

**Submission
No 29**

PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

Organisation: ACON
Name: Mr James Gray
Position: Associate Director of Policy, Strategy, Research
Date Received: 31 August 2017

HERE FOR HEALTH

SUBMISSION ON:

Youth Suicide Prevention

August 2017



ABOUT ACON

ACON is New South Wales' leading health promotion organisation specialising in HIV prevention, HIV support and lesbian, gay, bisexual, transgender and intersex (LGBTI) health. Established in 1985 as the AIDS Council of NSW, our mission is to enhance the health and wellbeing of our communities by ending HIV transmission among gay and homosexually active men, and promoting the lifelong health of LGBTI people and people with HIV.

Contact

If you would like further information about our submission, please do not hesitate to contact James Gray, our Associate Director Policy Strategy & Research, on [REDACTED]

Introduction

ACON welcomes the opportunity to provide input to the Committee on Children and Young People on the current approaches aimed at preventing youth suicide in New South Wales. We recognise that youth suicide has a lasting impact on friends, families, schools and communities.

Our submission focuses on the experiences of lesbian, gay, bisexual transgender and intersex (LGBTI) young people and in particular speaks to the Inquiry's following Terms of Reference: (d) provision of services for vulnerable and at-risk groups, (e) data collection about the incidence of youth suicide and attempted suicide, (f) provision of high-quality information and training to service providers and (g) approaches taken by primary and secondary schools.

It is well documented that young people who are gender or sexuality diverse face specific barriers to mental health and social inclusion and require tailored suicide prevention measures.

LGBTI youth are a significant population

LGBTI youth are a significant population. Research from the Australian Research Centre for Sex, Health and Society has found that 16.8% of secondary school students in Australia report that they are attracted to people of the same sex as them or to both sexes (Mitchell et al., 2014, Table 5.14).

Among the general population, the 2014 second national Australian Survey of Health and Relationships found that of over 20,000 people surveyed, 6.5% of men reported having sexual experiences that were not exclusively with the other sex and 13.5% of women reported having sexual experiences that were not exclusively with the other sex (Richters et al., 2014, Table 1).

Very few studies exist in Australia or internationally that attempt to estimate the prevalence of transgender populations and the Australian census does not adequately capture gender diverse people. The nationally representative New Zealand Adolescent Health Survey (Youth'12) of more than 8,500 young people indicates that around 4% of students may be transgender (Clark et al., 2014).

It is also difficult to accurately estimate the prevalence of intersex people in Australia, due to the lack of accurate recording of data on intersex diagnoses, and ideology (OII, 2013). Organisation Intersex International (OII) Australia recommends the intersex prevalence estimate suggested by Fausto-Sterling of 1.7% of all live births (Fausto-Sterling, 2000).

Given the significant levels of sexual identity, attraction and experiences among Australians that are not exclusively heterosexual, and the number of people who are not cisgender or have intersex variations, a comprehensive youth suicide prevention plan requires ensuring that LGBTI young people live in a safe and inclusive environment with appropriate support structures in place.

LGBTI people are a priority population for suicide prevention

LGBTI communities are at higher risk and in need of tailored approaches for suicide prevention. Suicide Prevention Australia has identified LGBT¹ youth as being particularly vulnerable to suicide (SPA, 2008). The Australian Institute for Suicide Research and Prevention conducted a study to identify factors specific to LGBT suicide cases in Australia, using data from the Queensland Suicide Register and psychological autopsy interviews with people who knew well an LGBT person who had died by suicide (Skerrett, 2015).

Their Final Report on Suicidal Behaviours in LGBT Populations found that '[y]ounger LGBT suicides were characterised principally by non-acceptance of sexuality/gender (by family but also by self)'. The study results paint the following picture of the lives of LGBT individuals who died by suicide:

- LGBT suicides were more likely than living control comparison groups to feel (very) bad about their identity and internalised trans/homophobia and internalised shame were also elevated.
- LGBT individuals who died by suicide went through 'coming out' milestones some 2 years earlier, on average, than living LGBT controls.
- There was high incidence of relationship conflict in the lives of LGBT people who died by suicide and older suicides were chiefly characterised by this.
- LGBT suicide cases were more likely than living LGBT people to have experienced a serious physical assault as well as a sexual assault.
- LGBT suicides had 23 times higher odds of a current major depressive episode than living LGBT people. Anxiety disorders were also more prevalent in LGBT suicides.
- Odds of a previous attempt were 9 times higher in LGBT suicides than living controls.
- The prevalence of substance use disorders was lower in LGBT than in the non-LGBT suicide cases but elevated in suicides compared to LGBT living controls.
- LGBT suicide cases were more likely to have been under the care of psychiatrist and to be on medication and been a resident of a correctional or mental health facility.
- There was a higher prevalence of HIV/AIDS in LGBT suicides than non-LGBT suicides but not between suicides and living controls.
- LGBT people may require targeted approaches in mental health services, school-based programs, and public health and stigma reduction campaigns.
- The need for services to be inclusive of sexuality and gender diversity is highlighted.

There is limited published information about suicidality among intersex people, however intersex people also report similar experiences of mental health in relation to perceptions of not presenting as a binary sex. Respondents in the *Intersex Stories and Statistics of Australia* report linked experiences of self-harm, suicide and negative wellbeing to other people's negative responses to their intersex variation and the impact of having undergone traumatising medical interventions, unwanted surgery and loss of autonomy, in addition to stigma, discrimination, isolation, rejection and bullying (Jones et al., 2016, 120-123).

¹ The use of the community acronym across this submission is varied due to the scope and population of research that is cited.

LGBTI youth face specific risk factors and higher rates of mental health issues

Young LGBTI people and those who are questioning their gender or sexuality may experience mental health issues more severely than do heterosexual, cisgender young people. Research indicates that younger LGBTI people are at an increased risk of depression, anxiety disorders, self-harm, and suicide (Brown 2002, pp. 2-3, Brennan et al. 2010, p. 255; Cochran and Mays, 2009, p. 1; Cochran, Greer Sullivan, and Mays 2003, p. 53; King et al. 2008, p. 1; Sandfort et al. 2001, p. 85).

In the study *Growing Up Queer: Issues facing young Australians who are gender variant and sexuality diverse*, 100% of bisexual, queer and questioning male to female trans people, 100% of gay, homosexual, lesbian, bisexual or questioning female to male trans people, and 100% of intersex people had thought about self-harm (Robinson et al., 2014, 23).

The onset of mental health disorders across the general population peaks between the ages of 16 and 24, followed closely by the 25-34 age group, coinciding (among the younger cohort) with the exploration of sexuality and formation of sexual identity (Slade et al. 2009, p. xii).

High rates of self-harm and suicidal thoughts have been linked to ongoing harassment and violence directed at same sex attracted young people (beyondblue 2010, p.13). The major risk factors contributing to the development of depression in youth include 'adjustment to sexual orientation', 'peer and societal reactions to same gender sexual orientation' and 'bullying and violence' (beyondblue 2010, p. 14).

Aboriginal and Torres Strait Islander LGBTQI Sistergirl and Brotherboy populations are particularly vulnerable (Bonson, 2017; ATSIPEP, 2015), and Aboriginal and Torres Strait Island people are recognised in the forthcoming Fifth National Mental Health Plan alongside people with culturally and linguistically diverse (CALD) background as having 'specific needs.' In some parts of Australia, the suicide rate among young Indigenous people is at the very high end of the global spectrum (a suicide rate of 90.8 per 100,000 population among Indigenous males aged 25 – 29 years). Social and cultural considerations, including experiences of marginalisation, discrimination, criminalisation and incarceration, must be taken into account in developing approaches to suicide prevention.

Marginalisation further impacts people's access to and retention within support services. People living in regional, rural and remote settings continue to face barriers to appropriate service provision in addition to basic infrastructure. Stigma and discrimination are often related to social, legal and cultural marginalisation, and this marginalisation can be a precursor to the development of mental illness and suicidality.

NSW suicide prevention strategies should use Lifespan model

In 2016 the NHMRC Centre of Research Excellence in Suicide Prevention at the Black Dog Institute produced a guidance document for Primary Health Networks, entitled *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring* (hereafter the 'Commissioning Guidelines'). These Commissioning Guidelines specifically state that LGBTI communities are identified as higher risk and in need of tailored approaches (Ridani, 2016, 5), and offer a systems approach to suicide prevention with nine strategies likely to lead to suicide reduction:

- Aftercare and crisis care (strategy one)
- Psychosocial and pharmacotherapy treatments (strategy two) –
- GP capacity building and support (strategy three)
- Frontline staff and gatekeeper training (strategies four and five)
- School programs (strategy six)
- Community campaigns (strategy seven)
- Media guidelines (strategy eight)
- Means restriction (strategy nine)

The nine strategies within the Lifespan Model and these Commissioning Guidelines could be adapted for use by Local Health Districts for a similar approach in NSW to commissioning suicide prevention services.

School programs are particularly important for LGBTI youth suicide prevention

For LGBTI youth, schools are a primary place in which suicide prevention programs can have significant impact. A tailored approach for suicide prevention among LGBTI people requires specific programs within the school system.

In the La Trobe University study of 3134 same sex attracted and gender questioning (SSAGQ) young people, *Writing Themselves In 3: The third national Australian study on the sexual health and wellbeing of same sex attracted and gender questioning young people*, researchers found that (Hillier et al. 2010, p. 39):

- 61% of young people reported verbal abuse because of homophobia,
- 18% of young people reported physical abuse because of homophobia,
- 80% of those who were abused experienced the abuse at school,
- 69% reported other forms of homophobia including exclusion and rumours, and
- Young men and genderqueer young people reported more abuse than young women.

These experiences were associated with feelings of being unsafe, excessive AOD use, self-harm and suicide in young people. For more than half of the respondents, homophobia impacted on a range of aspects of schooling (Hillier et al., 2010, p. 49). In that study, only 19% of young people attended a school that was supportive of their sexuality and over a third described their school as homophobic (Jones and Hillier, 2010).

Similarly, in the *Growing Up Queer* study, young people experienced homophobic and transphobic harassment and violence in schools, from families, in the workplace, on the streets, and at other public sites and sporting events:

Almost two-thirds of the 1032 young people who completed the survey experienced some form of homophobia and/or transphobia, with some experiencing multiple forms of abuse – 64% had been verbally abused, 18% physically abused, and 32% experienced other types of homophobia and transphobia. Schools were identified as the major site in which homophobia and transphobia prevailed (Robinson et al., 2014, v).

A survey of 564 LGBTIQ individuals in 2015 by Bully Zero Australia Foundation report that over 50% of same-sex attracted or gender diverse young people in Australia have experienced verbal abuse and over 70% of these homophobic and transphobic incidents take place in schools (Bully Zero Foundation, 2017).

Bullying and discrimination can impact on young people's mental health, self-esteem and sense of safety and can affect attendance, concentration and academic achievement. The beyondblue report *From Blues to Rainbows* on mental health and wellbeing of trans and gender diverse young people in Australia found that almost two thirds of the young people had experienced verbal abuse in response to their gender presentation or non-conformity and one fifth had experienced physical abuse. Over 90% of young people who experienced physical abuse had thought about suicide in response to their experience (Smith et al., 2014)

General anti-bullying approaches have been ineffective in reducing bullying among our communities. Specific support for LGBTI students in schools is a requisite part of suicide prevention. The Commissioning Guidelines state that 'To better equip the LGBTI population to manage their sexual and mental health, school programs that address bullying, homophobia, and transphobia should be factored into the school framework' (Ridani, 2016, 20). Strategy six of the Guidelines is 'focused on increasing health-seeking, mental health literacy, and knowledge of suicide warning signs and help strategies' (Ridani, 2016, 2).

Research demonstrates that LGBTI health relies upon the promotion of progressive sexuality education messages addressing homophobia in classrooms (Jones and Hillier, 2012). Social inclusion must be built into school curriculum and policies. *Writing Themselves In 3* found that young people who attended a school that was supportive, rather than homophobic, were less likely to self-harm and attempt suicide (Hillier et al., 2010). Research from beyondblue identifies this population as needing targeted and tailored support at school where leadership address students with their preferred pronouns, are flexible about uniform and bathroom arrangements and took a stand against bullying (Smith et al., 2014).

Sexuality and gender indicators are necessary in data collection

In order to meet the specific needs of LGBTI youth at risk of suicide, we need accurate information about rates and experiences of suicide attempts within this population. The Commissioning Guidelines recommend that hospitals include gender and sexuality indicators for individuals who have made a suicide attempt and state that all PHNs should aim to acquire additional data related to gender and sexuality to make visible the needs of specific at-risk populations (Ridani, 2016, 14).

There is now precedent for the uptake of improved gender and sexuality indicators in Victoria, where VIC Health and Human Services have recently amended the HIV Notification form to more accurately capture gender. In addition the NSW Alcohol and Drug Association (NADA) have also incorporated our recommended gender and sexuality indicators in their minimum data set in 2016, requiring community based AOD sector organisations to collect this data across NSW. Including these questions will allow NADA, their member organisations and their research partners to begin to build the evidence base to better understand how LGBTI people are accessing mainstream services and the treatment outcomes they experience.

Capacity building and inclusivity training of mainstream services

Suicide prevention among LGBTI youth requires both resourcing of specific services and capacity building of mainstream services. LGBTI youth need access to services that are inclusive, sensitive, culturally appropriate, non-judgmental with an adequately trained workforce.

The Commissioning Guidelines state that LGBTI inclusivity training should be a key component of a local suicide prevention action plan (Ridani, 2016, 9). This involves GP capacity building and support (Strategy 3) in addition to frontline staff and gatekeeper training (Strategies 4 and 5) to better support LGBTI clients (Ridani, 2016, 18-19) and identify appropriate referral pathways. This includes training for all mental health and alcohol and other drugs (AOD) services.

In addition, LGBTI inclusive mental health professionals should be identified and included in locally-based resource packs (Ridani, 2016, 14, 16). Strong linkages should be built between LGBTI specific services and mainstream mental health and AOD services.

ACON provides a wide range of training and consultancy services to assist with all aspects of LGBTI inclusion. MindOUT!, the National LGBTI mental health and suicide prevention project, helps mainstream mental health and suicide prevention organisations to be more responsive to the needs of LGBTI people and communities.

A peer approach is most effective

Approaches to suicide prevention must be informed by people with lived experience. LGBTI specific services and LGBTI staff can provide positive role models, strategies for coping with stigma and tailored interventions. ACON has a long history of developing and delivering effective and engaging peer-led health promotion and support programs.

Configurations of caring networks can be different among LGBTI communities, which can have implications for suicide prevention, crisis care and aftercare. There is a need to identify who community gatekeepers are in LGBTI communities, and who are the most appropriate carers, family, friends or kin to be incorporated into care plans. These carer networks may be overlooked or not initially identified, so understanding LGBTI models of caring networks is crucial.

Unique mental health promotion campaigns

The high rates of suicidality in LGBTI communities indicate unique issues that must be responded to in unique ways. Mainstream mental health campaigns do not always resonate with LGBTI people because of experiences of stigma, discrimination and coming out. As such, suicide prevention efforts must include LGBTI specific mental health promotion campaigns (Ridani, 2016, 22).

The Commissioning Guidelines recommend in Strategy Seven that 'PHNs are encouraged to work closely with local communities and government organisations to identify existing programs and ensure targeted, consistent messaging' (Ridani, 2016, 2).

Strategy 8 recommends the responsible reporting of suicide by the media. It is common for LGBTI people to be outed or misgendered in media coverage, which can be sensationalist and stigmatising, particularly for people with trans experience. Media guidelines for reporting suicide should include guidance for how LGBTI people are referenced to avoid additional stigma.

Recommendations

We make the following recommendations for youth suicide prevention in NSW, to meet the specific needs and unique risk factors facing LGBTI youth.

- LGBTI people must be recognised as a priority population with unique needs;
- Data systems for monitoring suicide and suicide attempts must include appropriate sexuality and gender indicators;
- Mainstream services must see LGBTI young people as a core constituency;
- Specialised support services are required; and
- Schools require specific resources and training to address LGBTI youth suicide.

References

- Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP). 2015. Sexuality and Gender Diverse Populations (Lesbian, Gay, Bisexual, Transsexual, Queer and Intersex - LGBTQI) Roundtable Report. The Healing Foundation, Canberra.
- Beyondblue. 2010. Clinical Practice Guidelines: Depression in adolescents and young adults, beyondblue: the national depression initiative, Melbourne.
- Bonson, Dameyon. 2017 Voices from the Black Rainbow: Aboriginal and Torres Strait Islander LGBTQI Sistergirl and Brotherboys people in health, wellbeing and suicide prevention strategies. Indigenist: Western Australia.
- Brennan, D.J., Ross, L.E., Dobinson, C., Veldhuizen, S., and Steele, L.S. 2010, 'Men's Sexual Orientation and Health in Canada', Canadian Journal of Public Health, Vol. 101, Iss. 3, pp. 255-258.
- Brown, R. 2002. 'Self Harm and Suicide Risk for Same Sex Attracted Young People: A family perspective', Australian eJournal for the Advancement of Mental Health, Vol. 1, Iss. 1
- Bully Zero Australia Foundation. 2017. What is Homophobic Bullying? accessed at <http://bzaf.org.au/homophobic-bullying/> on 29 March 2017.
- Clark, T. C., Lucassen, M. F., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., & Rossen, F. V. 2014. The health and well-being of transgender high school students: results from the New Zealand adolescent health survey (Youth'12). *Journal of Adolescent Health*, 55(1), 93-99.
- Cochran, S.D. and Mays, V.M. 2009. 'Burden of Psychiatric Morbidity among Lesbian, Gay, and Bisexual Individuals in the California Quality of Life Survey, *Journal of Abnormal Psychology*, Vol. 118, Iss. 3, pp. 647-658.
- Cochran, S.D., Greer Sullivan, J., and Mays, V.M. 2003. 'Prevalence of Mental Disorders, Psychological Distress and Mental Health Services Use among Lesbian, Gay, and Bisexual Adults in the United States', *Journal of Consulting and Clinical Psychology*, Vol. 71, No. 1, pp. 53-61.
- Jones, T., Hart, B., Carpenter, M., Ansara, G. Leonard, W, Lucke, J. 2016. *Intersex: Stories and Statistics from Australia*. Cambridge, UK: Open Book Publishers.
- Jones, T., Hillier, L. 2012. 'Sexuality education school policy for Australian GLBTIQ students', *Sex Education*, 12:4, 437-454.
- King, M., Semlyen, J., See Tai, S., Killaspy, H., Osborn, D., Popelyuk, D., and Nazareth, I. 2008, 'A Systematic Review of Mental Disorder, Suicide, and Deliberate Self Harm in Lesbian, Gay and Bisexual People', *BMC Psychiatry*, Vol. 8, No. 70.
- Fausto-Sterling, A. 2000. *Sexing the body: Gender politics and the construction of sexuality*. New York City: Basic Books.
- Mitchell A, Patrick K, Heywood W, Blackman P, Pitts M. 2014. *5th National Survey of Australian Secondary Students and Sexual Health 2013*, (ARCSHS Monograph Series No. 97), Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia. Table 5.14
- OII Australia. 2013, September 28. *On the number of intersex people*. Retrieved October 24, 2013, from OII Australia - Intersex Australia: <http://oii.org.au/16601/intersex-numbers/>
- Richters, J., Altman, D., Badcock, P. B., Smith, A. M., de Visser, R. O., Grulich, A. E., ... & Simpson, J. M. 2014. Sexual identity, sexual attraction and sexual experience: the Second Australian Study of Health and Relationships. *Sexual health*, 11(5), 451-460. Table 1.
- Veale, J. F. 2008. The prevalence of transsexualism among New Zealand passport holders. *The Australian and New Zealand Journal of Psychiatry*, 1-9.

Robinson, KH, Bansel, P, Denson, N, Ovenden, G & Davies, C 2013, *Growing Up Queer: Issues Facing Young Australians Who Are Gender Variant and Sexuality Diverse*, Young and Well Cooperative Research Centre, Melbourne.

Ridani, R., Torok, M., Shand, F., Holland, C., Murray, S., Borrowdale, K., Sheedy, M., Crowe, J., Cockayne, N., Christensen, H. 2016. An evidence-based systems approach to suicide prevention: guidance on planning, commissioning, and monitoring. Sydney: Black Dog Institute.

Sandfort, T.G.M., de Graaf, R., Bijl, R.V., and Schnabel, P. 2001. 'Same Sex Sexual Behavior and Psychiatric Disorders: Findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS)', *Archives of General Psychiatry*, Vol. 58, Iss. 1, pp. 85-91.

Skerrett, D. M., Kølves K., & De Leo, D. 2015. Suicidal Behaviours in LGBT Populations. Final Report to the *beyondblue*.

Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., Saw, S. 2009. The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra.

Smith, E., Jones, T., Ward, R., Dixon, J., Mitchell, A., & Hillier, L. 2014. From Blues to Rainbows: Mental health and wellbeing of gender diverse and transgender young people in Australia. Melbourne: The Australian Research Centre in Sex, Health, and Society

Suicide Prevention Australia. 2009. Position Statement: Suicide and self harm among gay, lesbian, bisexual and transgender communities.