Submission to the National Children's Commissioner: examination of intentional self-harm and suicidal behaviour in children

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1. Introduction

The authors of this submission commend the National Children's Commissioner for examining intentional self-harm and suicidal behaviours in children and young people and welcome the opportunity to make comment. Suicide is the leading cause of death for people aged 15-24 years in Australia (Australian Bureau of Statistics (ABS), 2014) and non-fatal self-injury contributes significantly to overall morbidity. Indeed these are major public health issues that have devastating and immeasurable impacts on affected individuals and families, with ongoing implications for the wider community.

Encouragingly, suicide deaths in Australian young people, particularly males aged between 15-24 years, have declined dramatically since peaking in the mid 1990's (Morrell et al., 2007). While there are numerous possible explanations for this, many public health experts have attributed this decline to large-scale population wide preventive interventions, beginning with the introduction of the National Youth Suicide Prevention Strategy in 1995, and subsequent increases in public awareness of mental health issues and improved access to and efficacy of psychiatric treatments (Morrell et al., 2007; McPhedran and Baker, 2008) Accordingly, it is integral that such efforts are sustained for continued outcomes. However, declines in suicide and self-harm have not been observed across all population groups over this time, as evidenced by the relatively stable rates of suicide deaths observed in young females (McPhedran and Baker, 2008) and persistent disparities in rates of suicidal behaviours and self-harm experienced by young Aboriginal and Torres Strait Islander Australians (Department of Health and Ageing (DHA), 2013) and young people who are sexuality diverse, trans, gender diverse and/or intersex (Suicide Prevention Australia, 2009).

This submission focuses on presenting current evidence about suicide and self-harm in young people of diverse sexualities, genders or intersex status, and recommends key actions to effectively prevent and respond to these critical issues.

1.1 Scope of the submission

This submission is jointly made by Twenty10 incorporating GLCS NSW and researchers from the University of Western Sydney, Australia, who conducted the *Growing Up Queer: Issues Facing Young Australians Who are Gender Variant and Sexuality Diverse* (Robinson et al., 2014) research report, launched earlier this year. Our proposal focuses on issues 1, 3, 5, 7, 8 and 9 set out in the terms of reference in the National Children's Commissioner's call for submissions with an emphasis on: (1) why young people who are sexuality diverse, intersex, trans and/or gender diverse engage in intentional self-harm and suicidal behaviour, and (2) what can be done to prevent and respond to suicide and self-harm in these populations. In this context, this submission also addresses other provisions of the Terms of Reference that are incidental to understanding, preventing and responding to suicide and self-harm in these communities.

The authors also wish to express support for and endorsement of the recommendations made by the National LGBTI Health Alliance's submission to the Commissioner.

1.2 About the authors

Twenty10 incorporating GLCS NSW is a community-based, non-profit, state-wide organisation, working with and supporting people of diverse genders, sexes and sexualities, their families and communities. We provide a wide range of prevention and early intervention services across New South Wales including housing, counseling (online, face-to-face and telephone), case management, social support, primary healthcare clinics, family support services, community education and offer specialist training for schools and service providers.

The research team members from the *Growing up Queer* research are academics at the University of Western Sydney, Australia. They are situated within the Sexualities and Genders Research Network in the School of Social Sciences and Psychology. This research was funded by the Young and Well Cooperative Research Centre as part of the Engaging Creativity project stream.

1.3 Key terms explained

This submission examines suicide and self-harm in young people of diverse sexuality, gender or intersex status. It should be acknowledged that there is considerable variation in the use of and meanings attributed to terms employed in health and social research in this topic as a result of the significant breadth and diversity in people's bodies, identities and sexual feelings. Accordingly, this section seeks to clarify and explain how different terms are used in this submission.

At times, this submission makes specific reference to young people on the basis of sexual orientation. In these instances, the phrase ‘sexuality diverse’ is used to describe young people who are same sex attracted, questioning or who otherwise would not describe their sexuality as ‘heterosexual’. This submission also makes reference to participants on the basis of gender identity and intersex experience. In these instances, the phrase 'trans, gender diverse and intersex' is used to differentiate people who identify with a gender that is different to that which they were assigned at birth, and/or who are intersex.

The following explanations are adapted from the National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Health Alliance guidelines on inclusive language (National LGBTI Health Alliance, 2013).

What is trans and who are trans people?

In Australia, people are classified at birth as female or male. People assigned female or male at birth are respectively raised as girls and boys. Trans people identify with a gender that is different to that which they were classified at birth. For example, a female-assigned person who identifies as male may describe themselves as a transman or simply a man. Similarly, a male-assigned person who identifies as female may describe themselves as a transwoman or simply a woman. Some trans people identify their gender simply as 'trans'. In this document, 'trans' is used as a collective term to describe these diverse experiences.

What is gender diversity and who are gender diverse people?

'Gender diverse people' include people who identify as 'agender' (having no gender), as bigender (both a woman and man) or as non-binary (neither woman nor man). Other individuals identify as androgynous or gender- queer. These are all categories of 'gender diverse' people.

What is intersex and who are intersex people?

People are born with many different kinds of bodies. Although the terms 'intersex' and 'trans' are sometimes conflated, the term intersex refers to a diversity of physical characteristics. Intersex people have natural variations that differ from conventional ideas about 'female' or 'male' bodies. These natural variations include genitals, chromosomes and a range of other physical characteristics. Most intersex people identify simply as women or men

2. Executive summary

Despite overall declines in youth suicide deaths in Australia since 1997, available data suggests that the prevalence of suicide attempts, suicidal ideation and intentional self-harm in young people who are sexuality diverse, trans and/or gender diverse remains stubbornly high. However, estimating reliable suicide mortality statistics for these populations remains challenging as sexual orientation, intersex status and gender diversity, unlike other demographical characteristics, are not necessarily publicly known, or readily identifiable, through existing data collection methods (such as coronial records).

Notwithstanding the paucity in mortality data, what is clear is that while same-sex attraction, gender diversity and intersex status are not themselves pathogenic, they may make these children and young people more vulnerable to negative experiences and discrimination that in turn increases risk for mental health problems, self-harm and suicide. Homophobic and transphobic discrimination in particular is ubiquitous, and results in conflicted familial and other social relationships, and diminished emotional and practical support. Accordingly, it is vital that suicide and self-harm prevention initiatives are informed by and sit within a broader mental health promotion framework that addresses these factors as critical social determinants of reduced mental health and increased suicidal behaviours among this population. Moreover, there is no single cause of suicide and self-harm, and as such, there is no single solution to this problem. Efforts must be comprehensive and multidisciplinary, particularly given that many of the contributing factors lie outside of the jurisdiction of the health system.

Early childhood settings and schools must have policies, programs, strategies and practices that actively affirm all diversity, including sexuality and gender, and that address homophobia, transphobia and heterosexism. Educators, physicians and other health professionals also require ongoing professional development to integrate current evidence-based research and best practice in their dealings with intersex, sexuality and gender diverse children and young people. Tertiary education programs for teachers, physicians and other health professionals must also be reviewed in order to ensure that future professionals in these disciplines are adequately informed and trained to address the needs of *all* young people. Current degrees and other training should incorporate and reflect current best practice evidence-based research in the areas of intersex, sexuality and gender diversity. In addition, intersex, sexuality, sexual health and relationships education in schools needs to be inclusive of intersex, gender and sexuality diverse young people. Without targeted inclusion of intersex, gender and sexuality diversity in this discipline (which should be implemented with whole-school gender and sexuality diversity specific policies and practices) there are serious implications for the health and wellbeing of intersex, gender and sexuality diverse young people.

The intersectionality of intersex, gender and sexuality identity with ethnicity, cultural background, socio-economic status, class, ability and so on needs to be taken into consideration when implementing programs that aim to prevent and/or respond to self-harm and suicide. Many young people are negotiating multiple forms of marginalisation, which impacts on their mental and physical health and wellbeing.

3. Recommendations

The following recommendations are also situated within the context to our responses to issues 1, 3, 5, 7, 8 and 9 set out in the terms of reference.

Recommendation 1: Research is needed to understand suicide and self-harm in trans, gender diverse and intersex children and young people in terms of the incidence and prevalence of self-harm and suicide as well as key risk and protective factors to guide effective strategies for supporting these populations.

Recommendation 2: The inclusion of sexual orientation, gender identity and intersex status in mental health promotion and suicide prevention policies, and other policies that address the broader determinants of mental health and wellbeing.

Recommendation 3: Mandating within policy the provision of LGBTI-inclusive services, including mental health promotion and suicide prevention policies.

Recommendation 4: LGBTI representation on government bodies dealing with suicide and mental health.

Recommendation 5: Sexual orientation and gender identity should be included when collecting data for purposes such as coronial records and reports prepared by police to assist coroners, as well as in other health contexts (where appropriate and relevant). Inclusion of intersex status in these contexts should also be explored, in partnership with intersex communities.

Recommendation 6: All early childhood settings and primary schools should have policies, programs, strategies and practices that actively affirm all diversity, including sexuality and gender. This includes celebrating and affirming diverse constructions of family, gender, and sexuality in addition to ethnicity, cultural background, ability and so on. Policies needs to name and affirm gender and sexuality diversity, and explicitly outline strategies and practices to address homophobia and transphobia.

Recommendation 7: All secondary schools should have policies, programs, strategies and practices that actively affirm all diversity, including sexuality and gender. This includes celebrating and affirming diverse constructions of family, gender, and sexuality in addition to ethnicity, cultural background, ability and so on. Policies need to name and affirm gender and sexuality diversity, and explicitly outline strategies and practices to address homophobia and transphobia.

Recommendation 8: Private and religious affiliated schools need to be included within Australian anti-discrimination laws. The *Growing up Queer* research highlighted that some educators in private and religious affiliated schools were more likely than educators in government schools to perpetrate homophobia and/or transphobia. Conversely, students in government schools were more likely to perpetrate homophobia and/or transphobia in government schools than in private and religious affiliated schools.

Recommendation 9: Comprehensive sexuality, sexual health and relationships education in schools needs to be inclusive of diverse genders and sexualities. Educators require targeted training and ongoing professional development to ensure that sexuality and gender diversity is explicitly targeted according to best practice models and evidence based research. There needs to be a whole-school approach to addressing these issues.

Recommendation 10: All educators in early settings and schools require ongoing professional development in anti-homophobia and anti-transphobia programs. An audit and evaluation of all tertiary education programs for teachers, physicians and other health professionals is required to ascertain the current level of the inclusion of gender and sexuality diverse issues in these programs. These degrees and training programs need to be updated to reflect current best practice evidence-based research in these areas.

Recommendation 11: There is a need for further targeted research around the intersections between cultural values, religious faith, ethnicity and homophobia and transphobia. Targeted research is also required in increasing understandings of the issues faced by gender and sexuality diverse young people from Aboriginal and Torres Strait Islander backgrounds, as well as those from geographically isolated areas, and rural and regional areas.

Recommendation 12: Medical and health professionals require ongoing, comprehensive training in the health and wellbeing issues (especially sexual and mental health) needs of gender and sexuality diverse young people. Tertiary training needs to be comprehensive and to reflect current best practice, evidence-based research in these areas. This is especially significant in primary health care (GP's, nurse practitioners, and ER physicians).

Recommendation 13: Public education campaigns should be a component of a comprehensive, targeted strategy, addressing homophobia, transphobia, heterosexism and affirming gender and sexuality diversity across Australian communities. Public education campaigns should be designed to address systemic (institutional) discrimination (policies, practices, beliefs, attitudes and language use) rather than targeting gender and sexuality young people's resilience.

Recommendation 14: It is critical to develop creative strategies to address young people's need for a balance between face-to-face and online sources of information and support. Given the low uptake of gender and sexuality diverse young people accessing support services online, as indicated in the *Growing up Queer* research there needs to be a comprehensive strategy to increase young people's awareness of relevant social support services and what they offer online. Social networking sites can play a significant role in disseminating information about online support services for young people.

4. Magnitude of the problem and key contributing factors

4.1 The prevalence of intentional self-harm and suicidal behaviour in young people who are sexuality diverse, trans, gender diverse and/or intersex

Available data on suicide in sexuality diverse, trans, gender diverse and/or intersex populations in Australia is poor and seldom provides a comprehensive picture. The barriers to collecting and reporting data in these communities are discussed further in section 5. Due to the paucity of data, particularly in terms of suicide deaths in these populations, much of the literature instead focuses on established indicators of suicide risk. These primarily include measures of suicidal ideation, attempted suicide and self-harm collected through population health surveys. Accordingly, while reliable comparisons of suicide deaths between young people in these populations and the wider population are not possible, it is feasible to compare groups on the basis of risk.

Despite overall declines in youth suicide deaths in Australia since 1997, available data suggests that the prevalence of suicide attempts, suicidal ideation and intentional self-harm in young people who are sexuality diverse, trans and/or gender diverse remains stubbornly high. Early studies between 1999-2003 reported that same sex attracted young people were, on average, six times more likely than their heterosexual peers to have attempted suicide (Nicholas & Howard, 1998; Dyson et. al., 2003). More than fifteen years later, the national *Growing Up Queer* study (Robinson et.al., 2014) reports the same findings, as well as providing insights into trans and gender diverse young people. In the overall *Growing Up Queer* sample, 41% had thought about self-harm and/or suicide: 33% had harmed themselves; and 16% had 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 & Heller, 2014; Centre for Adolescent Health, 2013).

Significantly, the findings in *Growing Up Queer* (Robinson et al., 2014) were intensified for young people who identified as transgender. In this particular sample of young people, 62% and 64% had thought about self-harm and suicide, respectively; 62% had harmed themselves; and 22% had attempted suicide. Published case reports from Northern America (Bockting et al., 2006; Ontario Public Health Association (OPHA), 2003), and anecdotal evidence provided by mental health professionals working with transgender people, highlight that self-harming behaviour in this population also manifests differently than in other adolescent populations. These studies note in particular that genital mutilation was common amongst transgender young people, compared to other presentations of self-injury (OPHA, 2003).

Far less is known about suicide and self-harm in intersex children and young people, though data from the limited research conducted in adult intersex populations internationally suggests that these groups are at heightened risk. Such studies report self-harm and suicide rates were much higher among intersex adults than the national averages (Rosenstreich, 2011; Schutzmann et al., 2009).

Recommendation 1: Research is needed to understand suicide and self-harm in trans, gender diverse and intersex children and young people in terms of the incidence and prevalence of self-harm and suicide as well as key risk and protective factors to guide effective strategies for supporting these populations.

Immense diversity exists within and between sexuality diverse, trans, gender diverse and intersex communities; both in terms of their experiences of sexuality, gender and intersex, but also with respect to socioeconomic, cultural, ethnic, religious and geographical demography. Age and disability are also factors that play a significant role in enhancing the diversity of these communities. Consideration must therefore be given to the multiple layers of identity and experiences of sexuality diverse, trans, gender diverse and intersex young people and how these intersectionalities may, in turn, influence patterns of suicide and self-harm. Disparities in patterns of suicide and self-harm between different groups identified within the overall Australian population are also reflected amongst sexuality, trans, gender diverse and intersex populations. In particular, young people within these populations who are Aboriginal and/or Torres Strait Islanders, from culturally and linguistically diverse (CALD) backgrounds, and/or those residing in rural and remote areas have been identified as being at higher risk. This diversity must be taken into account when assessing suicide and self-harm risk, and developing accessible and relevant prevention strategies.

Although the prevalence of suicidal behaviour and self-harm has been well documented and provides a compelling case for targeted suicide prevention and mental health promotion efforts, the inclusion of sexuality diverse, trans, gender diverse and/or intersex populations in mainstream health policies and plans is and has been limited. These populations are not referenced as *a matter of course* in mental health-related Government policies. *The Roadmap for National Mental Health Reform 2012-2022* (Council of Australian Governments (COAG), 2012) 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, preventive efforts targeting children and young people in these communities remain poorly resourced and uncoordinated, threatening to further widen disparities. Indeed, Twenty10 incorporating GLCS NSW, which provides specialist counseling and support to these populations, does not receive any mental health specific state or federal government funding for delivering these services.

Recommendation 2: The inclusion of sexual orientation, gender identity and intersex status in mental health promotion and suicide prevention policies, and other policies that address the broader determinants of mental health and wellbeing.

Recommendation 3: Mandating within policy the provision of LGBTI-inclusive services, including mental health promotion and suicide prevention policies.

Recommendation 4: LGBTI representation on government bodies dealing with suicide and mental health.

4.2 Why sexuality diverse, transgender, gender diverse and intersex young people engage in intentional self-harm and suicidal behaviour

Suicide and self-harm are multidimensional issues, and accordingly, there is no 'single sufficient cause'. However, it is clear that sexuality diverse, transgender, gender diverse and intersex young people experience a multitude of risk factors, many of which are specific to or compounded by issues surrounding sexual orientation, gender identity and/or intersex status, that substantially increases the likelihood of suicide and self-harm (Suicide Prevention Australia, 2009). In particular, available evidence demonstrates that these communities experience ubiquitous discrimination and harassment, and are less likely to be protected by

strong family connections, peer support and access to culturally competent healthcare (Suicide Prevention Australia, 2009).

Crucially, it must be understood that sexual orientation, gender identity and/or intersex status alone do not necessarily elevate risk; rather, experiences of heterosexism, homophobia and transphobia are known to contribute to social isolation, poorer mental health outcomes, substance misuse, and other sociocultural and economic problems and conditions, which in turn place children and young people from these populations at greater risk of suicide and self-harm. These issues are further compounded by rapid social and physical development that occurs within adolescence, as well as major life transitions, identity exploration, relationships, and a growing need for autonomy – as is common to all children and young people.

The relationship between experiences of homophobia and transphobia and self-harm and suicide these children and young people has been extensively documented in numerous national studies. As illustrated in Figure 1, *Writing Themselves In 3* (Hillier et al., 2010) found the prevalence of self-harm, suicidal ideation and suicide attempts amongst same sex attracted, intersex and gender diverse young people (SSAIGD) who report having experienced physical or verbal abuse is significantly higher than observed in those who had never experienced abuse.

Figure 1. Correlation between experiences of homophobia and self-harm and suicide (source: Hillier et al., 2010, p. 51)

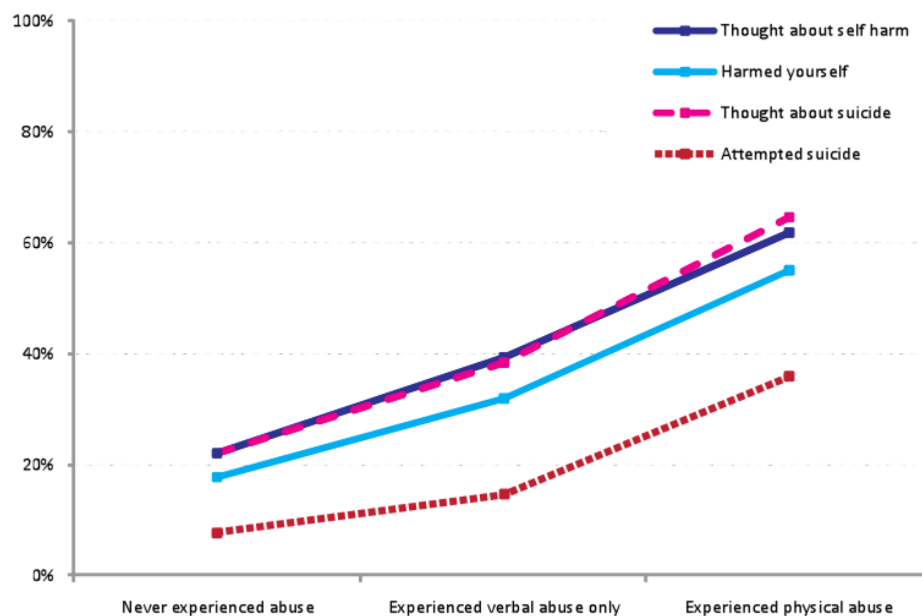
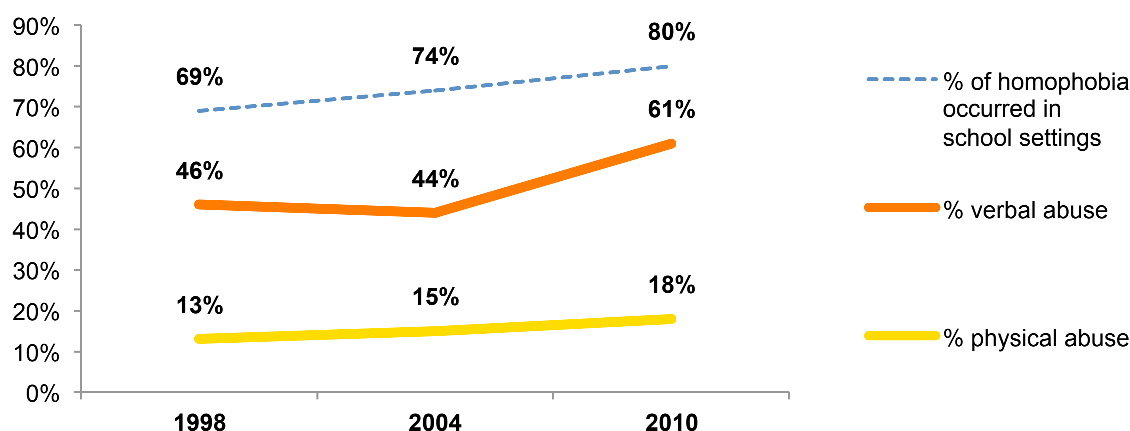


Figure 1 shows that 18 per cent of young people aged 14 to 21 years who identified as same sex attracted and/or gender diverse, who had never been subjected to physical or verbal heterosexist abuse, had self-harmed. The percentage jumps to 31 per cent for those who had experienced verbal abuse only and to 55 per cent for those gender and sexuality diverse young people who had experienced physical heterosexist abuse. These findings were replicated in the

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.

Disturbingly, in spite of public beliefs that 'things are getting better': there is evidence that levels of heterosexist discrimination and harassment are increasing amongst younger age cohorts (see Figure 2). The proportion of 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).

Figure 2. % SSAIGD young people who report experiencing verbal & physical homophobic abuse 1998-2010



Source: Hillier et al. (2010)

The research also shows that heterosexist abuse is most commonly reported to occur in educational settings (particularly schools, for sexuality, transgender, gender diverse and intersex children and young people), and on the street (Hillier et al. 2010; McNair & Thomacos 2005; 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.

What is clear is that while same-sex attraction, gender diversity and intersex status 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.

When conceptualising these contributing factors, it must also be noted that very little is known about the causal mechanisms underpinning suicide and self-harm — particularly for transgender children and young people — since the majority of research conducted so far has predominantly focused on same-sex attracted young people. However, studies of transgender adults report that up to 70%of those who had previously attempted suicide directly attributed their behaviour to frustration and exasperation over their gender identity and the isolation, rejection and body dissatisfaction that often accompany gender issues (Suicide Prevention Australia, 2009). This emphasizes the importance of ensuring gender diverse and transgender children and young people, and their families, have access to competent care and support in relation to gender identity issues.

Furthermore, the absence of representative data on intersex children and young people and the small numbers of intersex respondents in the few LGBTI surveys in which they are included make it difficult to examine suicide and self-harm in this group. However, anecdotal evidence and reports to intersex support groups suggest that intersex people are subject to particular pressures that may place them at increased risk of mental ill-health. 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 gender identity.

5. Data: identifying and recording self-harm and suicide in young people who are sexuality diverse, trans, gender diverse and/or intersex

It is extremely difficult to estimate reliable suicide mortality rates for sexuality diverse, transgender, gender diverse and/or intersex young people who are likely to be under-represented in suicide death statistics due to methodological limitations surrounding the way in which data on sexuality, gender identity and intersex status is collected. Studies report that suicide attempts by gender and sexuality diverse people often occur while these individuals are still coming to terms with their sexuality and/or gender identity, and often prior to disclosing their identity to others (Dyson et al., 2003; Hillier & Walsh, 1999; Nicholas & Howard, 1998) or, for transgender individuals, before engaging in any gender-related treatment, such as counseling or therapy (Cole et al., 1997). Thus, sexual orientation, gender identity—unlike other demographical characteristics such as race or ethnicity—are not always readily observable, and may not be known by family and friends at the time of death (Bagley & Tremblay, 1997; Dyson et al., 2003; Hillier & Walsh, 1999).

Recommendation 5: Sexual orientation and gender identity should be included when collecting data for purposes such as coronial records and reports prepared by police to assist coroners, as well as in other health contexts (where appropriate and relevant). Inclusion of intersex status in these contexts should also be explored, in partnership with intersex communities.

6. Effective Prevention and Support Programs

Strategies aimed at reducing suicide and self-harm amongst sexuality diverse, transgender, gender diverse and/or intersex children and young people must focus on addressing the core social determinants that increase risk in these groups in the first instance. Accordingly, they should focus in building socially inclusive and supportive environments that affirm diversity. This, in itself, is a complex task that will require efforts to address the often-hostile social environments in which many of these children and young people live, study and play. Challenging homophobia and transphobia at the interpersonal, sociocultural, and institutional levels is critical. Furthermore, such efforts require collaborative, multidisciplinary approaches, given these determinants generally lie beyond the health sector. Best practice evidence (Suicide Prevention Australia 2009) emphasises a dual approach that incorporates both mental health promotion and crisis intervention strategies that are accessible and, where appropriate, are culturally specific to sexuality diverse, transgender, gender diverse and/or intersex young people.

Programs, policies, strategies and practices that effectively target and support children and young people who are sexuality diverse, transgender, gender diverse and/or intersex, need to be implemented *early* in children's lives in order to prevent intentional self-harm and suicidal behaviours amongst children and young people. Given that homophobia, transphobia and heterosexism are experienced across a range of sites, the findings from the *Growing up Queer* (Robinson, et al., 2014) research overwhelmingly demonstrate the need for greater awareness of the inequities, isolation and discrimination faced by gender and sexuality diverse children and young people in families, schooling, TAFE, universities, and in the workplace. This discrimination needs to be addressed through ongoing education in early childhood settings and schools, and targeted training of educators, physicians, health professionals, families and the broader community. In this response we address sites in which systematic early intervention is required.

6.1 Early childhood and primary schooling

Research demonstrates that discrimination around difference starts early in children's lives and that affirming diversity and addressing discrimination needs to begin in early childhood (Kutner, 1985; Palmer, 1990; Glover, 1991; Alloway, 1995; Robinson & Jones Diaz, 2006). Children's discriminatory practices include harassing, bullying, isolating and marginalising children who transgress 'normative' gender practices and behaviours stereotypically associated with their sex. Children can also experience bullying and discrimination from other children if they are viewed to come from non-traditional family contexts – for example, from same-sex and gender diverse families (Davies & Robinson, 2013). This bullying and discrimination around gender and sexuality, which can persevere throughout a child's early life into adolescence can send strong negative messages about being different, which can have a long-term impact on children's and young people's health and wellbeing, as they internalise homophobia and transphobia. A lack of effective intervention in this bullying and discrimination in the early years can contribute to the likelihood that those who bully and discriminate around difference continue these behaviours into adolescence.

Recommendation 6: All early childhood settings and primary schools should have policies, programs, strategies and practices that actively affirm all diversity, including sexuality and gender. This includes celebrating and affirming diverse constructions of family, gender, and sexuality in addition to ethnicity, cultural background, ability and so on. Policies need to name and affirm gender and sexuality diversity, and explicitly outline strategies and practices to address homophobia and transphobia.

6.2 Secondary Schooling

In the *Growing up Queer* research, schools were identified as a major site in which homophobia and transphobia prevails. Peers were most frequently the source of this homophobia and transphobia, but for many, it was the homophobia and transphobia perpetrated by some teachers that had the most profound impact on their lives. Homophobia and transphobia was experienced in the form of social isolation, physical, verbal and written abuse, being the target of rumours, graffiti, cyberbullying and humiliation. School curricula, policies and practices were not inclusive of all young people's lives and experiences and this was particularly problematic in curriculum areas that addressed diversity, sexuality education, health and wellbeing (see also, Davies & Robinson, 2010; Jones & Hillier, 2012; Jones, 2013). Gender and sexuality diverse participants in this study overwhelmingly reported that sexuality education in schools does not respond to their needs or experiences, a failing that exposes them to a range of social and health risks. Further, homophobia and/or transphobia had serious impacts on many young people's educational experiences, with some changing schools multiple times, while others dropped out of school all together. Similar findings have also been documented in the *Writing Themselves In* reports, and other studies (Hillier, L. et al. 2010; Davies & McInnes, 2012; Jones, 2012, 2013).

Recommendation 7: All secondary schools must have policies, programs, strategies and practices that actively affirm all diversity, including sexuality and gender. This includes celebrating and affirming diverse constructions of family, gender, and sexuality in addition to ethnicity, cultural background, ability and so on. Policies need to name and affirm gender and sexuality diversity, and explicitly outline strategies and practices to address homophobia and transphobia.

Recommendation 8: Private and religious affiliated schools need to be included within Australian anti-discrimination laws. The Growing up Queer research highlighted that some educators in private and religious affiliated schools were more likely than educators in government schools to perpetrate homophobia and/or transphobia. Conversely, students in government schools were more likely to perpetrate homophobia and/or transphobia in government schools than in private and religious affiliated schools.

Recommendation 9: Comprehensive sexuality, sexual health and relationships education in schools needs to be inclusive of diverse genders and sexualities. Educators require targeted training and ongoing professional development to ensure that sexuality and gender diversity is explicitly targeted according to best practice models and evidence based research. There needs to be a whole-school approach to addressing these issues.

Recommendation 10: All educators in early settings and schools require ongoing professional development in anti-homophobia and anti-transphobia programs. An audit and evaluation of all tertiary education programs for teachers, physicians and other health professionals is required to ascertain the current level of the inclusion of gender and sexuality diverse issues in these programs. These degrees and training programs need to be updated to reflect current best practice evidence-based research in these areas.

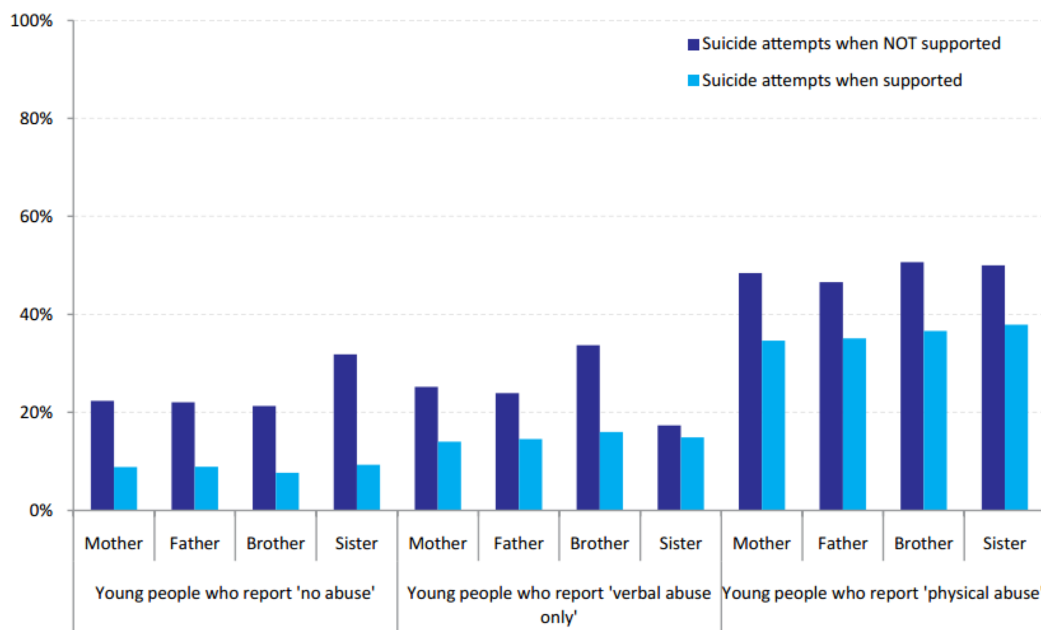
6.3 Working with Families

The *Growing Up Queer* research highlighted that rejection by families, resulting from homophobia and transphobia, exacerbated the isolation and despair felt by many of the young

gender and sexuality diverse research participants. Family rejection often leads to non-school attendance, homelessness, economic instability and/or destitution for some young people — factors that exacerbate feelings of hopelessness, anxiety and depression, and contribute to self-harm and suicidal behavior.

Conversely, and encouragingly, data from *Writing Themselves in 3* shows the protective role of supportive family relationships against suicide and self-harm in sexuality and gender diverse young people (see Figure 3). The data show reduced rates of self-harm for young people who are supported by their families, even when experiencing verbal or physical homophobic abuse (Hillier et al. 2010). The implications of these findings are that prevention programs must also focus on assisting families to accept and support sexuality diverse, transgender, gender diverse and intersex children and young people.

Figure 3. Rates of attempted suicide in young people when supported or rejected by family (source: Hillier et al. 2010)



Growing up in rural and isolated communities can also exacerbate some young people's feelings of being alone, with access to support services, such as mental health and LGBTQI specific services and resources often limited or non-existent in these areas (Edwards, 2007). Research demonstrates that rural and remote areas tend to be more homophobic than urban areas (Flood & Hamilton, 2005; Foster, 1997).

The *Growing up Queer* research reported that homophobia and transphobia founded in cultural values related to different ethnicities and religious affiliations often influenced family, peer, and community reactions to young gender and sexuality diverse people's feelings of social exclusion. Culturally and linguistically diverse (CALD) communities, and Aboriginal and Torres Strait Islander communities face additional pressures to conform to cultural expectations associated with gender and sexuality (Department of Health and Aging 2007a). Young people belonging to religious faiths that express negative discourses about homosexuality are particularly vulnerable to suicide and self-harm. This often results in psychological dissonance and identity conflicts, which may contribute to suicide and self-

harm risk.

Recommendation 11: There is a need for further targeted research around the intersections between cultural values, religious faith, ethnicity and homophobia and transphobia. Targeted research is also required in increasing understandings of the issues faced by gender and sexuality diverse young people from Aboriginal and Torres Strait Islander backgrounds, as well as those from geographically isolated areas, and rural and regional areas.

In the *Growing up Queer* report (Robinson, et al., 2014), gender and sexuality diverse young

In the *Growing up Queer* report (Robinson, et al., 2014), gender and sexuality diverse young people commented that they often felt uncomfortable approaching doctors and other health professionals who were often ill informed about gender and sexuality diversity. Some medical and health professionals were homophobic and/or transphobic.

Recommendation 12: Medical and health professionals require ongoing, comprehensive training in the health and wellbeing issues (especially sexual and mental health) needs of gender and sexuality diverse young people. Tertiary training needs to be comprehensive and to reflect current best practice, evidence based research in these areas. This is especially significant in primary health care (GP's, nurse practitioners, and ER physicians).

6.4 The role of public education campaigns

Public education campaigns that alert families, peers and communities to the serious impacts of homophobia and transphobia on the health and wellbeing of gender and sexuality diverse young people should be a component of the comprehensive recommendations outlined in sections 6.1- 6.3.

Public education campaigns are most effective when supported by a range of strategies to address homophobia, transphobia, heterosexism, and policies and practices that actively affirm gender and sexuality diversity. Targeted campaigns need to be carefully framed so that they do not pathologise sexual orientation and gender identity when conceptualising self-harm and suicide risk among gender and sexuality diverse young Australians (SPA, 2009).

Recommendation 13: Public education campaigns should be a component of a comprehensive, targeted strategy, addressing homophobia, transphobia, heterosexism and affirming gender and sexuality diversity across Australian communities. Public education campaigns should be designed to address systemic (institutional) discrimination (policies, practices, beliefs, attitudes and language use) rather than targeting gender and sexuality diverse young people's resilience.

6.5 The role of digital technologies and media in preventing and responding to intentional self-harm and suicidal behavior among sexuality diverse, transgender, gender diverse and intersex children and young people

As outlined by Suicide Prevention Australia (SPA) in their position statement, the Internet and related information communication technologies (ICT) offer significant potential as tools and settings for mental health promotion and suicide prevention for gender and sexuality diverse young people (SPA, 2009). These young people face significant challenges in

accessing information and support around gender identity, intersex experiences and/or sexuality due to the stigmatisation and sensitive nature of these issues (Hillier et al., 2001; Hegland & Nelson, 2002; Drabble, Keatley, & Marcelle, 2003).

The *Growing up Queer* research reinforces the importance of the Internet as a source of information for gender and sexuality diverse young people (Robinson et al, 2014). In this research 98% of gender and sexuality diverse young people indicated that they had access to the Internet. Of these 98%: 49% pointed out that the Internet was a place where they could 'find friends they could trust', and 78% used the Internet as a source of information about sexuality and/or gender identity. However, only 24% of these young people are using the Internet to access support services. Other studies support the proposition that gender and sexuality diverse people utilise the Internet as a primary means of learning more about sexuality and gender identity, as well as a way to connect with peers through participation in online communities and social networks (Hegland & Nelson, 2002; Hillier et al., 2001; SPA Position Statement).

Significantly, the *Growing up Queer* research highlights, despite the importance of the Internet and ICT's, face-to-face contact in a 'safe space' is critical for gender and sexuality diverse young people (Robinson et al, 2014). Participants spoke of the isolation that was experienced despite accessing online technologies and that face-to-face contact was seen to address this isolation in a way that online technologies did not. Gender and sexuality diverse young people indicated the potential value of interactive videos/websites with information about sex, sexuality, gender, and safe sex practices to supplement learning (Robinson et al, 2014). They also requested inclusive sex education in schools. Young homeless participants and participants from low socio-economic status backgrounds do not have easy access to online technologies, and may therefore have low technical literacy in this area. Face-to-face contact was imperative for these participants.

Recommendation 14: It is critical to develop creative strategies to address young people's need for a balance between face-to-face and online sources of information and support. Given the low uptake of gender and sexuality diverse young people accessing support services online, as indicated in the *Growing up Queer* study, there needs to be a comprehensive strategy to increase young people's awareness of relevant social support services and what they offer online. Social networking sites can play a significant role in disseminating information about online support services for young people.

Thank you for reviewing our submission. We look forward to working with you to improve the lives of all young people.

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