





# **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	2
LGBTI people have significantly poorer mental health and higher rates of suicide than other Australians	3
Discrimination and exclusion are the key causal factors of LGBTI mental ill-health and suicidality	4
There is a robust evidence base but still significant knowledge gaps	5
LGBTI people have specific issues	6
Existing initiatives are not effective for this high-risk group	8
It is necessary to prioritize inclusion, targeted initiatives, prevention and partnership	9
Role of the National LGBTI Health Alliance	11
References	12

# 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.<sup>i</sup>
- 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.<sup>ii</sup>

*"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, eg 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.<sup>iii</sup>
- Most intersex people and many trans people simply identify as male or female most or all of the time.

- 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).

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

- '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.<sup>iv</sup>
- At least 36.2% of trans people and 24.4% of gay, lesbian and bisexual people currently meet the criteria for experiencing a major depressive episode, compared with 6.8% of the general population.<sup>v</sup> This rate soars to 59.3% of trans women (male to female) under 30 in a LaTrobe University study.<sup>vi</sup>
- 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%).<sup>vii</sup>
- 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.<sup>viii</sup>
- Where differentiated data is available, it indicates that rates of depression and anxiety are highest among trans and bisexual Australians.
- Intersex adults show psychological distress at levels comparable with traumatized non-intersex women, eg those with a history of severe physical or sexual abuse<sup>ix</sup>

## Suicide and Self-Harm:

- LGBTI people have the highest rates of suicidality of any population in Australia
- 20% of trans Australians<sup>x</sup> and 15.7% of lesbian, gay and bisexual Australians<sup>xi</sup> report current suicidal ideation (thoughts)
- Up to 50% of trans people have attempted suicide at least once in their lives.<sup>xii</sup>
- Same-sex attracted Australians have up to 14x higher rates of suicide attempts than their heterosexual peers.<sup>xiii</sup> Rates are 6x higher for same-sex attracted young people (20-42% cf. 7-13%)<sup>xiv</sup>
- The average age of a first suicide attempt is 16 years – often before ‘coming out’<sup>xv</sup>

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*“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)

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- 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<sup>xvi</sup>
- 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<sup>xvii</sup>
- 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<sup>xviii</sup>
- 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<sup>xix</sup>

# 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.<sup>xx</sup> This is sometimes referred to as minority stress.<sup>xxi</sup>

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

- 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 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. 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.<sup>xxii</sup>
- 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 remains very high for many LGBTI Australians and LGBTI people remain a marginalised group.<sup>xxiii</sup>

*“Shock, anger, concern plus ‘Maybe we should send you to a psychiatrist’ from my father. ‘I would rather you were dead than be one of those’ from my mother”*

(lesbian, on coming out to her parents, in Stewart 1993)

- Up to 80% of same-sex attracted and gender questioning young people experience public insult, 20% explicit threats and 18% physical abuse and 26% ‘other’ forms of homophobia (80% of abuse occurs at school).<sup>xxiv</sup>
- 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.<sup>xxv</sup> 49% of trans respondents to a NSW study reported having been sexually assaulted.<sup>xxvi</sup>

- Little data is available on the experiences of intersex Australians, however recent 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.<sup>xxvii</sup>
- LGBTI people can also internalize homophobia and transphobia as they are socialized in the same environment as their peers with negative messages in relation to sexuality, sex and gender diversity. 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 and associated simplistic understandings of biological sex and gender always being identical and stable and as exclusively binary (either male or female). It does not necessarily 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.

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

- 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.<sup>xxviii</sup> 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.<sup>xxix</sup>
- 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
  - o More harmful and frequent levels of alcohol and other drug misuse.<sup>xxx</sup>
  - o Homelessness and poverty, in particular among trans people.<sup>xxxi</sup>
  - o Disengagement from schooling.<sup>xxxii</sup>
  - o Chronic health conditions.<sup>xxxiii</sup>
- There is some evidence that older LGBTI people exhibit crisis competence – reflecting resilience and hardiness.<sup>xxxiv</sup>

# 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, 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<sup>xxxxv</sup>
- Sexual orientation, gender identity and intersex status, unlike other demographical 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)
- 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. This leads to inaccuracy in reporting and significant underestimates.
- Estimating mental health outcomes, and in particular suicide mortality or suicidal behaviours, for LGBTI populations therefore remains highly problematic
- 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 utilised.

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)

# 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.

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*“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)

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- ‘Coming Out’ refers to identifying oneself 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.<sup>xxxvi</sup> Suicide attempts by trans people are usually made before the person has engaged in any gender-related treatment, counselling or therapy.<sup>xxxvii</sup> 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 that 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. This too can be a source of stress given considerations of potential impact. Many LGBTI people are only ‘out’ in some contexts and may, for example, not always acknowledge having a partner or describe them as a ‘friend’. One in five trans Australians have been threatened with being involuntarily ‘outed’.<sup>xxxviii</sup> 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.

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

- 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. Numerous groups and organisations have grown out of LGBTI communities, 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.
- 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%).<sup>xxxix</sup> Figures are likely to be even higher for trans people. Many LGBTI people are more likely to seek or receive primary support from friendship/peer support networks, sometimes referred to as ‘families of choice’<sup>xl</sup>
- 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.<sup>xli</sup> 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<sup>xlii</sup>
- 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.<sup>xliii</sup> There are a range of barriers to access such services, including approval from psychiatrists and high financial costs.
- 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. 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. 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.<sup>xliv</sup>

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*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)

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- 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.<sup>xlv</sup> Some intersex people feel that intrusive examinations combined with stigma and secrecy within the family also made them vulnerable to sexual abuse as children.
- 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

- Exclusion from generic mental health and suicide prevention policies and programs, including lack of acknowledgement in current National Suicide Prevention Strategy, National Mental Health Plan or LIFE Frameworks, and lack of visibility within public awareness programs result in LGBTI people not being reached and their needs not being addressed
- Barriers to health service access include LGBTI people's fear of discrimination or rejection. Unless services are explicitly inclusive, 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. Fear of discrimination and stigma can result in
  - o LGBTI people not accessing preventative or responsive mental health services at all, or
  - o delaying their access to services, exacerbating the health issue<sup>xvi</sup>
- Lack of LGBTI knowledge and cultural competence in generic services<sup>xviii</sup> resulting in poor quality service provision, for example ill- or uninformed advice and inappropriate treatment<sup>xix</sup> (eg pathologising their sexual orientation or gender identity) and failure to take the person's (potential) strengths/social resources into account
- There is a tendency to focus on psychological intervention, rather than on social intervention to minimize risk factors such as homophobia, transphobia and heterosexism. 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'

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

- 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 communicating 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<sup>xvii</sup>
- Lack of acknowledgement of social determinants of health, eg social isolation and discrimination, can result in key causal or contributing factors for LGBTI people not being addressed
- Lack of capacity in targeted services, eg no dedicated funding for LGBTI community-based services, resulting in few dedicated services being available and those that are available having limited outreach and often limited ability to build the skills and provide the services LGBTI people seek
- 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.

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*“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)

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

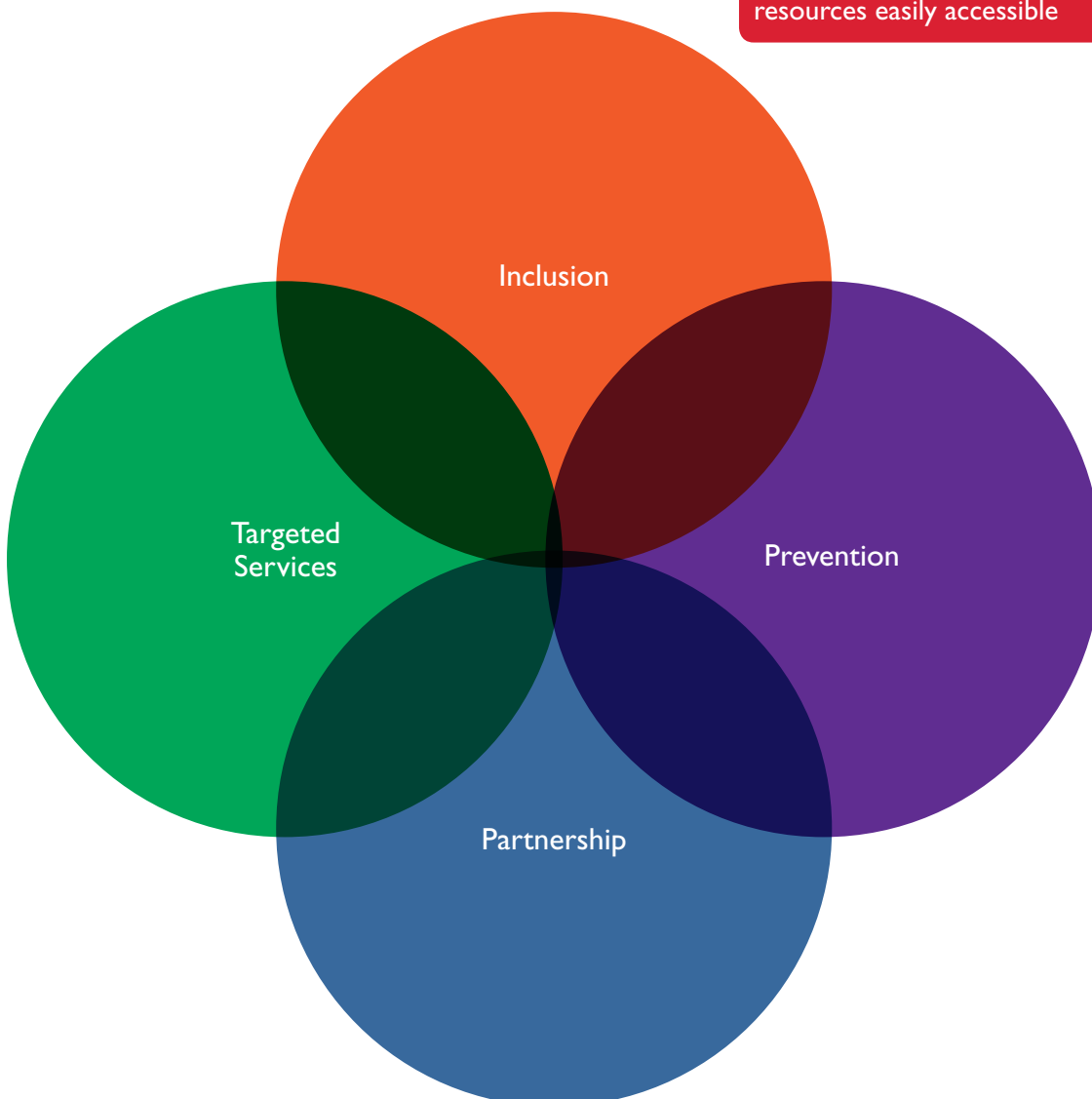
The mental health needs of LGBTI people are complex and diverse. Addressing them requires specific effort and a range of interrelated mechanisms.

## 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

- LGBTI specific 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
- Inclusion requires above all visibility of LGBTI people and their issues in
  - o programs, services and resources
  - o policy frameworks and guidelines
  - o research, monitoring and reporting

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



- Inclusive practice is a multidimensional approach that encompasses human resources (eg recruitment, diversity competence, workforce development), paradigms (eg client-centred care, strengths-based approaches, supervision that addresses heteronormative assumptions), scope (eg types of services, target groups), organisational structures (eg physical setting, policies, procedures, governance and decision making), marketing strategies (eg niche marketing), stakeholder relationships, resources (eg funding criteria, resource allocations), etc.
- 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, eg Aboriginal and Torres Strait Islanders, older people, people with disabilities, rural and remote communities, refugees, multicultural communities, parents, children and young people, etc.

## Targeted initiatives

- Targeted LGBTI-specific initiatives are required to complement inclusive generic initiatives. These can be LGBTI-specific services and custom-made/tailored services within inclusive generic programs
- 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)
- Barriers to inclusion in generic consultations require targeted consultations and specific strategies to engage with this disparate and hard-to-reach population

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*“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)

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## Prevention

- 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
- Move from crisis intervention and predominantly medical models of mental health to 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

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

## 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<sup>ii</sup>
- 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
- 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

**Refer people to LGBTI organisations as appropriate, work with them to increase inclusion within your organisation, support them to build their own capacity around suicide prevention, collaborate on targeted suicide prevention 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 105 members across Australia, including 62 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.

In so far as its capacity allows, the Alliance:

- initiates, facilitates and delivers national projects. For example the MindOut LGBTI Mental Health and Suicide Prevention Project launched in 2011 strives to strengthen linkages between the LGBTI sector and mainstream mental health and suicide prevention agencies
- provides advice to government and other key stakeholders, for example in formal submissions, by participating in advisory bodies and providing ad hoc advice
- facilitates partnerships or referrals to its members
- facilitates consultation with the LGBTI community
- builds capacity within the LGBTI community sector by facilitating collaboration and the sharing of ideas and resources among its members
- proactively builds and disseminates knowledge, for example in the Health in Difference National LGBTI Health Conference

See [www.lgbtihealth.org.au](http://www.lgbtihealth.org.au)

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