



## Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing.

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**Re: Submission to the *Because mental health matters- a new focus for mental health an wellbeing in Victoria consultation paper May 2008***

On behalf of the Victorian Ministerial Advisory Committee on Gay, Lesbian, Bisexual Transgender and Intersex Health and Wellbeing (GLBTI MAC), I would like to thank you for the opportunity to provide comment on the *Because mental health matters- a new focus for mental health an wellbeing in Victoria consultation paper May 2008*.

The GLBTI MAC was established to provide advice to the three Human Services Ministers covering the portfolios of Health, Mental Health, Community Services, Senior Victorians and Housing and the Department of Human Services on action required to promote and support the health and well-being of gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians and to ensure optimal access to mainstream and, where appropriate, specialist health services.

The Committee's submission does not provide a response to each of the questions in the discussion paper. It describes the effect of discrimination and abuse against GLBTI individuals and communities and the associated adverse impacts on mental health and wellbeing. It also suggests a number of improvements to the mental health services system in Victoria

I would like to take this opportunity to thank Minister Neville and all those involved in the consultation process for promoting discussion about how best to address the mental health and wellbeing of GLBTI Victorians.

The GLBTI MAC looks forward to the outcomes of the consultation process

Yours sincerely

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Chair GLBTI MAC

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## Preface

The Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing (GLBTI MAC) in making its submission to the *Because Mental Health Matters consultation paper* wants to make a clear statement that the most effective prevention strategy to mental health problems in GLBTI communities would be to minimise and eliminate discrimination on the basis of sexual orientation and gender identity. To do this would require a significant whole of government commitment and approach but in the context of implementation of the *Charter of Human Rights* and the government's response to the imminent release of the *Equal Opportunity Review Final Report: An Equality Act for a Fairer Victoria* it seems to the community members of the GLBTI MAC that the time is right.

It is commonly accepted that a person's health is determined by a number of social forces including employment, education, place of residence, socio-economic status, and connectedness to community. Increasingly national and international research suggests that experiences of discrimination, on the basis of sexual orientation and/or gender identity, have a detrimental impact on health, particularly mental health. Many GLBTI individuals dealing with the constant pressure of homophobia experience anxiety, stress and depression.

The compounding effects of discrimination can mean that someone could experience discrimination in relation to their sexual orientation and/or gender identity as well as discrimination regarding their mental health or ill-health status.

## What is the impact of discrimination on Health and Wellbeing?

The *Private Lives* report of the largest study ever of GLBTI people in Australia documented aspects of the health and wellbeing of GLBTI people and explored the impact of homophobia and discrimination.

The report's most significant finding was the widespread prevalence of depression and suicide ideation among participants, which is consistent with other national and international studies (see Attachment One References). This indicates a need for action in the health care system, particularly the mental health system, as well as society in general. The report also provided new evidence that young people most acutely experience some of the health-related inequalities and negative outcomes associated with being GLBTI.

The survey conducted by Warner et al. found high levels of perceived discrimination based on sexuality and a strong relationship between these and depression and suicide ideation. There were high rates of deliberate self-harm and psychiatric morbidity. The findings support the need for strategies to raise awareness of the vulnerability of gay, lesbians and bisexuals to psychological distress and self harm as a result of exposure to homophobia; and in those under 40, a higher risk of harmful drinking which can compromise mental health and wellbeing.

Banks (2001) reported the negative effects of homophobia and their economic impact on gay men, lesbians and bisexuals in Canada, showing higher rates of chronic stress due to coping with discrimination and society's negative attitudes as well as experiences of violence. Suicide and depression were two major health issues examined. Direct and indirect economic costs were substantial and included: funding for ambulance, hospital, medical and specialist services (for suicide costs of autopsies, funerals and police investigations) and the loss of productivity and of future taxes.

Issues of access to and quality of health care services were also examined. The effects of prejudice, discrimination and inadvertent or intentional alienation by social and health/mental health care organisations and workers resulted in:

- inappropriate treatment choices and reduced success
- delayed or refused medical treatment because of fear of discrimination and discomfort in 'coming out'

- patients' discomfort leading to lack of shared information, delays in treatment and reluctance to have routine medical checks.

Couch et al., in the first and largest survey of transgender people in Australia and the world, found similarly high levels of depression. Participants expressed strong fears for their safety based on their own experiences of discrimination, those of friends or an awareness of general attitudes to transgender people. 87 per cent had experienced at least one form of stigma/discrimination whether they lived in metropolitan or rural areas (see Attachment Two).

Pitts et al (2006) emphasis the importance of legitimising GLBTI lives and relationships, stating

*The single most important contribution to improved health and wellbeing in GLBTI people is likely to be increased legitimation and acceptance of their lives, their relationships and of the positive contribution they make to society. Legislative reform to remove discrimination and stigmatisation clearly has a large contribution to make. (p. 63).*

The Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing (GLBTI MAC) submission supports the submission made by Gay and Lesbian Health Victoria (GLHV). This GLBTI MAC submission acknowledges the significant value of the data in the GLHV submission and has used it to underpin its response. As GLHV and the GLBTI MAC co-hosted a community forum there are overlaps between the two submissions.

### **General comments**

For consistency the terms 'sexual orientation' and 'gender identity' are used to cover the range of identities within the GLBTI communities. These are the attributes defined in the *Victorian Equal Opportunity Act* as the basis on which discrimination is prohibited. 'Sexual preference' is not a recommended term.

While using the term 'GLBTI communities' it should be acknowledged that there is significant diversity within and across these communities.

Representatives of GLBTI communities at the community consultation expressed a strong belief that mental health should be more than the absence of mental ill health and seek more use of the terms mental wellbeing and mental wellness.

In addressing some of the focus areas the GLBTI MAC would like attention to be given not just to improvements in service delivery but to the idea of understanding and responding to mental health and wellbeing issues that might arise at all stage of an individual's life.

The most commonly used model of key transition periods is the progression from: childhood and adolescence, formation of intimate relationships, family formation, mid- life to ageing. These stages have a different importance in the lives of GLBTI people compared to heterosexuals and are impacted upon by discrimination against sexual orientation and gender identity (Mc Nair and Harrison in Leonard *What's the difference?*).

An extra transition point for most GLBT people is the process of coming out to family, friends, employers, work colleagues, which may happen at any of the traditional transition periods. Coming out can cause stress through the fear of rejection, discrimination and receiving less equal treatment in, for example, aged care settings. For example, research indicates that many older gay men in aged care facilities or nursing homes are depressed because their needs are not met and partners or significant friends are not acknowledged.

Funding for research is needed to document the effects of these transition points on the mental health and wellbeing of many in the GLBTI communities, to assess what interventions are needed and their effectiveness. Funding for research and systematic data collection and analysis is critical in order to better target the expenditure on mental health prevention, care and treatment.

Another consideration for the issue of what is known about mental health in Victorian GLBTI communities and at various life stages is that of the 'hard to reach groups' for example closeted gays and lesbians (often in older age groups or living in outer metropolitan and rural areas); bisexual living mainly 'straight' lives, members of CALD communities or groups, or in low socio economic groups with disjointed social lives.

Participants at the community consultation (jointly hosted by Gay and Lesbian Health Victoria and the Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing) acknowledged the reality of funding processes and so identified the following as early priorities for funding:

- ongoing statewide funding for the ssatyp peer support/network groups and for the workers who support them
- development and dissemination of resources (e.g. training programs and materials) to DHS policy and program staff and to DHS funded services
- development of a Gender Centre (along the lines of that in NSW see Transgender Care p.8 of submission) for the transgender community.

The substantial part of this submission responds to Part B, however the following issues relating to Part A were raised.

### **A system based on wellness and recovery p. 21**

Such a system needs to be developed and supported in a society that is genuinely inclusive and accepting of a wide range of diversities which would also be one that is clearly against homophobic and transphobic discrimination.

### **A consumer centred approach p.23**

In order to 'recognise the rights of consumers and their families' service system reform needs to acknowledge the diversity of the GLBTI communities, their families and their networks social and others. Development of case studies that reflect the experiences and perspectives of actual users of mental health services is an effective way to create evidence-based good practice. A partnership approach involving individuals, consumer groups/advocates and service planners and providers might generate better reform outcomes.

### **Equity and diversity p.23**

The understandings of diversity must include the diversity of GLBTI people and their communities.

### **Children, youth and families p.28**

Many young people are questioning their sexual orientation or gender identity leaving them vulnerable to anxiety, stress or depression or more seriously self harm and attempted suicide. Other young people who are 'out' are also vulnerable to mental health problems due to discrimination, harassment and bullying. This can lead to early school leaving and, in some cases, being rejected from families and home.

### **Gender Issues p.30**

Sexual orientation and gender identity needs to be included.

<b>Focus Area 1</b>	<b>Prevention</b>
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### **Anti-discrimination**

A significant primary prevention approach would be to strengthen social inclusion efforts across whole of government. As stated in the preface, a renewed focus on developing, promoting and maintaining a genuinely diverse and inclusive society should be the overall objective, to

prevent discrimination. International and national research has shown very strong links between homophobia and discrimination and levels of anxiety, stress and depression.

The development of a stronger focus on young people up to age 25 as means of preventing chronic mental illness such as depression and anxiety later in life is critical. Recurrent funding for statewide programs and networks that support same-sex attracted and transgender young people (ssatyp) and those government and non-government workers who work with them is fundamental.

A new and very significant Department of Education and Early Childhood Department (DEECD) policy (*Supporting Sexual Diversity in Schools* <http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality/forprincipals.htm>) explicitly addresses the needs of ssatyp in schools and provides a great framework for whole of government responsiveness in ending the invisibility of ssatyp in the provision of mental health treatment and care services as well as for broader health and wellbeing.

### **Drug and alcohol use in the context of experiencing discrimination**

Hillier's work (1998, 2005) documents problematic drug and alcohol use amongst ssatyp and provides two possible explanations. One is that it is part of the "gay recreational culture" (2005, p.58), but more pertinent to this submission is the explanation that drug use is a means of escaping the isolation and stress of homophobic discrimination and abuse or, in a small percentage, as means of suicide (2005, p.58.). Staff in DHS program areas and funded Alcohol and Drug services need training to understand the links between experiences of homophobia and drug and alcohol use.

### **Data gaps**

Having current data about the incidence of GLBTI in the population is also critical for planning and delivery of culturally appropriate and respectful assessment, treatment and care. However researchers acknowledge the difficulty of collecting data about sexual orientation or gender identity as there are community fears about privacy and the confidentiality of data collection. Most telephone counselling services, except Kids Helpline, do not seek or record information about sexual orientation when responding to calls about self harming or suicidal behaviours.

Funding needs to be targetted for data collection and analysis, as the current evidence base is limited by a number of factors:

- much health research is driven by national priorities or legislation which often omit GLBTI people's health needs
- undertaking representative research is difficult, as often those who are least confident about their identity don't get 'researched' and also don't access health or support services leaving them more vulnerable to poor health
- population wide surveys e.g. the national census currently doesn't ask about sexual orientation or gender identity.

A wide variety of data collection systems are used throughout DHS and other government departments and agencies, particularly in the health service system. Many are capable of being adapted to include extra information.

The Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing is well placed to develop advice for the Human Services Ministers, particularly the Minister for Mental Health, about how best to include questions or means of data collection to solicit the "missing" information.

<b>Focus Area 2</b>	<b>Early Intervention</b>
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### **Intervening earlier in life**

A very early opportunity for early intervention is with new parents and families of preschool children. Being informed about sexual orientation and gender identity, the incidence in the

community and that family acceptance is critical to the mental health and wellbeing of their children who may be not heterosexual is a very big step towards social acceptance. Committees of management and staff in childcare and preschool settings should have opportunities to engage in awareness-raising and training programs so that their organisations have genuinely inclusive policies and practices. This early intervention could mean less homophobia in primary school settings and less teasing, bullying and harassment all of which have a negative effect on mental health.

As noted earlier, many, but not all, same-sex attracted and transgender young people (ssatyp) experience levels of anxiety, stress and depression as they come out (which is an ongoing process) and a number self-harm and attempt suicide. Appropriate mental health support would at the very least acknowledge that young people may be questioning their sexual orientation or gender identity or have come out or be in transition to their preferred gender and wish to be respected for that. It is the GLBTI MAC's view that earlier recognition of individual needs regarding coming out and/or dealing with discrimination would reduce the high levels of anxiety, stress and depression within GLBTI communities.

Dyson et al.'s review of international and national literature showed the difficulty of establishing conclusive links between sexuality and suicidal behaviours as young people questioning their sexual orientation are hard to identify.

However it did identify a growing body of evidence demonstrating that same sex attracted young people are significantly *at risk* of self-harming and suicidal behaviours. The work found that youth workers in mainstream agencies are concerned about this group of at risk young people but feel unprepared to address their issues – this shows a clear need for training.

There is an increasing focus on vulnerable young people and their disengagement from school. For ssatyp, this can be affected by homophobic and transphobic bullying, and also because they feel invisible in school settings even if they not being bullied or harassed - their invisibility or non-acknowledgment means that many school programs seem irrelevant for them - they don't see themselves as connected to the school and are often isolated.

Increased and sustainable funding for existing and future peer support groups for ssatyp is vital; evaluation consistently shows that the Rainbow Network is meeting the needs of ssatyp particularly in rural areas. Hardly any of the workers in the Rainbow Network have designated or recognised responsibility to work with ssatyp but do so in response to identified needs.

*WayOut, Rural Victorian Youth & Sexual Diversity Project* is a partnership between Cobaw Community Health Service and Gay & Lesbian Health Victoria (GLHV) that works with communities in rural Victoria to raise awareness about homophobia and to provide an environment that is welcoming to same sex attracted young people. After a successful pilot it now receives on-going funding, however its success has increased the demand for its services across the state so more ongoing funding for another project officer is needed.

More effective collaboration with available mental health services for vulnerable young people is needed. Those in leadership position and all staff at services such as the Centre for Adolescent Health, Murdoch Childrens Research Institute, the CAMHS system, and Orygen Youth Mental Health should participate in accredited professional development. Targetted reviews of policies and practices are also needed.

Participants at the community consultation identified the need for funding to either establish or provide more secure and sustainable funding for peer support groups for older gay, lesbians, bisexuals and transgender people. There are some support groups but they either dependent on volunteers or are erratically funded and so are not a consistent source of social support.

**Focus Area 3      Access**

**Accessible and respectful services**

*"Hesitation and confusion was noted in a doctor's actions recently as she found it difficult to concentrate on what she had to do when once she found out I was a lesbian". Fair for all – the wider challenge good LGBT practice in the NHS p. 50*

Mainstream services will start to improve and be more accessible to clients in GLBTI communities when they are genuinely inclusive of and sensitive to their range of mental health needs. Respondents at the community consultation said they often felt invisible. Some suggested that the visibility of GLBTI communities could be increased by data collection for example service registration/intake forms providing multiple options for sex or gender:

Male  Female  Transgender  Intersex  Other

However other participants at the community consultation were concerned about the confidentiality of data storage and how such data might be misused.

A key issue in relation to access is ensuring that mental health settings are welcoming of GLBTI people.

McNair and Thomacos found that over 20 per cent of respondents had experienced discrimination in mental health care settings in relation to same sex relationships; and those with children were more likely to have experienced discrimination.

Couch et al. (2006) included descriptions by transgender people regarding the best and worst experiences of consulting a mental health professional and using a mental health service about transgender health issues. In the best experiences respondents felt accepted or supported so that their chosen names and appropriate pronouns were used and efforts were made to alter existing records to fit with gender identities. Respondents felt respected and "like everyday, 'normal' people" (p.32).

*"My psychiatrist treated me like a rational adult and didn't make me go through various silly hoops" (TranZnation p. 33).*

The worst experiences meant respondents had confronted hostility ranging from discomfort and resentment to occasions of ridicule, refusal of treatment and outright displays of disgust.

*'Fear of the health system. After bad experiences I'm scared to use it because I know it's not really there for me' (TranZnation p. 33).*

GLBTI communities want general health, particularly, mental health services to:

- Acknowledge and accept sexual orientation and gender diversity as one aspect of clients' lives
- Recognise the wide range of their needs in the provision of appropriate and respectful mental health and welfare care.
- Be really inclusive and more responsive to wider range of diverse needs e.g. to acknowledge their partners and significant others, to use appropriate and respectful language in conversation and on records.
- Collaborate in development of accreditation standards for GLBTI inclusive practice.
- Be accredited against standards for GLBTI inclusive practice.
- provide training in diversity competency for all staff.
- Provide access to information about general health issues including about sexual health, and drug and alcohol use.
- Provide access to/information about a range of complementary services and venues.
- Be accessible to different age groups across the state: outer metropolitan Melbourne, provincial cities, regional and rural areas with recognition of the importance of ensuring privacy in small communities.

## Sensitive care and accreditation

Feedback from the community forum (co-hosted by GLHV and the GLBTI MAC) suggested that it was along term goal to have mainstream services meeting best practice GLBTI sensitive and inclusive practice standards was a long term goal. So in the short term GLBTI specific services will need to be developed and supported.

Gay and Lesbian Health Victoria has developed a *sexual diversity health services audit* which can be used in mental health care and treatment settings (see Attachment Three). In the UK, the Commission for Social Care Inspection supports service providers with resources and professional development to ensure that their services meet the needs of a diverse range of people (see Attachment Four Checklist for Action).

The GLHV Clearinghouse could be funded to manage an Info Line as at present many hits on its website are for information about GLBTI sensitive providers. In the absence of accredited systems or processes GLHV is not in a position to respond to such requests.

GLBTI inclusive and sensitive accredited services could be included in the DHS Human Services Directory to support GPs and other health care practitioners; DHS BetterHealth channel could also include such services for general consumers.

There is clearly articulated need in GLBTI communities for a range of specific mental health services and support groups; the following email sequence is a current example of a significant service and support gap for lesbians.

**Subject:** FW: Help

Hi GP (at a clinic known for GLBT inclusive practice)

I read your article on Lesbian health inequalities. I am looking for a support group for lesbians with mental health issues for myself to attend. Are you aware of any in Melbourne? X

**Subject:** Reply

Dear

X

I am not aware of any specific support group at the moment. The best place to ask would be at Victorian Aids Council - they have lesbian-sensitive counsellors there and would know of any groups that I don't know of: phone- 9865 6700. Good luck and Regards GP

**Subject:** Reply again

Hi GP

I contacted Vic Aids, but no go. They referred me to Drummond St – har har. Around on the merry go round we go. I can't believe how much trouble I have had trying to find a queer friendly support group for mental illness issues, especially when it is so rife in our community; depression, anxiety etc ... .There seems to be a real deficit of support for mental health in the queer community. It's sad really.

I'm not sure if you are interested yourself, or have colleagues who might be interested, but setting up a support group, even with a fee, for GLTB people with mental health issues would be a huge step in the right direction.

Please feel free to pass this on to any colleagues you think might be interested. Alternatively, if you have any information on how one might start a support group of this sort, please let me know. I think I might have to do it myself at this rate-). Thanks again X

## Community support

A mixture of recurrent and limited term funding needs to be identified to develop and promote a statewide network of support groups for age groups other than young people. Currently ssatyp have access to a wide range of support groups through the Rainbow Network which

needs to be funded on a recurrent basis and WayOut which needs at least one other full-time project worker funded on a statewide basis to meet the increasing demands on its services.

## Transgender care

Many in the transgender community want gender identity to be removed from the Diagnostic and Statistical Manual of Mental Disorders as they do not consider themselves to be suffering a mental health problem. They are more likely to experience mental health problems as a result of lack of acceptance of their gender identity or discrimination because of it.

There is support in the transgender community for a specialist and specific Gender Centre to be established in Victoria based on the NSW model. As a holistic care and welfare centre it offers:

- counselling services for clients and partners, families and friends of people with gender issues; and education, support and referrals to a range of specialist counselling
- training, support and workshops for employers, service providers, students and other people interested in gender issues
- social & support services, referrals for medical HIV/AIDS education, training, employment, legal, welfare, housing and other community services to residents and clients living in the community.
- an outreach worker
- support, education and referrals to a wide range of health, legal, welfare and other community services for partners, families and friends of people with gender issues; and social and support groups for them
- resource development service: information packages, fact sheets
- residential service: semi-supported share accommodation for up to 11 residents of age 16 and above. Residents can stay up to twelve months and are supported to move towards independent living.
- case management service
- a drug & alcohol service.
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### Focus Area 4 Specialist care

#### Goal 4.3 improving consumer and care experiences, making sure those expectations with regard to access rights equity and respect are met.

This goal will be met when specialist care services accept and acknowledge the sexual orientation and/or gender identity of consumers and accept their partners or significant others in decision making re treatment and care.

### Focus Area 5 Complex clients

There is insufficient data about the sexual orientation or gender identity of clients receiving treatment and care for acute mental illness. At the GLHV and GLBTI MAC community consultation one participant recounted the experience of treatment and care as one that did not acknowledge the sexuality of *any* patient.

With regard to the Discussion Paper's Goal 5.2 (Improving access to stable and affordable housing), it should be noted that ssatyp are at risk of being rejected from the family home when they reveal their identity and become homeless. Being homeless also makes it more difficult to remain engaged in schooling or training.

### Focus Area 6 Workforce

#### Workforce training

A knowledgeable, skilled and sustainable mental health workforce would be one which has participated in accredited professional development and workplace training that is inclusive of sexual orientation and gender identity; is developed and implemented in the framework of the charter of human rights and responsibilities and is grounded in understanding that ongoing

discrimination (e.g. racist, sexist, homophobic, transphobic,) has an impact on mental health and wellbeing.

Any training and professional development programs developed to improve service culture need to incorporate an understanding that sexual orientation and gender identity is a *risk factor* for anxiety, stress, depression and self-harming rather than a *causal* factor.

Training and professional development programs should be flexible enough to target different sectors of the workforce, and organisations and funded agencies and services.

This should include boards of funded services, leadership, management, and administration of policy and program areas and funded services; staff in broader health and community networks that offer the support services accessed by users with a range of mental ill health problems; specialist mental health services; staff in emergency services and at emergency access and treatment points: ambulance officers, triage staff, paramedics and psychiatrists, and Child Adolescent Mental Health Services (CAMHS) staff.

Training for mental health service providers re specific issues for gay men, lesbians, bisexuals and transgender people and to understand role of mental health care should be ongoing for new staff and for all staff as new mental health issues emerge in these communities.

## **Focus Area 7      Partnerships**

Anecdotal information suggests that fragmentation across services impedes timely access of mental health services.

### **Goal 7.4**

An excellent Centre for Mental Health Intervention would collaborate with:

- Gay and Lesbian Health Victoria and the Australian Research Centre in Sex Health and Society
- Centre for Adolescent Health
- Murdoch Children's Research Institute
- Orygen for Youth Mental Health
- Curriculum Corporation – MindMatters program (program supporting Australian secondary schools to promote and protect emotional wellbeing)

to develop policy and support program delivery that is inclusive of sexual orientation and gender identity.

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## Health and Wellbeing, including mental health, for GLBTI people - research summaries

NB Researchers note the emerging finding of survey respondents describing or identifying themselves as 'mainly heterosexual' people. These people may be same-sex attracted at times, but don't identify as gay lesbian or bisexual, and are an at risk group for mental health problems as they may not connect with support groups or seek appropriate mental health care.

### **Couch M et al. *TranzNation a report on the health and wellbeing of transgender people in Australia and New Zealand 2007***

This is arguably the first and largest survey of transgender people in the world and, significantly, one not from a clinical perspective. 253 respondents completed the on-line survey: 220 from Australia (90.5%) and 24 from New Zealand (9.5%); 30 % from Victoria. Respondents were aged between 18 and 73, median age of 41.1years.

#### **Stigma and Discrimination and Depression**

Participants expressed strong fears for their safety based on experiences of discrimination either their own; those of friends or an awareness of general attitudes to transgender people. 29% had been refused services in a range of health services. Gender identity discrimination was compounded by other forms of discrimination. That 60%+ of the respondents had experienced 10-12 kinds of discrimination and were depressed shows a clear relationship between discrimination, stigma and depression.

### **Fergusson, D., L. et al. 1999 *Is sexual orientation related to mental health problems and suicidality in young people***

A twenty-one year longitudinal study of 1265 children from birth; of the 1007 21 year olds who were asked their sexual orientation:

- 2.8% identified as gay, lesbian or bisexual.

The survey found that GLB young people were

- 6.2 times more likely to have attempted suicide than heterosexual young people
- 5.4 times more likely to have thought of suicide than heterosexual young people
- 4 times more likely to have had depression than heterosexual young people
- 2.8 times more likely to have experienced anxiety than heterosexual young people

### **Gilman and Kessler, 2001 *Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey***

In a representative household survey to assess their mental health status 5877 people aged 15-54 were asked about their sexual activity:

- 2.1% of men reported 1 or more same sex sexual partners in previous 5 years
- 1.5% of women reported 1 or more same sex sexual partners in previous 5 years.
- 

It was reported that those with same-sex partners had higher rates of anxiety; mood disorders, suicidal thoughts and substance use disorders.

### **Hunt R and Fish J 2008 *Prescription for Change - Lesbian and bisexual women's health check*, Stonewall, London. <http://www.stonewall.org.uk/campaigns/2296.asp> accessed on 16 July 2008**

With 6000 women in this study it is the biggest survey of lesbian health outside of USA. The following statistics report on the mental health lesbian and bisexual women who participated in this study:

- 5% had attempted suicide
- 16% under 20 had attempted suicide

- 20% had deliberately self-harmed (75% cut themselves) compared to 0.4% of general population
- 50% had under 20 deliberately self-harmed (compared to 6.6% of teenagers generally)
- 20% had eating disorders/problems compared to 5% in general population
- 10% have or have had bulimia compared to 2% of general population
- 7% of have or have had anorexia compared to 1% of general population

Some respondents felt that some staff saw their mental health problems as a result of their sexual orientation.

Respondents felt mental health services failed:

- to acknowledge their identity and their partners if they had one
- to recognise their needs
- to provide inclusive services.

**Jorm et al. 2002 *Sexual orientation and mental health: results from a community survey of young and middle-aged adults***

Findings of the first year of 20-year longitudinal study conducted by questionnaire and interviews of 4824 men and women in 20-24 and 40-44 age cohorts. Responses to 'are you predominantly heterosexual, homosexual, bisexual or don't know?'

- **20-24:** 1.0% gay; 1.8% lesbian 1.8% bisexual men, 2.7% bisexual women
- **40-44:** 1.6% gay; 2.0% lesbian, 0.8% bisexual men, 0.8% bisexual women

The survey found that

- levels of depression, anxiety and suicidality were higher in gay, lesbian and bisexual people than heterosexuals.
- bisexuals had the highest levels of depression and anxiety and less support from families and friends and more financial problems

**McNair et al. 2004, 'The mental health status of young adult and mid-life non-heterosexual Australian women'**

This population based self-completion survey found that of the

**Young cohort (9283)**

91.4% were exclusively heterosexual  
6.8% were mainly heterosexual  
0.9% were mainly/exclusively lesbian  
0.8% were bisexual

**Mid-aged cohort (10299)**

97.4% were exclusively heterosexual  
1.2% were mainly heterosexual  
1.2% were mainly/exclusively lesbian  
0.2% were bisexual

- In young mainly heterosexual; mainly/exclusively lesbian, and bisexual women cohort levels of depression, anxiety and suicide attempts were twice as high as for exclusively heterosexual young women.
- Mid-age mainly heterosexual women had levels of depression that were 1.8 more than for exclusively heterosexual mid-age women and levels of anxiety that were twice as high.
- Bisexual women were 3.5 times more likely to self harm than exclusively heterosexual women.
- All non heterosexual women in both age cohorts reported higher levels of stress and lifetime abuse with outcomes of poorer mental health.

## **Mc Nair & Thomacos *Not Yet Equal - report on the VGLRL same sex relationships survey, 2005***

652 participants

- 62 % female; 37% male
- 90% identified as gay or lesbian
- 5% as bisexual
- Average age mid-thirties, very few under 18 (0.9%) or over 60 (2.2%)
- 85.3% Anglo Celtic
- Sample highly educated - 33.3 % women and 25% men with post graduate tertiary qualifications
- 639 lived in Victoria with majority living in Melbourne

The survey of experiences of same-sex couples reported unacceptably high and even increasing levels, of indirect public insult, verbal and physical harassment and discrimination within health systems with 20% of respondents experiencing discrimination in accessing healthcare systems.

## **Hillier L et al. *Writing Themselves in Again: 6 years on, the second national report on the sexuality, health and well-being of same sex attracted young people in Australia 2005***

Of the 1749 young people (14-21 yo) who responded to online survey - 1106 young men and 643 young women and 9 transgender young people - 80% were from major cities, 15% from inner regional Australia and 5% from remote areas

Homophobic abuse had a profound effect on young people's health and wellbeing. Young people who had been abused fared worse on almost every health and wellbeing indicator in comparison to those who had not. They

- felt less safe at school, at home; on social occasions and at sporting events
- more likely to self-harm, report an STI, and use range of legal and illegal drugs
- 35% reported two main methods of self harm: self mutilation and attempted suicide
- more likely to have talked to someone or accessed a support organisation.

## **Pitts, M et al. *Private Lives A Report on the Health and Wellbeing of GLBTI Australians, 2005***

The on-line survey was responded to by:

- 5476 participants aged between 16-92 (mean age 34); 26.4% Victorians
- 63% male; 35 %female
- 52% identified as "gay man"; 18% as "lesbian" 10% as "bisexual"
- 100 transgender and 18 intersex participants

### **Common health conditions**

Depression was the most commonly reported health condition with averages ranging from 30% of men and 38% of women to 57% of intersex females and 63% of intersex males.

### **Mental health**

Nearly 75% of sample reported some depression in past. High prevalence of depressive disorders 49% of men and 44% of women scoring at least one of two criteria for major depressive disorders. 16% of gay men indicated suicidal ideation in the two weeks prior to the survey - compared to 10% of heterosexual men.

### **Experiences of health services**

Overwhelming experiences of the majority of health services, including specific mental health services contacts, were either positive or neutral. 87.6% avoided disclosure of gender identity and/or sexual orientation in some instances with health care providers

### **Sandfort et al. 2001 Same-sex sexual behaviour and psychiatric disorders.**

This national mental health survey personally interviewed 5988 people aged between 18-64 of whom in the previous year: 2.8% of men had same-sex partners and 1.4% of women had same-sex partners

The survey found that:

- psychiatric disorders were more prevalent amongst homosexually active people
- gay men were:
  - 2.9 times more likely to experience depression than heterosexual men
  - 2.6 times more likely to experience anxiety than heterosexual men
- lesbians were:
  - 2.4 times more likely to experience depression than heterosexual women and had
  - 4 times higher levels of substance use than heterosexual women.

Sexual Diversity Health Services Audit - see PDF

Attachment Four

## Checklist

### ***Checklist for Action – providing appropriate services for lesbian, gay bisexual and transgender people (Commission for Social Care Inspection UK March 2008)***

- 1 Develop an overall strategy for working on GLBT equality issues which is adopted at a management level and enable managers to familiarise themselves with the issues.
- 2 Decide how to involve GLBT people using services and staff in all the developments.
- 3 Review key organisational documents, particularly equality policies, statements of purpose, and service user guides to ensure that they include GLBT people.
- 4 Review key policies, procedures and forms to take account of issues for GLBT people, particularly assessment/admission forms, complaints and harassment procedures, sexuality/relationship policies, confidentiality policy, next of kin, staff recruitment questions.
- 5 Make sure that employment practices, including staff terms and conditions, support and encourage the employment and retention of GLBT staff.
- 6 Review staff training on equality issues to ensure inclusion and coverage of specific GLBT issues.
- 7 Communicate changes to staff and people using the service on a regular basis.
- 8 Review assessment processes to ensure that they are appropriate for GLBT people.
- 9 Assess the environment (and any leisure activities if applicable) to check that they are inclusive and welcoming for GLBT people.
- 10 Assess how well the service enables people to maintain links with their friends and communities.
- 11 Obtain information on local GLBT organisations providing support, social activities and advocacy.
- 12 Consider ways in which the service could be more flexible to allow people more choice over staff, times of service and tasks undertaken.
- 13 Introduce monitoring of sexual orientation and gender identity in quality assurance processes and ensure that actions are taken as a result.
- 14 Consider how to involve a diverse range of people using services in staff recruitment.
- 15 Consider whether to develop a specific list of 'GLBTI-friendly' staff and to advertise this.
- 16 Review progress through quality assurance and feedback from GLBT people regularly