LGBTI People
Mental Health & Suicide

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Contents

Lesbian, gay, bisexual, trans, intersex and other sexuality, sex and gender diverse (LGBTI) people make up a significant part of Australian society

- Lesbian, gay and bisexual people are sexually attracted to and/or have romantic relationships with people of the same sex as themselves. 9% of adult men and 15% of women in Australia report same-sex attraction or having had sexual contact with someone of the same sex, although only approximately 2% actually identify as lesbian, gay or bisexual.[1]
- Trans people have an internal sense of gender (their gender identity) that differs from their birth sex. The term 'trans' is an umbrella term that includes transsexual, genderqueer, sistergirl and other identities. Transgender is another common umbrella term. Recent international estimates of the prevalence of trans people lie between 1:500 and 1:11,500.[2]

"Imagine living within a body opposing your mental gender, - it's tough. This is what I go through every day of my life"

(transwoman, 17 years, in Simply Trans 2007)

- Intersex people are born with a physical variation that differs from current expectations of male or female sex, e.g. they have atypical genitals, XXY chromosomes or unusual hormone production levels. Estimates of the number of intersex people vary from 1:200 to 1:2000 depending on the conditions included.[3]
- Most intersex people and many trans people simply identify as male or female most or all of the time.

Never make assumptions about people's sexual orientation, sex or gender identity or what this means to them

- Sexual orientation, sex and gender identity are different aspects of identity and not directly connected (i.e. trans and intersex people can be heterosexual, homosexual or bisexual, just like everyone else).
- 'LGBTI' is a commonly used acronym that encompasses all people whose sexual orientation, gender identity or sex differ from heterosexual or male/female sex and gender norms, regardless of the identity labels people use. Sometimes the term 'sexuality, sex and gender diversity' is used to be inclusive of all these groups.
- There is great diversity of identities and experiences within and between LGBTI communities, influenced by age, ethnicity, geographical location, (dis)ability, migration experience, socioeconomic status, etc. LGBTI people are part of all other population groups, while also forming a specific marginalized population group, with specific health needs.

LGBTI people have significantly poorer mental health and higher rates of suicide than other Australians

Although most LGBTI Australians live healthy, happy lives, a disproportionate number experience worse health outcomes than their non-LGBTI peers in a range of areas, in particular mental health and suicidality. These disproportionately poor outcomes are found in all age groups of LGBTI people.

Mental health:

- The mental health of LGBTI people is among the poorest in Australia.[4]
- At least 36.2% of trans and 24.4% of gay, lesbian and bisexual Australians met the criteria for experiencing a major depressive episode in 2005, compared with 6.8% of the general population.[5] This rate soars to 59.3% of trans women (male to female) under 30 in a La Trobe University study[6]
- Lesbian, gay and bisexual Australians are twice as likely to have a high/very high level of psychological distress as their heterosexual peers (18.2% v. 9.2%).[7] This makes them particularly vulnerable to mental health problems. The younger the age group, the starker the differences: 55% of LGBT women aged between 16 and 24 compared with 18% in the nation as a whole and 40% of LGBT men aged 16-24 compared with 7%. Results only begin to be similar across the population groups at age 65.[8]

"As a GLBT person, what is the most important thing that has happened in your life in the last year?"
Respondent A: "Nothing. Too scared to live"
Respondent B "Not killing myself"

(Survey respondents, in Leonard et al. 2012)

- More than twice as many homosexual/bisexual Australians experience anxiety disorders as heterosexual people (31% vs 14%) and over three times as many experience affective disorders (19% vs 6%). The rates are higher across any age group, country of birth, income level, area of residence or level of education/employment.[9] Nearly 80% of LGBT respondents reported having experienced at least one period of intense anxiety in the 12 months prior to completing a 2011 survey, with the highest proportion of those experiencing frequent episodes of anxiety in this period being lesbian, bisexual and transwomen and transmen.[10]
- Where differentiated data is available, it indicates that rates of depression, anxiety and generally poor mental health are highest among trans and bisexual people, especially bisexual women.[11]
- Intersex adults show psychological distress at levels comparable with traumatized non-intersex women, e.g. those with a history of severe physical or sexual abuse.[12]

Suicide and Self-Harm:

- LGBTI people have the highest rates of suicidality of any population in Australia.
- 20% of trans Australians[13] and 15.7% of lesbian, gay and bisexual Australians[14] report current suicidal ideation (thoughts). A UK study reported 84% of trans participants having thought about ending their lives at some point.[15]
- Up to 50% of trans people have actually attempted suicide at least once in their lives.[16]
- Same-sex attracted Australians have up to 14x higher rates of suicide attempts than their heterosexual peers.[17] Rates are 6x higher for same-sex attracted young people (20-42% cf. 7-13%).[18]

"Knowing what was facing me religion-wise and with my family I was pretty suicidal between the ages of about 16 and 19 … Not so much because of people's homophobia but because of feeling totally trapped between a religion/family that didn't accept homosexuality and being who I was"

("Peggy", aged 20, in Hillier et al. 2008)

- The average age of a first suicide attempt is 16 years – often before 'coming out'.[19]
- There is a lack of data on intersex people but overseas research and anecdotal evidence in Australia indicate that intersex adults have rates of suicidal tendencies and self-harming behaviour well above those of the general population.[20]
- Indigenous LGBTI Australians, LGBTI migrants and refugees, LGBTI young people and LGBTI people residing in rural and remote areas are likely to be at particularly high risk of suicide, in line with tendencies of high risk identified in the population as a whole.[21]
- There is increasing concern that older LGBTI Australians may also have a particularly high risk of suicide, with many having endured persecution, including legal condemnation and ostracism and fearing dependency on potentially discriminatory mainstream aged care services, especially as they are less likely to have children to care for them.[22]
- Many LGBTI people who attempt suicide have not disclosed their sexual orientation, gender identity or intersex status to others, or to only very few people.[23]

Discrimination and exclusion are the key causal factors of LGBTI mental ill-health and suicidality

- The elevated risk of mental ill-health and suicidality among LGBTI people is not due to sexuality, sex or gender identity in and of themselves but rather due to discrimination and exclusion as key determinants of health.[24] This is sometimes referred to as minority stress.[25]
- Homophobia and transphobia are a fear of and/or prejudice against people who are perceived to be homosexual or trans respectively, or more generally to not conform to mainstream male or female gender norms. They are often expressed as stereotyping, ostracizing, discrimination, harassment, and violence. Heterosexism is discrimination in favour of heterosexual and against homosexual and bisexual people as well as people who challenge assumptions that there are only two genders. It can be regarded as encompassing homophobia and transphobia and the discrimination of intersex people. Thus for LGBTI people, exposure to heterosexism can be a key determinant of health.
- Exposure to and fear of discrimination and isolation can directly impact on people's mental health, causing stress, psychological distress and suicidality.[26]

Be very clear that being lesbian, gay, bisexual, trans, intersex and/or questioning is not in itself a problem

- There is currently a lack of protection from discrimination on the basis of gender identity, gender expression, sex and sex characteristics and sexual orientation at a Commonwealth level and the level of protection offered in the states and territories varies. At both levels of government, significant exemptions apply, in particular for faith-based organisations providing community services. 2012 the Commonwealth government began consultation on proposed new federal anti-discrimination legislation that includes greater protection for LGBTI people.[27]
- Despite recent improvements to legislative equality in Australia and advances in the general acceptance of homosexuality and – to a lesser extent – of trans and intersex people in some sectors, experience of homophobic and transphobic discrimination and exclusion both within families and in broader society remains very high for many LGBTI Australians: LGBTI people remain a marginalised group.[28]

"I might hate myself for it but I wish she had died instead. What a trivial existence it seems, the life of a gay person… Betrayal is all I can see, betrayal of me as a mother. She rejects my beliefs, my principles and my femininity. … I can't forgive her, I can't respect her and I certainly can't understand her. I don't want to love her any longer"

(mother of a lesbian daughter, quoted in McDougall 2006)

- Up to 80% of same-sex attracted and gender questioning young Australians experience public insult, 20% explicit threats and 18% physical abuse and 26% 'other' forms of homophobia (80% of this abuse occurs at school).[29]
- The most common types of heterosexist abuse experienced by LGBT people during the 12 months prior to a 2011 survey were non-physical: verbal abuse (25%), harassment (15%), threats of physical violence (9%) and written abuse (7%).[30]
- Rates of almost all types of violence are highest against trans people. Approximately 50% of adult trans Australians experience verbal abuse, social exclusion and having rumours spread about them. A third have been threatened with violence, with 19% having been physically attacked (and a similar number reporting discrimination by the police), 11% experience obscene mail and phone calls and damage to personal property. 64% modify their behaviour due to fear of stigmatization and discrimination.[31] 49% of trans respondents to a NSW study reported having been sexually assaulted.[32]
- Little data is available on the experiences of intersex Australians, however extensive consultation in New Zealand affirmed anecdotal evidence in Australia that the secrecy and shame associated with intersex conditions leave intersex people vulnerable to discrimination and abuse and that some intersex people also experience similar discrimination to trans people.[33]

"For me, the worst thing about discrimination has been the way I have, in the past, taken responsibility for it, thinking it was my job to stay out of the firing line… I was always trying to second guess what people were thinking and act accordingly to manage what I thought were their expectations. As a result, I faced little direct discrimination, but that came at great cost to my happiness."

(gay man, 25-45 years, metropolitan Victoria, quoted in beyondblue 2012)

- Many LGBTI people avoid certain situations due to fear of discrimination and/or fear of being 'outed',[34] thus limiting the very social connectedness known to contribute to developing resilience and wellbeing.

Combat transphobia, homophobia, biphobia, heterosexism and heteronormativity within your own sphere of influence and support antidiscrimination campaigns led by others

- LGBTI people can also internalize homophobia and transphobia: they are socialized in the same environment as their peers, thus receiving the same negative messages in relation to sexuality, sex and gender diversity. The vast majority have been told directly and/or via more diffuse 'public opinion' that they are not 'normal'.[35] The lack of visible positive role models and difficulty accessing affirming peer support can hinder the development of positive self-concepts, self-esteem and resilience and cause significant mental distress.
- Heteronormativity is the assumption of heterosexuality as the default or 'norm' and associated simplistic understandings of biological sex and gender always being identical and stable and as exclusively binary (a person is either male or female). It does not necessary involve prejudice, but rather invisibility due to the reproduction of norms that exclude LGBTI people, for example through language and social institutions such as marriage.
- Both explicit discrimination and the invisibility that results from heteronormativity also occur within primary health care, mental health services and other community services. Even where LGBTI identity is acknowledged, indirect discrimination can occur. For example, the treatment intersex people receive often focuses on physical issues such as hormone replacement therapy. Psychological issues may be brushed over during medical appointments or left out altogether.[36] The failure of generic health interventions and prevention strategies to be inclusive of LGBTI people and their needs thus also exacerbates mental health problems and suicidality not directly linked to sexual orientation, sex or gender identity issues by reducing LGBTI people's ability to access support in times of need. [37] See below "Existing initiatives are not effective for this high-risk group".
- Discrimination and social exclusion also contribute to LGBTI people experiencing a higher prevalence of other risk factors associated with mental ill-health and suicidality than the rest of the population, such as
    - More harmful and frequent levels of alcohol and other drug misuse[38]
    - Homelessness and poverty, in particular among trans people[39]
    - Disengagement from schooling[40]
    - Chronic health conditions[41]
- There is some evidence that older LGBTI people exhibit crisis competence – indicating resilience and hardiness.[42]

There is a robust evidence base but still significant knowledge gaps

- While Australian and international research demonstrate areas of significant concern and provide a robust evidence base of mental health indicators, suicidal ideation (thoughts) and self harm among LGBTI people, knowledge gaps remain. These relate in particular to protective factors, comorbidity (the co-occurrence of more than one type of ill-health),[43] effective interventions and the specific issues of population groups known to face particularly high risk, such as intersex people, bisexual people, trans people, and Indigenous, elderly and rural LGBTI people. This is due to a lack of inclusion in most administrative data and generic research, and to a lesser extent to some methodological issues relating to data collection for these populations.[44]
- Sexual orientation, gender identity and intersex status, unlike other demographic characteristics, are not necessarily known, even by family members, nor are they readily identifiable through existing data collection methods (such as coronial records, surveys, administrative data collected by services).[45]

Include sexual orientation, sex and gender identity and related factors in data collection to monitor who you are reaching (acknowledging that disclosure issues will invariably lead to underestimates)

- From those who have survived suicide attempts it is known that many LGBTI people attempt suicide before having disclosed their sexual orientation or gender identity to others.[46] Therefore even where attempts are made to gather such data on suicides, a significant underestimate can be assumed.
- Due to homophobia, transphobia and stigma around intersex status, agencies often hesitate to ask about sexual orientation, sex and gender identity even when questions are included in forms or surveys. In addition many LGBTI people will not disclose unless they are confident of anonymity or confidentiality.[47] This leads to inaccuracy in reporting and significant underestimates.

"Some of us are still haunted by the spectre of our identity as circus freaks in the not-too-distant past. It is time that our identities and experiences were given the same respect as the rest of the community."

(Woman born with an intersex condition, quoted in Human Rights Commission 2008)

- Estimating mental health outcomes, and in particular suicide mortality or suicidal behaviours, for LGBTI populations therefore remains highly challenging.
- Even where LGBTI data is collected, it is frequently not analysed or made available, and rarely taken into account in policy, research or practice.
- LGBTI people and services are seldom consulted in the development of research, policies or programs in relation to mental health or suicide prevention, resulting in existing knowledge not being utlised. As has long been acknowledged in relation to other marginalised population groups, the failure to fully involve LGBTI people in all stages of research design and implementation reduces both its effectiveness in reaching LGBTI people and the validity of its results as their needs and experiences are unlikely to have been appropriately considered.
- While LGBTI-community specific research provides an extremely valuable evidence base for the development of policies and programs, the inclusion of LGBTI variables and issues in generic research is also essential to enable robust comparison across population groups and identification of the factors that contribute to or pose a risk to mental health and wellbeing. This remains the exception.[48]
- The inclusion of sexual orientation, gender identity and intersex status in the baseline data provided by the Australian Census as well as in all major surveys would contribute significantly to understanding and addressing the issues identified in the research reviewed for this paper.[49]
- International best practice with the robust collection of sexual orientation data as a demographic variable is now well advanced.[50] It can be applied to both research and administrative data collection.
- The challenges that remain in relation to the capture of robust gender identity data that meets user needs are beginning to be explored.[51] The consistent collection and utilisation of sex and gender data by Commonwealth and state/territory government agencies is one of the key recommendations of the 2012 Australian National Diverse Sex and Gender Roundtable.[52]

LGBTI people have specific issues

Aside from discrimination and exclusion causing and contributing to mental ill-health and barriers to support, a number of other issues may be relevant when working with LGBTI people, for example:

- Due to the high rates of suicide in LGBTI populations, LGBTI people are disproportionately affected by the suicide of friends and community figures. In addition, until recently a large proportion of LGBTI characters in film and books suicided. Both lived experience and fictional models thus increase the likelihood of perceiving suicide as an option and of contagion. The lack of LGBTI-inclusive bereavement support services and, in some cases, secrecy, also exacerbate the risk factor of distress.
- 'Coming Out' refers to identifying ones self as LGBTI. Lesbian, gay, bisexual and trans people often go through a process of questioning their sexual orientation and/or gender identity which they may not disclose to others for some time, if at all. This is sometimes referred to as 'coming out' to yourself. For many people there is stress associated with coming to terms with one's sexual orientation, gender identity or sex identity and the potential impact of associated life changes and (feared or actual) experience of discrimination. Research shows that the majority of first suicide attempts by LGBT people are made prior to coming out to others.[53] Suicide attempts by trans people are usually made before the person has engaged in any gender-related treatment, counselling or therapy.[54] For some people an 'internal coming out' is concluded with self-identifying as lesbian, gay, bisexual, trans, intersex or another identity label and then 'coming out' to others. However, for other people this can be a complex, fluid and multidimensional process that is revisited at various times in their lives, with associated changes in their identity over time.
- Heteronormativity means people generally assume heterosexuality and cisgender status (not being trans or intersex). Therefore the decision on whether and how to communicate one's sexual orientation, sex or gender identity to others is faced in almost every new social contact, including contact with health professionals and other service providers. This too can be a source of stress given considerations of potential impact. Many LGBTI people are only 'out' in some contexts and may hide their sexual orientation, gender identity or intersex status for fear of discrimination or abuse, especially when accessing services and in public,[55] for example, not acknowledging having a partner or describing them as a 'friend'. One in five trans Australians have been threatened with being involuntarily 'outed'.[56] Given high rates of discrimination, including physical violence, refusal of employment, etc, on the basis of being identified as trans, such threats have significant psychological and practical impact.
- Sexual orientation, sex and gender identity usually have implications for more than sexual behaviour. They are sometimes described as cultural belongings, with shared language, knowledge, history, customs, literature, social settings, institutions, media, etc into which LGBTI people are socialised. LGBTI communities are very diverse and represent a potential resource for LGBTI people. They can be a source of empowerment, in particular by providing access to positive role models, peer support, social belonging, etc. Social connectedness is known to be a key determinant of health.[57] Numerous groups and organisations have grown out of LGBTI communities in Australia, especially in urban centres. They provide a wide range of services and social activities. The Internet has facilitated community development for LGBTI people, however connecting with LGBTI communities still often remains challenging.[58]
- Lesbian, gay and bisexual Australians are twice as likely as heterosexual Australians to have no contact with family or no family to rely on for serious problems (11.8% v. 5.9%).[59] Figures are likely to be even higher for trans people. Many LGBTI people are more likely to seek or receive primary emotional support and health information and advice from friendship/peer support networks, in particular LGBTI friends, sometimes referred to as 'families of choice'.[60] At the same time, less than half of LGBTI people state that they would feel confident dealing with the situation if someone close to them had a mental health problem or had thoughts of suicide or self-harm.[61]

"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. …There is a mental challenge to balance culture, connection to land and sexuality acceptance within our kinships"

(Aboriginal lesbian, personal communication 2010)

Be sensitive around issues of disclosure. Have clear policies around confidentiality and make them known. Remember that family and friends may not know certain things, or if they do, may not necessarily be supportive

- Although children of LGBTI people are generally at least as well adjusted as other children, they often also experience homophobic and transphobic discrimination and prejudice in relation to their parents.[62] This can also be the case for other family members and associates.
- Consensual sex between men was a criminal offence in Australia until the 1990s and the World Health Organisation did not remove homosexuality from its International Classification of Diseases until 1992. Most older LGBTI people in Australia have thus grown up in an environment of legal persecution and pathologisation by the medical profession. People in same-sex relationships also experienced the economic disadvantage of exclusion from tax concessions available to their heterosexual peers. Those who grew up pre 'gay liberation' experience ageing differently and have different needs to the baby boomer cohort which is now approaching retirement.[63]
- Being trans remains classified as a psychological disorder (gender dysphoria) and transsexual people seeking medical interventions are required to have this diagnosis and gain approval from a psychiatrist in order to access them. This can be a source of significant tension for people seeking to affirm a positive identity. Without significant medical interventions it is currently impossible for trans people to change their sex on their legal documentation.
- For some transsexual people, access to medical interventions to affirm their gender of identity (eg realignment surgery, hormones) represents, quite literally, a matter of life or death.[64] Certainly, a 2012 UK study showed that those trans people who wanted "gender reassignment or transition" but were as yet unable to access it and those who were unsure whether or not they wanted to had the lowest rates of life satisfaction. Most trans people who had undergone such a process reported being more satisfied with their lives since then (70%), with improved mental health (74%) and lower rates of suicidal ideation (thoughts) and attempts (63%). The 2% who reported being less satisfied with their lives post-intervention explained this in terms of experiences of transphobia, including loss of family, friends and employment, and/or poor surgical outcomes.[65] There are a range of barriers to accessing such medical interventions, including approval from psychiatrists and high financial costs (with simultaneously reduced economic opportunities).[66]
- Not all trans people wish to access medical interventions to affirm their gender identity, however, most experience the process of beginning to express rather than supress their gender identity as a transition with wide-reaching implications, both in terms of
    - challenges, such as increased vulnerability to discrimination and rejection (and associated loss) and the stress of having to manage a potentially complex process while also adjusting to a new gender role with its associated social expectations
    - increased wellbeing gained from self-expression and self-acceptance, knowledge, insight, confidence, better quality relationships, community and a sense of belonging (in particular by connecting with other trans people) and feeling they have a future.[67]
- Practical barriers to accessing health services face many trans and some intersex people where they present as one gender but their official documentation reflects another. The 'involuntary outing' associated with accessing services or participating in some other areas of life (such as renting, voluntary or paid work that required police checks or international travel) is often avoided where possible, with implications for health and wellbeing. Those trans people who change their official documentation of gender (dependent on extensive medical

interventions not accessible to all) still face barriers where, for example, old documentation carries a name and/or gender that no longer applies. This can, for example, lead to problems providing academic transcripts or job references.

- The birth of an intersex child is often treated by health professionals as a 'psycho-social emergency', however, little support and information is available to parents or, later, the children themselves. Intersex infants and children are often subjected to non-consensual, non-essential medical interventions (including genital surgery) to make them more 'normal. This can impact on their lives and health in various ways. There is a significant risk that this assignment of the child's sex may not be consistent with their adult gender identity. Whether (and to what extent) such intervention is necessary for the child's physical and mental health, or whether it is both physiologically and psychologically harmful, remains a contentious issue. The 2012 Australian Diverse Sex and Gender National Health Roundtable criticised use of medical intervention aimed at 'normalising' rather than addressing actual health issues and recommended regulation of surgery performed on intersex children (in consultation with intersex representatives).[68]

I was never asked if I would agree to be changed. I didn't know I was XXY. They knew but they never told me.

(Intersex person, quoted in Human Rights Commission 2008)

- Sometimes parents and medical professionals do not inform people of their intersex condition due to stigma and shame. Discovering that they are intersex can be a shock. Combined with having limited information and often no access to medical records, this can leave people feeling very isolated and betrayed.[69]
- Many intersex people have experienced trauma from medical examinations during the process of being diagnosed, often in childhood or adolescence. Intersex people may be reluctant to ask for psychological help and other forms of support due to feelings of mistrust, shame and/or embarrassment.[70] Some intersex people feel that intrusive examinations combined with stigma and secrecy within the family also made them vulnerable to sexual abuse as children, with resulting impact on mental health.[71]
- Gay and bisexual men continue to have the highest risk of HIV in Australia, with associated specific issues in relation to responses to diagnosis, living with HIV, medication related side-effects, AIDS related dementia, etc.

Existing initiatives are not effective for this high-risk group

- Recently there has been increased acknowledgement of LGBTI people's risks and issues in relation to mental health and suicide in Australia. Some mainstream mental health organisations, such as *beyondblue* and Headspace, are beginning to contribute to LGBTI visibility in health promotion activities and there have been recent government moves towards inclusion. However, exclusion from generic mental health and suicide prevention policies and programs continues to result in LGBTI people not being reached and their needs not being addressed.[72]
- Barriers to health service access include LGBTI people's fear of discrimination or rejection,[73] as well as fear of breach of confidentiality.[74] Unless services are explicitly inclusive, many LGBTI people will often assume a lack of understanding and/or potential discrimination. This is particularly the case in faith-based services, due to a history of explicit homophobia from some religious institutions.[75] Fear of discrimination and stigma can result in

Build diversity competence, including soft skills, use of gender neutral language, specific LGBTI knowledge

  - LGBTI people not accessing preventative or responsive mental health services at all, or
  - delaying their access to services, exacerbating the health issue.[76]
- A UK study showed that trans people who are so distressed that they feel they need urgent support either don't approach anyone or if they do, are most likely to contact their friends, followed by their GP or partner. Relatively few choose to approach designated mental health or suicide prevention services.[77] Australian LGBTI studies show a similar pattern.[78] At the same time less than half of LGBTI Australians report feeling confident in dealing with the situation if they or someone close to them had a mental health problem (46%) or thoughts of suicide (40%).[79]
- Where LGBTI people do access mainstream services, the quality of care they receive is often unsatisfactory: In at least some cases the fear of discrimination and/or inappropriate behaviour by service staff is justified. Experiences of LGBTI people include violence, refusal or reluctance to treat or if treating to acknowledge a health concern directly related to their sexual orientation, gender identity or intersex status.[80] They also include homophobic and transphobic treatment paradigms, for example, pathologising LGBTI identity as a symptom of mental ill-health[81] and using conversion therapies for same-sex attracted people (also known as reparative therapy). This practice claims to change sexual orientation and has been condemned the Australian Psychological Society and numerous other Australian and international professional associations as not only not working (as it is based on false premises) but also as unethical and harmful to the wellbeing of those who undergo it.[82]
- Discrimination is also anticipated and experienced from other clients, with few organisations taking steps to protect LGBTI clients in such cases.[83]
- Heteronormativity is a further, associated barrier. It results in some mental health professionals not automatically considering the possibility that their client may be LGBTI and expressing their assumptions in language choice, etc. Thus if they do access services, LGBTI people are required to challenge this assumption if they wish to address anything associated with their sexual orientation, sex or gender identity. Due to a fear of discrimination or withdrawal of care LGBTI people may have difficulty disclosing even where they believe these issues are directly relevant.[84]
- Failure to consider LGBTI needs can result in structural exclusion,e.g.where clients are separated on the basis of sex and no appropriate policies are in place regarding the placement of trans and intersex clients.[85]

"Seeing health professionals in general is often a scary and intimidating experience for transfolk. I've learnt the hard way that being a medical professional doesn't make someone knowledgeable about trans issues… if I wanted to see some kind of mental health professional in the future, I would only see one that had previous exposure to Trans issues so I wouldn't have to educate them and wouldn't feel violated."

(Transsexual, queer, 24-45 years, Metropolitan South Australia, quoted in Beyondblue 2012)

- Lack of acknowledgement of social determinants of health,e.g.social isolation and discrimination, can result in key causal or contributing factors for LGBTI people not being addressed.
- Lack of capacity in targeted services,e.g.no dedicated funding for LGBTI community-based services, results in few dedicated services being available. Those that are available having limited outreach and often limited ability to build the skills and provide the services LGBTI people seek.

- A lack of LGBTI knowledge and cultural competence in generic services[86] result in poor quality service provision, for example ill- or uninformed advice and inappropriate treatment [87] (e.g. pathologising their sexual orientation or gender identity) and failure to take the person's (potential) strengths/social resources into account (e.g. engaging with the family of origin but not friends or LGBTI community groups).
- LGBTI people often feel that they need to educate the health professional first in order to receive satisfactory service. This places a significant burden on a person when they are already in a vulnerable state.
- Where LGBTI people are identified as such, service providers often focus on their sexual orientation, their trans identity or their intersex status rather than the mental health issue or suicidality with which they are presenting. For trans and intersex people this can be a focus on physical issues such as hormone treatment or surgery. Psychological issues may be brushed over or left out altogether.[88] This can exacerbate the mental health problems and suicidality.[89]
- Where mental health issues are acknowledged by services, there is a tendency to focus on individual psychological intervention, rather than on social intervention to minimize risk factors such as homophobia, transphobia and heterosexism or empowerment approaches to build resilience and develop strategies to effectively respond to discrimination. While research indicates strong linkages between experience of discrimination and exclusion associated with sexual orientation, sex and gender identity and poor mental health, to date few initiatives have sought to reduce these causal factors.[90]
- LGBTI people seldom inform service providers that the service they have received has not been satisfactory, leaving organisations often unaware that they are not fulfilling their mission for this population group.[91]
- There are few mental health or suicide prevention initiatives targeting LGBTI people. Those that do exist are generally poorly resourced and occur in relative isolation from one another and from the generic initiatives and stakeholders. This limits their ability to provide the level of support required.

"I haven't accessed GLBTI services due to my internalised doubt about my legitimacy. In my teens, I didn't think I had the right to access them because I'd never had a girlfriend and so couldn't 'prove' I was bi. Later, I didn't think I could access them because I had an opposite-sex partner, even though my anxiety was about my bisexuality. Now I have a hard time thinking I should access them because I'd be draining limited resources when my problems are much smaller than many others. And I don't want to access mainstream resources because they might be discriminatory."

(bisexual woman, 25-45 years, metropolitan South Australia, quoted in beyondblue 2012)

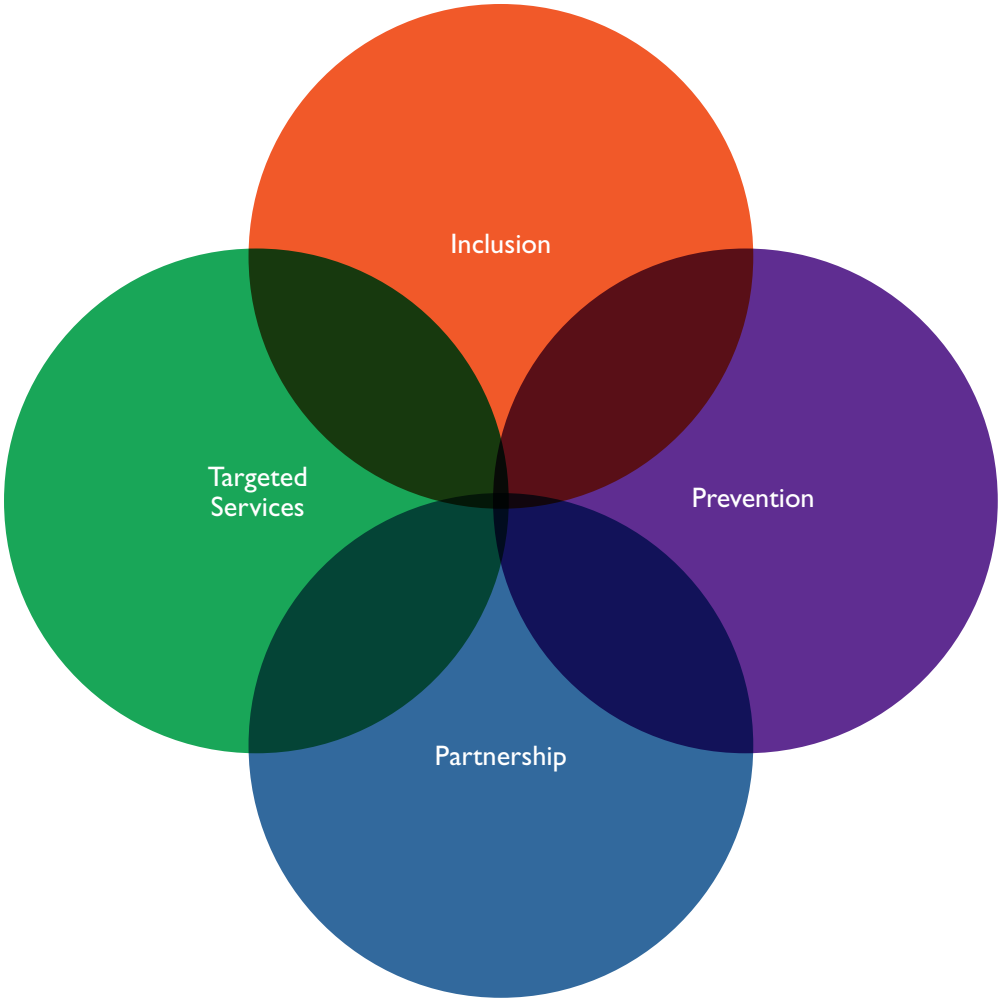
It is necessary to prioritize inclusion, targeted initiatives, prevention and partnership

The mental health needs of LGBTI people are complex and diverse. Addressing them requires specific effort and a range of interrelated mechanisms.[92]

Inclusion

- Most LGBTI people access generic/mainstream mental health and suicide prevention services so these services must serve the needs of this population.
- Generic mental health and suicide prevention initiatives (research, policy and practice) must be proactively inclusive of LGBTI people and their diverse issues and demonstrate this in order to reduce access barriers and provide appropriate services. 97% of LGBTI respondents to the 2011 MindOut! Survey considered it important that mainstream mental health and suicide prevention services are LGBTI sensitive and aware.[93]
- LGBTI specific services must be proactively inclusive of mental health and suicide related issues. As of 2011 although 89% and 72% of LGBTI organisations considered mental health and suicide respectively to be one of the most significant issues in the LGBTI community, only 35% included mental health and suicide prevention in their goals and/or strategic plans and less than half felt that their staff and volunteers would be confident and competent dealing with someone who presented with a mental health problem or risk of suicide.[94] Adequate inclusion of these issues is often challenging given the limited resourcing of this sector and its reliance on volunteers and peer support models. It thus requires investment in LGBTI community sector capacity.

Demonstrate that your organisation is inclusive, e.g. posters, signage, forms, advertising in LGBTI media, examples and images used in resources, LGBTI-specific resources easily accessible



"When my GP made the referrals, it was important to her that she find me gay-friendly providers. Having bipolar disorder was/is unrelated to me being gay, but some of the pressures of life as a gay man mean that those stressors need to be examined and put into order to prevent life stresses from contributing to a situation where I could become unwell."

(gay man, 25-45 years, rural Victoria, quoted in beyondblue 2012)

- Inclusion requires above all visibility of LGBTI people and their issues in
  - programs, services and resources
  - policy frameworks and guidelines
  - research, monitoring and reporting
- Awareness training for GPs and mainstream mental health and suicide prevention service providers were named as two of the top three priorities by LGBTI respondents to the 2011 MindOut! Survey when asked what could make a positive difference to mental health and suicide prevention (the third being targeted LGBTI services).[95] It should be noted, however, that while training to promote awareness and diversity competence are essential to inclusive practice, they are not sufficient in isolation.
- Inclusive practice is a multidimensional approach that encompasses human resources (e.g. recruitment, diversity competence, workforce development), paradigms (e.g. client-centred care, strengths-based approaches, supervision that addresses heteronormative assumptions), scope (e.g. types of services, target groups), tools (e.g. screening forms), organisational structures (e.g. physical setting, policies, procedures, governance and decision making), marketing strategies (e.g. niche marketing), stakeholder relationships, evaluation, resources (e.g. funding criteria, resource allocations), etc.[96]
- To be effective, inclusive practice requires a multidimensional approach to diversity, considering issues of sexual orientation, sex and gender identity in a differentiated manner and in relation to all population groups, e.g. Aboriginal and Torres Strait Islanders, older people, people with disabilities, rural and remote communities, refugees, multicultural communities, parents, children and young people, etc. This applies equally to LGBTI and mainstream organisations.
- LGBTI organisations can support mainstream organisations with both the development and the evaluation of their inclusive practice (see also 'partnership' below).

Targeted initiatives

- Targeted LGBTI-specific initiatives are required to complement inclusive generic initiatives. 86% of LGBTI respondents to the MindOut! survey feel that having LGBTI specific mental health and suicide prevention services is important, as do 82% of LGBTI organisations.[97] These include both LGBTI-specific services and custom-made/tailored services within inclusive generic programs.[98]

"I believe access to mental health services is incredibly poor if non-existent. My only free psych care was after a suicide attempt I'm one who has hidden, we tend to break down and come out in our 40s. Coming out then is very dramatic and sudden and [we have] lives that we're in the process of tearing down, and you need help… I really needed help initially to survive and function and then I guess I needed help to come to terms with and learn to accept myself for who I was"

(Transwoman, in Human Rights Commission 2008)

- LGBTI community ownership reduces barriers and contributes to effectiveness of initiatives, for example by enabling peer support, empowerment and community development.
- The current underresourcing of the LGBTI community sector requires the prioritisation of LGBTI services in mental health and suicide prevention funding allocations and strategic planning.
- Targeted research and monitoring is required to address knowledge gaps in particular in relation to small populations such as trans people (alongside inclusion in generic research).
- There are barriers to inclusion in generic consultations that make targeted consultations and specific strategies necessary to engage with this disparate and hard-to-reach population.

Prevention

Support programs and activities that help LGBTI people to flourish, eg donate, publicize, advocate

A focus on health promotion and prevention as well as intervention and postvention will make a long term improvement in the health outcomes of LGBTI Australians.

- The current focus on crisis intervention and predominantly medical models of mental health needs to be expanded into a comprehensive approach that builds protective factors and addresses the social determinants of suicide and mental ill-health..
- Ultimately, to improve LGBTI mental health outcomes and reduce suicidality, heterosexism, homophobia, transphobia and the stigma associated with intersex conditions must be addressed at the interpersonal, sociocultural, and institutional level.

Partnership

- Collaboration between government agencies, mainstream mental health and suicide prevention services and LGBTI organisations can effectively bring together the respective expertise of the sectors.
- "Not about us without us" – effective mechanisms are required to utilise the expertise of the LGBTI community in development, delivery and evaluation of initiatives, with targeted inclusion of particularly marginalised groups.[99]
- Working in partnership builds the capacity of both LGBTI community services (in mental health promotion and suicide prevention) and mainstream services (to deliver culturally relevant and accessible services).
- Efficient use of the respective resources of the sectors.
- Improved service coordination – a 'no wrong door' approach and robust referral pathways.[100]
- Cross-sectoral initiatives that address the underlying determinants of suicide and mental-ill health.
- Targeted investment is required to build the capacity of the LGBTI community sector to engage with the mental health and suicide prevention sector as partners.

In 2010 the Australian Senate Community Affairs Reference Committee recommended that LGBTI people be recognised as an at-risk group in suicide prevention strategies, policies and programs.[101] Some initial steps have been taken to implement this recommendation, alongside increased government attention being given to mental health issues for this population group. These steps include Federal and some state funding of initiatives that address all four of these areas: inclusion, targeted initiatives, prevention and partnership. For example the MindOut! LGBTI Mental Health and Suicide Prevention Project, delivered by the National LGBTI Health Alliance (2011-13). This project strives to strengthen linkages between the LGBTI sector and mainstream mental health and suicide prevention agencies, increasing awareness and providing the foundation for appropriate and targeted policy responses for LGBTI people.[102]

Refer people to LGBTI organisations as appropriate, work with them to increase inclusion within your organisation, support them to build their own capacity around mental health and suicide prevention, collaborate on targeted activities

Role of the National LGBTI Health Alliance

The National LGBTI Health Alliance is the peak, national body representing organisations and individuals that work to improve the health and wellbeing of LGBTI Australians. The Alliance currently has 177 members across Australia, including 82 organisations representing the vast majority of the LGBTI community services sector in addition to key researchers, health practitioners and individual consumers and carers.

If you can't treat someone with respect and openness, ensure that they get support from someone who can

Members of the National LGBTI Health Alliance share the vision of healthy, resilient and flourishing LGBTI people and communities fully participating in a socially inclusive Australian society They work on the basis of a holistic understanding of health and wellbeing, and consider social as well as medical determinants.

Members of the Alliance provide a wide variety of programs, services and research in the area of LGBTI health and wellbeing. They often combine consumer/carer and practitioner perspectives.

The Alliance works on a national level to address systemic barriers 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.

It provides a national voice on LGBTI health issues and builds the capacity of the health and wellbeing sector to address them.

Mental health and suicide prevention are key health issues for LGBTI people and a priority area for the Alliance. Alliance members include organisations whose work to improve LGBTI health and wellbeing includes a mental health component and organisations whose work specifically focuses on mental health issues across population groups, including but not limited to LGBTI people. The Alliance is a member of the Mental Health Council of Australia and Suicide Prevention Australia, among other national peak bodies.

The Alliance:

- initiates, facilitates and delivers national projects. For example, the multifaceted MindOUT! LGBTI Mental Health and Suicide Prevention Project
- provides advice to government and other key stakeholders, for example, in formal submissions, by participating in advisory bodies and providing ad hoc advice. For example, providing written and oral submissions to the Senate Community Affairs References Committee Inquiry into Suicide in 2009-2010 and jointly chairing a steering committee for the development of a National LGBTI Ageing and Aged Care Strategy in 2012[103]
- develops tools and resources to support organisations to work inclusively of LGBTI people. For example, Practice Wisdom Resources for Australian mental health professionals for the counselling and therapy of LGBTI clients and a Cultural Competency Framework for mainstream mental health and suicide prevention organisations and services[104]
- facilitates partnerships or referrals to its members. For example, the Alliance is worked with beyondblue to develop a national database of LGBTI counselling services[105]
- facilitates consultation with the LGBTI community. For example, as part of the Federal Government's 2012 national consultation on ageing and aged care
- builds capacity within the LGBTI community sector by facilitating collaboration and the sharing of ideas and resources among its members. For example, hosting Australia's first National Diverse Sex and Gender Health Roundtable 2012[106]
- proactively builds and disseminates knowledge. For example, in the 'Health in Difference' National LGBTI Health Conference, presentations, such as the key note speech at the National GLBT Mental Health Roundtable 2009,[107] and publications, such as this one and *Pathways to inclusion: Frameworks to include LGBTI people in mental health and suicide prevention services and organisations* (2012).

  See www.lgbtihealth.org.au to find out more and to identify Alliance member organisations in your state/territory.

References

[1] Smith et al. (2003)

[2] Department of Health (2008); Olyslager and Conway (2007)

[3] Diamond (2004); Blackless, et al. (2000)

[4] Leonard et al. (2012); Corboz et al. (2008); Suicide Prevention Australia (2009)

[5] Pitts et al. (2006)

[6] Couch et al. (2007). See also McNeil et al. (2012): 88% of trans respondents to a UK study report either currently or previously experiencing depression.

[7] Australian Bureau of Statistics. Unpublished data

[8] Leonard et al. (2012)

[9] Australian Bureau of Statistics (2007)

[10] Leonard et al. (2012). See also McNeil et al. (2012), which showed 75% of UK trans respondents to have experienced significant anxiety, however, often without this having been diagnosed.

[11] Leonard et al. (2012); Dodge and Sandfort (2007); Jorm et al. (2002)

[12] Schutzmann et al (2009)

[13] Couch et al. (2007). Cf. 27% in a recent UK study and 63% reporting suicidal ideation within the past year, McNeil et al. (2012)

[14] Pitts et al. (2006)

[15] McNeil et al. (2012)

[16] Di Ceglie (2000); Holman and Goldberg (2006); Perkins (1991: 53) quoted in National Transgender HIV/AIDS Needs Assessment Project (Australia) et al. (1994); Ontario Public Health Association (2003); McNeil et al. (2012)

[17] Commonwealth Department of Health and Aged Care (2000); Suicide Prevention Australia (2009)

[18] Dyson et al. (2003)

[19] Nicholas and Howard (1998)

[20] Schutzmann et al (2009)

[21] National LGBT Health Alliance (2009)

[22] Institute of Medicine (2011); Suicide Prevention Australia (2009); National LGBTI Health Alliance (2009)

[23] Dyson et al. (2003); Nicholas and Howard (1998); Hillier and Walsh (1999)

[24] Wilkinson and Marmot (eds)(2003); Rosenstreich (2011)

[25] Meyer (2007); Institute of Medicine (2011)

[26] Hillier et al. (2010); Suicide Prevention Australia (2009)

[27] See www.ag.gov.au/consultations/pages/ConsolidationofCommonwealthanti-discriminationlaws.aspx and www.antidiscrimination.gov.au [viewed 8/3/13]

[28] Leonard et al. (2012); Australian Medical Association (2002); Flood and Hamilton (2005)

[29] Hillier et al. (2010); Howard and Arcuri (2006); Hillier et al. (2004)

[30] Leonard et al. (2012)

[31] Couch et al. (2007); See also Leonard et al. (2012) and McNeil et al. (2012).

[32] National Transgender HIV/AIDS Needs Assessment Project (Australia) et al. (1994); N.B. this figure relates to 'ever' having been sexually assaulted. National data collected using a different methodology indicated a rate of 6.8% of trans women reporting a sexual assault over the previous 12 months. This was almost 2.5 times the average of the total LGBT survey sample. Leonard, W. et al. (2012).

[33] Human Rights Commission (2008)

[34] McNeil et al. (2012); Pitts et al. (2006); Leonard et al. (2012)

[35] E.g. McNeil et al. (2012)

[36] AIS Support Group Australia (AISSGA), personal communication 2011

[37] Dyson et al. (2003); Couch et al. (2007); Hillier et al. (2005)

[38] AIHW (2011); Pitts et al. (2006); Howard and Arcuri (2006); McNair et al (2003); Leonard et al. (2012)

[39] Ray (2006); McNeil et al. (2012)

[40] Hillier et al. (2010)

[41] Australian Bureau of Statistics. Unpubl. data

[42] Institute of Medicine (2011)

[43] Hughes et al. (2010) identified a link between sexual orientation, mental health and at risk use of alcohol and other drugs. Further research is required to understand the interrelationships.

[44] Institute of Medicine (2011); Pega et al.(2010)

[45] Suicide Prevention Australia (2009)

[46] Dyson et al. (2003); Nicholas and Howard (1998); Hillier and Walsh (1999); Cole (1997)

[47] Dyson et al. (2003); Gibbons et al. (2008)

[48] Most notably in Australia, the National Survey of Mental Health and Wellbeing included sexual orientation indicators in 2007, Australian Bureau of Statistics (2007 and unpubl. data) as did the 2010 National Drug Strategy Household Survey, AIHW (2011)

[49] This is, for example, a key recommendations of the 2012 Australian National Diverse Sex and Gender Roundtable, National LGBTI Health Alliance (2012b)

[50] Pega et al. (2010)

[51] Office for National Statistics (2009)

[52] National LGBTI Health Alliance (2012b)

[53] Dyson et al. (2003); Nicholas and Howard (1998); Hillier and Walsh (1999)

[54] Cole (1997)

[55] Leonard et al. (2012); McNeil et al. (2012)

[56] Couch et al. (2007)

[57] Leonard et al. (2012)

[58] Leonard et al. (2012)

[59] Australian Bureau of Statistics. Unpubl. data

[60] Institute of Medicine (2011); Leonard et al. (2012)

[61] Price Waterhouse Coopers (2011)

[62] Institute of Medicine (2011)

[63] National LGBT Health Alliance (2010)

[64] Kotula (2002)

[65] McNeil et al. (2012)

[66] Grant et al. (2010)

[67] McNeil et al. (2012)

[68] National LGBTI Health Alliance (2012b)

[69] Human Rights Commission (2008)

[70] AIS Support Group Australia (AISSGA), personal communication 2011

[71] Personal communications

[72] Rosenstreich et al. (2011)

[73] Mayer et al. (2008); Heck et al. (2006); Birkenhead and Rands (2012); McNeil et al. (2012)

[74] Gibbons et al (2008)

[75] National LGBTI Health Alliance (2012a)

[76] Pitts et al. (2006); Pitts et al. (2009); McNeil et al. (2012)

[77] McNeil et al. (2012)

[78] Institute of Medicine (2011); Leonard et al. (2012)

[79] Price Waterhouse Coopers (2011)

[80] Israel et al. (2011); Lucksted (2004); Birkenhead and Rands (2012); Couch et al. (2007); Senreich (2011); McNeil et al. (2012)

[81] E.g. McNeil et al. (2012); National LGBTI Health Alliance (2012b)

[82] See, for example, www.psychology.org.au/publications/inpsych/lgtiq/ [viewed 8/3/13]

[83] Clarke (2004)

[84] Semp (2006); Huygen (2006)

[85] Birkenhead and Rands (2012); McNeil et al. (2012); National LGBTI Health Alliance (2012b)

[86] Leonard (2002); Price Waterhouse Coopers (2011); Gibbons et al. (2008)

[87] Pitts et al. (2006)

[88] AIS Support Group Australia (AISSGA), personal communication 2011

[89] Dyson et al. (2003); Couch et al. (2007); Hillier et al. (2005)

[90] Corboz et al. (2008)

[91] Gibbons et al. (2008)

[92] See Rosenstreich et al. (2011) for a discussion of primary health care reform in relation to LGBTI health inequities.

[93] Price Waterhouse Coopers (2011)

[94] Price Waterhouse Coopers (2011)

[95] Price Waterhouse Coopers (2011)

[96] Some examples of good practice measures can be found in Rosenstreich (2010b); National LGBTI Health Alliance (2012a); Barrett and Stephens (2012)

[97] Price Waterhouse Coopers (2011)

[98] The funding of targeted programs for trans and intersex people, developed and delivered in conjunction with representatives of the diverse sex and gender community, is a recommendation of the Australian National Diverse Sex and Gender Roundtable, National LGBTI Health Alliance (2012b)

[99] Rosenstreich (2010a); National LGBTI Health Alliance (2012b)

[100] Birkenhead and Rands (2012)

[101] Community Affairs References Committee (2010)

[102] See Price Waterhouse Coopers (2011); www.lgbtihealth.org.au/mindout [viewed 2/3/13]

[103] Australian Government 2012

[104] National LGBTI Health Alliance (2012a)

[105] National LGBTI Health Alliance (2012a)

[106] National LGBTI Health Alliance (2012b)

[107] Rosenstreich (2009)

Literature

AIHW (2011) 2010 *National Drug Strategy Household Survey Report*. Australian Institute of Health and Welfare. Canberra www.aihw.gov.au/publication-detail/?id=32212254712 [viewed 8/3/13]

Australian Bureau of Statistics (2007) National Survey of Mental Health and Wellbeing: Summary of Results. 4326.0. Australian Government. Canberra.

Australian Bureau of Statistics. Unpublished data from the 2007 National Survey of Mental Health and Wellbeing provided to Queensland Association of Healthy Communities in 2010

Australian Government (2012) *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy.* Australian Government. Canberra. www.health.gov.au/lgbtistrategy [viewed 6/3/13]

Australian Medical Association (2002) AMA Position Statement; Sexual Diversity and Gender Identity. AMA

Barrett, C. and Stephens, K. (2012) Beyond: *'we treat everyone the same'. A report on the 2010-2011 program: How2 create a gay, lesbian, bisexual, transgender and intersex inclusive service.* Gay and Lesbian Health Victoria. Melbourne.

Beyondblue (2012) *In My Shoes: Experiences of discrimination, depression and anxiety among gay, lesbian, bisexual, trans and intersex people.* beyondblue. Melbourne. www.beyondblue.org.au/index.aspx?link-id=4.1167&tmp=FileDownload&fid=2456 [viewed 8/3/13]

Birkenhead, A. and Rands, D. (2012) Let's Talk About Sex. Auckland District Health Board. Auckland. www.mentalhealth.org.nz/file/downloads/pdf/file_346.pdf [viewed 8/3/13]

Blackless, M. et al. (2000) How Sexually Dimorphic Are We? Review and Synthesis. American Journal of Human Biology, 12: 151-166

Clarke, S. (2004) *Acute Inpatient Mental Health Care: Education, Training and Continuing Professional Development for All.* NIMHE/SCMH. London www.centreformentalhealth.org.uk/pdfs/acutetrainingguide.pdf [viewed 8/3/13]

Cole, C. et al. (1997) Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses. Archives of Sexual Behavior, 26(1):13-26

Commonwealth Department of Health and Aged Care (2000) LIFE – A framework for prevention of suicide and self-harm in Australia: Learnings about suicide, CDHAC. Canberra

Community Affairs References Committee (2010) The Hidden Toll: Suicide in Australia. Commonwealth of Australia. Canberra.

Corboz, J. et al. (2008) *Feeling Queer and Blue: A Review of the Literature on Depression and Related Issues among Gay, Lesbian, Bisexual and Other Homosexually Active People.* A Report from the Australian Research Centre in Sex, Health and Society, LaTrobe University, prepared for beyondblue: the national depression initiative. Melbourne

Couch, M. et al. (2007) *Tranznation – a report on the health and wellbeing of transgender people in Australian and New Zealand.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Department of Health (2008) *Trans: A practical guide for the NHS. Department of Health*. London www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089941 [viewed 16/4/11]

Di Ceglie, D (2000) 'Gender Identity Disorder in Young People', Advances in Psychiatric Treatment, 6: 458-466

Diamond, M. (2004) Pediatric Management of Ambiguous and Traumatized Genitalia. Contemporary Sexuality, 38(9): i-vi

Dodge, J. and Sandfort, TGM (2007) A review of mental health research on bisexual individuals when compared to heterosexual individuals. In B. Firestein (ed) *Becoming Visible: Counselling Bisexuals Across the Lifespan.* Columbia University Press. New York. Pp. 28-51

Dyson, S et al. (2003) *Don't ask, don't tell. Report of the same-sex attracted youth suicide data collection project.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Flood, M. and C. Hamilton (2005) *Mapping Homophobia in Australia*. Australia Institute Webpaper http://unilife.curtin.edu.au/sexualdiversity/documents/MappingHomophobiainAustralia.pdf [viewed 16/4/11]

Gibbons, M. et al. (2008) *Recognising LGB Sexual Identities in Health Services. The Experiences of Lesbian, Gay and Bisexual People with Health Services in North West Ireland.* The Equality Authority. www.hse.ie/eng/services/Publications/topics/Sexual/LGBExperienceHealth_Services.html [viewed 8/3/13]

Grant, J. et al. (2010) *Injustice at every turn.* National Gay and Lesbian Task Force and National Centre for Transgender Equality. Washington

Heck, J. et al. (2006) Health care access among individuals involved in same-sex relationships. *American Journal of Public Health* 96(6); 1111-1118

Hillier, L. and J. Walsh (1999) Abused, silenced and ignored: Creating more supportive environments for same sex attracted young people. *Suicide Studies Bulletin*, 3: 23-27

Hillier, L. et al. (2004) Drug-use patterns of heterosexual and non-heterosexual women: Data from the Women's Health Australia Study. In D.W. Riggs and G.A. Walker (eds) *Out in the Antipodes: Australian and New Zealand Perspectives on Gay and Lesbian Issues in Psychology*. Bently

Hillier, L. et al. (2005). *Writing themselves in again: 6 years on - the 2nd national report on the sexuality, health & well-being of same-sex attracted young people.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Hillier, L. et al. (2008) 'I couldn't do both at the same time': same-sex attracted youth and the negotiation of religious discourse. *Gay and Lesbian Issues and Psychology Review*, 4(2): 80-93 www.glhv.org.au/files/Hillier_Mitchell_Mulcare_2008.pdf [viewed 12/2/13]

Hillier, L. et al. (2010) *Writing Themselves In 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people.* Australian Research Centre in Sex, Health and Society, La Trobe University. Melbourne

Howard, J, & Arcuri, A (2006) Drug use among same-sex attracted young people. In P. Aggleton et al. *Sex, Drugs and Young People.* Routledge

Human Rights Commission (2008) *To Be Who I Am. Report of the Inquiry into Discrimination Experienced by Transgender People.* Human Rights Commission. Auckland.

Huygen, C. (2006) Understanding the needs of lesbian, gay, bisexual and transgender people living with mental illness. *Medscape General Medicine*, 8(2): 29

Institute of Medicine (2011) *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.* National Academies Press. Washington

Israel, T. et al. (2011) Policies and Practices for LGBT Clients: Perspectives of Mental Health Services Administrators. *Journal of Gay and Lesbian Mental Health*, 15(2): 152-168

Jorm, A. et al. (2002) Sexual orientation and mental health: Results from a community survey of young and middle-aged adults. *The British Journal of Psychiatry*, 180: 423-427

Kotula, D. (2002) *In the Phallus Palace.* W.E. Parker (consulting editor). Alyson Publications. Los Angeles

Leonard, W (2002) *What's the Difference? Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians: Research Paper.* Ministerial Advisory Committee on Gay and Lesbian Health, Victorian Government Department of Human Services. Melbourne

Leonard, W. et al. (2012) *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Lucksted, A. (2004) Lesbian, Gay, Bisexual and Transgender People Receiving Services in the Public Mental Health System. *Journal of Gay and Lesbian Psychotherapy*, 8(3/4): 25-42

Mayer, K. et al. (2008) Sexual and gender minority health: What we know and what needs to be done. *American Journal of Public Health* 98(6): 989-995

McDougall, B. (2006) *My Child is Gay. How parents react when they hear the news.* Allen & Unwin, Crows Nest

McNair, R. et al (2003) Addressing health inequalities in Victorian lesbian, gay, bisexual and transgender communities. *Health Promotion Journal of Australia*, 11(1): 32-38

McNeil, J. et al. (2012) *Trans Mental Health Study 2012*. Scottish Transgender Alliance. Edinburgh. www.scottishtrans.org [viewed 8/3/13]

Meyer, I. (2007) Prejudice and discrimination as social stressors. In I. Meyer and M. Northridge (eds) *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*. Springer. Pp.242-267

National LGBT Health Alliance (2009) *Submission to the Senate Community Affairs References Committee Inquiry into Suicide in Australia.* National LGBT Health Alliance. www.lgbthealth.org.au/publications [viewed 14/4/11]

National LGBT Health Alliance (2010) *Submission to the Productivity Commission Inquiry into the Aged Care System in Australia 'Caring for Older Australians'*. National LGBT Health Alliance. Sydney. www.lgbthealth.org.au/ageing [viewed 15/4/2011]

National LGBTI Health Alliance (2012a) *Pathways to Inclusion: Frameworks to include LGBTI people in mental health and suicide prevention services and organisations.* National LGBTI Health Alliance. Sydney. www.lgbthealth.org.au/ageing [viewed 15/2/13]

National LGBTI Health Alliance (2012b) *Diversity in Health: Improving the health and wellbeing of transgender, intersex and other sex and gender diverse Australians.* National LGBTI Health Alliance. Sydney. www.lgbthealth.org.au/dsg [viewed 15/2/13]

National Transgender HIV/AIDS Needs Assessment Project (Australia) et al. (1994) *Transgender lifestyles and HIV/AIDS risk.* National Transgender HIV/AIDS Needs Assessment Project. School of Sociology, University of New South Wales, Kensington, N.S.W

Nicholas, J. and J. Howard (1998) Better Dead Than Gay? Depression, Suicide Ideation and Attempt Among a Sample of Gay and Straight-Identified Males Aged 18-24. *Youth Studies Australia,* 17(4): 28-33

Office for National Statistics (2009) *Trans Data Position Paper.* Office for National Statistics (UK). Newport. www.ons.gov.uk/ons/guide-method/measuring-equality/equality-data-review/trans-data-position-paper.pdf [viewed 8/3/13]

Olyslager, F. and L. Conway (2007) *On the Calculation of the Prevalence of Transsexualism.* Paper presented at WPATH 20th International Symposium, Chicago, Illinois, Sept 5-8 2007. http://ai.eecs.umich.edu/people/conway/TS/Prevalence/Reports/Prevalence%20of%20Transsexualism.pdf [viewed 16/4/11]

Ontario Public Health Association (2003) Trans Health Project. *A position paper and resolution adopted by the Ontario Public Health Association.* Toronto www.opha.on.ca/our_voice/ppres/papers/2003-06_pp.pdf [viewed 16/4/11]

Pega, F. et al. (2010) *Sexual orientation data in probability surveys: Improving data quality and estimating core population measures from existing New Zealand survey data.* Official Statistics Research Series, 2. [viewed 8/3/13]

Pitts, M. et al. (2006) Private Lives: *A report on the wellbeing of GLBTI Australians.* Australian Research Centre in Sex, Health and Society, LaTrobe University. Melbourne

Pitts, M. et al. (2009) Health Service Use and Experiences of Transgender People. Australian and New Zealand Perspectives. *Gay & Lesbian Issues and Psychology Review,* 5(3): 167-176

Price Waterhouse Coopers (2011) *National LGBTI Health Alliance - Mental Health and Suicide Prevention Project Final Report.* Price Waterhouse Coopers. Sydney

Ray, N. (2006) *Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness.* National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless. New York

Rosenstreich, G. (2009) *Problems and Responses.* Presentation to the Gay, Lesbian, Bisexual, Transgender and Intersex People Mental Health Roundtable. Melbourne 17 December. www.lgbtihealth.org.au/Mental-Health [viewed 8/3/13]

Rosenstreich, G. (2010a) *Excluded from the table: LGBT health and wellbeing.* Health Voices, 6: 12-14

Rosenstreich, G. (2010b) I*nclusive Practice: Reducing Barriers to Sexuality, Sex and Gender Diversity.* Workshop presentation to the 4th Asia-Pacific Regional Conference of the International Association for Suicide Prevention. Brisbane www.lgbtihealth.org.au/sites/default/files/Rosenstreich-LGBTI-Inclusive-Suicide-Prevention-20101119.pdf [viewed 8/3/13]

Rosenstreich, G. et al. (2011) Primary Health Care and Equity: the case of LGBTI Australians Australian *Journal of Primary Health*, 17(4): 302-308

Rosenstreich, G. (2011) Discrimination, LGBTI Mental Health and Suicide. *Australian Journal on Psychosocial Rehabilitation*, newparadigm, Spring 2011: 16-19

Schutzmann, K. et al (2009) Psychological distress, self-harming behaviour, and suicidal tendencies in adults with disorders of sex development. *Archives of sexual behaviour*, 38(1): 16-33

Semp, D. (2006) *A public silence: A report on sexual orientation and public mental health services in New Zealand.* Unpublished paper. Psychology Department, University of Auckland

Senreich, E. (2011) The Substance Abuse Treatment Experiences of a Small Sample of Transgender Clients. *Journal of Social Work Practice in the Addictions*, 11(3): 295-299

Simply Trans (2007) Perth Inner City Youth Service. Perth. (Resource written by various trans people). www.glcs.org.au/pdf/Simply_Trans.pdf [viewed 11/4/11]

Smith, A. et al. (2003) Sex in Australia: Sexual Identity, Sexual Attraction and Sexual Experience Among a Representative Sample of Adults. *Australian and New Zealand Journal of Public Health,* 27(2): 138-145

Suicide Prevention Australia (2009) *Position Statement Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities,* SPA. Sydney

Wilkinson, R. and M. Marmot (eds)(2003) *Social Determinants of Health – The Solid Facts*. World Health Organisation. Geneva.

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