

Discrimination, LGBTI mental health and suicide¹

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Current Australian mental health and suicide prevention policy and practice fail to adequately consider let alone address the issues facing lesbian, gay, bisexual, trans², intersex³ and other sexuality, sex and gender diverse (LGBTI) people. This is particularly concerning as this population group experiences significantly poorer mental health and significantly higher rates of suicidality than other groups in Australia (Corboz et al., 2008, Suicide Prevention Australia, 2009).

With up to 14 times more suicide attempts among LGBTI people than their peers (Commonwealth Department of Health and Aged Care, 2000) and rates of depression over 5 times higher among trans people and 3.5 times higher among lesbian, gay and bisexual people than in the general population (Pitts et al., 2006; Australian Bureau of Statistics, 2007), it is clearly time to engage with the specific issues of this group of Australians.

This article will consider discrimination as the key determinant of these disproportionately poor outcomes and outline implications for services seeking to prevent suicide and/or support people experiencing mental health problems.

Discrimination as a determinant of mental health

The elevated risk of mental ill-health and suicidality among LGBTI people across all demographic groups is not due to their sexual orientation, sex or gender identity in and of themselves, as is evident from the many LGBTI people living healthy, happy lives. Rather, it is due to discrimination and exclusion as key determinants of health (Meyer, 2007; cf. Wilkinson & Marmot, 2003).

Homophobia and transphobia are a fear of and/or prejudices against people perceived to be homosexual or trans respectively, or more generally to not conform to male or female gender norms. These fears are often expressed as stereotyping, ostracising, harassment, and violence. Heterosexism is discrimination in favour of heterosexual and against homosexual and bisexual people and 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. In contrast, heteronormativity does not necessarily involve prejudice but rather the assumption of heterosexuality and associated simplistic understandings of biological sex and gender always being identical and stable and exclusively binary (either male or female). It excludes LGBTI people by ignoring their existence.

Exposure to and fear of discrimination and isolation can directly impact on the mental health of LGBTI people; causing stress, psychological distress and suicidality (Hillier et al., 2010). Research shows that despite recent improvements to legislative equality and social acceptance of homosexuality and – to a lesser extent – of trans and intersex people, experience of homophobic and transphobic discrimination and exclusion remains common (Australian Medical Association, 2002; Flood & Hamilton, 2005). For example:

- up to 80 per cent of same-sex attracted and gender questioning young Australians experience public insult, 20 per cent threats, 18 per cent physical abuse and 26 per cent 'other' forms of homophobia (Hillier et al., 2010; Howard & Arcuri, 2006)

¹ This article is based on the briefing paper 'LGBTI People Mental Health and Suicide' (Rosenstreich, 2011)

² The term 'trans' is an umbrella term for people with an internal sense of gender identity that differs from their birth sex. It includes transsexual, genderqueer, sistergirl and other identities. Transgender is a common alternative term. Like other collective identity labels, these terms are contested and their use changes over time.

³ Intersex people are born with a physical variation to current expectations of male or female sex, e.g. atypical genitals or XXY chromosomes. Please note that most intersex people and many trans people simply identify as male or female most or all of the time and that sexual orientation, sex and gender identity are different aspects of identity that are not directly connected (i.e. trans and intersex people can be heterosexual, homosexual or bisexual).

- fifty per cent of adult trans Australians experience verbal abuse, social exclusion and having rumours spread about them. A third have been threatened with violence, 20 per cent with being involuntarily 'outed', 19 per cent physically attacked, eleven per cent experience obscene mail and phone calls and damage to personal property. Sixty-four per cent modify their behaviour due to fear of stigmatisation and discrimination (Couch et al., 2007)
- the secrecy and shame associated with intersex conditions leave people vulnerable to discrimination and abuse and some intersex people experience similar discrimination to trans people (Human Rights Commission, 2008). Overseas research shows that intersex adults have psychological distress at levels comparable with traumatised non-intersex women such as those with a history of severe physical or sexual abuse (Schutzmann, 2009).

Institutional discrimination persists. For example, although homosexuality was removed from the International Classification of Diseases in 1992, being trans remains classified as a psychiatric disorder ('gender dysphoria'). This pathologises people seeking to affirm a positive identity, especially as the diagnosis is the requirement to undergo significant medical interventions, which are in turn required to change sex on legal documentation. For some people, access to medical interventions to affirm their gender of identity (e.g. surgery, hormones) represents, quite literally, a matter of life or death (Kotula, 2002). There are a range of barriers to access such interventions, including psychiatric assessments and high financial costs.

LGBTI people can also internalise homophobia and transphobia. The lack of positive role models and difficulty accessing affirming peer support can make 'coming out' extremely stressful, hinder the development of positive self-concepts, self-esteem and resilience and cause significant mental distress.

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 alcohol and other drug misuse (Pitts et al., 2006; Howard & Arcuri, 2006; McNair et al., 2003) and homelessness (Ray, 2006).

They also have indirect impact: For example, high rates of LGBTI suicide mean that LGBTI people are disproportionately affected by the suicide of friends and community figures, increasing the likelihood of perceiving suicide as an option and of contagion, and discrimination by family and friends denies LGBTI people a key potential support in time of vulnerability.

Support services

Direct and indirect discrimination of LGBTI people are evident in generic mental health and suicide prevention policies and programs, including lack of acknowledgement of this high-risk group in the current *National Suicide Prevention Strategy* and *National Mental Health Plan*. This is reflected in support services. A recent survey undertaken by the National LGBTI Health Alliance revealed that 97 per cent of LGBTI respondents felt it is important for mainstream mental health/suicide prevention services to be LGBTI sensitive and aware of the issues for this population. Together with both LGBTI-specific and mainstream services, LGBTI respondents prioritised awareness training as most important to make a positive difference. Yet even among those mainstream mental health services sufficiently interested to respond, only 28 per cent offered their staff any form of LGBTI awareness training (PricewaterhouseCoopers, 2011).

Failure to be aware of and address the issues faced by LGBTI people results in them being neither reached nor supported by existing initiatives. Barriers that prevent health services from reaching LGBTI people include fear of discrimination or rejection. Unless services are explicitly inclusive, LGBTI people will often assume a lack of understanding and/or potential discrimination. Fear of discrimination and stigma can result in LGBTI people not accessing preventative or responsive mental health services at all, or delaying their access to services (Pitts et al., 2006). Thus the failure of generic health interventions and prevention strategies to be inclusive of LGBTI people 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 (Dyson et al., 2003; Couch et al., 2007; Hillier et al., 2005).

Barriers that prevent LGBTI people being adequately supported even when they do access services include direct discrimination by practitioners (the fears noted above are not always unfounded). Heteronormativity is a further, associated barrier. It results in many practitioners not considering the possibility that their client may be LGBTI and

communicating their assumptions through their language. Thus LGBTI clients are required to challenge assumptions if they wish to address anything associated with their sexual orientation, sex or gender identity. Fear of discrimination, such as withdrawal of care, may lead LGBTI people to have difficulty disclosing even where they believe these issues are directly relevant, to the detriment of their care (Semp, 2006; Huygen, 2006).

A lack of LGBTI knowledge and cultural competence (Leonard, 2002) results in:

- poor quality service provision even where LGBTI people are acknowledged, such as ill- or uninformed advice and inappropriate treatment (Pitts et al., 2006), (e.g. pathologising their sexual orientation or gender identity)
- lack of acknowledgement of social determinants of health (e.g. social isolation and discrimination) resulting in key causal or contributing factors not being addressed, and
- failure to take the person's (potential) social resources, such as LGBTI community networks, into account.

In part, as a response to inadequate support from many generic/mainstream services, a number of LGBTI-specific organisations have been established. Some include a mental health component in their work and the majority consider mental health and suicide prevention to be key health issues for LGBTI people (PricewaterhouseCoopers, 2011). However, they generally lack the resources (staff, funding, skills) to adequately address these issues, and have limited outreach and often limited ability to provide the services LGBTI people seek.

The mental health needs of LGBTI people are complex and diverse. Addressing them requires specific effort and a range of interrelated mechanisms in four areas: inclusion, targeted initiatives, prevention and partnership.

Inclusion

Ninety-seven per cent of LGBTI people see a need for mainstream services to be responsive to LGBTI issues (PricewaterhouseCoopers, 2011). Reducing barriers to service access depends on proactive inclusion of LGBTI people. 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), organisational structures (e.g. physical setting, policies, procedures, governance and decision making), marketing strategies (e.g. niche marketing), stakeholder relationships (e.g. strategic partnerships), resources (e.g. funding criteria, resource allocations), evidence (e.g. data collection, monitoring), etc. (see Rosenstreich, 2007, 2010b).

To be effective, inclusive practice also 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. (cf Rosenstreich and Riggs, 2010). Services not only need to be inclusive, they also to demonstrate this to potentially apprehensive clients e.g. displaying LGBTI resources, naming this group in public documents, questions on forms, diverse images in materials.

Alongside this, LGBTI-specific community services must be proactively inclusive of mental health and suicide related issues. This is often challenging given the limited resourcing of this sector and its reliance on volunteers and peer support models, and requires investment in LGBTI community sector capacity.

Targeted initiatives

Eighty-six per cent of LGBTI people consider it important to have LGBTI-targeted mental health and suicide prevention services, as do 82 per cent of LGBTI community organisations (PricewaterhouseCoopers, 2011). Targeted initiatives, in particular those with clear LGBTI community ownership, have potential strengths, such as reduced barriers to access due to clients presuming safety from discrimination and sensitivity to their needs and building social connectedness and resilience by enabling peer support, empowerment and community development. However, there are also some challenges, such as barriers to access for those people who do not self-identify with the terminology used, focussing on one aspect of identity and potentially excluding other relevant aspects (e.g. disability)

(Rosenstreich, 2007). Rather than being a stand-alone solution, as a complement to and in partnership with inclusive generic initiatives, targeted initiatives can be a significant tool to improve wellbeing.

The current underresourcing of the LGBTI community sector significantly limits the sector's ability to provide targeted services. Prioritisation of LGBTI-community services in mental health and suicide prevention funding allocations and strategic planning is required.

Targeting can also be an effective mechanism in other forms. For example:

- specific tailored services and resources within inclusive generic programs and services
- targeted research and monitoring to address knowledge gaps (alongside inclusion in generic research)
- targeted consultations and specific strategies to engage with this disparate and hard-to-reach population in the development and evaluation of activities and policies.

Prevention

Services have a tendency to focus on individual psychological or pharmaceutical intervention. Only 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. This requires a move from crisis intervention and predominantly medical models of mental health to a comprehensive holistic approach that builds protective factors and addresses the social determinants of suicide and mental ill-health. To improve LGBTI mental health outcomes and reduce suicidality, the risk factor of discrimination based on heterosexism, heteronormativity, homophobia, transphobia and the stigma associated with intersex conditions must be addressed at the interpersonal, sociocultural, and institutional level (Corboz et al., 2008).

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. LGBTI people and services are currently seldom consulted in the development of research, policies or programs. 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 (Rosenstreich, 2010a). Given the current lack of resourcing, however, 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.

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 to LGBTI people). It allows for the efficient use of the respective resources of the sectors and improved service coordination: A 'no wrong door' approach and robust referral pathways reduce access barriers for those in need of support. In addition, cross-sectoral initiatives are needed if we are to effectively address discrimination as the underlying determinant of LGBTI suicide and mental ill-health.

Recent Government acknowledgements of LGBTI specific mental health and suicide prevention needs represent a positive step towards progress in these areas (e.g. Senate Community Affairs References Committee, 2010). Federal Government funding has now made it possible for the National LGBTI Health Alliance, the peak body representing community organisations and individuals that work to improve the wellbeing of LGBTI Australians, to deliver the MindOUT! project. This multifaceted project aims to strengthen partnerships between the LGBTI sector and mainstream mental health and suicide prevention agencies, to build the capacity of generic mental health and suicide prevention agencies to address the issues faced by LGBTI people (enabling inclusive practice), and to address gaps in targeted LGBTI community specific services (see www.lgbtihealth.org.au/mindout). If this project is able to begin to reduce discrimination by mental health and suicide prevention services and increase their ability to take discrimination into account as a causal and contributing determinant of health, such an approach may make a significant contribution to improving the mental health and reducing the suicidality of LGBTI Australians.

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