LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER & INTERSEX (LGBTQI) SUICIDE POLICY POSITION STATEMENT JULY 2020

POSITION

1. Australia needs population-level data and accurate recording of deaths by suicide through counting LGBTQI people in the Census, and improving data collection by coroners to inform policy, service and program development.
2. Governments across Australia should fund peer-led organisations to develop tailored mental health and suicide prevention initiatives, services and programs to build community capacity and resilience.
3. There should be greater investment in the education and training of mainstream healthcare and social services to build a workforce able to respond and meet the needs of LGBTQI communities and other priority populations.
4. There should be greater investment in general and specialist community-controlled and mainstream LGBTQI mental health services to address the barriers faced by LGBTQI communities accessing healthcare services.
5. The Australian Government should ensure federal legislation does not permit discrimination against LGBTQI communities.

CONTEXT AND COMMENTARY

LGBTQI people have higher rates of mental ill-health and suicide than the general population in Australia. LGBTQI young people aged 16 to 27 are five times more likely to attempt suicide in their lifetime, for transgender people aged 18 and over they are eleven times more likely, and for people with a variation in sex characteristics (sometimes known as intersex) aged 16 and over they are almost six times as likely[1].

The evidence shows the elevated risk of suicidality experienced by LGBTQI people links strongly with their continuing experience of discrimination and exclusion, and the subsequent trauma from these experiences[2]. LGBTQI still face discrimination in their familial, personal and employment relationships: some families still, for example, lack acceptance of their LGBTQI relatives[2], and discrimination has been shown to negatively affect the mental health and wellbeing of LGBTQI people in the workplace[3]. The levels of discrimination faced by LGBTQI people are particularly multi-layered and complex when identities intersect and minority stress is compounded, for example

[1] National LGBTI Health Alliance. (2019). The Statistics At a Glance: The Mental Health of Lesbian, Gay, Bisexual, Transgender and Intersex People in Australia - National LGBTI Health Alliance. Retrieved 28 November 2019, from https://lgbtihealth.org.au/statistics/#_edn5

[2] Eckstrand, K.L. & Potter, J. (2017). Trauma, resilience, and health promotion in LGBT patients: What every healthcare provider should know, *Springer.*

[3] Australian Human Rights Commission. (2011). *Addressing sexual orientation and sex and/or gender identity discrimination*. Sydney. Retrieved from http://file://spau.local/SPAUNS/Profiles/caitlin.bambridge/Downloads/SGI_2011.pdf

where a LGBTQI person also has a disability, lives with a mental illness, is Aboriginal and/or Torres Strait Islander, or belongs to a culturally and linguistically diverse background.

The need for accurate, reliable, timely data

Accurate, reliable and timely demographic data is essential if we are to effectively target suicide prevention efforts to LGBTQI communities.

LGBTQI people, however, are routinely left out of health planning and policy due to the current lack of systemic data collection mechanisms in Australia. The current Australian Bureau of Statistics (ABS) Census does not ask questions on sexual orientation, gender identity and intersex status, and as a result fails to capture LGBTQI communities in the provision of population-level data. Invisibility in the Census has far reaching implications as government funding and investment is underpinned by Census data, and is used to inform healthcare and social services planning. Inclusion in the Census will further provide data on intersecting identities (e.g. LGBTQI people who are also Aboriginal and/or Torres Strait Islander, living with a disability, or belong to a culturally and linguistically diverse background) as these questions already exist within the Census.

We also need standardised questions on sexual orientation, gender identity and intersex status in suicide death data records. Currently, reporting methods and systems vary between jurisdictions and it is unclear how many LGBTQI people die by suicide each year. Without appropriate accurate and available data collection, service providers and policy makers frequently rely on small scale studies undertaken typically by community-based organisations, non-government organisations (NGOs), international research and anecdotal evidence, which are not able to provide a holistic, representative picture of the health of Australian LGBTQI communities.

For effective targeted suicide prevention efforts, we need population-level data, and coordinated systemic data collection among mental health services and programs of LGBTQI communities. This should involve introducing questions on sexual orientation, gender identity and intersex status in the ABS Census to begin capturing population level data, and instituting consistent Suicide Deaths registers and reporting mechanisms across all jurisdictions.

LGBTQI people face barriers to accessing services

LGBTQI people face unique barriers in accessing critical services during times of mental health crisis.

A recent mixed methods study of LGBTI+ people involving an online survey (n=472) and 10 follow-up interviews by La Trobe University in partnership with Lifeline reports '71% of participants chose not to use a crisis support service during their most recent personal or mental health crises'[4]. The study identified key barriers to accessing crisis and mental health support services as 'anticipation of discrimination, burden narratives, lack of awareness of mainstream crisis support services and LGBTI+ specialist counselling and mental health support services, and physical access, technological, and financial barriers'[4].

Of the 334 participants who reported they did not use a crisis support service during their most recent personal or mental health crises, '32.6% (n=109) cited concerns relating to experiencing discrimination', in particular, 'the expectation or perception' of discrimination[4]. Existing exemptions in legislation which allow for religious organisations to discriminate against LGBTQI people, and

[4] Waling, A., Lim, G., Dhalla, S., Lyons, A., & Bourne, A. (2019). *Understanding LGBTI+ Lives in Crisis*. Bundoora, VIC & Canberra, ACT: Australian Research Centre in Sex, Health & Society, La Trobe University & Lifeline Australia.

legally, exclude people from service, pose a significant barrier to service access. Legislation which permits the discrimination of minority groups, whether enacted or not, will contribute to anticipated discrimination and is not conducive to proactive public health policy.

At a minimum, governments must adequately fund mainstream health and social services to equip themselves with the skills and knowledge to appropriately respond to the needs of LGBTQI communities, and provide public visibility of their inclusive policies and services. These programmes and services must be adequately funded and resourced at all levels of service entry to improve accessibility, encourage help-seeking behaviours, and provide safe environments where LGBTQI people are comfortable disclosing important information to healthcare providers that could impact care coordination plans[4].

We need to see tailored mental health and suicide prevention initiatives, including both clinical and community-based support, to build the capacity and resilience of LGBTQI communities. Peer-led organisations with a focus on improving health outcomes for LGBTQI communities are best placed to deliver tailored mental health and suicide prevention services.

LGBTQI people must be identified as a priority population

National mental health and suicide prevention strategies are inconsistent in the way they identify LGBTQI communities as a priority population. In cases where LGBTI communities are identified as a priority population, there has been a lack of government funding and resourcing to implement initiatives specifically targeted to address the unique suicide risks they experience.

The *Fifth National Mental Health Plan* identifies that LGBTQI people 'have disproportionate experiences of mental health problems and mental illness', with higher rates of major depressive episodes, psychological distress and suicide than the general population[5]. To date, however, Government funding for LGBTQI mental health has been inconsistent and insufficient, with jurisdictions taking differing approaches in the way that funding is directed: even with the specific communities targeted. Australia's *Living Is For Everyone (LIFE) Framework* for suicide prevention, for example, only identifies gay and lesbian communities as communities at highest risk for suicide and suicidal behaviour, leaving out bisexuals, transgender people and intersex people[6].

Mental health and suicide prevention programs and services that receive Commonwealth funding must have specific LGBTQI inclusion in their service agreements and program guidelines that clearly describe service delivery expectations and standards for LGBTQI people. These programs and services, along with peer-led organisations, should be adequately resourced and supported to proactively and strategically increase their accessibility to LGBTQI people.

[5] COAG. (2017). *The Fifth National Mental Health and Suicide Prevention Plan*. South Australia. Retrieved from https://apo.org.au/sites/default/files/resource-files/2017/10/apo-nid114356-1220416.pdf

[6] Australian Government Department of Health and Ageing. (2007). *Living Is For Everyone (LIFE) Framework*. Canberra: Commonwealth of Australia. Retrieved from https://www.lifeinmindaustralia.com.au/splash-page/docs/LIFE-framework-web.pdf