National LGBTI Health Alliance
Lesbian, gay, bisexual, transgender, and intersex people, and other sexuality and gender diverse (LGBTI) people and communities
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2 June 2014

National Children's Commissioner
GPO Box 5218
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Australia

Dear Commissioner

RE: Submission on intentional self-harm and suicidal behaviour in children

The National LGBTI Health Alliance is pleased to make a submission on intentional self-harm and suicidal behaviour in children and young people. We appreciate the explicit inclusion of young people of all sexual orientations and genders in this investigation. We also encourage the future inclusion of intersex children and young people in such investigations. Intersex is an umbrella term to describe a variety of innate physical characteristics, as distinct from sexuality and gender.

About the National LGBTI Health Alliance

The Alliance is the national peak health organisation for organisations and individuals from across Australia that work together to improve the health and wellbeing of lesbian, gay, bisexual, transgender, and intersex people, and other sexuality and gender diverse (LGBTI) people. We support measures that contribute to improved health and wellbeing for LGBTI Australians.

Formed in 2007, the Alliance includes the major providers of services for LGBTI people in Australia and Members from each State and Territory. The Alliance provides a representative national voice to develop policy and to support LGBTI health issues; to seek increased commitment to services for LGBTI people; to develop the capacities of LGBTI organisations; and to support evidence-based decision-making through improved data collection covering relationships, sexuality, gender identity, and intersex status.

Intentional self-harm and suicidal behaviour in LGBTI children and young people

1. LGBTI-specific factors for intentional self-harm and suicidal behaviour

In addition to sharing similar needs and concerns to those of other young people in Australia, LGBTI children and young people also face unique risk factors for intentional self-harm and suicidal behaviour. As detailed in the submission by our Member Organisation, Twenty10 incorporating GLCS NSW, research both within Australia and overseas documents that LGBTI young people have substantially higher rates of suicidal behaviour than in the general population (e.g., Robinson, Bansel, Denson, Ovenden, & Davies, 2014; Schutzmann, Brinkmann, Schacht, & Richter-Appelt, 2009). Evidence suggests that these higher suicide rates are primarily due to environmental rather than innate factors.

Some of the multiple risk factors for suicidal ideation in young LGBTI people are low social support; prospective victimisation and bullying on the basis of their gender, body, or sexuality; violence; discrimination; and verbal and physical harassment (e.g., Berlan, Corliss, Field, Goodman, & Austin, 2010; Liu & Mustanski, 2012; Mustanski & Liu, 2013). LGBTI young people with disability labels and/or physical and/or cognitive impairments may be at particular risk for suicidal behaviour due to these and other factors (Morgan, Mancl, Kaffar, & Ferreira, 2011).

In addition to these interpersonal and peer-based factors, some intra-familial factors such as childhood history of psychological abuse by parents, identifiability of a young person's sexuality by parents, being considered gender atypical by parents, the ability to be open about their sexuality with family members, and parental attempts to prevent desired gender expression have been associated with higher reported suicide attempt rates (D'Augelli, Grossman, Salter, Vasey, Sparks, & Sinclair, 2005).

Distinct factors associated with greater self-harm include victimisation and hopelessness, and some evidence suggests that girls, young women, and young people of trans or gender diverse experience are at greater risk of intentional self-harm than other LGBTI young people (Liu & Mustanski, 2012).

In the case of intersex young people, multiple reports have been discussed in clinical literature and by intersex organisations of intersex people who considered or attempted suicide or engaged in intentional self-harm as a result of coerced or involuntary medical treatment that continues to be routine practice in Australia (see the Senate Community Affairs References Committee Report on the involuntary or coerced sterilisation of intersex people in Australia.

2. Diversity and heterogeneity of LGBTI children and young people

LGBTI children and young people are found in all communities in Australia, including within populations that also have higher suicide risks than the national average. These include children and young people from rural and remote regions, those from Aboriginal and Torres Strait Islander communities, and those from Culturally and Linguistically Diverse communities. Evidence also suggests that LGBTI young people may experience homelessness and juvenile detention at higher rates than other young people (see our Submission on the Juvenile Detention Population in Australia 2012 Report).

Lesbian, gay, bisexual, trans, and intersex people are distinct but sometimes overlapping populations with particular needs. Thus approaches to investigating intentional self-harm and suicidal behaviour need to consider separately the needs and concerns of each of these populations. For example, existing denials and delays of gender-affirming medical interventions can result in attempts by trans and gender diverse young people to affirm their genders through physical modifications obtained without medical supervision or support; these unsupervised and unassisted efforts can often lead to intentional and unintentional self-harm (e.g., Garofalo, Deleon, Osmer, Doll, & Harper, 2006). We also refer to our Submission on the Prevalence of different types of speech, language and communication disorders and speech pathology services in Australia, which identified vocal fold damage from unintentional self-harm by trans and gender diverse people in Australia as a result of gaps in voice therapy services for gender affirmation.

3. Limitations of the 'contagion' and 'clustering' approach

According to the 'contagion' paradigm, a single exposure to another person's suicidal behaviour can lead to suicidal behaviour in the person who is exposed. However, some researchers have critiqued this approach, noting that 'contagion' only appears to occur for people who have a pre-existing vulnerability to suicidal behaviour (e.g., Berman & Jobes, 1994). 'Pre-existing vulnerabilities' that can increase the risk of suicidal behaviour in LGBTI populations are typically independent risk factors for suicidal behaviour. Thus it is difficult to distinguish between individual vulnerability and societal disparities that contribute to greater suicide risk across population 'clusters'.

The conceptual framework of suicide 'contagion' may promote a suicide prevention paradigm that treats vulnerable individuals as responsible for suicide clusters. This misguided approach can have the unfortunate consequence of blaming young people who consider or attempt suicide due to marginalisation, bullying, and discrimination for the suicidal behaviour of peers whose suicidal behaviour is motivated by similarly traumatic experiences.

4. The importance of a strengths-based approach that incorporates protective factors

Strengths-based approaches that incorporate protective factors and address youth resiliency have been increasingly adopted, based on growing awareness of the negative consequences that can result from applications of the disease-based 'contagion' model and other deficit perspectives, which treat young people primarily as risks to be managed. The benefits of these strengths-based approaches to research on LGBTI and youth populations have been recognised and applied across diverse contexts (e.g., Anderson, 1998; Eisenberg & Resnick, 2006; Singh, Hays, & Watson, 2011; Herrick, Lim, Wei, Smith, Guadamuz, Friedman, & Stall, 2011).

Horn, Kosciw, and Russell (2009) note that even approaches aimed at approaching young people from a strengths-based perspective instead of a risk-focused perspective often treat these young people as homogeneous groups and overlook key dimensions of their lives that do not match researchers' predetermined priorities. For example, Horn et al. note the ongoing omission of family relationships from research on LGBT young people's lives, despite findings that the extent to which families accept these young people can have profound effects on their mental health (e.g., D'Augelli et al., 2005; Rosario, Scrimshaw, & Hunter, 2009; Ryan, Huebner, Diaz, & Sanchez, 2009). Protective factors such as family support and personal strengths such as resilience should be incorporated into both research design and self-harm and suicide prevention efforts.

5. Barriers which prevent LGBTI children and young people from seeking help

Many LGBTI people constitute 'hidden populations': Many such people are not part of an organised community of others with whom they can share their sexuality (including relationship status), gender identity (including gender history, experience, or characteristics), or intersex status. Efforts limited to public LGBTI events or urban metropolitan areas will likely overlook many LGBTI people, particularly those from homeless, incarcerated, regional and remote, Aboriginal and Torres Strait Islander, and Culturally and Linguistically Diverse communities and those with differing physical and cognitive abilities. In addition, intersex and trans people who live as and identify as heterosexual typically do not consider efforts designated as 'LGBTI' or

'queer' to be relevant or appropriate. Intersex, trans, and gender diverse people may also be less likely to use telephone-based services, due to concerns about other people's perceptions of their vocal gender. Targeted approaches are needed to address these and other concerns.

LGBTI people often experience barriers to adequate school-based, medical, and mental health services, including denials, delays, invisibility, and exclusions from consideration in policies, programs, and services. These barriers are often the result of insufficient awareness among well-intentioned professionals and organisations, rather than hostility. The Trans Mental Health Study 2012, which was the first largest survey in Europe to focus on trans and gender diverse people's mental health needs, found that most people needed urgent help or support at some point, and many reported that they had avoided seeking urgent help because of their trans history or identity. Multiple participants described how being misgendered (i.e., described using language that misattributes how they identify their own genders) by mental health professionals had triggered them to self-harm or had led to suicidal ideation. Anecdotal evidence from within Australia suggests similarly high crisis needs and service avoidance for similar reasons. The study found that people with variable or fluid non-binary genders had the highest avoidance of seeking help when in crisis, a finding that highlights the need for clear guidance on affirming and inclusive responses to people who do not identify as women or men. In addition to the issues faced by people with variable or fluid non-binary genders, research documents that bisexual and trans young people can experience particular forms of exclusion and invisibility in service delivery (e.g., Grossman & D'Augelli, 2007; Pallotta-Chiarolli & Martin, 2009).

6. Inclusive and accurate data collection, identification, and recording

We remain concerned by the ongoing exclusion of adequate measures for equitable inclusion of LGBTI young people in national reports by Australian Government agencies, such as the Australian Bureau of Statistics and the Australian Institute of Health and Welfare (see our Submission on the Juvenile Detention Population in Australia 2012 Report and our Submission on the ABS Review of the Sex Standard). The inadequacy and inconsistency of existing national reporting methods and procedures inhibits the conditions that would be necessary to collect comprehensive information which could meaningfully inform policy, programs, and practice on self-harm and suicidal behaviour in LGBTI children and young people. This conclusion is supported by evidence of numerous gaps, inconsistencies, and inadequacies in existing methods and procedures both in general and with regard to LGBTI children and young people in Australia (e.g., Carman, Corboz, & Dowsett, 2012; De Leo et al., 2010; De Leo, 2010).

LGBTI-inclusive research and data collection methods should be treated as being of equal importance and necessity as other considerations for accurate reporting. An issue of particular concern that has been under-addressed in Australian data collection contexts is cisgenderism, the systems of thinking and practice that delegitimise people's own understanding of their genders and bodies (Ansara & Hegarty, 2012). It will be important for research and data collection processes to formally adopt and implement best practice guidelines for reducing heterosexism and cisgenderism in their research, such as Ansara and Hegarty's (2014) guidelines for reducing cisgenderism in research and data collection.

7. Considerations for LGBTI-inclusive database design and implementation

A national child death and injury database and a national reporting function could be useful tools in suicide prevention efforts, However, the usefulness of these tools will depend in large part on whether insights from marginalised communities such as LGBTI populations are considered and the nuances of accurate reporting in these populations addressed as discussed above. For example, widespread misgendering and exclusions of intersex, trans, and non-binary gender young people as a result of inadequate database design aspects can lead to inaccurate reporting, privacy violations, inappropriate service delivery, and psychological harm.

8. Evidence-based programs and practices to address LGBTI children and young people

Researchers have documented a gap between evidence and policy in Australian national policy and national interventions, with LGBTI people excluded from mental health policies and interventions even in areas where there are documented needs greater than in the general population (Carman, Corboz, & Dowsett, 2012). Even when LGBTI young people are included in public education and support campaigns, these efforts often overlook existing evidence and young people's own stated needs and preferences (e.g., Craig, McInroy, Alaggia, & McCready, 2014). Evidence also suggests that strategies and practices need to address not only hostile forms of oppression but also unintentional and benevolent forms of exclusion, marginalisation, and delegitimisation (e.g., Ansara & Hegarty, 2012). Public education campaigns aimed at reducing the number of children and young people who engage in intentional self-harm and suicidal behaviour need to engage in consultation with a variety of children and young people and to ensure that intervention design is informed by available evidence.

9. Benefits and concerns of digital technologies and media

The Alliance's QLife project is Australia's first nationally oriented counselling and referral service for LGBTI people. This project aims to provide nation-wide, early intervention, peer supported telephone and web-based services to diverse people of all ages experiencing poor mental health, psychological distress, social isolation, discrimination, experiences of being misgendered, and/or other social determinants that impact on their health and wellbeing. The success of this project documents the potential utility of digital technologies and media. However, interventions need to address the factors that children and young people actually find helpful in preventing and responding to intentional self-harm and suicidal behaviour.

Recommendations

Based on the responses provided above, we make the following recommendations:

Recommendation 1: We recommend targeted research on self-harm and suicidal behaviour in LGBTI children and young people that acknowledges the diversity and heterogeneity across lesbian, gay, bisexual, sexuality diverse, intersex, trans, and gender diverse populations. This research should address incidence rather than focusing solely on prevalence, to better identify the intervention strategies that will be most helpful to children at critical junctures. This research should also distinguish between self-harm and suicidal behaviour, with particular focus on the challenges faced by trans and gender diverse young people who seek medical and other modifications for gender affirmation and by intersex young people who are or have been subjected to unwanted medical procedures.

Recommendation 2: The 'contagion' and 'clustering' approach to conceptualising self-harm and suicidal behaviour in children and young people should be replaced by a strengths-based approach that highlights protective factors, young people's resiliency, and the environmental rather than innate factors that research shows can contribute to 'clusters' of suicidal behaviour among young people who experience similar or identical forms of marginalisation and oppression.

Recommendation 3: The inclusion of items about sexual orientation, gender identity, and intersex status should be mandated in all national data collection and research funded by Australian Government agencies, such as the Australian Bureau of Statistics and the AIHW. Although individuals should be able to opt out of providing this personal information when possible, these demographic variables should be consistently included and not treated as irrelevant or optional add-ins in population-based research design.

Recommendation 4: LGBTI communities should be consulted regarding how to sensitively and accurately collect data for coronial records, police reports to coroners, and in relevant health contexts. Information about gender identity and intersex status should be protected to preserve individuals' privacy; appropriate methods of collecting these data must be developed in collaboration with intersex, trans, and gender diverse people and communities. Sexual orientation data may be particularly sensitive for people in rural and remote, Aboriginal and Torres Strait Islander, and Culturally and Linguistically Diverse communities. Consultation with these communities is necessary to provide the safest methods of collecting these data.

Recommendation 5: Researchers who conduct national data collection should be required to complete an online training on LGBTI-inclusive research practices and data collection methods. This online training module, which should be developed and promoted by Australian Government agencies in collaboration with the National LGBTI Health Alliance and our Member Organisations, should clarify the distinctions between sexual orientation, gender identity, and intersex status.

Recommendation 6: LGBTI-inclusive services should be mandated, and the distinctions between sexual orientation, gender identity, and intersex status addressed, in all Australian policies related to mental health, wellbeing, harm reduction, and suicide prevention.

Recommendation 7: Government bodies working on self-harm, suicide, and mental health should be required to have LGBTI representation, with particular effort to ensure that intersex, trans, and gender diverse people's needs are included.

Recommendation 8: We reiterate the recommendation by our Member Organisation, Twenty10 incorporating GLCS NSW, that all early childhood settings, primary and secondary schools, and healthcare settings should have policies, programs, strategies and practices that actively affirm all diversity, including but not limited to the celebration and affirmation of diverse family constellations (including non-biological and chosen kinship ties in the definition of 'family'), relationships, sexuality, gender history, gender identity, gender expression, bodies, and intersex status. This affirmation of diversity should be incorporated into existing policies regarding diversity of ability, ethnicity, and culture. We concur with Twenty10 incorporating GLCS NSW that policies needs to name and affirm the variety of genders, bodies, sexualities, and relationships across LGBTI young people.

Recommendation 9: We reiterate the recommendation by Twenty10 incorporating GLCS NSW for the removal of the federal exemption which allows faith-based and private schools to discriminate against children and young people on the basis of their sexual orientation, gender identity, or intersex status. This recommendation is particularly necessary based on the finding by Robinson et al. (2014) that some educators in private and religious affiliated schools were more likely than educators in government schools to perpetrate hostile treatment on the basis of sexual orientation or gender identity, history, and expression.

Recommendation 10: Sexuality, sexual health and relationships education in schools needs to include affirming and accurate information about LGBTI people. In addition, education about bodies and genders should provide non-discriminatory and inclusive information about intersex, trans, and gender diverse people. We refer the Commissioner to the concerns and recommendations outlined in our Submission on the Draft Australian Curriculum: Health and Physical Education Foundation to Year 10.

Recommendation 11: All educators in early childhood settings and primary and secondary schools should be required to receive ongoing professional development that addresses both hostile and benevolent forms of discrimination and both intentional and unintentional forms of exclusion and marginalisation experienced by young people on the basis of their sexual orientation (including relationship status), gender identity (including gender history, experience, or characteristics), and intersex status.

Recommendation 12: We reiterate the recommendation made by Twenty10 incorporating GLCS NSW for an audit and evaluation of all tertiary education programs for teachers and medical professionals. Such an audit and evaluation would identify the current level of LGBTI inclusion in these programs. We concur with Twenty10 incorporating GLCS NSW that these degrees and training programs need to be updated to reflect current best practice evidence-based research in these areas.

Recommendation 13: Public education campaigns, resources, strategies, and media to address young people's self-harm and suicide prevention needs must be informed by available research evidence and targeted approaches provided across each population within LGBTI. These efforts should address diverse forms of systemic exclusion, marginalisation, and delegitimisation such as

heterosexism and cisgenderism, which can be unintentional or motivated by benevolent aims.

We wish to reiterate our support for the submission made to the Commissioner by our Member Organisation, Twenty10 incorporating GLCS NSW. We encourage the Commissioner to consult further with the National LGBTI Health Alliance and our Member Organisations.

We thank you for taking the time to consider this submission.

Yours sincerely

Rebecca Reynolds
EXECUTIVE DIRECTOR

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