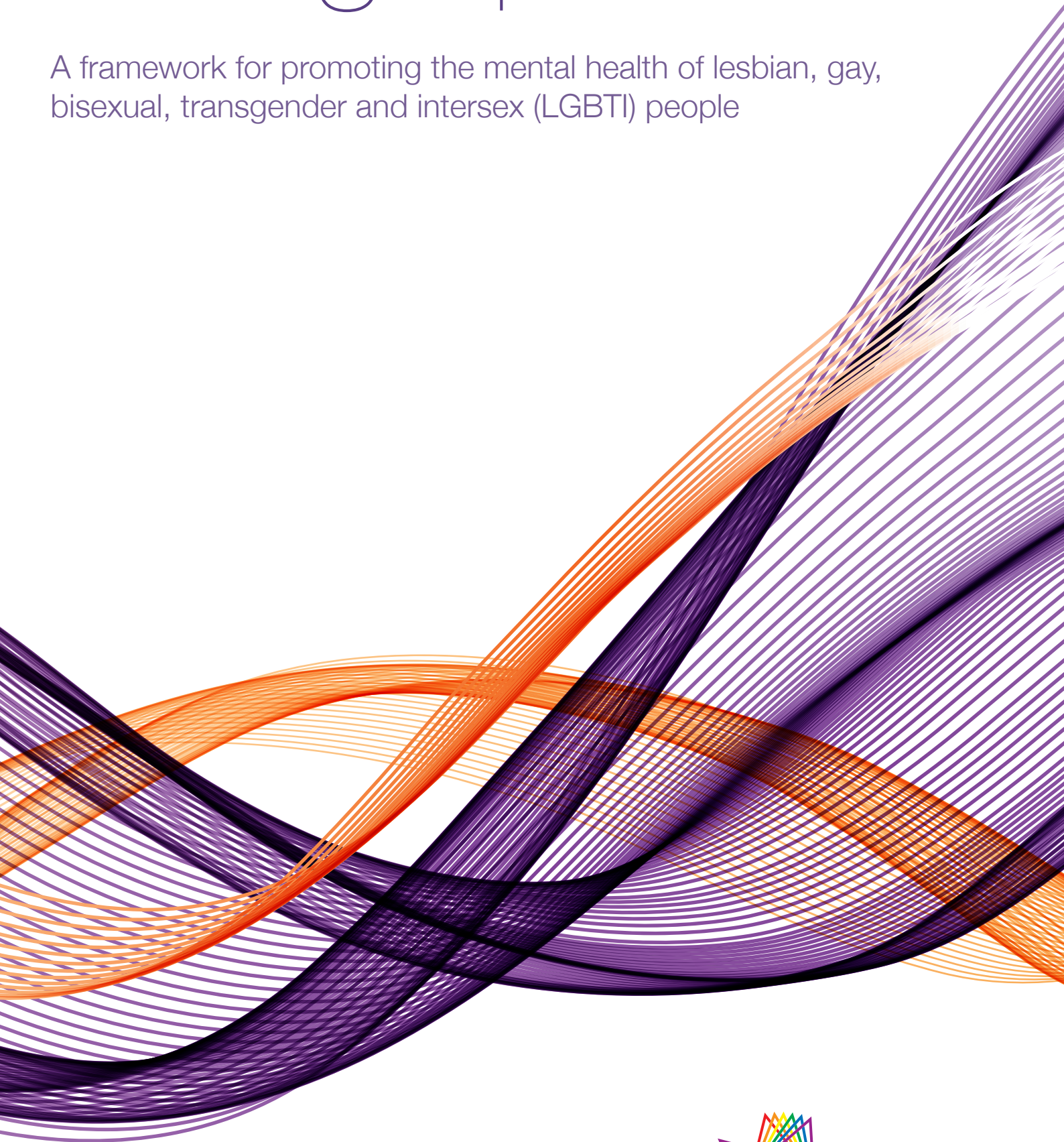


Going upstream

A framework for promoting the mental health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people



Going upstream: a framework for promoting the mental health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people

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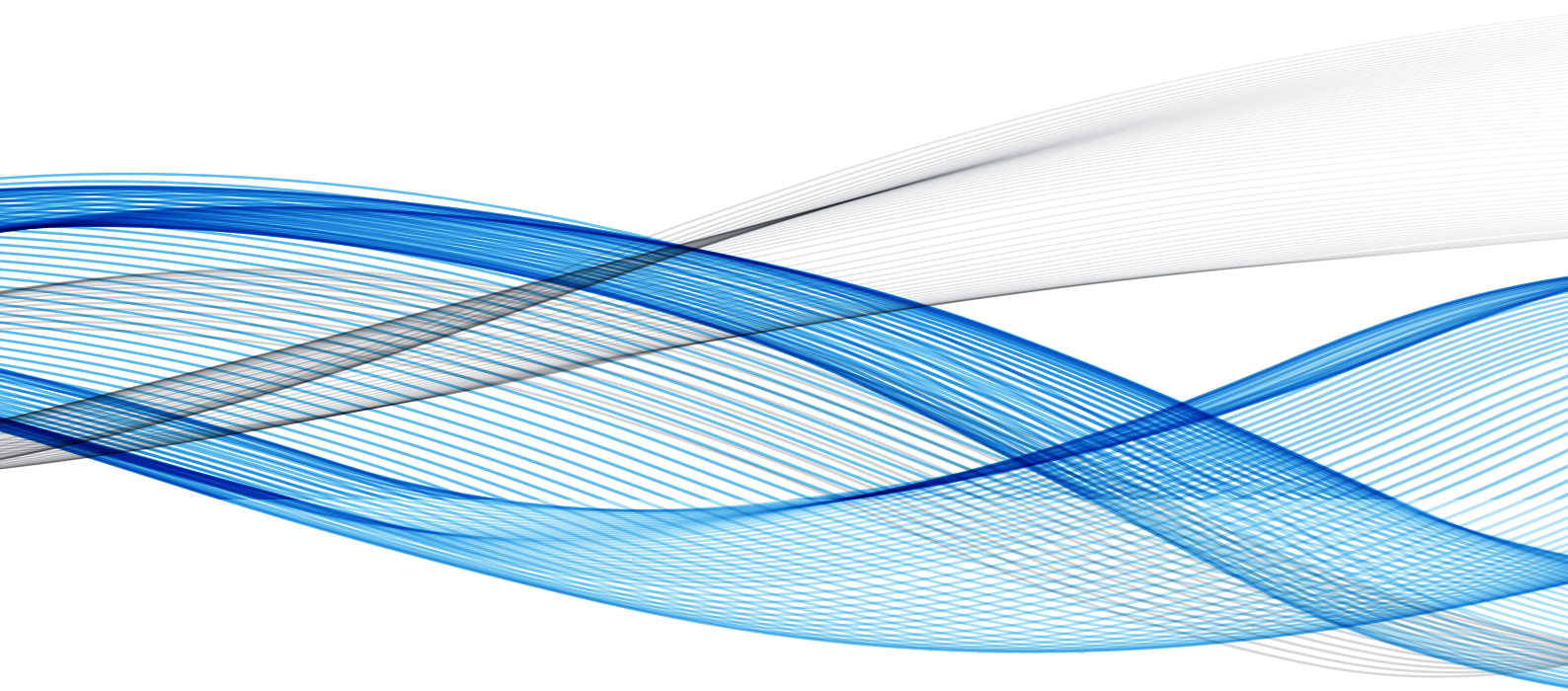
The Alliance acknowledges the right of each individual to describe their identity in their own words. The inclusion of images of people in this document does not imply the gender, behaviour, or sexuality of those depicted.



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1 Introduction

1.1 Background

Mental health is identified as one of nine national public health priority areas in Australia (Australian Institute of Health and Welfare (AIHW), 2013), and mental health problems are one of the most significant health challenges facing lesbian, gay, bisexual, transgender and intersex (LGBTI) Australians. The prevalence of mental health problems in LGBTI Australians is disproportionately high and carries significant human, social and economic consequences. While there have been recent improvements in both access to and efficacy of treatments for mental health problems, including initiatives designed to make mental health services more inclusive for LGBTI people, there is renewed emphasis on the importance of promoting mental health and wellbeing and preventing the development of mental health problems before they occur.

This document provides a framework that aims to specifically guide the development and implementation of strategies for the promotion of mental health and wellbeing and prevention of mental health problems in LGBTI Australians. The document draws on a growing body of Australian and international research on the mental health and wellbeing of LGBTI people and identifies key factors known to have particular influence on mental health for these communities. A core theme is the effects of deeply held prejudice and discrimination on

the mental health and wellbeing of LGBTI people and the need for health policy to incorporate this understanding in the development and delivery of LGBTI-inclusive mental health promotion programs.

An LGBTI mental health promotion strategy must address these social determinants of reduced mental health among LGBTI people, including deeply embedded heterosexist beliefs and practices. It must also build on the capacity of LGBTI people and organisations to develop social relationships and networks within the LGBTI community and between the LGBTI community and the mainstream. Such individual and collective relationships are a source of resilience and social capital that act as protective factors against the increased risk of mental ill-health and suicidal behaviours for LGBTI people.

As many of the factors influencing mental health lie outside of the health system, this framework necessarily encourages partnerships with individuals and organisations in other sectors and settings. It outlines a range of initiatives, and while the framework recognises supporting individuals to develop skills for good mental health, it emphasises that actions must also focus on creating environments that are conducive to mental health and wellbeing through advocacy, legislative reform, capacity building and community strengthening.

However, current research suggests that a narrow focus on tackling heterosexist¹ discrimination and its effects may no longer be sufficient for continued improvements in LGBTI Australians' mental health and wellbeing. In Australia, despite over 20 years of legislative and more recently social reform, LGBTI people continue to experience mental health problems at significantly higher rates than the general population (Leonard, et al., 2012). While studies show improvements in the general health of LGBTI Australians over this time, their risk of mental ill-health has remained the same. What these findings suggest is a difference between *tolerating* and *affirming* LGBTI people. It is possible to object to discrimination against LGBTI people while nonetheless continuing to find their sexualities, gender identities and intersex status problematic. In the absence of overt *public* affirmation many LGBTI people will continue to struggle to achieve that sense of personal and social worth on which improvements in their mental health depend.

The major challenge facing the development of a comprehensive LGBTI mental health promotion framework is how to maintain this dual focus, to affirm LGBTI people and the dignity and value of their sexualities, gender identities and intersex status *while* addressing a history of heterosexist discrimination and its continued impact on their mental health and wellbeing.

1.2 Development of the framework in context: the MindOUT Project

In 2011, the National LGBTI Health Alliance (the Alliance) released *LGBTI People: Mental Health and Suicide* (Rosenstreich, 2011). The briefing paper reviewed the research and policies on LGBTI mental health and concluded that discrimination and exclusion are the 'key causal factors' leading to poorer mental health and higher rates of suicide among this population (p.4). In the same year, the Commonwealth Department of Health (DoH) provided the Alliance with three-year funding for the MindOUT! Project. The aim of the project is to work with LGBTI organisations and mainstream mental health care

providers to improve mental health and suicide prevention outcomes for LGBTI people and communities.

MindOUT! is one of a small but growing number of policy and program initiatives funded by State, Territory and Commonwealth Governments, that acknowledge and address the effects of systemic discrimination and deeply entrenched prejudice on LGBTI Australians' lives. While some of these initiatives target LGBTI subpopulations that are particularly vulnerable to heterosexist discrimination and abuse – including same-sex attracted, intersex and gender diverse (SSAIGD) young people², older LGBTI people, and LGBTI people with particular religious and cultural affiliations – nearly all address mental health as a primary area of concern.

In 2012, as part of MindOUT!, the Alliance convened an LGBTI Mental Health Promotion Task Group³ to oversee the development of a national LGBTI mental health promotion framework. The Group included individuals and organisational representatives with a diverse range of experience and expertise in LGBTI and mainstream mental health and suicide prevention policy, programs and services (Appendix A). The focus of the group was to develop a framework that addressed the social determinants of reduced mental health and increased suicidal behaviours among LGBTI people.

This document is the result of this work and it provides a framework for understanding and promoting mental health and wellbeing and preventing mental ill-health and suicidal behaviours among LGBTI Australians. The strategy complements the other initiatives being undertaken by the MindOUT! Project (see Figure 1). While MindOUT as a whole includes initiatives that aim to improve access to mental health and suicide prevention services, the focus of this framework is explicitly focused on 'upstream' action. By focusing on illness prevention and mental health promotion, this strategy therefore aims to also reduce LGBTI people's demand for 'downstream' clinical services.

Importantly, this framework is informed by and builds on existing mental health promotion frameworks and both national and state/territory level population mental health strategies. These are discussed in more detail in Section 3.

1 Heterosexism has been used to describe a social system that privileges heterosexuality and cisgender people at the expense of minority sexualities and gender identities. Heterosexism assumes that the relationships among sex, gender and sexuality are fixed at birth: men are born masculine, women are born feminine (cisgenderism) and sexuality is the reciprocal gendered attraction between male and female. Heterosexism has been used to justify discrimination against: gay men, lesbians and bisexual people whose sexuality includes attraction to those of the same-sex; trans people whose gender identity does not conform to the sex they were assigned at birth; and intersex people who challenge the belief in a binary model of sex (Leonard 2010). More broadly, Cisgenderism describes the systems of thinking and practice that delegitimise people's own understanding of their genders and bodies (Ansara and Hegarty, 2012/2013/2014; Blumer, Ansara, and Watson, 2013).

2 The term SSAIGD young people is a recent addition to the acronyms used to describe a diverse coalition of queer youth. See Radcliffe J., Ward, R. and Scott, M. (2013). *Safe schools do better: A guide to supporting sexual diversity and gender diversity in schools*. ARCSHS and GLHV, La Trobe University, Melbourne at www.sscv.org.au In this document SSAIGD will be used to as an umbrella term covering a range of other acronyms including SSAGQ (same-sex attracted and gender questioning) young people and SSASGD (same-sex attracted and sex and gender diverse) young people.

3 The full title of the group was the LGBTI Mental Health Promotion Framework Task Group.

Focus of this document				
Promotion	Prevention	Early intervention	Treatment	Recovery
MindOUT projects: ● Mental health promotion framework ● LGBTI Inclusivity Guidelines		MindOUT projects: ● LGBTI Inclusive Practice Guidelines ● Practice wisdom resource for clinicians ● Training mainstream service providers on LGBTI inclusiveness and LGBTI-related mental health and suicidality ● Training LGBTI organisations on mental health and suicide prevention ● Piloting an LGBTI champions programme in mental health and suicide prevention services		
Timing: before a specific mental health problem has been identified		Timing: in the early stages of symptom onset	Timing: after a specific mental health problem has been identified	Timing: after a specific mental health problem has been identified
Strategic goal: reduce the incidence of mental health problems and improve the mental health and wellbeing of LGBTI Australians		Strategic goal: intervene early in order to halt progression and ultimately reduce the severity and frequency of illness	Strategic goal: provide appropriate care with the ultimate goal of achieving as close to a symptom-free state as possible	Strategic goal: prevent recurrence or frequency of episodes of mental ill health and improve positive mental health and wellbeing
← Cross-continuum initiatives → ● Advocacy and policy submissions on mental health and suicide prevention initiatives ● Facilitating forums and networking opportunities for discussion, information sharing and research on LGBTI mental health and suicide prevention				

Figure 1 Focus of this framework relative to other MindOUT! Projects.

1.3 Framework audience and applications

The three key audiences for this framework are:

- Mainstream organisations operating in a range of sectors and settings (health, social services, arts, sports, industry, volunteer and community)
- LGBTI organisations in a range of sectors and settings (health, social services, arts, sports, industry, volunteer and community)
- Funding bodies seeking to promote mental health and prevent suicide
- Policymakers and administrators.

The framework aims to assist in the development, implementation and evaluation of LGBTI mental health promotion initiatives. Specifically it seeks to provide guidance in:

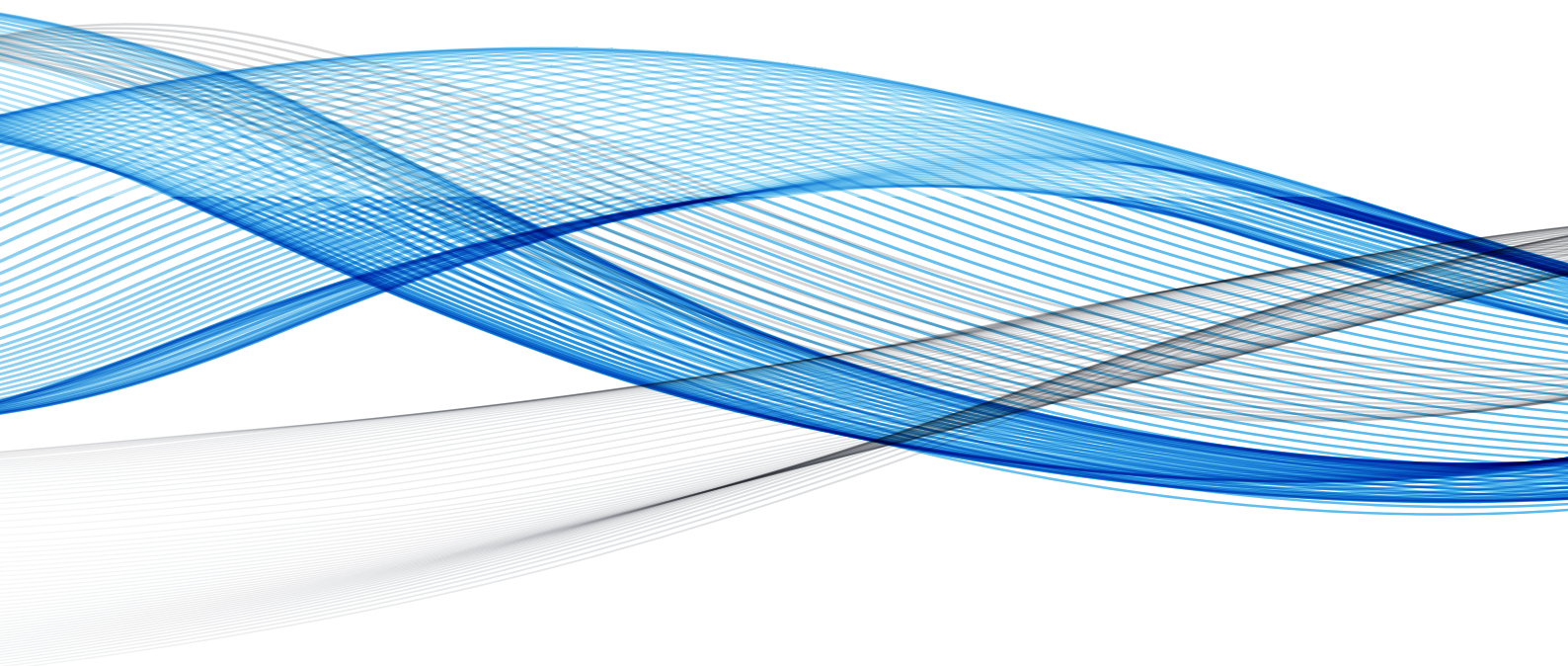
- Defining key outcomes and build a shared vision to work towards
- Setting priorities for action and investment
- Identifying domains, ‘actors’ and settings for action
- Strategically targeting initiatives towards key populations within the LGBTI community
- Ensuring the best available evidence is used to guide action
- Fostering collaboration and strengthening partnerships
- Improving monitoring and evaluation
- Improving coordination.

1.4 Structure and principles

This framework has as its outer casing the public affirmation of LGBTI people’s sexualities, gender identities and intersex status as part of the difference that constitutes the diversity of the population as a whole. Initiatives that target protective factors for LGBTI mental health, as well as those which aim to address heterosexism and its effects sit within this broader casing.

1.4.1 Structure

This document is divided into four sections. **Section 1** outlines the purpose, structure and history behind the development of the strategy. **Section 2** gives an overview of current data on the mental ill-health and suicidality of LGBTI Australians, including comparative analyses of rates and patterns of mental ill-health and suicidality *between* LGBTI and mainstream communities and *within* LGBTI communities. Key contributing factors specific to LGBTI mental health outcomes are also presented. **Section 3** reviews mental health promotion models and theory and considers the limitations of mainstream mental health promotion policies in relation to social and economic determinants of mental health in LGBTI communities. This section also introduces current evidence and concepts in relation to mental health promotion methods and actions. **Section 4** presents the framework for promoting mental health in LGBTI populations, and explains each of the core components of the framework in more detail.



1.4.2 Principles

Dignity

- Recognition of the dignity and inherent value of LGBTI people's sexualities, gender identities and intersex status.

Diversity

- Acknowledgment that minority sexualities and gender identities, and intersex status are all part of the diversity that constitutes our shared humanity
- A recognition that LGBTI people are diverse and that differences in their sexualities, gender identities and intersex status are cross-cut by other social determinants including (but not limited to), HIV status; Aboriginal and Torres Strait Islander background; ethnic, cultural and religious affiliation; geographic location; age; disability; and socioeconomic status.

Equity

- A commitment to equity in the provision and delivery of all services regardless of sexuality, gender identity and intersex status, including health and community services, employment, education, sport and culture
- A commitment to delivering LGBTI-inclusive mainstream and, where appropriate, LGBTI-specific mental health promotion initiatives
- A recognition that LGBTI-inclusive programs necessarily recognise and, where appropriate, address, the differences and diversity among LGBTI individuals and communities.

Promotion and prevention

- A fundamental recognition that mental health is more than the absence of illness and a commitment to assisting LGBTI people to realise their full potential, as individuals and as citizens, free from all forms of discrimination and abuse

- Promote LGBTI inclusion and participation in all areas of social life
- Ensure that quality LGBTI mental health and suicide prevention services are informed by and sit within a broader health promotion framework that acknowledges the value of LGBTI people and addresses the social determinants of reduced mental health and increased suicidal behaviours among this population.

Consultation and participation

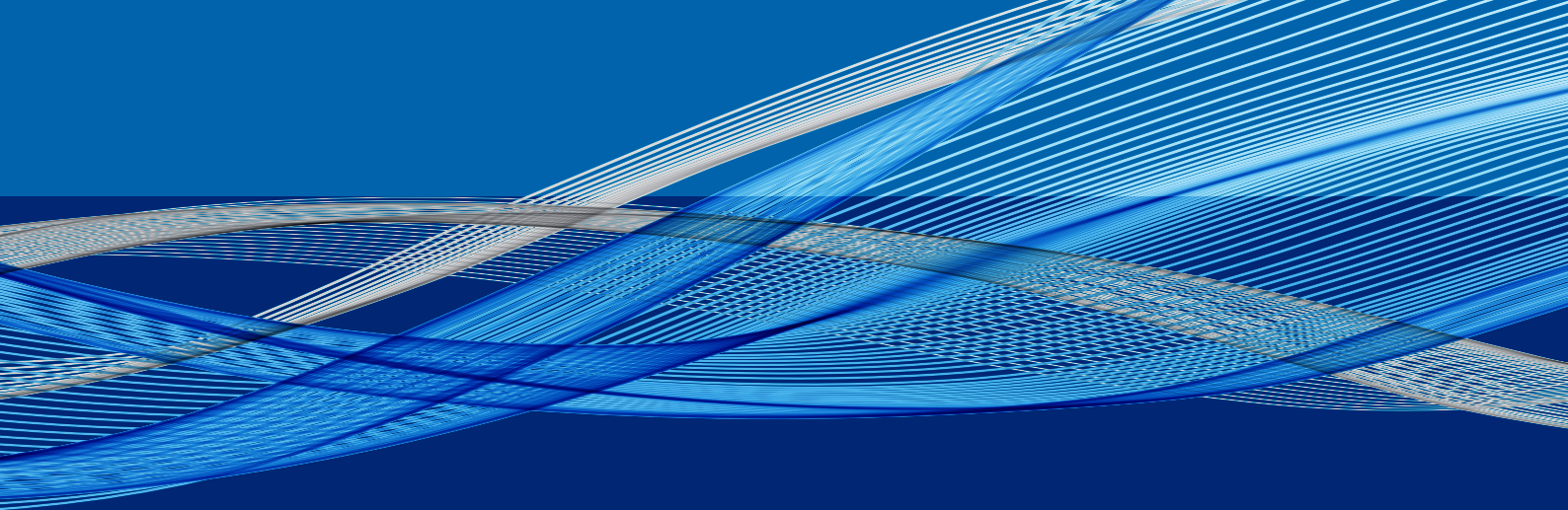
- LGBTI individuals and community representatives are consulted with, and participate in, the planning, delivery and review of mental health promotion initiatives.

Evidence and knowledge

- A commitment to research and a sustainable evidence-base on which to develop and assess the effectiveness of LGBTI mental health promotion policies and programs.

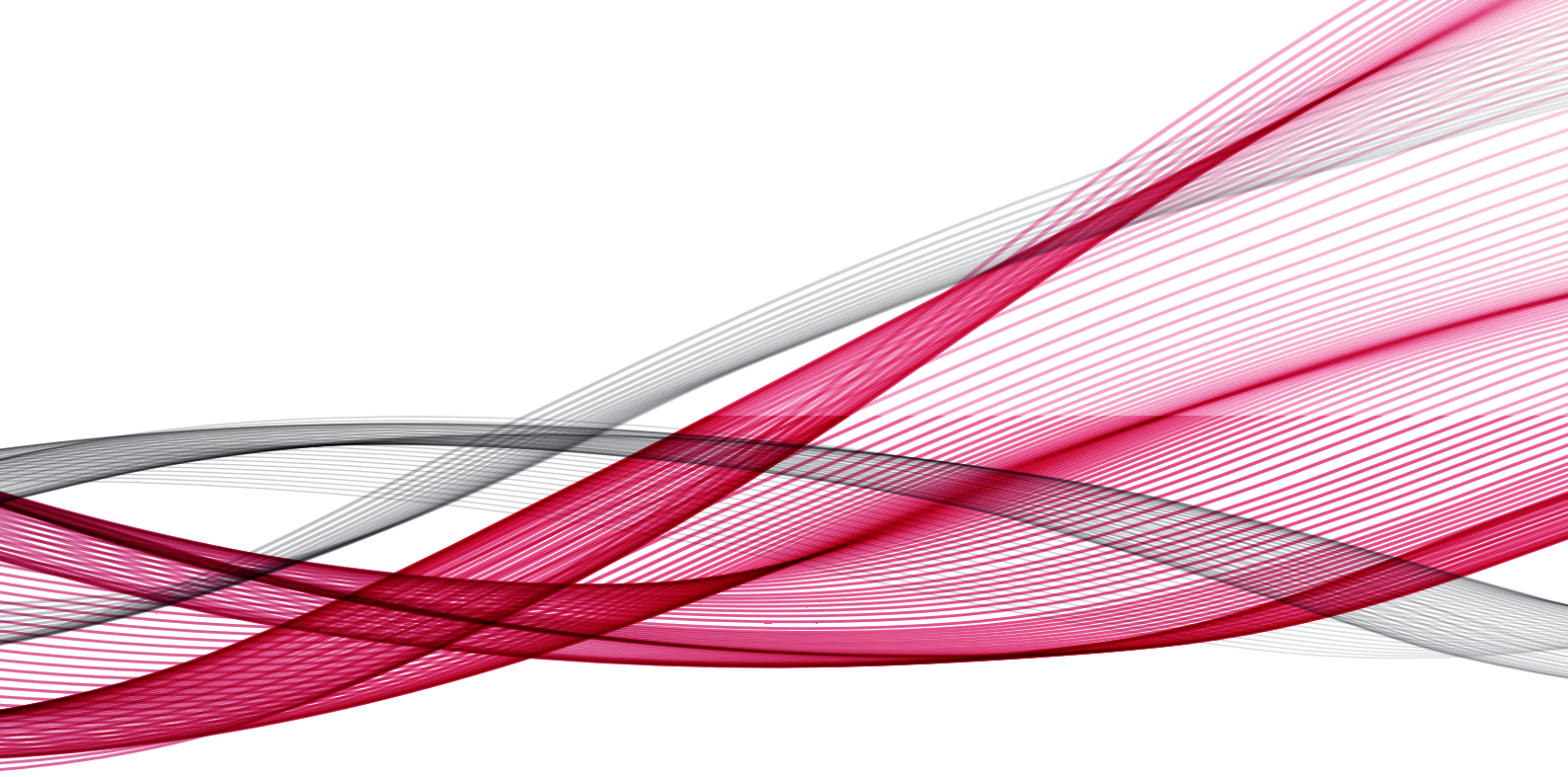
Partnership

- An emphasis on building and strengthening partnerships, including partnerships between LGBTI individuals and organisations, and between LGBTI organisations and organisations within and outside the health sector (e.g. community and social services, workplaces, education, the arts, sports clubs and cultural organisations)
- Partnerships between government, health, and the academic sector in the planning and delivery of LGBTI mental health promotion and LGBTI-inclusive mental health care.



While there have been recent improvements in both access to and efficacy of treatments for mental health problems, including initiatives designed to make mental health services more inclusive for LGBTI people, there is renewed emphasis on the importance of promoting mental health and wellbeing and preventing the development of mental health problems before they occur.





2 The mental health of LGBTI Australians

The Australian Government has recognised the enormous social impact of mental ill-health by including mental health as one of its nine national health priority areas (Australian Institute of Health and Welfare 2013). According to the findings of the *National Survey of Mental Health and Wellbeing* 2007, 3.2 million Australians (20% of the population aged between 16 and 85 years) had a mental disorder in the twelve months prior to the survey (Australian Bureau of Statistics, 2007).⁴ The *Burden of Disease and Injury in Australia* indicated that mental disorders constitute the leading cause of disability burden in Australia, accounting for an estimated 24% of the total years lost due to disability (Begg, et al., 2007).

2.1 Data collection

2.1.1 National population data

The 2007 National Survey was one of the first national Australian surveys to include a question on sexual orientation. This was a major step forward in acknowledging and gathering data on the lives of same-sex attracted and bisexual people. However, the survey used a fairly narrow understanding of sexual orientation

framing the question as a division between ‘heterosexual’ and ‘homosexual/bisexual’. This division does not reflect the complex and sometimes fluid relationships among sexual activity, attraction and identity that constitute human sexualities (Smith, et al., 2003). At the same time, the survey did not include questions on gender identity and intersex status (Irlam, 2013, p.11).

This lack of definitional subtlety, combined with the absence of questions on sexuality or sexual orientation in many other key national population surveys (Irlam, 2013, p.11), makes it difficult to compare rates and the burden of mental ill-health and suicidal behaviours *between* heterosexual and non-heterosexual populations. It makes it even more difficult to consider how sex, gender and other social determinants including: HIV status; Aboriginal and Torres Strait Islander background; ethnic, cultural and religious affiliation; geographic location; age; disability; and socioeconomic status interact with minority sexualities to produce variations in rates and patterns of mental-ill health and suicidality *among* LGB people and *within* LGB communities.

In the absence of any questions on gender identity and intersex status there is no representative national data on the mental health of trans and intersex Australians and no way of comparing trans and intersex rates of mental ill-health and suicidal behaviours with that of LGB and mainstream communities. This absence also

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⁴ Mental disorders in the 2007 Survey include anxiety, depression and affective and substance use disorders.

means that national data sets cannot be used to gauge the particular mental health and service needs of each of these populations, how these needs may be shaped by the intersection of gender identity and intersex status and other social determinants, and how the mental health needs of trans and intersex Australians vary across the life course.

2.1.2 LGBT(I) data

In Australia, the majority of national data on the health and wellbeing of sexual and gender identity minorities comes from a limited number of research studies that focus primarily, if not exclusively, on LGBT(I) people and communities. These surveys rely on selective sampling techniques, often using LGBT(I) professional and community networks to recruit participants. The use of selective sampling is common to research on 'marginal and hard-to-reach populations', including LGBTI communities (Pitts and Smith, eds. 2007). This raises complex methodological questions about how reliable these samples are and whether they can be used as a point of comparison with national *representative* population data. Furthermore, few LGBT(I) surveys have included questions on intersex status and, when they have, the numbers of intersex respondents have been so small that no statistically significant conclusions could be drawn (Pitts, et al., 2006).

Nonetheless, over the past decade a small but growing number of national LGBT research projects and surveys has been undertaken in Australia and in comparable western democracies such as Canada, the UK, the US and Ireland. Although the research techniques do not guarantee a representative sample, the numbers of participants are large enough to allow meaningful comparisons between LGBT and mainstream populations and, in some instances, between different subpopulations *within* LGBT communities.

2.2 The extent of the problem: prevalence of mental health problems, suicide and self-harm amongst LGBTI populations compared to the general population

Australian data suggest that LGBTI people experience the same *range* of mental health disorders as the population as a whole. However, the data also show significant variations in the *prevalence* and *patterns* of mental ill-health between these two populations. While LGBTI and mainstream communities experience similar rates of low prevalence, high impact mental health disorders such as schizophrenia and bi-polar disorder, the data indicates that LGBTI people are at increased risk of a number of mental health problems, including anxiety disorders, depression, substance use disorders, self-harm and suicide (Leonard, 2012; Corboz, et al., 2008; Herek and Garnets, 2007).

2.2.1 Mental health disorders

The results of the *National Survey of Mental Health and Wellbeing* 2007 reveal significantly higher rates of mental health disorders among homosexual/bisexual Australians compared with the heterosexual population. According to the Survey's findings, people who identify as homosexual/bisexual report higher levels of anxiety disorders (31.5 per cent vs 14.1 per cent), affective disorders (19.2 per cent vs 6.0 per cent) and substance use disorders (8.6 per cent vs 5.0 per cent) in the 12 months prior to completing the survey (Australian Bureau of Statistics, 2007; Corboz, 2008).

The results of *Private lives 2: The second national survey of the health and wellbeing of GLBT Australians* 2012 (PL2), show that LGBT Australians also experience higher levels of self-reported psychological distress and poorer rates of general mental health than the national population (Leonard et al., 2012). PL2 participants scored higher than the national average using the K10 scale of non-specific psychological distress (19.6 vs 14.5)⁵ and reported lower levels of general mental health using the SF36 mental health subscale (69.5 in PL2 vs 73.5 for women and 75.3 for men in the national survey)⁶.

The PL2 findings also show significant variations in mental health according to age between PL2 respondents and the general population. For example, 55 per cent of females and 40 per cent of males aged 16 to 24 years in the PL2 sample reported high levels of psychological distress (K10 scores between 22 and 50) compared with 18 per cent of young females and 7 per cent of young males in the national sample (Leonard, et al., 2012, p.36). People who score in this range are particularly vulnerable to mental health problems (Andrews and Slade, 2001). Furthermore, the percentage of the PL2 sample that reported high levels of psychological distress remains considerably higher than the national average across most of the life course, with the differences between the two populations only disappearing between 55 and 65 years of age (p.36).⁷

5 The K10 scale is scored from 0–50 with a higher score indicating increased psychological distress. National comparative data come from the *National Survey of Mental Health and Wellbeing* 2007, (Australian Bureau of Statistics, 2007) reported in Slade, et al., 2011.

6 The SF36 scale is scored from 0–100 with a higher score indicating better general mental health. National comparative data come from the *Household, Income, and Labour Dynamics in Australia (HILDA)*, 2007, (University of Melbourne, 2009).

7 These findings are consistent with national data showing a decline with age in rates of self-reported mental health problems (Australian Bureau of Statistics, 2007). However, they complicate a body of research on LGBTI aging which suggests that many older LGBTI people continue to experience reduced mental health and wellbeing due to the ongoing effects of having lived through earlier periods of virulent heterosexism (See Fredriksen-Goldsen and Muraco, 2010 and Haber, 2009 for reviews of the research on LGBTI aging).

2.2.2 Suicide and self-harm

Suicide

According to Suicide Prevention Australia (2009) 'Available research ... demonstrate[s] that the prevalence and rates of self-harm and attempted suicide are significantly higher amongst LGBT people than among non-LGBT populations' (p.2). In Australia and overseas there are major barriers to estimating rates of suicide among LGBT people. In Australia, data on death by suicide rarely include sexual orientation, gender identity or intersex status (Dyson, et al., 2003, Suicide Prevention Australia, 2009, p.2). Studies suggest that a significant percentage of suicide attempts among this population are associated with people's struggles to come to terms with heterosexism and prejudicial attitudes toward LGBT people prior to disclosing their identity to others (Dyson, et al., 2003; Hillier, et al., 2010). Furthermore, there is little data on how aging impacts on rates of suicide and completed suicide among LGBT people, and in particular older LGBT people, despite Australian data showing increased risk of suicide among older men aged late 70s to early 80s (KPMG, 2013, pp.12–13).

Given the barriers to gathering data and information on rates of LGBT suicide the majority of the research has focused on establishing indicators of risk (Suicide Prevention Australia 2009, p.2). Nonetheless, some recent international studies have shown a link between higher rates of suicide deaths among men in same-sex relationships compared with those in heterosexual relationships. For example, Mathy et al., (2011) concluded from a review of Danish death certificate data (1990 and 2001) that 'Suicide risk appears greatly elevated for men in same-sex relationships in Denmark' (p.111).

Studies conducted over the past 15 years suggest that LGB people attempt suicide at 3.5 to 14 times the rates of heterosexuals (National Institute for Mental Health in England 2007; Nicholas and Howard 1998). A recent US study suggests that rates of attempted suicide are even higher among transgender people with 41 per cent of transgender respondents reporting having attempted suicide at least once in their lifetime compared with only 1.6 per cent of the general population (Grant, et al., 2011).

Levels of suicidal ideation are also high amongst LGBT people. In one Australian survey, 15.7 per cent of LGBT respondents reported suicide ideation in the two weeks prior to completing the survey (Pitts et al., 2006). That figure jumps to 20 per cent in a joint Australian and New Zealand study of transgender health and wellbeing (Couch, et al., 2007).

Self-harm

Australian studies conducted in the 1990s showed higher levels of self-harm among LGBT Australians compared with non-LGBT Australians. In one Australian study, 20 per cent of lesbians and 20.8 per cent of gay men reported

deliberate self-harm compared with 8.3 per cent and 5.4 per cent of heterosexual females and males respectively (Nicholas and Howard, 1998). The same study found an even higher incidence of deliberate self-harm among bisexual women and men with rates at 34.9 per cent and 29.4 per cent respectively.

More recent studies of the health and wellbeing of same-sex attracted, intersex and gender diverse (SSAIGD) young people have revealed alarmingly high rates of self-harm among this population. One national study has shown that 18 per cent of SSAIGD young people aged 14 to 21 years who had never been subjected to physical or verbal heterosexual abuse had self-harmed (Hillier, et al., 2010, p.51). The percentage jumps to 31 per cent for those who had experienced verbal abuse only and to 55 per cent for those SSAIGD young people who had experienced physical heterosexual abuse. Similarly, data from the 2013 *Growing Up Queer* study found that 33% of young people had harmed themselves as a result of homophobia or transphobia (Robinson, et al., 2014).

Unpublished data from *Writing Themselves in 3* show that rates of self-harm are even higher among gender diverse young people, with almost half of this group reporting having self-harmed and 28 per cent having attempted suicide. These figures compare with national estimates of between 4 and 7 per cent of Australian youth aged 15 to 24 years having engaged in self-harming behaviours (De Leo, 2004; Centre for Adolescent Health, 2013).

Again, there is a lack of data on rates of suicide and self-harm among intersex people. The limited overseas research that does exist and anecdotal evidence in Australia suggest that rates are much higher among intersex adults than the national averages (Rosenstreich, 2011; Schutzmann, et al., 2009).

2.3 Variations *within* LGBT communities

The research on LGBT health and wellbeing shows that the distribution of mental health problems not only varies significantly between LGBT and mainstream communities but also *within* LGBT communities. Variations in rates and patterns of mental ill-health within LGBT communities are observed in relation to differences in sexuality, gender identity and intersex status and the interactions between heterosexism and other social determinants including: discrimination, harassment and violence; social connection; HIV status; Aboriginal and Torres Strait Islander background; ethnic, cultural and religious affiliation; geographic location; age; disability; and socioeconomic status.

Sexuality

Australian and international research shows that people who identify as bisexual have poorer mental health than people who identify as either same-sex attracted or

heterosexual (Dodge and Sandfort, 2007; Leonard, et al., 2012; Pitts, et al., 2006). According to the findings of PL2, bisexual women and men report higher levels of psychological distress than lesbians and gay men (21.8 and 20.5 vs 19.04 and 18.83 respectively, K10 scale) and poorer general mental health (64.7 and 68.3 vs 70.1 and 71.6 respectively, SF 36 scale) (Leonard, et al., 2012, pp.36–37).

However, the PL2 data also show marked variations in mental ill-health between bisexual women and men. For example, bisexual women were nearly twice as likely as bisexual men to report having been diagnosed with or treated for an anxiety disorder in the past three years (38.3 per cent vs 20.9 per cent). These findings are consistent with US studies and a recent review of comparative mental health research on bisexuals and heterosexuals which document higher rates of mental health problems among bisexual women than bisexual men (Dodge and Sandfort, 2007; Mathy, et al., 2004).

Gender identity

A number of population surveys show that transgender people experience poorer mental health and have a higher suicide risk than same-sex attracted and bisexual people. According to PL2 data, 38.3 per cent of transgender males and 50 per cent of transgender females reported having experienced depression in the last three years compared with 24.5 per cent of males and 33.9 per cent of females (Leonard, et al., 2012, p.31).⁸ Transgender males were nearly 2.5 times more likely than other males in the PL2 sample to report having often experienced episodes of anxiety in the past twelve months (p.39). Transgender males and transgender females also reported the highest levels of psychological distress.

A recent Australian review of LGBTI mental health reported that 50 per cent of transgender Australians had attempted suicide at least once in their lifetime (Rosenstreich, 2011). These rates are almost identical to a recent UK study in which 48 per cent of transgender respondents reported having attempted suicide at some point in their lives (McNeil, et al., 2012). The data presented in Section 2.2.2 show that SSAIGD young people are particularly at risk of suicide. A 2012 report from the Royal Children's Hospital in Melbourne found that all 21 transgender young people in a sample group being assessed for hormone treatment reported symptoms of anxiety or depression while many also reported suicidal ideation (Hewitt, et al., 2012).

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⁸ The PL2 data was analysed according to both sexual identity and gender identity. When using gender identity as the primary lens the sample was divided into five categories: Females, males, trans females, trans males, and respondents who chose another term to describe their gender identity (Leonard, et al., 2012, p.4).

Intersex status

The absence of representative data on intersex people and the small numbers of intersex respondents in the few LGBTI surveys in which they are included make it difficult if not impossible to compare their mental health with that of LGBT people. However, anecdotal evidence and reports to intersex support groups from consumers suggest that intersex people are subject to particular pressures that may place them at increased risk of mental ill-health (National LGBTI Health Alliance, 2013; Victorian Government Department of Human Services, 2003). These include:

- Trauma associated with medical examinations, treatment, and, for some, recurrent surgical interventions, extending from infancy through adolescence (and beyond)
- Physical difficulties associated with unnecessary childhood genital surgery including impairment of genital sensitivity, scarring, urinary issues and chronic pain
- Negative body image and problems with sexual intimacy associated with genital difference, and
- For some, a dissonance between their 'surgically assigned' sex at infancy and their adult gender identity.

2.3.1 Cross-cutting social determinants

Few studies on LGBTI health and wellbeing have looked at how heterosexism and sexuality, gender identity and intersex status interact with other established social determinants to increase the risk of mental ill-health within and between LGBTI communities (Leonard, 2002; Suicide Prevention Australia, 2009, p.6). However, population health surveillance studies of LGBTI communities provide some insights into which social determinants of mental health appear to be most influential.

Discrimination, harassment and violence

Epidemiologists favour the following definition of discrimination, offered by sociologists, when considering its impact on health:

'... the process by which a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of their membership of that group...this unfair treatment arises from socially derived beliefs each group holds about the other, and patterns of dominance and oppression, viewed as expressions of a struggle for power and privilege.'
(Oxford and Collins Dictionaries of Sociology, cited by Krieger 2001).

Krieger (1999) also observes that people can experience multiple forms of discrimination, for example, on the grounds of one or more of the following: race and ethnicity, gender, intersex status, sexual preference, disability, age, religion and social class. VicHealth's *Mental Health Promotion Framework* (VicHealth, 2005, p.15)

explains that, as well as being perpetrated by individuals discrimination can be practised by institutions (often termed ‘institutional discrimination’), though, for example:

- Under-representation of minority group members in the media
- Reinforcement of negative stereotypes in media reporting involving minority groups
- Limitations on or exclusions from access to education, healthcare or social services and employment for minority group members.

As these examples illustrate, discrimination is not necessarily overt and may not always involve direct or interpersonal harassment, vilification or violence. However, the relationships between all types of discrimination and negative health outcomes are well established (VicHealth, 2005). Numerous studies have illustrated a direct association between discrimination and many of the key risk factors for suicide and self-harm (particularly mental illness) (Department of Health and Ageing, 2007). More specifically, literature reviews undertaken by Rosenstreich (2011) and Suicide Prevention Australia (2009) outline compelling evidence about the impact of heterosexist discrimination and violence on LGBTI people’s mental health and wellbeing. These highlight that heterosexist discrimination is associated with social isolation, family rejection, self-denial, guilt, self-loathing and internalised homophobia or transphobia, and can also serve as a barrier to accessing health and social services.

The relationship between homophobic abuse, self-harm and suicide in SSAIGD young people has also been documented in numerous national studies. As illustrated in Figure 2, *Writing Themselves In 3* found the prevalence of self-harm, suicidal ideation and suicide attempts amongst SSAIGD young people who report having experienced physical or verbal abuse is significantly higher than observed in those who had never experienced abuse. These findings are again consistent with data from 2013 in the *Growing Up Queer* study, in which participants also articulated how the following types of homophobia and transphobia contributed to their engagement in self-harm, suicidal ideation and/or suicide attempts: social exclusion, persistent bullying (including cyberbullying) and harassment, physical/mental/emotional abuse and a lack of intervention when homophobia/transphobia had taken place.

Additionally, *Writing Themselves In 3* shows that experiences of homophobic and/or transphobic physical and verbal abuse is associated with increased alcohol and other drug misuse in SSAIGD young people, which further increases risk of mental health problems and suicide. As Leonard (2008 cited in Hillier, et al., 2010, p. 54) explains: ‘there has been a tendency in the literature to think of the higher rates of drug use in LGBTI adults as connected with sociability and the gay lifestyle, however this has recently been challenged. Research with SSAGQ youth suggests that higher rates of drug use are associated

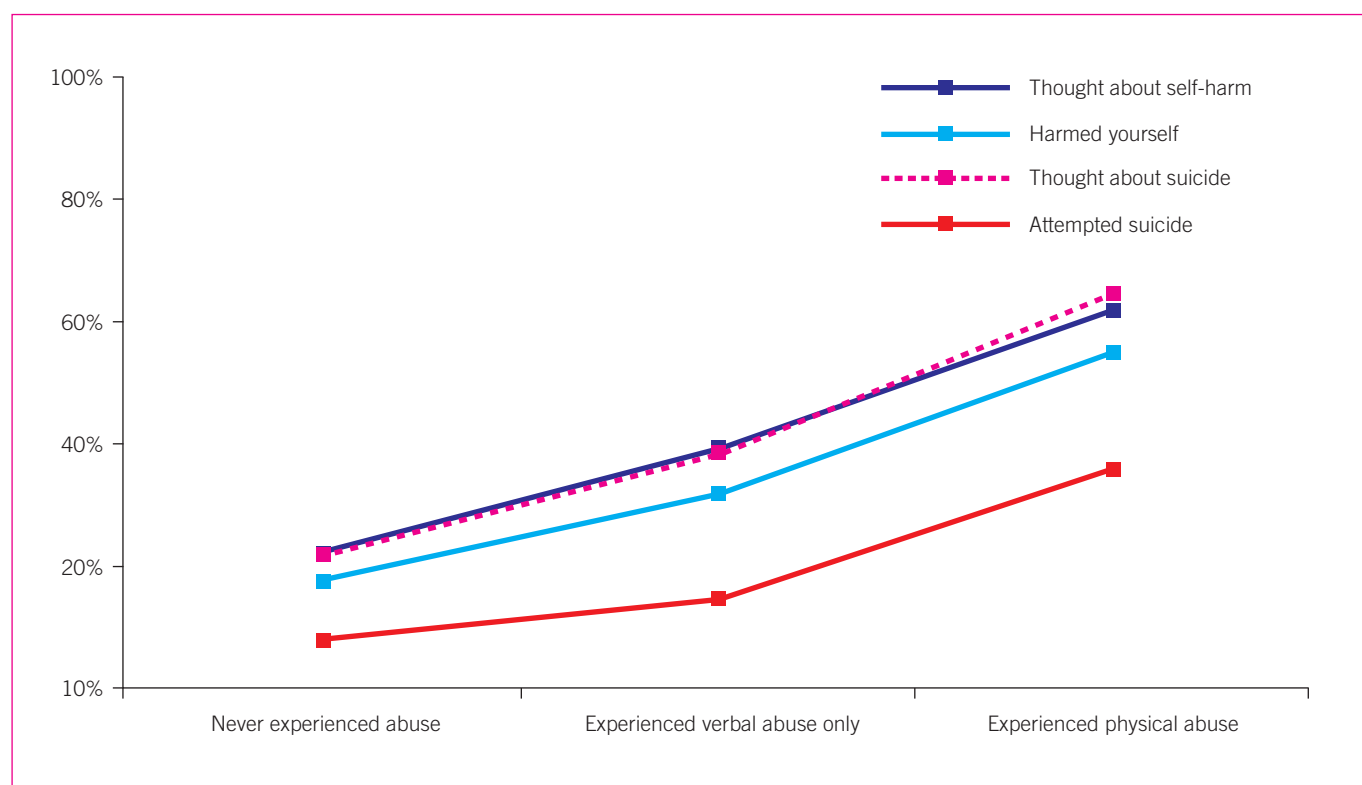


Figure 2 Experiences of homophobic abuse, self-harm and suicide in SSAIGD young people. Source: Figure 14. Relationships between homophobic abuse, self-harm and suicide (Hillier et al., 2010).

with homophobic abuse. We have concluded that many of these young people are in fact self medicating to ease the pain of the rejection and hostility in their families, schools and communities.'

Prevalence of heterosexual discrimination, harassment and violence

Despite recent Australian legislative reforms recognising the rights and responsibilities of LGBTI people and same-sex couples, levels of violence against LGBTI people have remained constant over the past decade (Leonard, Mitchell, et al., 2008). *Private Lives 2* reports that the most common type of abuse experiences by LGBTI people is non-physical, from verbal abuse (25.5 per cent), to harassment (15.5 per cent), threats of physical violence (8.7 per cent), and written abuse (6.6 per cent). Types of physical abuse were less common, with 2.9 per cent of respondents reporting being sexually assaulted in the past 12 months because of their sexuality or gender identity, and 1.8 per cent reporting physical attack or assault with a weapon. *Private Lives 2* also found that rates of almost all types of non-physical and physical abuse were higher for transgender males and females. For example, while 26.0 per cent of males and 22.5 per cent of females reported verbal abuse in the past 12 months, the percentages jump to 46.7 per cent and 36.9 per cent for trans males and females respectively.

Disturbingly, there is evidence that levels of heterosexual discrimination and harassment are increasing amongst younger age cohorts (see Figure 3). The proportion of SSAIGD young people participating in the *Writing Themselves In* studies reporting verbal abuse rose from 46% in 1998 to 61% in 2010, while the prevalence of physical abuse rose by 5% over the same period.

In 2013, *Growing Up Queer* reported that 64% of young people surveyed had been verbally abused because of their sexuality and/or gender identity, while 18% had been physically assaulted and 32% said they experienced other types of homophobia or transphobia, including: social exclusion, cyberbullying, being humiliated, tolerating homo/trans-phobic language, graffiti, written abuse or having rumours spread about them (Robinson et al., 2014).

The research also shows that heterosexual abuse is most commonly reported to occur in educational settings (particularly schools, for LGBTI young people), workplaces and on the street (Hillier, et al., 2010; McNair and Thomacos, 2005; and Robinson, et al., 2014). Of particular significance is that 9% of the young people surveyed in *Growing Up Queer* who had experienced homophobia and or transphobia at school were forced to move schools, with some having to do this more than once, and 7% leaving school altogether. Discrimination in employment was also highlighted in this study as a particular issue for trans young people whose designated gender (and name) on legal documents did not match their preferred name or identification. Negotiating physical education and sport was also difficult for these young people, with experiences of homophobia and/or transphobia resulting in many dropping out of sports or extra-curricula activities altogether. Robinson, et al., (2014) emphasised that 'what is particularly concerning is the fact that in many cases, when teachers and school managers were informed about the homophobic and transphobic harassment experienced by young people, they did not intervene in an appropriate manner'.

Many LGBTI individuals employ strategies to reduce the likelihood of experiencing heterosexual violence and abuse.

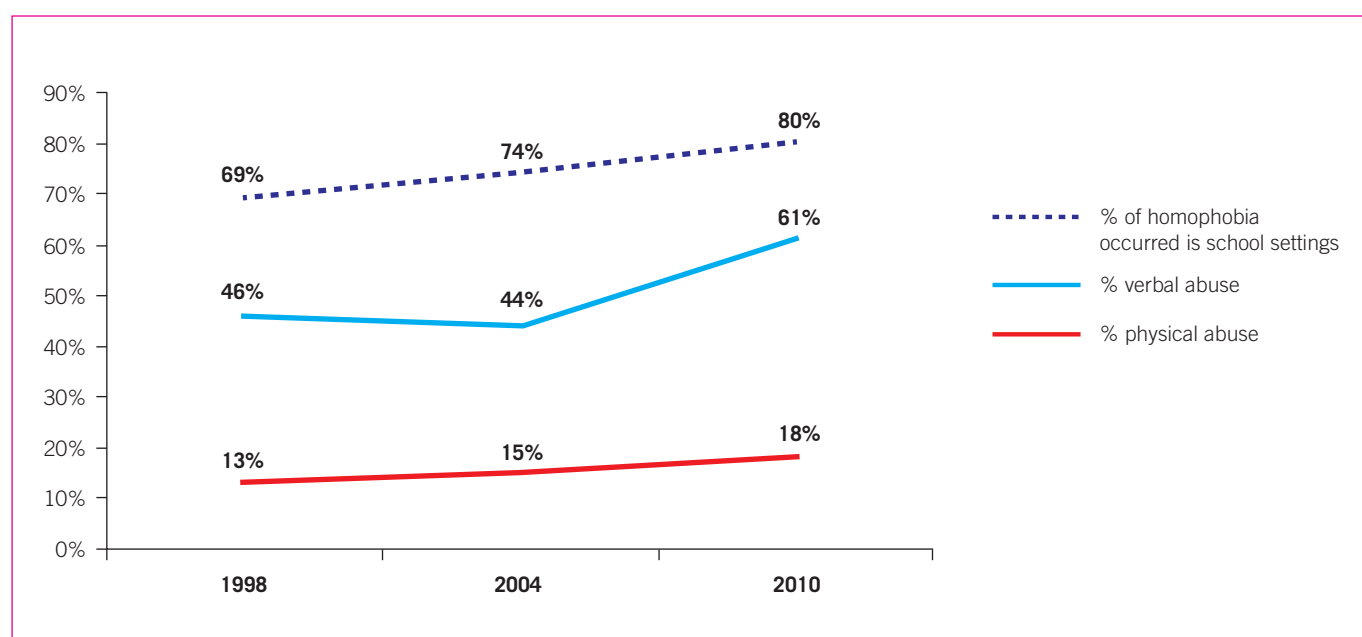


Figure 3 SSAIGD young people who report experiencing verbal and physical homophobic abuse 1998–2010. Source: Hillier et al., (2010).

For instance, *Private Lives 2* found that nearly one in two LGBT people 'occasionally or usually' hid their sexuality or gender identity in public, and one in three did so when accessing services, for fear of prejudice or discrimination. These figures were higher in a recent Queensland report, which found that 74 per cent of LGBT respondents usually or occasionally hid their sexuality or gender identity in public, for fear of heterosexual abuse (Berman and Robinson, 2010 cited in Leonard, 2012).

Encouragingly, data from *Writing Themselves in 3* suggests that SSAIGD young people are more likely to feel safe and less likely to engage in self-harm or attempt suicide in schools that have introduced policies and practices that recognise and value sexual and gender diversity (Hillier, et al., 2010).

Attitudes and beliefs about same-sex attracted people held by the general population: some indicators

- *The Global Divide on Homosexuality Study*, by the Pew Research Center reports that in 2013 nearly one in five Australians (18%) did not believe society should accept homosexuality. Younger respondents were generally more accepting of homosexuality than those aged 50 and above (Kohut, 2013).
- A study of over 24,000 Australians aged 14 and above found that 35 per cent of participants believed homosexuality is immoral. When broken down by gender, nearly 43 per cent of men and 27 per cent of women took this view (Flood and Hamilton, 2005).
- Flood and Hamilton (2005) also report that large city areas in all states were generally less homophobic than country areas, but there are exceptions – for example the Newcastle and Hunter region of NSW is less homophobic than several areas of Sydney.

Legislative and social reforms – current state

Over the past two decades there has been a raft of legislative reforms at state, territory and Commonwealth levels that afford LGBTI people many (but not all) of the rights and responsibilities non-LGBTI Australians take for granted. All states and territories include sexual orientation, gender identity and, in some jurisdictions, intersex status, as protected attributes in Equal Opportunity legislation. More recently, amendments to the *Sex Discrimination Act* make it unlawful to discriminate against a person on the basis of sexual orientation, gender identity and intersex status under federal law.⁹ The amendments also provide protection for same-sex couples who are now included under the definition of 'marital or relationship status'.

⁹ The *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* (Cth) (SDA Amendment Act) inserts these new grounds into the *Sex Discrimination Act 1984* (Cth) (SDA) accessible at www.humanrights.gov.au/new-protection

In April 2012 the federal government amended the *Aged Care Act* to include LGBTI people as a special needs group. The amendment led to the development of Australia's first *National LGBTI Ageing and Aged Care Strategy* (2012) which aims to ensure that 'LGBTI people have the same opportunities and options in aged care that are available to all Australians' (Commonwealth of Australia, 2012, p.2).

In its report on sexual orientation and gender identity discrimination the Australian Human Rights Commission (2011) noted that a majority of respondents called for federal legislation that would give greater national consistency in anti-discrimination protection (p.19). Many of the submissions argued legislative reform is a significant driver of cultural change and has led to improvements in the lives of LGBTI people (p.17). Nonetheless, many respondents suggested that this was an incomplete process, citing exemptions from state and territory anti-discrimination statutes, marriage equality, and adoption rights as areas where LGBTI people are still subject to discrimination (pp. 33, 39 and 42 respectively). The report also noted the need for legislative reform to work in tandem with social policy including public education on LGBTI issues, improved access to health services particularly for transgender and intersex people, government-funded LGBTI-support services and the appointment of a national LGBTI representative or commissioner (pp.37–42).

Social connection

Much of the data on LGBTI mental health and suicide prevention focuses on the negative impact of heterosexual discrimination. However, there is a growing body of work that demonstrates the positive impact of social connection and participation on people's mental health, and the extent to which this may mitigate the trauma associated with experiences of harassment and discrimination. Within this theme, the WHO has identified a number of protective factors for the recurrence or onset of mental ill-health (De Leeuw and WHO, 2006). These include:

- A sense of belonging
- Supportive social networks
- Supportive relationships.

The Victorian Health Promotion Foundation (VicHealth, 1999) argues that supportive relationships can also mitigate the negative mental health effects of discrimination. This is particularly true for members of marginal and stigmatised populations, including LGBTI people, for whom supportive relationships and social participation can act as protective factors against the negative impact of heterosexual discrimination.

A sense of belonging and mental health: the evidence

Corboz and Dowsett (2012) in their review of the research literature on depression and anxiety among LGB people

conclude that a sense of belonging to LGB and mainstream communities is linked to lower levels of depression. Improving LGBTI people's sense of belonging involves at least two-related processes. The first one ensures that mainstream organisations, including community groups, educational institutions, workplaces and cultural and sporting associations, are welcoming and supportive of LGBTI people. This can involve a broad range of activities including advocacy on the part of LGBTI people and their representative bodies and mainstream LGBTI champions, and legislation mandating the inclusion of LGBTI people and communities as part of the core business of publicly funded programs and services.

The second draws on the strengths and resilience of LGBTI people and communities, increasing their capacity to generate and sustain social relationships among themselves and between the 'LGBTI sector' and non-LGBTI people and groups. This involves resource commitment and capacity building directed at:

- LGBTI individuals and organisations, including the consolidation of existing LGBTI programs and services within and outside the health system, and
- Identifying gaps in the LGBTI sector and supporting new programs and initiatives.

For example, a paper commissioned by the Victorian Government on standards of treatment and care for transgender Victorians identified significant gaps in service provision for this client group including support services for transgender people and those closest to them (Sinnott, 2005). The paper recommended the provision of a drop in centre for transgender people to meet and provide mutual support, and separate information and support for their friends, family and relatives.

Supportive social networks and relationships

Friendship

An early Australian study of the mental health of lesbians showed that friendship networks enhance their health and wellbeing (Lienhert, 1999). According to the findings of *Private Lives 2*, 73 per cent of LGBT respondents rated LGBT friends most highly for emotional support, ahead of biological family at 53 per cent (Leonard, et al., 2012). The importance of friendship to positive mental health applies across the life course. For example, *Writing Themselves in 3* shows that for most SSAIGD young people, friends are their first confidants for coming out and that in the majority of cases the reactions are 'overwhelmingly supportive'. This is important because the report's findings also show that a negative or unsupportive response to a young person's coming out as LGBT or I, increases their risk of depression and self-harm.

Intimate relationships

In a national Australian survey, 42 percent of lesbians and 26 per cent of gay men reported 'being in a relationship'

as their first choice when asked to nominate the 'three best things in life' (Pitts et al., 2006). These findings are supported by an earlier Sydney-based study of gay men's health that found that the single most important source of emotional support for gay men is their partner (Prestage 1997). Many older LGBTI people report that the death of a long-term partner or difficulties in partnering led to a sense of social isolation and loneliness (Robinson 2008). For some, these feelings of loneliness and isolation are exacerbated by a youth-focused, commercial queer culture in which they feel neither valued nor welcome (Leonard, et al., 2013).

Family

Writing Themselves in 3 shows the importance of family to the mental health and wellbeing of SSAIGD young people. The data show reduced rates of self-harm for young people who are supported by their families (Hillier, et al., 2010). *Private Lives 2* found that LGBT Australians were more likely to name 'biological family' than LGBT friends as carers when they were sick (60.5 per cent versus 36.0 per cent of respondents – Figure 4.)

The importance of family cuts across differences within LGBTI communities, including differences of ethnic, cultural and religious affiliation. A NSW report on the effects of homophobia in Arabic-speaking communities noted the added pressure faced by LGB people as they negotiated cultural and religious values that privileged family and traditional gender roles (ACON 2011). While many talked of hiding their same-sex attraction from family for fear of being ostracised and bringing shame on their relatives, others talked of the importance of acceptance by family to their mental wellbeing, at the time of coming out or over time.

There are also a range of sometimes complex familial issues unique to LGBTI people all of which carry increased risk of anxiety and depression, and, for some, suicidal behaviours (Victorian Government Department of Human Services, 2003, pp. 20–21). These include:

- Coming out as same-sex attracted or transgender/ gender diverse within a heterosexual marriage or long-term relationship
- Same-sex and transgender and gender diverse parents having to negotiate when and where to be open about their sexuality or gender identity, and
- The pressures that children of same-sex and transgender and gender diverse parents face, including when and where to be open about their parent/s' sexuality or gender identity.

Socioeconomic status

Socioeconomic disadvantage is recognised in the research literature as a determinant of poor health, including increased risk of mental health problems and suicidal behaviours (ABS, 2011; Kawachi, et al., 2002;

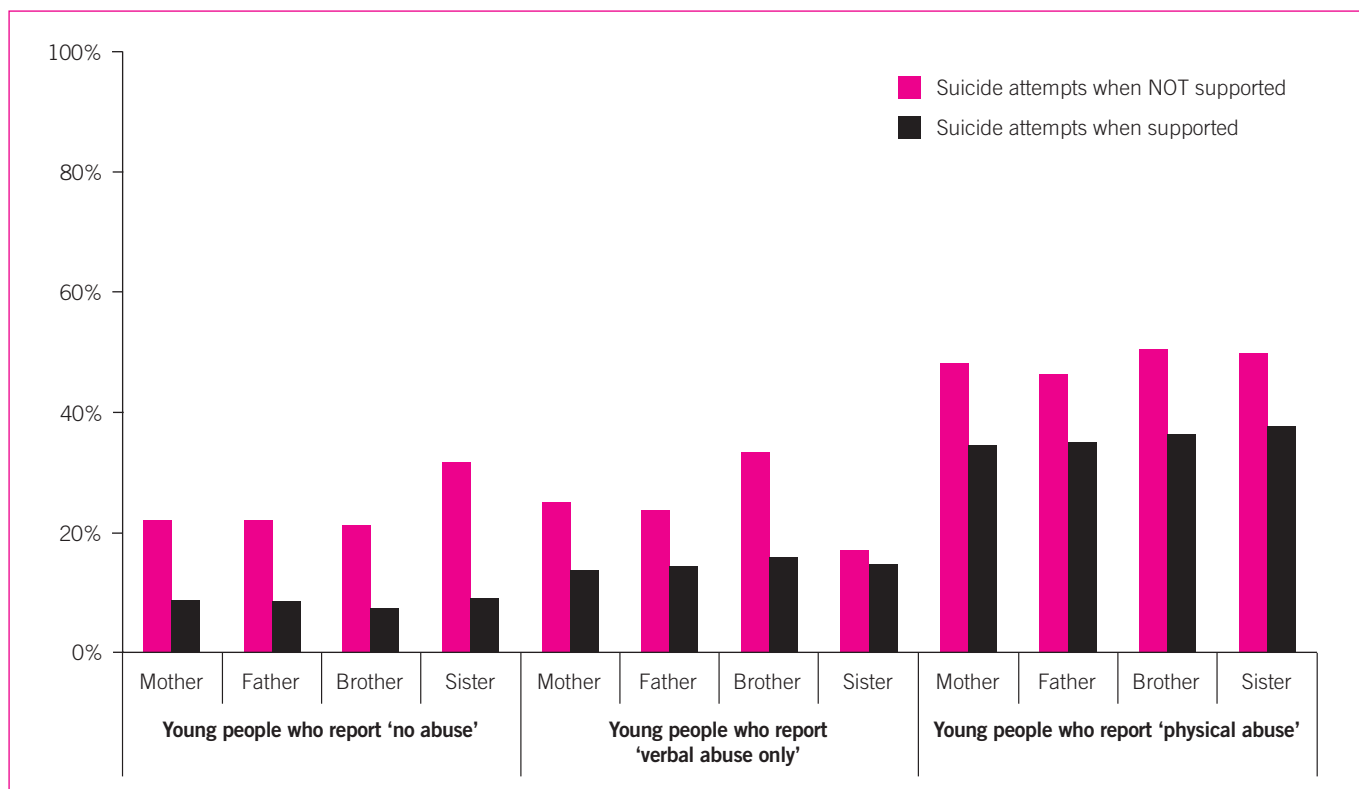


Figure 4 Rates of attempted suicide in young people when supported or rejected by family. Source: Hillier et al., (2010).

and McKenzie, et al., 2002). For example, a recent Australian retrospective cohort study found a correlation between underemployment and suicidal behaviours (Page, et al., 2013).

Indicators of socioeconomic disadvantage include reduced income and access to and level of education and employment. Few studies have explored the relationship between socioeconomic status and minority sexual orientations, gender identities and intersex status. However, the research that has been done suggests that heterosexist discrimination has a negative impact on LGBTI people's social capital, including access to employment and income.

Earlier studies from the US paint a complex picture of the relationship between educational levels and income for LGB people. O'Halaran et al., (1997) reported that while gay men and lesbians in the US had higher educational levels than the general population they had lower annual incomes. Recent Australian studies suggest that the gap between educational and income levels is even higher for transgender people compared to both national and LGB populations. According to *Private Lives 2*, while the percentage of trans males and females with a university degree is similar to that for males and females in the survey sample, the percentage who report a weekly income of less than \$1000 or less is over 1.5 times higher (Leonard, et al., 2012, pp. 18–19). *Tranznation* data shows that many transgender people who had undertaken

sex and gender affirmation surgery were forced to give up their employment as a consequence of transphobic discrimination and lack of support during and after transition (Couch, et al., 2007, pp. 63–66).

Australian data also shows variations in socioeconomic status according to gender and HIV status. Women in Australia are more likely than men to fall below the poverty line, due to lower average income and increased likelihood of caring for dependent children (Leonard, 2002, p.6). These gendered differences may explain, in part, higher self-reported rates of depression and anxiety amongst bisexual and lesbian women compared with bisexual and gay men (Leonard, et al., 2012). Studies of people living with HIV show that many were experiencing financial hardship with nearly 29 per cent living below the poverty line (Grierson, et al., 2013).

HIV status

Grierson, et al., (2013) report that 48.1 per cent of HIV-positive respondents in a national Australian study had been diagnosed with a mental health condition.¹⁰ Of those reporting a diagnosis, 87.5 per cent had been diagnosed with depression and 17.2 per cent who had received a diagnosis had done so in the past two years. The next most common condition was anxiety reported

¹⁰ Eighty-three per cent of respondents in the survey identified as gay male (p.v).

by 57.7 per cent of those with a mental health condition. Down, et al., (2012) report that among a cohort of people recently diagnosed with HIV in Australia, 39.2 per cent of male participants were identified as having current major depression. The majority of these men reported that these feelings were 'more pronounced since their diagnosis and causing them more difficulty' (p.59).

In a study of major depressive illness among HIV-positive and HIV-negative gay men in Sydney and Adelaide, Mao, et al., 2009 found that being HIV-positive was not independently associated with an increased risk of depression (Grierson, et al., 2013, p.6). However, the study found that HIV-positive men had higher rates of depression associated with factors such as socioeconomic deprivation, isolation and withdrawal than HIV-negative men. A recent international review of the HIV burden of transgender women from a range of very different countries including Australia, found that trans women were 49 times more likely to be infected with HIV than all adults of reproductive age (Bara, et al., 2013). These rates did not differ between low, to middle, to high income countries.

Aboriginal and Torres Strait Islander background

National data shows that one third of Aboriginal and Torres Strait Islander Australians report high to very high rates of psychological distress, nearly twice the rate for non-Indigenous Australians (Australian Institute of Health and Welfare, 2011). The current *National Mental Health Plan 2009* includes initiatives that recognise the unique historical and social situation of Aboriginal and Torres Strait Islander Australians and the negative impact of colonialism and racism on their mental health and wellbeing (Commonwealth of Australia, 2009, p.21). The Mental Health Plan singles out grief and trauma associated with the forced removal and relocation of individuals and communities along with material disadvantage, social marginalisation and geographic isolation, as major risk factors for reduced mental health among this population.¹¹

There is very little research on mental ill-health and rates of suicide and self-harm among Aboriginal and Torres Strait Islander Australians who are LGBTI. However, a Queensland report argues that for this population, their sense of social exclusion from family, social and cultural groups following geographic relocation may be compounded by their experiences of sexual orientation and gender identity discrimination (Queensland Association for Healthy Communities, 2004).

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11 A Queensland report documents that particular Aboriginal and Torres Strait Islander populations are at increased risk of mental health problems including survivors of the stolen generation and prisoners (Holland 2013).

Ethnicity, religious affiliation and cultural and linguistic diversity

A number of recent Australian studies suggest that LGBTI people affiliated with particular cultural and religious groups may be at increased risk of mental disorders, including anxiety and depression. Reeders (2010) has called this 'double trouble' and involves some of these LGBTI people having to negotiate not only the heterosexual beliefs and practices of their cultural or religious communities but also racism and religious intolerance from within LGBTI communities.

An early study of a small cohort of gay-identifying Vietnamese men in Sydney showed the importance of family to cultural identity and the pressure these men felt to get married even as they continued to have sex with other men (Prestage, et al., 2000). A more recent study by Operario (2008) found higher levels of depression among Asian men-who-have-sex-with-men (MSM) than other MSM. A study released by ACON in 2011 documented the effects of homophobia in Arab-speaking communities in NSW (ACON, 2011). Survey participants talked of the tension between their Arabic cultural values of respect for elders, collective harmony and not bringing shame on themselves and their families, and being out as LGB. Many who were out were subject to heterosexual abuse and violence from within their Arabic community while others chose to remain invisible, some because of their feelings of guilt and others because they did not want to bring shame on their relatives. The report also found that within LGBT communities, many people from Arabic-speaking backgrounds were subject to racism and ethnic stereotyping.

The findings of *Writing Themselves in 3* show that SSAIGD (same-sex attracted, intersex and gender diverse) young people are particularly vulnerable to the tension between conservative religious beliefs and their same-sex attraction and/or gender identity. The respondents who mentioned religion were more likely to feel bad about their sexual attraction or gender identity and more likely to report thoughts of self-harm and suicide (Hillier, et al., 2010, p.91).

Geographic location

The PL2 data showed that while the percentages of LGBT respondents resident in each Australian state and territory were comparable to the national averages, there was a noticeable increase in the percentage of LGBT people resident in major cities (79 per cent of PL2 respondents vs 69 per cent nationally). This increase reflects the larger numbers of LGBT people moving to urban locations and may be indicative of higher levels of heterosexism and homophobia in rural and remote areas (Flood and Hamilton, 2005).

Research suggests that LGBTI people in rural areas are not only subject to increased heterosexist discrimination and abuse but that they have reduced access to LGBTI-inclusive mental health services and LGBTI community and support networks (Edwards, 2007; Leonard, 2002). Research suggests that LGBTI people's experiences of increased heterosexist discrimination in rural areas is compounded by these other factors, placing them at increased risk of mental ill-health, self-harm and suicide (Quinn 2003; Suicide Prevention Australia, 2009). Hillier, et al., 2010 report that rates of self-harm, suicidal ideation and attempted suicide are higher among SSAIGD young people living in rural versus urban areas (p.96).

Mental health problems across the lifespan

It is estimated that 75% of mental health problems have their onset prior to the age of 25 (Kessler, et al., 2007). Little is known about whether these patterns differ in LGBTI communities, though data from PL2 and other research reveals that the risk of mental health problems for LGBTI people may increase at particular stages across the lifespan.

The PL2 data presented in Section 2.3.1 clearly show that SSAIGD young people are particularly vulnerable to heterosexist discrimination (Leonard, et al., 2012). SSAIGD young people aged 16 to 24 years report higher rates of depression, psychological distress, self-harm and attempted suicide than any other age cohort. Furthermore, the results of *Writing Themselves in 3* show that there is a link between the degree and type of heterosexist abuse experienced by SSAIGD young people and their rates of mental health disorders, suicidal ideation, attempted suicide and problematic drug and alcohol use (Hillier et al., 2010). The SSAIGD young people who had been subject to physical heterosexist abuse were most at risk of these behaviours, followed by those who had been subject to verbal abuse only, and, finally, those who had experienced no heterosexist abuse.

A growing body of research suggests there is a range of factors that place older LGBTI people at increased risk of poorer mental health. Older LGBTI people have lived through a period of systemic and rabid heterosexism, which denied not only their sexualities and gender identities but their very humanity (Leonard, et al., 2013). Some older LGBTI people carry this history as a personal weight, having to deal with the psychological fall out of feelings of shame and guilt. Recent studies suggest that for some older LGBT adults this leads to increased rates of particular mental health problems, including anxiety and depression. However, the same research shows that some LGBT adults have used their experiences of exclusion and discrimination as sources of resilience and strength (Institute of Medicine 2011; Fredriksen-Goldsen, et al., 2011; Stonewall, 2011).

Research on older LGBT people's experience of aged and community care shows that many older LGBT people find themselves being pressured to return to the closet, to hide their sexuality, gender identity or intersex status from aged care service providers who may hold deeply heterosexist beliefs (Barrett, et al., 2009; Harrison, 2006; Leonard, et al., 2013). There is also a growing body of work exploring the relationships among HIV, aging and mental ill-health, including dementia (Birch, 2009).

LGBTI people with disabilities

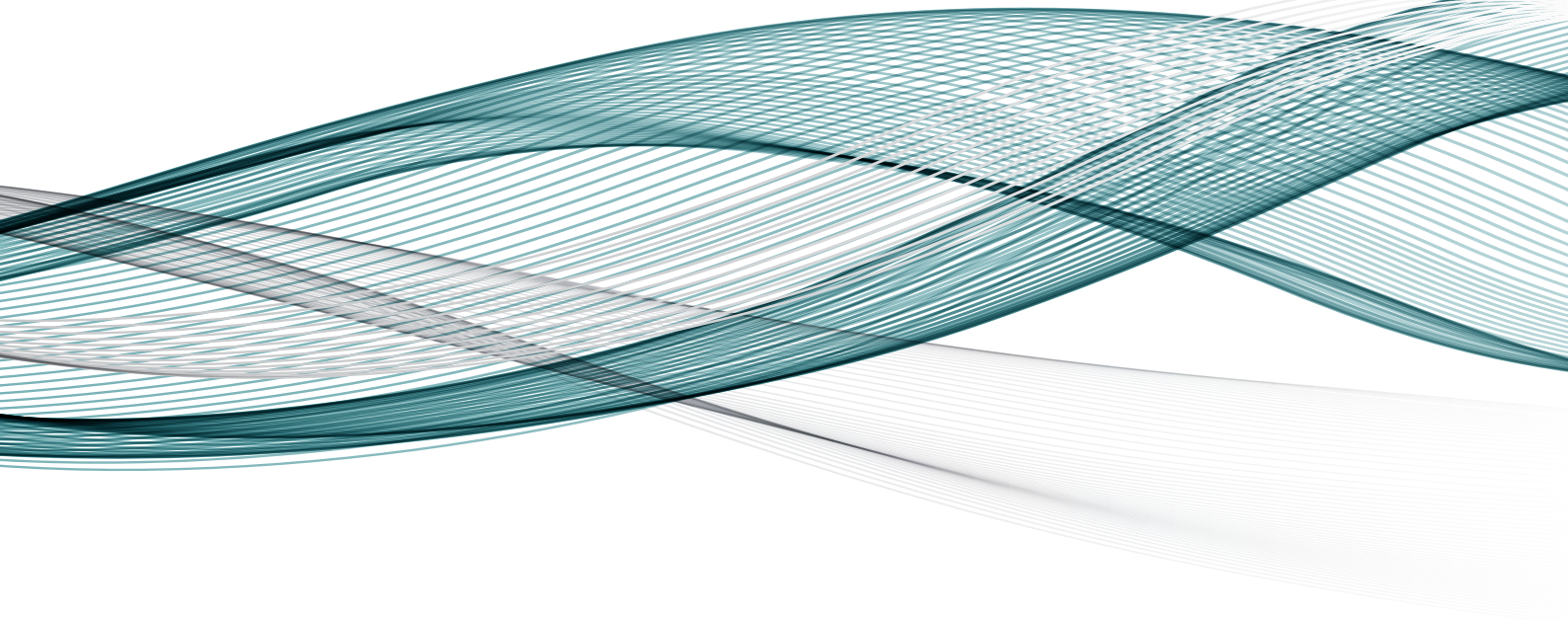
There is little research on the impact of disability or having a long-term health condition on the mental health and wellbeing of LGBTI Australians. A recent Australian survey showed that LGBTI people with a disability experienced greater discrimination than heterosexuals with a disability.¹² There is anecdotal evidence that many LGBTI people with disabilities do not feel supported or welcome within mainstream disability support networks or within LGBTI communities (Leonard, 2002, p.7). A 2001 Australian study found that LGBTI people with disabilities must contend not only with widely held beliefs that they are not or should not be sexual but with the added discrimination against same-sex attraction (Johnson, et al., 2001). All of these factors are likely to place LGBTI people with disabilities at increased risk of mental ill-health and self-harm.

There are also mental health issues for LGBTI people living with or caring for partners, friends or relatives with a disability. Approximately eight per cent of the LGBT respondents in an Australian survey reported having cared for a dependent with a disability or long-term health condition in the week prior to completing the survey (Leonard, et al., 2012, p.24).

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12 The 1-in-4 Poll project (unpublished results) at www.1in4pollaustralia.com





3 LGBTI mental health promotion

The Roadmap for National Mental Health Reform 2012–2022 (Council of Australian Governments 2012) lists among its long-term aspirations, ‘a society that values and promotes the importance of good mental health and wellbeing [and] maximises opportunities to prevent and reduce the impact of mental health issues and mental illness’ (p.3). Mental health promotion and prevention has featured as a cornerstone in all national population mental health plans developed in Australia to date, including *The Fourth National Mental Health Plan – an agenda for collaborative government action in mental health 2009–2014*, which highlights promotion, prevention and early intervention alongside social inclusion as two of the five key priority areas (Commonwealth of Australia, 2009).

The inclusion of LGBTI populations in mainstream mental health promotion policies and plans is and has been limited. LGBTI people are not referenced as a matter of course in mental health-related Government policies. *The Roadmap for National Mental Health Reform 2012–2022* includes LGBTI people under only one of its six priority areas, ‘Improve access to high quality services and support’ (p.24).

In the absence of established LGBTI specific policies, this framework draws on key concepts and guiding principles from established mental health promotion theory and practice. The following section considers how these can be applied with and for LGBTI people.

3.1 Mental health promotion: scope and purpose

The field of mental health promotion is relatively new and continues to evolve rapidly. While there have been significant improvements in both access to and efficacy of treatments for mental health problems, there is growing emphasis on the importance of preventing the development of mental health problems before they occur. This is reinforced by evidence about the existence of modifiable determinants known to positively or negatively influence the likelihood of developing mental health problems. Furthermore, without effective preventive interventions, it is expected that ‘downstream’ treatment services will not be able to adequately meet growing demand and associated costs (Zechmeister, et al., 2008; Inspire Foundation, 2014).

It is important to acknowledge that the goals of mental health promotion extend beyond just the prevention of illness. Critically, the WHO (2007) defines ‘mental health’ as much more than merely the absence of disease:

‘Mental health is a state of complete mental, spiritual and social wellbeing where every individual realises [their] own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community.’

Improving the mental health of a population demands a comprehensive approach to promoting mental health alongside prevention and treatment of mental ill health. The role of mental health promotion, relative to prevention, early intervention, treatment and relapse prevention is illustrated in the *Spectrum of Interventions for Mental Health* (Figure 5), first developed by Mrazek and Haggerty (1994 cited in Commonwealth of Australia 2000) and subsequently adapted by Australian and international mental health policies (Patterson 2009). This model articulates how actions that promote mental health and prevent mental illness may overlap. It demonstrates that mental health promotion can and should be directed at both populations who are free from illness as well as those who are already experiencing mental ill-health.

The seminal WHO Ottawa Charter of Health Promotion further emphasises that health promotion is a process, requiring broad participation. Fundamentally, it describes health promotion as ‘a process of enabling people to increase control over, and to improve, their health.’ The World Health Organization (1998) states that health promotion (broadly) may be understood as ‘actions and advocacy to address the full range of potentially modifiable determinants of health, including actions that allow people to adopt and maintain healthy lives and those that create living conditions and environments that support health’. More recently, the Melbourne Charter for Mental Health Promotion (VicHealth 2008) elaborated on these principles by defining mental health promotion more specifically as follows:

‘Mental health promotion is a strategic and sustainable approach to eliminating or minimising those factors which give rise to distress and loss of wellbeing and introducing and maximising those which create the circumstances in which all can flourish. It is also important in the process of recovery from illness or episodes of illness.’

3.2 Determining priorities for action

Etiological perspectives about mental illness and mental wellbeing provide a focus for mental health promotion interventions. The WHO (2005 p.9) suggest that the modifiable personal, social and environmental factors that determine mental wellbeing and mental illness can be clustered into three interrelated themes:

1. **The development and maintenance of safe, inclusive, healthy communities** in which people are safe and secure, have access to good housing, positive educational experiences, employment and other fundamental needs, including the right to self-determinant and freedom from violence
2. **Each person's ability and skills to deal with the social world**, where this includes positive experiences of early bonding, attachment, relationships, communication and feelings of acceptance, and
3. **Each person's ability to deal with thoughts and feelings, the management of life and emotional resilience.**

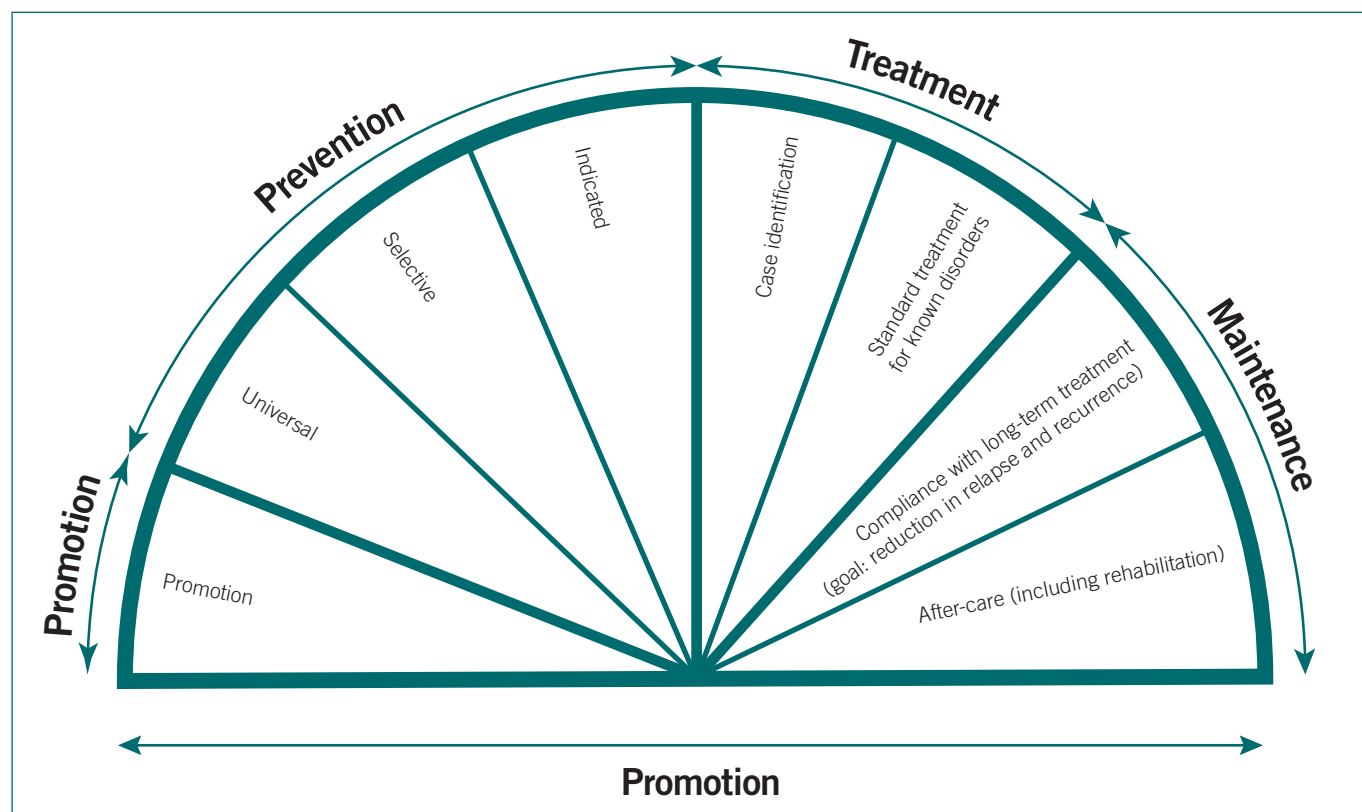


Figure 5 Spectrum for interventions in mental health.

There is considerable overlap between these themes and the determinants specific to LGBTI populations discussed in Section 2.3.1. Current and previous mental health plans in Australia also acknowledge the complex interplay of these determinants alongside other ‘risk’ and ‘protective’ factors that operate at an individual or interpersonal level across the lifespan (see Appendix B). Risk factors increase the likelihood that a mental health problem will develop, however single risk factors often have only a minimal effect on their own. Indeed, there is no single risk factor, which can explain more than 15% of the onset of a mental disorder (Herrman 2005). Risk factors instead may combine to have a strong interactive effect, and exposure to multiple risk factors over time has a cumulative effect (Commonwealth of Australia 2000).

Conversely, protective factors reduce the likelihood that a mental health problem will develop. They give people resilience, the capacity to cope with adversity, and moderate the impact of stress and transient symptoms on social and emotional wellbeing. They can be truly protective, reducing the *exposure* to risk, or they may be compensatory, reducing the *effect* of risk factors (Rutter 1985).

3.2.1 The ‘resiliency paradox’ in promoting the mental health of LGBTI populations

Population mental health policies are grounded in the ‘salutogenic approach’ (WHO 2005), in which comprehensive interventions aiming to increase resiliency by strengthening protective factors are prioritised. Paradoxically, LGBTI populations in Australia demonstrate high levels of resiliency in population health surveys such as *Private Lives 2*, despite the high prevalence of mental health problems. This observation suggests that while resiliency remains important, it is insufficient for preventing mental health problems in LGBTI populations. As discussed in more detail in Section 2, there are several other key social and structural determinants that account for the significant disparities in mental health outcomes between LGBTI people and the wider population. Accordingly, for LGBTI individuals and communities, the promotion of good mental health and wellbeing prioritises removing all forms of heterosexist discrimination and, with that, pockets of deeply held prejudicial attitudes and practices. It also necessitates a new take on *being* LGBTI, one that affirms and values LGBTI people’s sexualities, gender identities and intersex status as part of the rich diversity that constitutes our shared humanity. Affirmation is crucial not only to giving weight and value to LGBTI people’s lives but also in promoting social connection, participation and belonging on which LGBTI people’s positive mental health and wellbeing depend.

What is clear is that while same-sex attraction, gender dysphoria and intersex conditions are not themselves pathogenic, they may make people more vulnerable

- 1 Building healthy public policy** – this emphasises the role of all sectors in promoting mental health outcomes – for example, legislative reforms that recognise the rights and responsibilities of LGBTI people and same-sex couples; and those which make it unlawful to discriminate against individuals on the basis of sexual orientation, gender identity or intersex status. Affirmative policies, such as dedicated funding for LGBTI communities across government health programs is also critical.
- 2 Creating supportive environments in all settings** – for example, school-based programs such as Safer Schools Coalition Victoria, which aim to reduce homophobia and transphobia in schools.
- 3 Strengthening community action** – for example, advocacy initiatives, community consultation and action groups which determine goals for a community and influence planning and policy, such as the MindOUT! Community Mental Health Forums.
- 4 Developing personal skills** – for example, educational initiatives, which help people understand ways to look after their mental health and wellbeing, such as the Peace of Mind program delivered by ACON in NSW.
- 5 Reorienting services** – for example, building the capacity of LGBTI community organisations to undertake mental promotion; or reorientating drug and alcohol services which support clients to incorporate mental health promotion initiatives as well as delivering treatment.

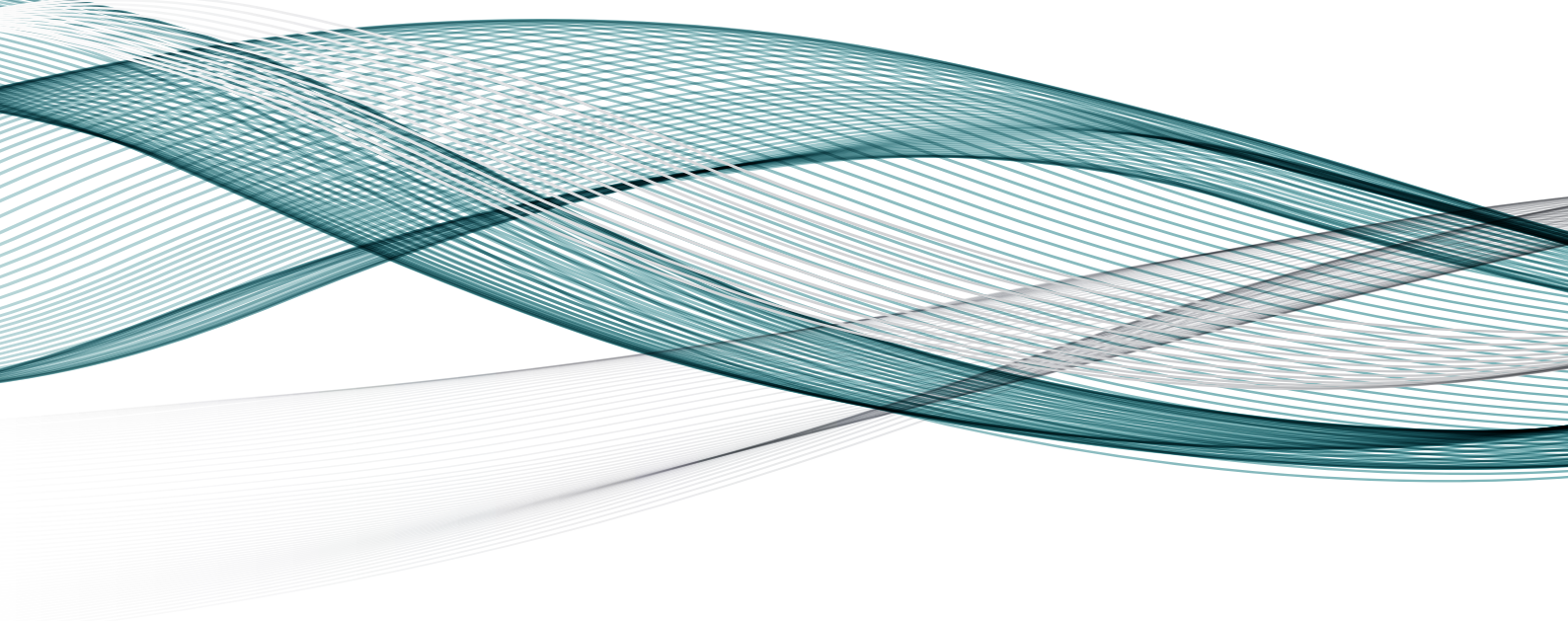
Figure 6 The five tenets of the Ottawa Charter for Health Promotion.

to negative experiences and discrimination that in turn increases risk for mental health problems. Discrimination is a significant issue that results in conflicted familial and other social relationships and diminished emotional and practical support.

3.3 Mental health promotion in practice: methods and strategies for and with LGBTI communities

As explained in section 3.1, much of the work in mental health promotion is also conducted within the framework of the *Ottawa Charter for Health Promotion* (WHO, 1986). Comprehensive approaches that integrate each of the five tenets of the Ottawa Charter (Figure 6), as well as the Jakarta Declaration (WHO 1997) and Yogyakarta Principles (accessible at www.yogyakartaprinciples.org/principles_en.htm) are considered the most effective way to achieve significant change in mental health outcomes.

Strong partnerships within and across different sectors, particularly those outside of the healthcare system, are essential in mental health promotion. Influencing the determinants of health will not be achieved by the health



sector alone, but rather through an intersectoral and multidisciplinary approach involving research, policy and practice in employment, education, justice, welfare, the arts, sports and through environmental changes.

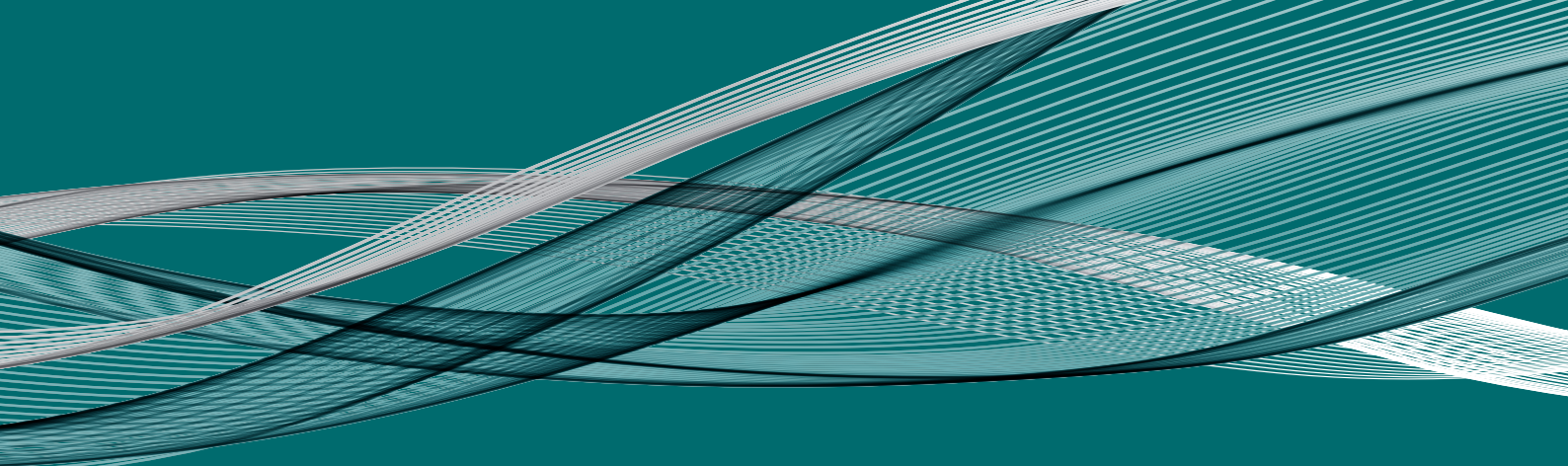
Furthermore, mental health promotion initiatives are not necessarily limited to direct participation programs such as educational initiatives. For instance, policy and legislative reform, and environmental modifications can be mutually reinforcing, and in combination with one another, can deliver significant and ongoing benefits once established. As Figure 7 illustrates, actions can be directed across individual, interpersonal and societal domains in a variety of settings.

Current priorities in LGBTI mental health promotion include legislation, policy, and public education – all of which have a profound impact on public understandings of sexual, gender identity and intersex minorities, their place (or lack thereof) in public institutions and society-at-large,

and LGBTI people's sense of their own individual and collective worth. They also include initiatives that draw on the strengths and resilience of LGBTI individuals and communities and in particular initiatives that promote LGBTI people's social connection and participation within LGBTI and mainstream organisations and network. As articulated in the *Melbourne Charter*, mental health and wellbeing is best advanced through respectful, participatory means where culture and cultural heritage and diversity is acknowledged and valued. It is therefore vital that LGBTI people themselves are involved in the development of mental health promotion initiatives. The next section of this document introduces a framework for guiding the development and implementation of mental health promotion initiatives with and for LGBTI communities.

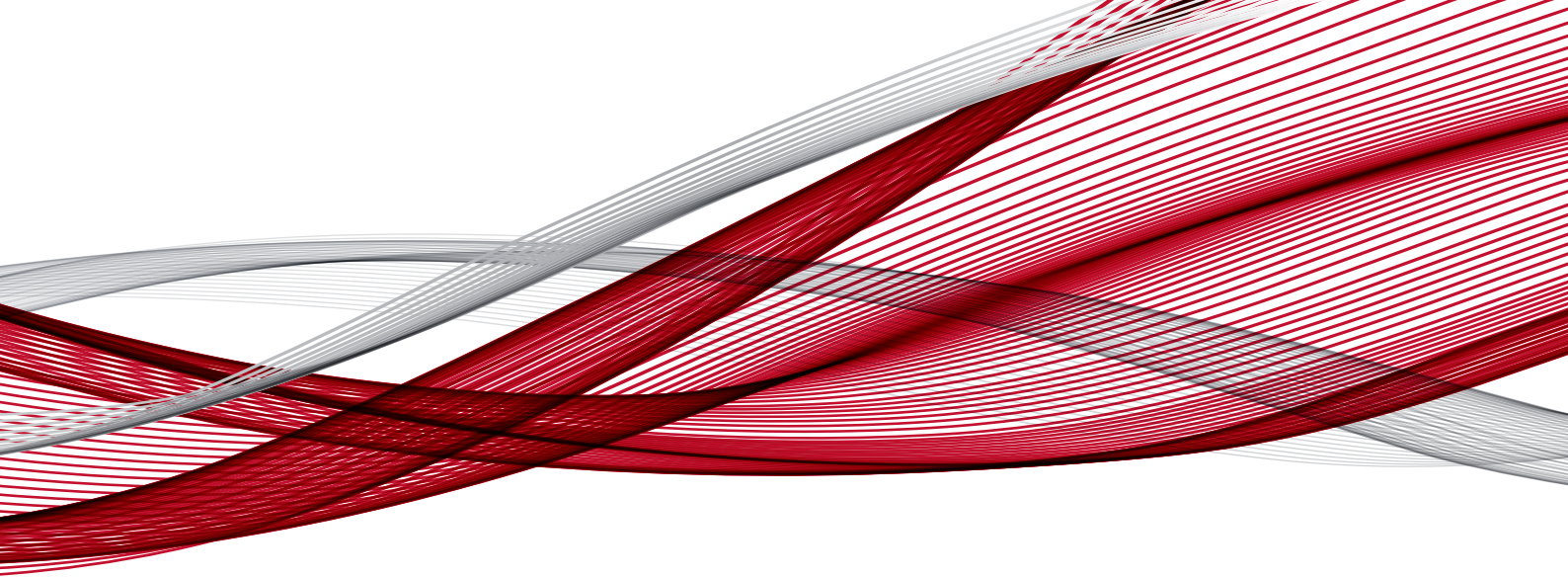


Figure 7 Mental health promotion interventions continuum (adapted from VicHealth, 2006).



What is clear is that while same-sex attraction, gender dysphoria and intersex conditions are not themselves pathogenic, they may make people more vulnerable to negative experiences and discrimination that in turn increases risk for mental health problems. Discrimination is a significant issue that results in conflicted familial and other social relationships and diminished emotional and practical support.





4 The framework in detail

This section presents the key components of a mental health promotion framework designed specifically to guide the development of mental health promotion actions that will improve the mental health and wellbeing of LGBTI populations and prevent the development of mental health problems. The format of the framework builds on established mental health promotion frameworks, particularly the VicHealth Participation for Health Framework (VicHealth, 2011) and draws on strategies to reduce race-based discrimination (VicHealth, 2007). The framework is evidence-based, consistent with best practice health promotion, and embodies the principles outlined in Section 1.4. Brief examples of LGBTI-inclusive mental health promotion are outlined in the following sections to illustrate key concepts and strategies within the framework.

4.1 Aims

The framework (Figure 8, overleaf) aims to promote the mental health and wellbeing of LGBTI Australians and reduce their burden of mental ill-health. It does so by valuing and affirming the dignity of LGBTI people's sexualities, gender identities and intersex status while addressing a history of heterosexist discrimination and its continued impact on LGBTI people's mental health and access to mental health care. Put differently, the framework involves bedding an understanding of heterosexism as a social determinant of health in a broader approach to

mental health promotion actions that affirm the lives of LGBTI people.

The overarching goals of the framework are to:

- Promote a culture that recognises and values a diversity of sexualities, gender identities and intersex status
- Facilitate the development of LGBTI-inclusive mental health promotion programs, and
- Improve the mental health literacy of LGBTI Australians enabling them to make informed decisions on how to improve their mental health and wellbeing and reduce their risk of mental ill-health.

How these are realised depends on:

- Building a shared vision among policy makers, LGBTI representative organisations and those involved in the delivery of services across a range of sectors, including shared aims, outcomes and strategies for action
- Fostering collaboration and strengthening partnerships within the LGBTI sector and between the LGBTI sector and government and mainstream organisations, including non-health related sectors including business, employment, education, sport and the arts
- Ensuring policies and programs that promote LGBTI mental health and wellbeing are evidence-based and informed by best health promotion principles and practice

KEY SOCIAL AND ECONOMIC DETERMINANTS OF MENTAL HEALTH FOR LGBTI POPULATIONS AND THEMES FOR ACTION				
Social connection	Access to social and economic resources	Freedom from violence and discrimination	Physical wellbeing and mental health promoting behaviours	
- Supportive relationships - Involvement in community and group activities - Civic engagement and social participation	- Equity of opportunity in relation to: - Employment - Housing - Education - Money - Healthcare access	- Valuing diversity - Physical security and respect - Equity of opportunity - Increasing empathy - Promoting positive social norms - Equitable and respectful relationships - Increasing personal and organisational accountability	- Physical activity - Increasing mental health literacy and self-esteem - Reducing misuse of alcohol and other drugs	
Target LGBTI populations				
- Older LGBTI people - Young LGBTI people - LGBTI people in rural and remote areas - Bisexual identified people - Aboriginal and Torres Strait Islander LGBTI people	- Intersex people - Transgender people - LGBTI people with disabilities and/or chronic illness - Culturally and Linguistically Diverse LGBTI people	Health promotion actions for change - Research, monitoring and evaluation - Direct participation programs - Organisational development (including workforce development)	- Strengthening communities and community environments - Communications and social marketing - Advocacy - Legislative and policy reform	
SETTINGS FOR ACTION				
- Online settings - Health and community services - Sports and recreation	- Workplace - Community and public spaces - Arts, media and culture	- Justice - Education - Hospitality and retail	- Corporate - Public sector and all levels of government (local, state, federal)	
INTERMEDIATE OUTCOMES				
Individual	Family	Organisational	Community and societal	
Individuals who: - Recognise the prevalence and impact of homophobia and transphobia - Have accurate knowledge about and are comfortable with being/being socially connected to people with different sexual orientations and/or are transgender, gender diverse and/or intersex - Recognise the benefits of diversity in genders, sexualities and bodies, support and feel pride in a diverse community - Interact with LGBTI people in respectful and just ways - Demonstrate mental health literacy and skills for maintaining and improving mental wellbeing - Demonstrate self-esteem and self-efficacy - Feel a sense of self-determination and control - Adopt and sustain mental health promoting behaviours	Families that: - Have accurate knowledge about diversity in sexual orientation, gender identity and intersex issues - Accept and are comfortable with people with different sexual orientations and/or are transgender, gender diverse and/or intersex - Celebrate same-sex relationships and affirm these as equal to heterosexual relationships - Recognise and support LGBTI people's right to self-determination (particularly as this relates to autonomy in decisions around medical interventions for transgender, gender diverse and/or intersex people)	Organisations that: - Have policies and procedures to reduce discrimination and ensure fair and equitable outcomes for clients and staff who are LGBTI - Have strong mechanisms for responding to homophobic and transphobic harassment and discrimination when it occurs - Are accessible, safe and supportive for clients and staff who are LGBTI - Have strong internal leadership in reducing homophobic and transphobic discrimination and model this to other organisations and the wider community - Model, promote and facilitate equitable and respectful inter-group relationships and interactions - Respect and value diversity as a resource - Reflect awareness of mental health and wellbeing issues	Environments that: - Encourage and facilitate positive relationships between people of diverse sexualities, gender identities and intersex status - Recognise the potential for homophobic and transphobic discrimination and inter-group conflict and have strong mechanisms for reducing and responding to it - Respect and value diversity as a resource and demonstrate pride in a diverse community identity - Are welcoming, safe and supportive for LGBTI people of varied backgrounds - Have strong leadership in the reduction of homophobia and transphobia and support of diversity A society that: - Has strong legislative ad regulatory frameworks and appropriate resource allocation to reduce homophobic and transphobic discrimination and support diversity - Demonstrates pride in a diverse population and promotes diversity as a national asset - Recognises and takes action to address the legacy of historical discrimination - Has policies, programs and resource allocation to facilitate positive mental health outcomes in LGBTI communities - Does not stigmatise people with existing mental illnesses	

KEY SOCIAL AND ECONOMIC DETERMINANTS OF MENTAL HEALTH FOR LGBTI POPULATIONS AND THEMES FOR ACTION (CONTINUED)				
LONG-TERM BENEFITS				
Individual	Family	Organisational	Community and societal	
● Reduced discrimination on the grounds of sexual, gender identity and intersex status ● Improved sense of belonging for LGBTI people ● Reduced levels of stress, anxiety, depression and suicide ● Improved health outcomes (inclusive of and beyond mental health) ● Reductions in risky alcohol and/or other drug use ● Reduced socio-economic disadvantage ● Increased productivity and participation ● Improved quality of life ● Positive sexual and gender identities for all ● Reduced pathologisation of intersex experiences and fewer non-consensual medical interventions	● Reduced experiences of familial rejection of LGBTI people ● Improved relationships and interactions within families ● Reduced levels of family and domestic violence ● Reduced levels of LGBTI youth homelessness ● Reduced pathologisation of intersex experiences and fewer non-consensual medical interventions	● Improved productivity and creativity ● Improved health outcomes ● Improved organisational outcomes ● Organisations that reflect a diverse community ● Reduced homophobic and transphobic discrimination, harassment and violence ● Improved productivity and creativity ● An inclusive, safe and accepting society that affirms diversity in all forms	● A culture that values and affirms a diversity of sexualities, gender identities and intersex status ● Reduced disparities in health outcomes between LGBTI populations and the mainstream ● Reduced homophobia and transphobia ● Reduced social isolation and improved relationships and interactions within and between LGBTI groups and mainstream ● Improved distribution of power, resources and opportunities between and within LGBTI groups and the mainstream ● Support for strong, thriving, vibrant and interconnected LGBTI communities ● Strong societal norms against homophobic and transphobic behaviours and institutional practices	

Figure 8 LGBTI Mental Health Promotion Framework.

- Improving monitoring and evaluation of LGBTI mental health promotion and suicide prevention policies, programs and services. This relies on programs defining specific and measurable objectives, and is critical to tracking progress and identifying emerging issues.

Operationally, the framework aims to guide the development, implementation and evaluation of LGBTI mental health promotion initiatives by:

- Defining key outcomes and build a shared vision to work towards
- Setting priorities for action and investment
- Identifying domains, 'actors' and settings for action
- Strategically targeting initiatives towards key populations within the LGBTI community
- Ensuring the best available evidence is used to guide action
- Fostering collaboration and strengthening partnerships
- Improving monitoring and evaluation
- Improving coordination.

The three key audiences for this framework are:

- Mainstream organisations operating in a range of sectors and settings (health, arts, sports, industry)
- LGBTI organisations in a range of sectors and settings (health, arts, sports, industry)
- Funding bodies seeking to promote mental health and prevent suicide
- Policymakers and administrators.

4.2 Key determinants and themes for action

The epidemiological data on the differences in mental health outcomes of mainstream and LGBTI communities, and data on variations in mental health within LGBTI communities, point towards a broad variety of modifiable social and behavioural factors that influence LGBTI people's mental health and wellbeing (see Sections 2 and 3). This framework prioritises four key themes within these that warrant a priority focus:

- Social connection
- Access to social and economic resources
- Freedom from discrimination and violence
- Physical wellbeing and mental health promoting behaviours.

These priorities cross individual, organisational, community and societal domains. In this regard, the framework integrates an ecological model of mental health and is consistent with current mental health promotion practice and concepts discussed in Section 3. Moreover, these four determinants are interrelated, such that they are mutually reinforcing of one another. For example, reducing discrimination is necessary to facilitating opportunities for

social participation, and by extension will also contribute to greater levels of social connection. Effecting change in these four priority determinants is also expected to result in positive impacts beyond population health.

4.2.1 Social connection

Increased social connection and participation are vital to improving the mental health and wellbeing of LGBTI people and reducing suicidal behaviours. Together, they build networks of belonging and value that promote positive mental health among LGBTI people and communities, and mitigate the effects of heterosexist discrimination.

Increasing LGBTI people's social connection and participation involves ensuring that LGBTI people are visible, and valued and active participants in all areas of social life. This requires advocacy and support from government and LGBTI and mainstream services and a commitment to tackling institutionalised heterosexism. It also requires addressing the impact of heterosexism on LGBTI people's friendships, intimate relationships and families. Promoting social connection involves increasing the capacity of LGBTI people to generate and maintain these relationships, including through:

- The provision of LGBTI peer support groups, social networks and other opportunities for participants to be involved in group activities and/or build their interpersonal skills
- Civic engagement, such as community involvement in planning, and
- Directing resources at LGBTI people's friends and families to improve mutual understanding, minimise prejudice, reduce social exclusion and to maximise meaningful, open and caring relationships.

4.2.2 Access to social and economic resources

LGBTI people and communities require access to the material resources and economic security that promote positive mental health and wellbeing and reduce suicidal behaviours. This involves removing the barriers that reduce LGBTI people's access to education and employment, which, in turn can lead to a reduction in their income and access to a range of essential services including health and housing. Many of these barriers are tied to institutionalised heterosexism and to the discriminatory beliefs and practices of individuals. There is also a need to increase the capacity and social capital of LGBTI individuals, organisations and communities to take advantage of the opportunities that accompany the deinstitutionalisation of heterosexism.

4.2.3 Freedom from heterosexist violence and discrimination

While all jurisdictions in Australia have enacted significant legislative reforms, LGBTI people still do not enjoy the full raft of rights and responsibilities afforded non-LGBTI

Australians. Furthermore, data showing high rates of violence and discrimination against LGBTI people suggest that more work needs to be done to tackle deeply held heterosexist prejudice and attitudes. In the absence of full legal and social equality, LGBTI Australians will continue to be at increased risk of mental ill-health linked to their experiences of heterosexist violence and discrimination. Countering negative stereotypes, discriminatory attitudes and practices through social marketing initiatives, public education, media and the arts are also key.

4.2.4 Physical wellbeing and increasing mental health promoting behaviours

Physical activity and wellbeing, including alcohol and other drug use, can significantly impact on mental health and wellbeing in a variety of ways. These factors feature in mainstream mental health frameworks and plans owing to strong evidence of bi-directional relationships between physical health and mental health (WHO, 2005). Available data shows that LGBTI people may be less physically active than their peers and, as discussed in section 2, are more likely to experience alcohol and other drug problems. LGBTI people face numerous barriers to participation in sports – with homophobia still a major concern within clubs and, trans and intersex people are routinely excluded on the grounds that many sports operate within a strict gender and sex binary. Additionally, with many LGBTI socialising in community venues that centre on alcohol, there is a need to promote more alcohol and other drug free social and community events.

While levels of mental health literacy in LGBTI populations have not been directly assessed, mainstream population surveys reveal that many people in Australia have poor mental health literacy (Reavley and Jorm, 2011). The National Survey of Mental Health Literacy and Stigma found many people could not recognise specific disorders or different types of psychological distress; and that beliefs about the causes of mental disorders, and how these can be most effectively prevented and treated differ from mental health expert views. Improvements to mental health literacy are also essential to alleviating stigma that causes additional stress and burden on those already experiencing mental illness, as well as facilitating behavior change and earlier identification of those who are at risk (Kitchener and Jorm, 2002). LGBTI mental health promotion information and resources need to be:

- evidence-based
- LGBTI-affirmative
- targeted at and relevant to LGBTI communities as well as particular subpopulations within those communities
- accessible.

4.3 Target populations

Broadly speaking, promoting LGBTI Australians' mental health and wellbeing involves policies, programs and services that:

- Target LGBTI communities as a whole, affirming their sexualities, gender identities and intersex status and their common experiences of heterosexist discrimination
- Recognise that LGBTI communities are diverse and address the different mental health promotion and service needs of different groups including same-sex attracted and bisexual people, transgender people and intersex people
- Recognise and address the impact of other key determinants, including HIV status; Indigenous, cultural or linguistic heritage; religious affiliation; geographic location; age; disability; and economic status on the mental health and wellbeing of LGBTI individuals and communities
- Promote and support LGBTI people's social networks and positive relationships with friends, partners and family.

While mental health promotion interventions are typically applied at a 'whole of population' level, this framework identifies several subpopulations where targeted approaches are necessary to addressing disadvantage or maximising opportunities for prevention at different stages of the life cycle. In particular, the data presented in section 2 of this document provide a strong rationale for prioritising the following groups on the grounds of their higher prevalence of mental health problems, greater exposure to risk factors and/or gaps in existing programs:

- Older LGBTI people, particularly those in or entering aged care
- Young LGBTI people, particularly those aged 14–25 years
- LGBTI people living in rural and remote areas
- Bisexual identified people
- Aboriginal and/or Torres Strait Islander people
- Intersex people
- Transgender and gender diverse people
- LGBTI people with disabilities and/or chronic illnesses (including HIV/AIDS) and people who live with and/or care for those with disabilities and/or chronic illnesses
- CALD LGBTI, particularly those negotiating cultural or religious beliefs and practices that are discordant with being LGBTI, which may also be compounded by experiences of racism and religious intolerance from within LGBTI communities.

It should be acknowledged that mental health problems affect society as a whole, and no groups are immune, despite the differences in risk distributed between different and within groups. The priority subpopulations identified

in the framework should not preclude also implementing actions that aim to improve mental health and wellbeing at a whole of population level. However, without targeted initiatives, the differences in the distribution of mental health outcomes between these groups and the wider population are likely to grow further.

4.4 Priority sectors and settings

Many of the influences on mental health identified in this framework occur in the settings in which people live their day-to-day lives, such as homes, schools, communities and workplaces. This means that many of the 'drivers' of mental health and wellbeing lie outside of the health care system. For this reason, the framework identifies a number of settings and sectors for action ranging from public spaces and education to sports clubs, health and community services, workplaces, the arts and media, justice, hospital and retail, corporate sectors and local governments. While the data presented in Section 2 highlights that many settings remain hostile (particularly schools, where the majority of experiences of homophobia and transphobia reported by young LGBTI people occurred), there is also emerging evidence of how online spaces play an important role in positively impacting LGBTI people's mental health. In particular, the *Growing Up Queer* study highlighted the important role of online settings in helping young people establish a sense of identity (85.1% reported using the internet to explore their sexuality and/or gender identity).

It is important to recognise that settings-based approaches in mental health promotion are not solely about using settings to reach people or deliver direct participation programs. Rather, a comprehensive settings-based approach should include actions that impact on the settings themselves, in order to foster changes to environments that in turn promote and support positive mental health. Collaborations and partnerships are therefore also integral to effective settings-based approaches. Evidence from strategies addressing race-based discrimination (VicHealth, 2009) suggest that the most important settings are those where:

- the greatest levels of discrimination occur
- experiences of discrimination are most likely to adversely influence an individual's future 'life chances', and
- it is possible and acceptable to implement discrimination reduction strategies.

4.5 Current and planned actions for change

As explained in Section 3, effective mental health promotion requires a comprehensive approach encompassing a variety of mutually reinforcing strategies. The framework highlights seven key actions or methodologies, which are grounded in evidence from

both mainstream and LGBTI specific mental health promotion practice:

- **Advocacy, legislation and policy reform** that impact on mental health, with particular focus on those which affirm diversity and protect against discrimination and violence
- **Communications and social marketing** such as traditional public awareness campaigns and using community forums, local press and social media
- **Strengthening communities and community environments** by facilitating civic participation and assisting communities to identify issues requiring action
- **Direct participation programs** that combine groups of people and places in ways that strengthen existing social ties, foster new social connections, or more broadly, create opportunities for people to participate in other activities that promote mental health
- **Organisational development** that involves workforce development and capacity building to design and implement strategies that increase LGBTI people's participation in a range of social, educational, economic activities, build safe and supportive environments, and ultimately promote mental health
- **Research, monitoring and evaluation** to improve the evidence base for LGBTI mental health promotion, monitor progress towards targets and ensure emerging issues are identified.

4.5.1 Advocacy, legislative and policy reform

Legislation and policy play a key role in facilitating social change. A culture that promotes good mental health is one that affirms difference and diversity and that ensures all people are free from discrimination and the threat of discrimination. This is particularly true for LGBTI Australians who are subject to a history of heterosexist discrimination and its continued impact on their mental health and wellbeing. Legislative reform needs to be implemented across all levels of Government in Australia, including:

- The full legal, social and symbolic recognition of LGBTI people and same-sex and non-heterogendered couples, and
- Changes to Equal Opportunity and anti-discrimination legislation protecting LGBTI people from all forms of heterosexist discrimination, including violence and harassment and the provision of goods and services.

In Australia there are few areas of public life in which LGBTI people are affirmed as LGBTI. In the absence of overt public and symbolic affirmation many LGBTI people will struggle to achieve that sense of personal and collective worth on which good mental health depends. Affirmative public policy and programs include:

- Recognition of LGBTI people and sexual orientation, gender identity and intersex status in federal, state and territory policies and programs that value and promote diversity

- The inclusion of LGBTI people and sexual orientation, gender identity and intersex status in mental health promotion policies, and other policies that address the broader determinants of mental health and wellbeing
- Mandating within policy the provision of LGBTI-inclusive services, including mental health promotion and suicide prevention policies
- LGBTI representation on government bodies dealing with diversity and social participation, and LGBTI inclusion in public events promoting diversity, and
- Funding for LGBTI community organisations and events to promote positive mental health among this population.

Ensuring that the ongoing development of mental health policies and programs:

- Includes LGBTI people's health concerns
- Is evidence-based, and
- Is informed by LGBTI consumers and representatives of LGBTI community, research and health-related organisations.

These would include a raft of policies directly related to mental health, including generic and population-specific mental health and suicide prevention plans. It would also include those policies that address factors known to have an impact on mental health and wellbeing including drug and alcohol use, social participation (including employment) and physical activity, among others. This approach acknowledges that mental health influences and is influenced by all aspects of a person's life and is consistent with the *Fourth National Mental Health Plan*. As the Foreword states 'The whole of government approach articulated within the Fourth Plan acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system' (p.ii).

As early as 2003 the Victorian Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) recommended the automatic inclusion of LGBTI people as a population group in all health-related state policies and the inclusion of sexual orientation and gender identity as descriptors in relevant Department of Human Services data collection (Victorian Government Department of Human Services 2003, p.40). The MACGLH also recommended that standards of quality LGBTI health care be developed and included in 'all funding and service agreements and evaluations of Department of Human Services programs' (p.40).

The recent inclusion of LGBTI people in the Aged Care Act has had an immediate and profound impact on aged care policy, programs and services. LGBTI people are now visible as a 'special needs group' and publicly funded aged and community care services must demonstrate the various ways in which they are meeting their LGBTI clients' needs. While there may be no opportunities to mandate the provision of LGBTI-inclusive mental health care in federal legislation, there are opportunities to ensure their inclusion

in relevant state, territory and federal policies and with that programs and services.

Advocacy

Further policy and legislative reforms requires advocacy initiatives that build collective activity around LGBTI issues and the mobilisation of community groups to:

- Develop policy submissions
- Facilitate representation LGBTI groups on government advisory committees
- Use the media to raise awareness and inform public debate, and
- Support the development of collaborations to progress activities.

For minority and marginal populations where discrimination has been identified as a determinant of reduced health and wellbeing, advocacy and community lobbying have been important health promotion tools. Advocacy for legal reform and LGBTI-inclusive mental health care may involve organisations not traditionally seen as part of a mental health promotion framework such as mainstream and LGBTI equal opportunity and human rights bodies and mainstream champions from outside the health sector.

The involvement of individual and organisational allies not identified as LGBTI is important in changing public attitudes and challenging and removing institutionalised heterosexist discrimination. And of course, allies also benefit from their involvement with LGBTI communities.

4.5.2 Organisational and sector development

Building the capacity for LGBTI-mental health promotion within and beyond the mental health sector involves linkages and co-ordination between:

- Mainstream mental health services
- Mainstream mental health and LGBTI health and community organisations; and
- Mental health and other, non-health services and programs that provide opportunities for health promotion such as:
  - Educational institutions
  - Local council programs; and
  - Disability, aged care and housing services.

It also involves workforce development actions, such as:

- LGBTI-professional development and diversity training for key workforces
- Organisational leadership initiatives that model inclusion
- Training in mental health promotion
- Developing specialist LGBTI-health promotion programs in mainstream health promotion agencies, and
- Increasing the capacity of LGBTI-health services to deliver mental health and suicide prevention programs to LGBTI people.

Within the community and health services sector, LGBTI inclusion starts from a position of affirmation while addressing the impact of heterosexism on LGBTI people's mental health and wellbeing, in addition to addressing other risk and protective factors. LGBTI-inclusive practice values LGBTI people and in no way repeats the heterosexist assumptions, values and practices that have contributed to higher rates of mental ill-health and suicidality among this population. Promotion of services that are actively inclusive of LGBTI people is also needed to ensure that communities are aware of and able to access these services.

4.5.3 Strengthening communities and community environments

The research shows that community building is a key strength of LGBTI people and organisations. However, community strengthening also involves building sustained relationships between LGBTI communities and mainstream groups and organisations in order to enhance social connection. This includes initiatives and partnerships between different community organisations to:

- promote diversity and affirm LGBTI people
- support leadership development of LGBTI people within the broader community who can champion causes
- build community identity (for example activities that acknowledge the presence and contributions of LGBTI communities in the built environment, for example, local architecture and signage)
- deliver community cultural development programs involving artists collaborating with LGBTI communities, and
- resolve conflicts.

Many of these partnerships will be at the local level and engage health professionals, government services, local business, community groups and others as part of a co-ordinated push to create mental health promoting communities. There is also an opportunity to use community-based organisations as opportunistic sites for LGBTI-mental health promotion.

4.5.4 Communications and social marketing

Communications and social marketing initiatives can raise awareness of mental health and wellbeing issues, contribute to developing positive social norms, promoting diversity as well as impact directly on entrenched heterosexist discriminatory attitudes and behaviours towards LGBTI people (including subtle/covert forms of discrimination). A broad range of media can be used in these initiatives (including TV, radio, print, social media and new technologies), which may target the whole population or particular population segments, such as young LGBTI people who are particularly vulnerable to experiencing homophobic and transphobic harassment. Social marketing strategies may also include:

- integrating pro-diversity into existing media, such as through the inclusion of LGBTI characters and stories in film and television or campaigns that highlight the strength and value of being LGBTI
- development of materials that aim to dispel myths and stereotypes, raise awareness and increase empathy (e.g. factsheets, brochures)
- community arts projects aimed at promoting positive imagery of LGBTI people.

They also include different types of public education campaigns including activities and programs that aim to promote mental health promoting behaviours; and the development and distribution of information and resources on LGBTI-inclusive mainstream and targeted mental health services.

Mainstream

Few jurisdictions in Australia have considered developing a comprehensive strategy that acknowledges and supports sexual, intersex and gender identity diversity or tackles heterosexism and its effects on the mental health and wellbeing of LGBTI people (Gray, et al., 2009). In 2001, the Tasmanian government included in its twenty year forward plan a whole-of-government blueprint for tackling homophobic harassment and its effects on LGBTI people (Department of Premier and Cabinet, 2001). However, the limited implementation of the blueprint did not include social marketing initiatives or public campaigns.

In the UK, the Terrance Higgins Trust has used government HIV prevention money to develop public anti-homophobia and education awareness campaigns.¹³ Australia has, until very recently, followed a similar 'model', with LGBTI organisations using limited government funds, often tagged 'HIV prevention', to develop targeted public education campaigns (Gray, et al., 2009). Anti-homophobia campaigns have been run in NSW and Victoria by their anti-violence projects (AVP NSW and AVP VIC respectively), but these have been time limited, developed on small budgets, and have not been part of broader, comprehensive approaches to challenging heterosexist attitudes and practices and acknowledging and supporting diversity.

In 2010, the Victorian Government provided a small amount of funding to a broad coalition of LGBTI community and mainstream mental health organisations to deliver

13 At www.tht.org.au/informationresources The THT is a national organisation that seeks to maximise sexual health in the UK and minimise the spread of HIV and STIs.

14 The *No To Homophobia* campaign represents a partnership between the Victorian Gay and Lesbian Rights Lobby, TransGender Victoria and the Anti-Violence Project of Victoria, with key support from the Human Rights Law Centre, headspace and the Victorian Equal Opportunity and Human Rights Commission. The *No To Homophobia* campaign received funding from the Victorian Department of Health in 2010, as part of the *With Respect Awareness Project* (WRAP). See www.notohomophobia.com.au

an anti-homophobia campaign tackling harassment and discrimination faced by LGBTIQ (queer) persons.¹⁴ The *No To Homophobia* campaign aimed to assist LGBTIQ people and the broader community to respond to and speak out against heterosexual harassment, and encouraged reporting of incidents of abuse to police and the Victorian Equal Opportunity and Human Rights Commission. The Campaign was the first of its kind to be broadcast on national television in Australia.

In 2012 beyondblue launched the national campaign *Stop. Think. Respect*, which seeks to challenge heterosexual discrimination and to encourage LGBTIQ people who are at risk of or experiencing mental health problems to seek help.¹⁵ beyondblue's LGBTIQ program is ongoing and includes a suite of online resources such as *Real Life Stories* from six LGBTIQ people, a position statement, printed materials and an advertisement that has been shown in cinemas and on TV across Australia. beyondblue's continued engagement with LGBTIQ people marks a radical departure for the organisation which had focused, primarily, on research projects and clinical outcomes. In seeking to improve the mental health of LGBTIQ people beyondblue has adopted a population approach and begun to explore the broader social determinants of increased rates of depression and anxiety among this population. This approach is indicative of a shift within mainstream mental health care agencies and growing recognition of the role that systemic discrimination and prejudice play in driving increased rates of mental health problems among not only LGBTIQ communities but other minority and marginal populations.

LGBTIQ communities

Both the *No to Homophobia* campaign and beyondblue's LGBTIQ program have a dual focus, working with mainstream and LGBTIQ communities. This reflects an emerging understanding that improvements in LGBTIQ health and wellbeing are dependent on two interrelated processes: changing public attitudes toward LGBTIQ people and increasing LGBTIQ people's access to and use of services.

In 2002 AVP NSW ran its *Violence can happen on any street* campaign which was directed at LGBT people and communities. The campaign provided information on how to minimise the risk of homophobic violence, what to do during an attack and where to make a report and seek help, including counselling, following a homophobic incident (Gray et al., 2009, p.25). At the same time AVP VIC developed the *Make some noise* campaign aimed at encouraging victims and witnesses to report incidents of homophobic and transphobic violence to police and to

seek appropriate assistance and care (Gray et al., 2009, p.25).

However, both these campaigns were limited in scope and dealt less with mental health promotion than with the immediate mental health consequences of isolated incidents of heterosexual violence. In Australia, few LGBTIQ organisations have either the resources or mandate to produce LGBTIQ mental health promotion campaigns. It is only recently that LGBTIQ and some mainstream organisations have considered developing resources and programs that affirm LGBTIQ people and encourage increased social participation, physical activity and healthy living as part of a comprehensive LGBTIQ mental health promotion strategy.

4.5.5 Research, monitoring and evaluation

There is a need for sustained research, monitoring and evaluation efforts in LGBTIQ mental health promotion, particularly in relation to:

- Gaps in our current understanding of the changing determinants of reduced mental health and wellbeing among LGBTIQ Australians
- Gaps in our current knowledge of the specific programs, services and activities that promote and maintain positive mental health outcomes for LGBTIQ people
- The mental health and service needs of subpopulations within LGBTIQ communities whose specific needs have not been addressed or who are particularly vulnerable to the negative mental health impacts of heterosexism including:
  - LGBTIQ and questioning young people
  - Older LGBTIQ people, and
  - Trans* people.

There is also a pressing need for research on the mental health of people with intersex conditions. Little is known of the effects of medical interventions on the mental health of people with intersex conditions across the life course, nor on the risk and protective factors that lessen the potentially negative effects of narrow conceptions of the sexed and gendered body. Little is also known of how the pressures placed on the parents and relatives of infants born with intersex conditions to have their children conform to narrow notions of sex and gender affect their mental health and with that their ability to make informed choices.

There is a need for more national data on LGBTIQ people's mental health and wellbeing. Questions on sexual orientation, gender identity and intersex status need to be included in national and state and territory population and secondary school surveys and in service usage and client entry data.

Monitoring and evaluation of activities associated with this framework is also essential and will need to be integrated into existing mental health promotion evaluation systems.

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15 At www.beyondblue.org.au/resources/for-me/gay-lesbian-bi-trans-and-intersex-glbti-people

The purpose of such research is threefold, and may be used (1) as the basis for planning, advocacy and awareness raising; (2) to monitor progress of programs in relation to reducing experiences of discrimination and improving mental health outcomes in LGBTI communities; (3) evaluation to build knowledge and improve practice and policy.

4.6 Outcomes

Through the implementation of this framework, the National LGBTI Health Alliances aims to make a measurable contribution to mental health promotion with and for LGBTI people. However, LGBTI mental health promotion is also expected to have a positive impact on the mental health and wellbeing of all Australians. In particular, addressing heterosexism in all its forms will result in a more open and inclusive society for all.

The framework defines numerous intermediate and long-term outcomes across individual, family, organisational and community/societal domains. These provide important guidance for both program design and policy makers. It must be acknowledged that while many of the actions and outcomes in this framework are grounded in evidence-based mental health promotion strategies and lessons from strategies addressing race-based discrimination, there is a lack of strong evidence in terms of LGBTI specific mental health promotion practice. This underscores the importance of monitoring and evaluating the implementation of this framework.

Intermediate outcomes

Intermediate outcomes describe targets for change in the short to medium term, as a result of implementing the framework.

Individuals who:

- Recognise the prevalence and impact of homophobia and transphobia
- Have accurate knowledge about and are comfortable with being/being socially connected to people with different sexual orientations and/or are transgender, gender diverse and/or intersex
- Recognise the benefits of diversity in genders, sexualities and bodies, support and feel pride in a diverse community
- Interact with LGBTI people in respectful and just ways
- Demonstrate mental health literacy and skills for maintaining and improving mental wellbeing
- Demonstrate self-esteem and self-efficacy
- Feel a sense of self-determination and control
- Adopt and sustain mental health promoting behaviours.

Families that:

- Have accurate knowledge about diversity in sexual orientation, gender identity and intersex issues
- Accept and are comfortable with people with different sexual orientations and/or are transgender, gender diverse and/or intersex
- Celebrate same-sex relationships and affirm these as equal to heterosexual relationships
- Recognise and support LGBTI people's right to self-determination (particularly as this relates to autonomy in decisions around medical interventions for transgender, gender diverse and/or intersex people).

Organisations that:

- Have policies and procedures to reduce discrimination and ensure fair and equitable outcomes for clients and staff who are LGBTI
- Have strong mechanisms for responding to homophobic and transphobic harassment and discrimination when it occurs
- Are accessible, safe and supportive for clients and staff who are LGBTI
- Have strong internal leadership in reducing homophobic and transphobic discrimination and model this to other organisations and the wider community
- Model, promote and facilitate equitable and respectful inter-group relationships and interactions
- Respect and value diversity as a resource
- Reflect awareness of mental health and wellbeing issues.

Environments that:

- Encourage and facilitate positive relationships between people of diverse sexualities, gender identities and intersex status
- Recognise the potential for homophobic and transphobic discrimination and inter-group conflict and have strong mechanisms for reducing and responding to it
- Respect and value diversity as a resource and demonstrate pride in a diverse community identity
- Are welcoming, safe and supportive for LGBTI people of varied backgrounds
- Have strong leadership in the reduction of homophobia and transphobia and support of diversity.

A society that:

- Has strong legislative and regulatory frameworks and appropriate resource allocation to reduce homophobic and transphobic discrimination and support diversity
- Demonstrates pride in a diverse population and promotes diversity as a national asset

- Recognises and takes action to address the legacy of historical discrimination
- Has policies, programs and resource allocation to facilitate positive mental health outcomes in LGBTBI communities
- Does not stigmatise people with existing mental illnesses.
- Support for strong, thriving, vibrant and interconnected LGBTBI communities
- Strong societal norms against homophobic and transphobic behaviours and institutional practices
- Improved productivity and creativity
- An inclusive, safe and accepting society that affirms diversity in all forms.

Long-term benefits

As a result of implementing the framework the following long-term changes and benefits are expected.

Individuals outcomes

- Reduced experiences of homophobia and transphobia
- Improved sense of belonging for LGBTBI people
- Reduced levels of stress, anxiety and depression
- Improved health outcomes (inclusive of and beyond mental health)
- Reductions in risky alcohol and/or other drug use
- Reduced socio-economic disadvantage
- Increased productivity and participation
- Improved quality of life
- Positive sexual and gender identities for all
- Reduced pathologisation of intersex experiences and fewer non-consensual medical interventions.

Family outcomes

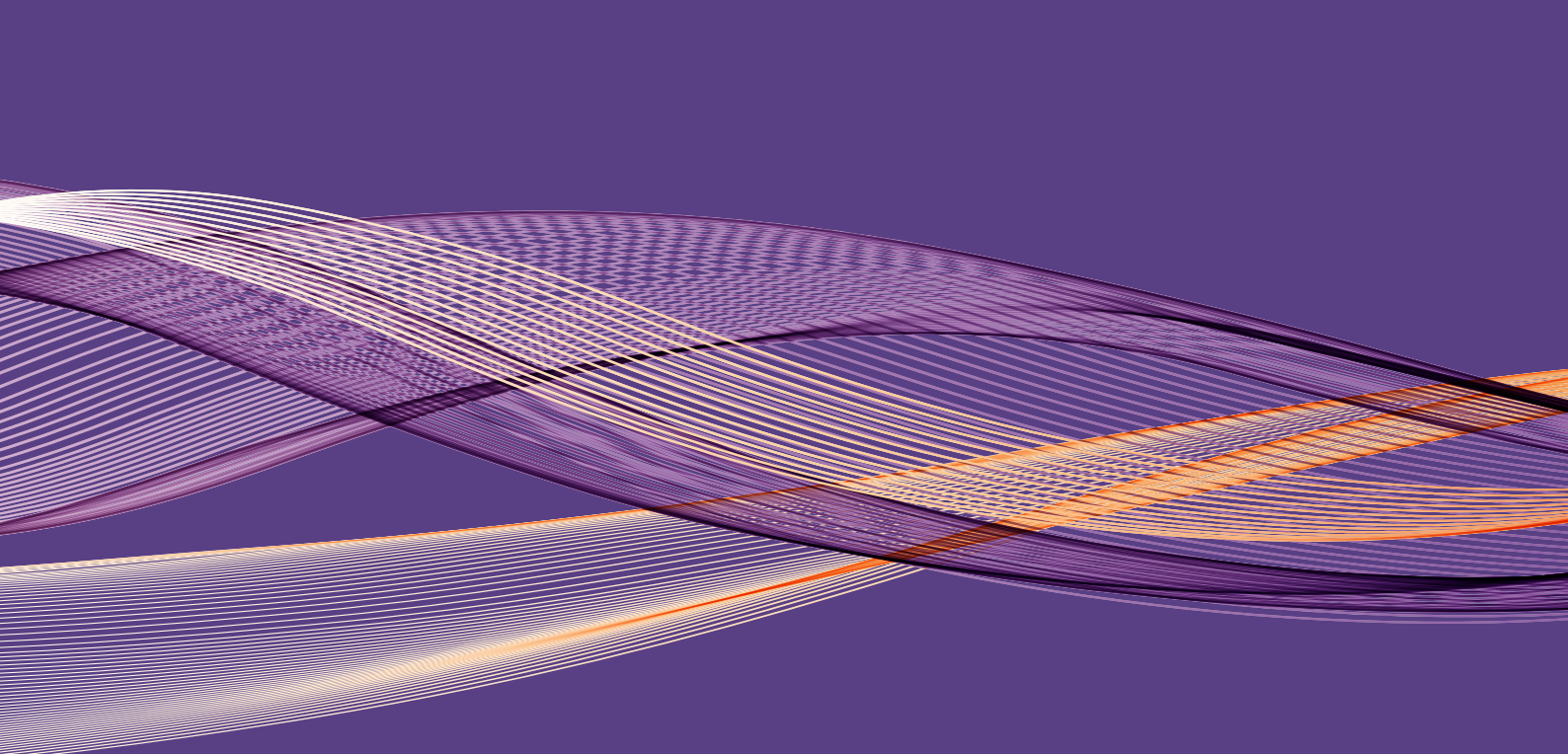
- Reduced experiences of familial rejection of LGBTBI people
- Improved relationships and interactions within families
- Reduced levels of family and domestic violence
- Reduced levels of LGBTBI youth homelessness
- Reduced pathologisation of intersex experiences and fewer non-consensual medical interventions.

Organisational outcomes

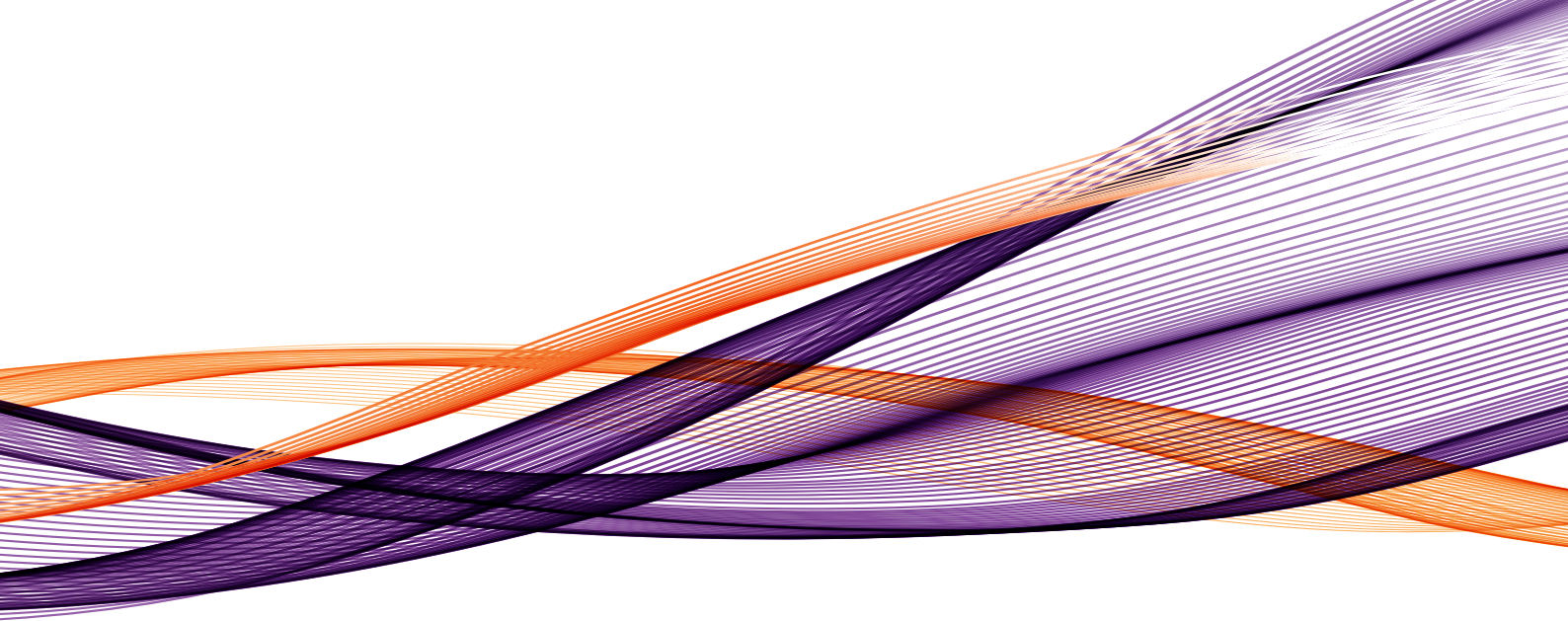
- Improved productivity and creativity
- Improved health outcomes
- Improved organisational outcomes
- Organisations that reflect a diverse community
- Reduced homophobic and transphobic discrimination, harassment and violence.

Community and societal outcomes

- Reduced disparities in health outcomes between LGBTBI populations and the mainstream
- Reduced homophobia and transphobia
- Reduced social isolation and improved relationships and interactions within and between LGBTBI groups and the mainstream
- Improved distribution of power, resources and opportunities between and within LGBTBI groups and the mainstream



Through the implementation of this framework, the National LGBTI Health Alliances aims to make a measurable contribution to mental health promotion with and for LGBTI people. However, LGBTI mental health promotion is also expected to have a positive impact on the mental health and wellbeing of all Australians. In particular, addressing heterosexism in all its forms will result in a more open and inclusive society for all.



Appendix A: Project Advisory Group

Name	Organisation
David Belasic	Mental health lived experience representative
Vicky Coumbes	Manager Ageing and Training, ACON
Megan Hansford	Project Advisor, Social Inclusion, Beyondblue
Liam Leonard	Director, Gay and Lesbian Health Victoria
Atari Metcalf	Evaluation Manager ReachOut.com by Inspire Foundation; Board Member: Twenty10 incorporating GLCS NSW; Suicide Prevention Australia; MHWG, National LGBTI Health Alliance
Sally Morris	MindOUT! Queensland Co-ordinator, Healthy Communities, Queensland AIDS Council
Daniel Parker PhD	Clinical Psychology, WA Health Older Adult Mental Health Service
Delaney Skerrett	Research Fellow, Australian Institute for Suicide Research and Prevention, Griffith University
Barry Taylor	Senior Project Officer, MindOUT! LGBTI Mental Health and Suicide Prevention Project, National LGBTI Health Alliance
Irene Verins	Program Manager, Social Connection, VicHealth

Appendix B: Risk and protective factors for mental health (WHO 2005)

Risk factors	Protective factors
Academic failure	Ability to cope with stress
Caring for chronically ill or dementia patients	Ability to face adversity
Child abuse and neglect	Adaptability
Chronic insomnia	Autonomy
Chronic pain	Exercise
Elder abuse	Feelings of security
Excessive substance use	Feelings of mastery and control
Exposure to aggression, violence and trauma	Good parenting
Family conflict or disorganization	Literacy
Loneliness	Positive attachment and early bonding
Medical illness	Positive parent-child interaction
Parental mental illness	Problem solving skills
Personal loss – bereavement	Pro-social behavior
Poor work skills and habits	Self-esteem
Social incompetence	Skills for life
Stressful life events	Social and conflict management skills
	Stress management
	Social support for family and friends

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