programs have regard to the particular needs of LGBT people;
- that the funding of LGBT-specific community organisations involved in health advocacy be enhanced, to allow the development of a partnership model between the Federal Government, State/Territory Governments and community organisations so as to arrest the suicide rate in the Australian LGBT community.

Partnership initiatives:

- that the Federal Government fund the development of targeted LGBT health education and awareness campaigns, to be delivered by LGBT organisations;
- that the Federal Government proactively engage with LGBT advocacy organisations and researchers, in the development of policy, education and services;
- that national guidelines be developed for service providers, in collaboration with LGBT community organisations, to ensure that practitioners have ready access to comprehensive information regarding the design and delivery of socially inclusive services to LGBT people[52]

[52] The UK Department of Health has developed comprehensive guides for the National Health Service along these lines in relation to sexual orientation and transgender issues. E.g www.pfc.org.uk/files/DH_089939.pdf & www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_095635.pdf

Inter-governmental initiatives:

- that, notwithstanding the need for further research toward better targeting LGBT people at risk of suicide, Federal and state/territory governments together develop and fund nationally consistent mental health programs targeting LGBT people, as a matter of priority. Such programs should target LGBT people identifiably at risk of suicide, and also include initiatives to promote resilience and self-care attitudes among young LGBT people generally;
- that the Federal Government consult with state/territory governments with a view to targeting LGBT people for suicide prevention programs in geographic areas with high populations of LGBT people. Federal, state and territory governments should initiate projects as soon as practicable to identify, from available research, where additional LGBT-specific health services need to be created or enhanced and provide funding for additional community based services;
- that the Federal Government specifically include LGBT people as priority population groups in national health strategies and in its Social Inclusion Agenda;
- that the Federal Government consult with state/territory governments with a view to reforming and harmonising laws that affect the right of transgender people to change their gender, and to allow alteration of identity and other legal documents;
- that Federal and state/territory governments together act to ensure that education, training, professional development and continuing education programs cover the specific needs and health issues of LGBT people at risk of suicide. In particular, tertiary education syllabi and professional development programs for health professions should be made nationally consistent, and should incorporate specialised units on the prevalence of mental illness, self-harm, and suicide among LGBT people in Australia, and regarding access issues. These programs should run alongside and complement similar syllabi regarding Aboriginal and Torres Strait Islanders, CALD and rural, regional and remote health issues, taking into account that LGBT people can be a sub-set of one or all of these groups.

The National LGBT Health Alliance would welcome the opportunity to provide the Committee with further information, and to work with the Government along with other community organizations to develop strategies to effectively reduce the risk of suicide and self-harm among sexuality and gender diverse people.

Developed by the National LGBT Health Alliance in consultation with other LGBT community organisations.

The views in this paper are those of the National LGBT Health Alliance, and do not necessarily represent those of the organisations or individuals that contributed to the paper.

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