



POSITION STATEMENT

Suicide and self-harm among Gay, Lesbian,
Bisexual and Transgender communities

Suicide Prevention Australia
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About Suicide Prevention Australia

Suicide Prevention Australia (SPA) is a non-profit, community organisation working as a public health advocate in suicide and self-harm prevention, intervention and postvention. SPA is the only national umbrella body active in suicide prevention throughout Australia, promoting:

- Community awareness and advocacy;
- Collaboration and partnerships between communities, practitioners, research and industry;
- Information access and sharing; and
- Local, regional and national forums, conferences and events.

As a national organisation, SPA supports and assists both individuals and organisations throughout Australia, by promoting collaboration and partnerships in suicide prevention, intervention and postvention. SPA is supported by funding from the Australian Government under the *National Suicide Prevention Strategy*.

SPA Position Statements

SPA regularly publishes position statements on priority areas of suicide and self-harm prevention and postvention in Australia. These foundation documents provide a basis for understanding, discussion, teaching, delivery and research, and reflect the diversity of voices within the sector.

They are not intended to be specific to or limited to policy-makers alone, but are instead written with a general cross-section of the educated lay public in mind (ie. broader community, media, and other NGOs). SPA Position Statements therefore represent a *starting point* for policy and strategy development, while supporting SPA's ongoing advocacy work and activities.

These documents are developed in close consultation with community and specialist reference groups and are ratified by the SPA Board. They are reviewed annually with the intention of being reaffirmed, revised or retired, and generally do not refer to issues previously covered by other SPA Position Statements or by those currently in the process of being drafted.

The development of SPA Position Statements is supported by the Australian Government as part of its funding agreement with SPA. Position statements support and build on the *Living Is For Everyone (LIFE) Framework* developed under the *National Suicide Prevention Strategy*.

SPA Position Statements can be downloaded from the SPA website:
<http://www.suicidepreventionaust.org/PositionStatements.aspx>



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To access accurate information about suicide and the portrayal of suicide in the media, please visit:
<http://www.mindframe-media.info/>

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Guiding Principles

- Research findings demonstrate that suicide attempt and self-harm rates among gay, lesbian, bisexual and transgender (GLBT) communities are significantly higher than among non-GLBT populations. However, estimating reliable suicide mortality statistics for these populations remains highly problematic as sexual orientation and gender identity, unlike other demographical characteristics, are not necessarily publicly known, or readily identifiable, through existing data collection methods (such as coronial records).
- It is important to acknowledge the diversity within and between GLBT communities. Factors such as gender, age, cultural background, location and disability may significantly impact on life experience and the determination of appropriate responses to individual situations. Sexual orientation and gender identity should also be distinguished as independent from one another, while also recognising that individuals may or may not identify with the commonly used terms 'gay', 'lesbian', 'bisexual', and/or 'transgender'.
- The risk of suicide and self-harm among GLBT communities is complex and is compounded by experiences of stigma, discrimination, and 'minority stress'. Sexual orientation and gender identity 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 GLBT individuals at greater risk of suicide and self-harm.
- SPA recognises that strategies aimed at reducing suicide and self-harm among GLBT communities must:
 - o Promote socially inclusive and supportive environments that affirm sexual and gender diversity. This, in itself, is a complex task that will require efforts to address the often hostile social environments in which many GLBT individuals live, work and study. Challenging homophobia and transphobia at the interpersonal, sociocultural, and institutional levels is critical.
 - o Be collaborative, multidisciplinary and incorporate both mental health promotion and crisis intervention strategies that are accessible and, where appropriate, are culturally specific to GLBT individuals.
- Suicide and self-harm prevention among GLBT communities requires a collective, cross-sector approach, within which there is significant potential for both GLBT and non-GLBT-specific health and community services to support and promote GLBT mental health and wellbeing.
- The internet and related information communication technologies offer significant potential to reduce social isolation and promote factors known to be protective against suicide among GLBT Australians.

Background

Suicide and self-harm in GLBT communities remains an issue of serious concern in Australia. Available research continues to demonstrate that the prevalence and rates of self-harm and attempted suicide are significantly higher amongst GLBT people than among non-GLBT populations — though the prevalence of completed suicide statistics remains unknown.

Many researchers acknowledge that it is extremely difficult to estimate reliable suicide mortality rates for this population and that, consequently, GLBT people may currently be under-represented in suicide death statistics due to methodological limitations surrounding the way in which data on sexuality and gender identity is collected (Beautrais, 1998; Remafedi, 1999). It is also believed that most suicide attempts by GLBT people occur while 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 and gender identity — unlike other demographical characteristics — 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).

Due to the paucity of data on completed suicides among GLBT populations, much of the literature focuses on established indicators of suicide risk. This focus has primarily been upon suicidal ideation and rates of attempted suicide and self-harm. Studies conducted over the last decade reveal that GLB individuals attempt suicide at rates between 3.5 and 14 times those of their heterosexual peers (Bagley & Tremblay, 1997; Garofalo et al., 1998; Herrell et al., 1999; National Institute for Mental Health in England, 2007; Nicholas & Howard, 2002; Remafedi et al., 1998). Meanwhile, findings from health assessment studies in North America reveal that the prevalence of attempted suicides among transgender communities ranges from between 16 to 47 per cent (Bockting, Knudson, & Goldberg, 2006; Clements-Nolle et al., 2001; Keatley et al., 2006; Kenargy, 2005; Leonard, 2002; San Francisco Department of Public Health, 1999).

The level of suicidal ideation among GLBT populations is also very high, with 20 per cent of transgender (Couch et al., 2007) and 15.7 per cent of cisgender¹ gay, lesbian and bisexual (Pitts et al., 2006) people living in Australia reporting current feelings of suicidal ideation.

¹ 'Cisgender' is a term used (often in preference to the phrase 'non-transgender') to describe an individual whose gender identity is considered to be consistent with heteronormative expectations for their birth sex.

Given the high levels of suicidal ideation and rates of attempted suicide, it is perhaps unsurprising that self-harm among GLBT communities is also significantly higher than among non-GLBT Australians. Comparatively, 28 per cent of lesbians versus 8.3 per cent of heterosexual females, and 20.8 per cent of self-identified gay men versus 5.4 per cent of heterosexual-identified males report deliberate self-harm (Nicholas & Howard, 1998). In an Australian study, bisexual young people exhibited an even higher prevalence of self-harm than their exclusively gay and lesbian-identified peers at 29.4 and 34.9 per cent for bisexual males and females respectively (Nicholas & Howard, 1998). While there is presently no Australian-specific data on self-harm among transgender populations, published case reports from Northern America (Gapka & Raj, 2003 in Bockting, Knudson, & Goldberg, 2006), and anecdotal evidence provided by mental health professionals working with transgender people, report rates of self-harming behaviour as also high; particularly in the form of genital mutilation (Ontario Public Health Association, 2003).

It is important not to pathologise sexual orientation and gender identity when conceptualising self-harm and suicide risk among GLBT Australians. Moreover, sexual orientation and gender identity alone do not elevate risk. Rather, experiences of heterosexism, homophobia and transphobia are known to contribute to social isolation, poorer mental health outcomes, substances use, and other sociocultural and economic problems and conditions, which in turn place GLBT individuals at greater risk of suicide and self-harm (Dyson et al., 2003; Hillier & Walsh, 1999; Russell, 2003). Thus, these outcomes may arise more as consequences of being same sex attracted (SSA) and/or transgender, rather than being SSA and/or transgender (Olgivie, 2000 in Howard & Arcui, 2006). The causation of suicide and self-harm related behaviours for these populations should, therefore, be analysed from a social determinants of health approach (World Health Organisation, 2003).

SPA's Position

SPA supports the *Living is for Everyone (LIFE) Framework* developed under the *National Suicide Prevention Strategy*, and encourages the active development of specific strategies to advance issues relating to GLBT communities within this national framework for the prevention of suicide and self-harm in Australia. More specifically, SPA acknowledges, advocates and seeks reform on a broader understanding of these issues, along with the following:

The complexity and diversity within and between GLBT communities

Immense diversity exists within and between GLBT communities; both in terms of their experiences of sexuality and gender, but also with respect to each one's socioeconomic, cultural, ethnic, religious and geographical demography. Age and disability are also factors that play a significant role in enhancing the diversity of the GLBT community. This diversity must be taken into account when assessing suicide and self-harm risk, and developing accessible and relevant prevention strategies.

The terms 'gay', 'lesbian', 'bisexual', 'transgender' and 'queer' are often used with little consideration of their complexity (Suicide Prevention Resource Center, 2008). A person's feelings (sexual attraction and/or sense of gender) and behaviours (sexual experience and/or gender expression) may change over time and may not necessarily be congruent with normative expectations of the sexual orientation and/or gender with which they identify. Additionally, individuals may or may not identify with the commonly used terms 'gay', 'lesbian', bisexual', or 'transgender'. For this reason, many community workers suggest that 'same sex attracted' (SSA) and 'diverse gender expression' may be more inclusive terms in some contexts; particularly when describing young people.

Furthermore, 'sexual orientation' and 'gender identity' should be distinguished as separate concepts that are subject to considerable debate; both within and beyond GLBT communities. In particular, the term 'transgender' is distinct from 'sexual orientation' in that it is generally used to describe people whose gender identity and/or expression is considered to be inconsistent with the cultural expectations for their birth sex. Indeed, transgender people may or may not also identify as 'heterosexual', 'gay', 'lesbian', or 'bisexual' in describing their sexual orientation. Thus, while many transgender and GLB people share common experiences of heterosexism, discrimination and stigma, the issues they face in coming to terms with their identities and their respective healthcare needs may differ.

SPA recognises that SSA and gender diverse people are not homogenous, and that different approaches will be required to meet the varying and unique needs of these communities. It is particularly important to develop strategies to reach individuals who do not identify closely with the GLBT community in order to ensure that they receive appropriate support.

Risk factors for self-harm and suicide among GLBT communities

Suicide is highly complex and often difficult to predict. However, there are numerous biochemical, psychosocial and environmental factors that are believed to be associated with an increased risk (Department of Health and Ageing

(DoHA, 2007b). However, not all of the risk factors experienced by SSA and transgender people may necessarily be related to sexual orientation and/or gender identity. Sexuality and gender identity “may play a distal or proximal role and interact with numerous other risk factors”; many of which are also common to the general Australian population (Howard et al., 2002, p. 7).

Nonetheless, it is deeply concerning that GLBT people in Australia experience a higher prevalence of risk factors related to suicide than their non-GLBT counterparts (Dyson et al., 2003). These include: previous suicide attempts or deliberate self-harm; current or past mental health difficulties (notably, depressive and affective disorders); exposure to attempted or completed suicide by a friend or relative; social isolation; family/relationship stress; harassment, physical or sexual abuse; discrimination; and substance use problems (DoHA, 2007b).

The largest Australian study into GLBT health and wellbeing to date, *Private Lives*, found that nearly three quarters of the 5,467 participants reported some experience of depression in the past (Pitts et al., 2006). The prevalence of depressive disorders was also high with 49 per cent of men and 44 per cent of women scoring on at least one of the two criteria for a major depressive episode (Pitts et al., 2006). Comparatively, the *Tranznation* health and wellbeing survey of transgender people in Australia and New Zealand (which used the same scale) found 53.4 per cent of respondents met at least one of these two criteria, and just over one third (36.2 per cent) met the two essential criteria for a current major depressive episode versus 24.4 per cent of all respondents in the *Private Lives* study and 6.8 per cent of the general Australian population (Couch et al., 2007).

Data also reveals that alcohol and other drug use among GLBT populations tends to be more frequent and at more harmful levels than among the general Australian population (Howard & Arcui, 2006; Pitts et al., 2006). This may further increase the likelihood of experiencing mental health problems, suicide and self-harm (McNair, Anderson, & Mitchell, 2003). Studies typically highlight the variation evident in substance use behaviours according to age and identification as GLBT, rural versus urban, ‘clubbers’ and ‘scene/non-scene’ (Howard & Arcui, 2006). Overall, those who spend more time within the ‘gay community’ are generally more likely to use more substances than those who consider themselves ‘non-gay-community attached’ (Crawford et al., 1998).

In addition to experiencing many of the risk factors for suicide and self-harm stated above, risk among GLBT communities is further compounded by unique issues, such as homophobia and ‘minority and gay-related stress’, often associated with coming to terms with gender and/or sexuality (Russell, 2003). As Dyson et al (2003, p. 8) articulate, “doubts or questions about sexuality or gender can compound social and emotional risk factors for suicide”. Furthermore, GLBT people are less likely to be protected by factors known to provide resilience, such as strong family connections, peer support and access to culturally competent mental health providers (Suicide Prevention Resource Center, 2008).

Many researchers agree that social isolation remains among the most salient risk factors for GLBT communities. Social researchers also observe that, unlike racial and religious minorities, GLBT people do not often share their ‘minority group status’ with their families since most generally have heterosexual, cisgender parents. Thus, many GLBT people are “socialised into values and beliefs that are discordant with their self definition” (Telljohann & Price, 1993 in Hillier & Walsh, 1999, p. 24), which may increase feelings of low self-worth, guilt and shame. The social exclusion of GLBT people is also suggested to “encourage social contacts in GLBT specific venues, such as pubs, clubs and bars”, which may, in turn, exacerbate drug and alcohol use (National Institute for Mental Health in England, 2007, p. 10)

There is also rising concern amongst health and community workers that body image issues may also contribute to poorer mental health of GLBT communities. Indeed, there is growing evidence that SSA men appear to be at greater risk of experiencing body image dissatisfaction and related depression and low self-esteem than their heterosexual peers (Russell & Keel, 2002). Social researchers suggest that such issues cannot be explained through mere psychological dissatisfaction alone; asserting that these are also reflective of the sexualised culture of gay male communities, and pressures to uphold a masculine appearance in the face of broader heterosexual attitudes and stereotypes surrounding homosexuality (Duggan & McCreary, 2004; Levesque & Vichesky, 2006).

Suicide prevention literature highlights that mapping individual, social and contextual risk and protective factors can guide action at a community level, but emphasises that these cannot be used to assess risk of an individual (DoHA, 2007b). SPA therefore recommends that initiatives focus on the constellations of risk and protective factors described above. For example:

- Reducing social isolation through activities that strengthen family connection, build social support networks, and help foster communities that are inclusive of sexual and gender diversity.
- Increase individual protective factors through activities that encourage help-seeking behaviours, foster positive peer-relationships, improve self-esteem, and support individuals coming to terms with their sexual orientation and/or gender identity to develop a positive sense of self.
- Reducing contextual risk by increasing the accessibility of health and community support services through activities, such as cultural awareness and competency skills training and development.

When conceptualising these risk and protective factors, it must also be noted that very little is known about the causal mechanisms underpinning suicide and self-harm — particularly for transgender populations — since the majority of research conducted so far has predominantly focused on SSA people. One study that did focus on transgender people found that 70 per cent 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 (Bockting, Knudson, & Goldberg, 2006; Cole et al., 1997; Kenargy, 2005; Xavier, 2000).

Heterosexism, homophobia and transphobia

Broadly, the term 'heterosexism' refers to negative attitudes towards GLBT people; the assumption that all people are and should be heterosexual, and that sex and gender (and the relationship between the two) are fixed at birth (Leonard, 2002). Heterosexism is sometimes used as an all-encompassing term that also includes 'homophobia' and 'transphobia' — a fear of diverse sexualities and gender identities that may manifest as prejudice, bias against, or discrimination toward GLBT people at an internalised, interpersonal, sociocultural and/or institutional level.

Numerous studies have illustrated a direct association between discrimination and many of the key risk factors for suicide and self-harm (particularly mental illness) (DoHA, 2007b). Similarly, heterosexist social attitudes have been associated with social isolation, family rejection, violence (and the ongoing threat of violence), social invisibility, self-denial, guilt, internalised homophobia or transphobia, and lack of access to culturally competent care (Bagley & Tremblay, 1997; Hillier et al., 2005; Leonard, 2002; Suicide Prevention Resource Center, 2008).

Discrimination and violence against GLBT communities in Australia remains widespread, with at least 84 per cent of GLBT people reporting at least one experience of discrimination or abuse in settings such as education, employment, medical treatment, police/law enforcement, and the provision of goods and services (McNair, Anderson, & Mitchell, 2003). More recent findings from a Victorian study of GLBT and intersex people showed that over 80 per cent of participants had experienced public insult, 70 per cent verbal abuse, 20 per cent explicit threats and 13 per cent physical assault (McNair & Thomacos, 2005). These findings are concurrent with the *Private Lives* survey results, which also revealed that the prevalence of discrimination, harassment and violence is highest amongst transgender people in Australia (Pitts et al., 2006).

Homophobia and transphobia in schools also remains a major concern. A nationwide study of SSA youth found that nearly 38 per cent of SSA young people had experienced discrimination, while nearly 50 per cent reported experiencing verbal abuse because of their sexuality (Hillier et al., 2005). Alarming, 74 per cent of this abuse occurred at school. It is perhaps unsurprising that SSA young people tend to leave school at a younger age than their heterosexual peers (Dyson et al., 2003) and that equally as many feel as unsafe at school as they do on the streets (Hillier et al., 2005). It has also been reported that homophobia frequently goes unchallenged by school teachers and staff (Hillier et al., 2005).

Health and community workers also highlight that heterosexism, homophobia and transphobia places additional pressures on GLBT people's relationships; particularly in terms of stress related to coming out and/or relationship disclosure, invisibility and lack of recognition of relationships, as well as ongoing self-censorship and modification of behaviour (such as avoiding public displays of affection). These issues can cause difficulties in terms of achieving and maintaining healthy relationships, particularly given that many relationship support and family and domestic violence services lack the knowledge and skills required to understand and address the needs of GLBT people in relationships.

Furthermore, the marginalisation and discrimination experienced by GLBT people contributes to barriers to the access of health and support services (Leonard, 2002; McNair, Anderson, & Mitchell, 2003). These barriers are compounded by health care providers often lacking the appropriate knowledge and skills around GLBT health (Leonard, 2002). This is particularly salient for transgender people who may require specialist medical treatment (such as hormone therapy and/or surgery), which is typically very costly. The limited number of culturally competent services available for GLBT people prohibits many individuals from accessing appropriate support, information and care (Leonard, 2002; Lombardi, 2001).

Strategies that actively address heterosexism, and promote inclusive, safe and supportive environments are therefore critical to suicide and self-harm prevention for GLBT communities. However, as Mayock and colleagues (2009), explain, challenging homophobia and transphobia are complex and multi-dimensional processes requiring us to think differently about gender and sexual orientation and about how social institutions are structured. Action is required across interpersonal, sociocultural, and institutional levels, ranging from community education campaigns and school-based approaches through to legislative measures, to help end discrimination.

Groups considered at greater risk of suicide and self-harm

Consideration must also be given to the multiple layers of identity and experiences of GLBT people and how these may, in turn, influence patterns of suicide and self-harm. It has been suggested that disparities in patterns of suicide and self-harm between different groups identified within the overall Australian population are likely to also be reflected among GLBT populations. In particular, young people, Indigenous Australians, individuals from culturally and linguistically diverse (CALD) backgrounds, and those residing in rural and remote areas have been identified as being at higher risk than the wider Australian population (DoHA, 2007a).

However, suicide and self-harm among GLBT individuals within many of these groups is not well understood and may or may not be directly related to issues surrounding sexual orientation and/or gender identity. There is insufficient knowledge about if and how sexual orientation and gender identity interacts with other characteristics (such as ethnicity, cultural background, age, disability, religious faith, and geography) and the subsequent impact on suicide and self-harm.

It is, however, indisputably clear that younger GLBT people are at an elevated risk of suicide and self-harm, with studies demonstrating that attempted suicide rates for this group are up to six times as high as their cisgender heterosexual peers (Dyson et al., 2003). The physical and psychosocial development that takes place during adolescence is believed to compound issues surrounding sexual orientation and gender identity; particularly in relation to developing a positive sense of self (Di Ceglie, 2000; Holman & Goldberg, 2006; Morrow, 2004). Additionally, family and peer rejection, harassment and bullying on the grounds of gender non-conformity and/or sexual orientation remain common experiences for many GLBT young people; further exacerbating feelings of isolation, self-loathing and shame, which substantially increases vulnerability to suicide and self-harm for this age group (Hiller et al., 2005).

Emerging research into experiences of GLBT people living in rural and remote communities also suggests that many of the issues facing GLBT individuals discussed earlier are compounded by geographical isolation, rural culture and limited (if any) access to culturally competent mental health services (Edwards, 2007). Several studies also demonstrate that, with few exceptions, rural and remote areas tend to be more homophobic than urban areas (Flood & Hamilton, 2005; Foster, 1997). These issues may further exacerbate the myriad risk factors specific to rural and remote communities more generally; significantly increasing the vulnerability of GLBT people living in these communities to suicide and self-harm (Quinn, 2003).

For more information on suicide in rural communities, download the position statement, 'Responding to suicide in rural Australia', available from the SPA website: <http://www.suicidepreventionaust.org>

Furthermore, while there is a paucity of research into suicide and self-harm among Indigenous Australians who are GLBT, it is acknowledged that these individuals experience high levels of social exclusion, either on the basis of gender non-conformity, sexual orientation, race or all three. Consequently, many Indigenous Australians who are GLBT (particularly those living in rural and regional areas) go through geographic relocation which may result in further loss of support networks, family and cultural connections; thereby compounding risk for suicide and self-harm (Queensland Association for Healthy Communities, 2004).

For more information on Indigenous suicide, download the position statement, 'Suicide Prevention and Capacity Building in Australian Indigenous Communities', available from the SPA website: <http://www.suicidepreventionaust.org>

Many service providers and healthcare professionals also acknowledge that GLBT individuals from CALD communities (including newly arrived refugees and migrants) face social isolation as well as additional stressors related to disclosure of their sexuality and/or gender identity, and pressures to conform with cultural expectations surrounding gender and (heterosexual) marriage. This often results in psychological dissonance and identity conflicts which may contribute to suicide and self-harm risk. Further research into this area is needed to better understand how best to support and promote the mental health and wellbeing of GLBT people from CALD backgrounds.

In addition to the groups discussed above, there is increasing concern that older GLBT Australians may also be over-represented in suicide and self-harm statistics for this age cohort. While there is limited published literature available at present, anecdotal reports from health professionals working with older GLBT Australians highlight that many belong to a generation that has experienced a history of severe persecution, abuse and ostracism and have had to survive amidst legal and social condemnation. While some older GLBT people are 'out', including many activists, most are likely to remain closeted to avoid stigma and discrimination, particularly from service providers (Barrett, Harrison, & Kent, 2009; Harrison, 2006).

Consequently, many older GLBT Australians may not identify with the GLBT community, resulting in severe social isolation and stigma that significantly increases risk of suicide and self-harm. Older GLBT people have themselves referred to the impact of ageing amidst a youth-oriented gay cultural milieu, which harms self-esteem through the promotion of negative ageist stereotypes (Harrison, 2005). There is an urgent need to resource further research and service development to better understand and respond to issues connected to suicide and older GLBT people.

Similarly, those belonging to religious faiths that promulgate negative discourses about homosexuality are particularly vulnerable to suicide and self-harm. Conflicts between spiritual or religious beliefs and sexuality can result in significant psychological dissonance as well as division and exclusion from family, friends and community.

For many, these experiences manifest in deep feelings of self-loathing and hatred that, in turn, severely elevate the risk of suicide and self-harm (Hillier et al., 2008). As one young SSA woman describes:

Knowing what was facing me religion-wise and with my family I was pretty suicidal between the ages of about 16 and 19...not so much because of people's homophobia but because of feeling totally trapped between a religion/family that didn't accept homosexuality and being who I was. ('Peggy', aged 20, in Hillier et al., 2008)

Furthermore, it has been suggested that HIV/AIDS may be associated with higher rates of depression in GLBT communities, particularly since people living with HIV are statistically more likely to experience poverty, discrimination and stigma (Grierson et al., 2006). However, there is conflicting evidence regarding whether any association exists between HIV/AIDS and depression, suicide and/or self-harm. One Australian study revealed that HIV-positive SSA men were more likely to report depressive symptoms and were at greater risk of suicide and self-harm (Pitts et al., 2006). These findings are, however, discordant with international literature, which reports that rates of depression do not differ significantly between HIV-positive and HIV-negative gay and other homosexually active men after controlling for HIV status (Cochran et al., 2003; Gilman et al., 2001). Furthermore, international research suggests that depressive symptom scores do not appear to differ significantly between HIV-positive heterosexual and non-heterosexual women (Cooperman et al., 2003). Further investigation exploring the role that HIV/AIDS may play with regard to suicide and self-harm among GLBT communities is warranted

In recognising that the above groups of GLBT people may be at greater risk of suicide and self-harm than others, SPA advocates for the development of targeted suicide prevention activities for these groups. Additionally, further research is urgently needed to better understand and respond to issues surrounding suicide and self-harm for GLBT people living in rural and remote Australia, Indigenous GLBT Australians, those living with HIV/AIDS, older GLBT individuals, and those from culturally and linguistically diverse backgrounds.

A multidisciplinary approach to GLBT suicide and self-harm prevention

It is clear that GLBT people experience a multitude of risk factors (some of which are specific to or compounded by issues surrounding sexual orientation and/or gender identity) that substantially increases the likelihood of suicide and self-harm. Furthermore, 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 culturally competent healthcare.

Strategies that aim to reduce suicide and self-harm amongst GLBT communities must therefore be comprehensive in their approach; integrating a range of health promotion, suicide prevention and crisis intervention efforts to reduce exposure to risk and promote factors known to protect and strengthen mental health. These may be adapted from or built into existing evidence-based approaches or may involve developing more specific initiatives and interventions. Given that many contributing factors for suicide and mental health lie outside the domain of the mental health sector alone, coordinated multidisciplinary action across health, education, social service and community sectors is necessary (Commonwealth Department of Health and Aged Care, 2000; Herman, Saxena, & Moodie, 2005).

Challenging heterosexism, homophobia and transphobia in Australia is an absolutely critical aspect of suicide and self-harm prevention for GLBT communities. There are no 'quick fix' solutions that can address the marginalisation that so many GLBT people face in their daily lives. Achieving social and institutional change requires collective and cross-sector efforts, with shared responsibilities across relevant government departments and policy sectors.

Additionally, there are numerous opportunities for positive intervention or change at the personal and interpersonal level that can be implemented by individuals, as well as institutions, to affirm sexual and gender diversity. Education settings, in particular, are well placed to address heterosexism, homophobia and transphobia. Training teaching staff in this area is one of several priority areas for action. Similarly, community programs that promote peer support and social inclusion also offer significant potential to reduce suicide and self-harm among GLBT communities (Brown, 1999).

Building community capacity for mental health promotion and suicide prevention

'Improving community strength, resilience and capacity in suicide prevention' is identified as a key focus area under the LIFE Framework and is particularly relevant to reducing suicide and self-harm among GLBT communities.

GLBT health and community service providers acknowledge that many currently lack the capacity to effectively undertake mental health promotion and suicide prevention work; citing an absence

of knowledge, skills, and resources as the key barriers. Conversely, mainstream mental health and suicide prevention organisations highlight gaps in current understanding and awareness of GLBT needs, resulting in inadequate service delivery.

Clearly, further training and targeted resources for both GLBT and mainstream services are required to raise awareness and to build the capacity to deliver adequate and accessible services. Additionally, further support for community-based organisations to promote factors known to be protective for mental health and wellbeing (such as self-esteem, social connectedness and self-efficacy) is also vital to building community strength and the prevention of suicide and self-harm.

The role of information communication technology (ICT) in preventing suicide and self-harm among GLBT Australians

Internet-based resources are acknowledged for their ability to engage and empower marginalised and traditionally 'hard to reach' groups via the transgression of geographical, logistical and even psychosocial barriers that may otherwise inhibit such groups from accessing offline health promotion programs or health care providers (Alexander, 2002; Burns et al., 2007; Cline & Haynes, 2001; Drabble, Keatley, & Marcelle, 2003). ICT therefore offers significant potential as a tool and setting for mental health promotion and suicide prevention for GLBT communities who face significant challenges in accessing information and support around gender identity and sexuality due to the stigmatisation and sensitive nature of these issues (Drabble, Keatley, & Marcelle, 2003; Hegland & Nelson, 2002; Hillier et al., 2001).

Studies support the proposition that GLBT 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). Both Hillier et al (2001) and Hegland and Nelson (2002) report that the positive self-worth gained from online experiences further enables young people (in particular) to feel confident in coming out to their friends and families and seeking offline help to support them in coming to terms with gender identity and sexuality issues. More recently, research has also identified the significance of online communication to older people, indicating that older GLBT people could benefit from online intervention and support (Aguilar, Boerema, & Harrison, 2009).

The literature identifies that the internet provides safety, support, information and friendship, which collectively assist in developing and affirming a positive sense of self in the face of pervasive heterosexism (Hillier et al., 2001). Hegland and Nelson (2002) emphasise that the internet provides an outlet for expressing and exploring identity that subsequently informs, enlightens, and in particular, leads to the discovery that one is not alone. It is suggested that the internet strikes a balance between anonymity, distance and intimacy, which enables GLBT people to feel safe in exploring and revealing their deepest feelings and thoughts without fear of disapproval or persecution (Hillier et al., 2001).

SPA Recommendations

- SPA strongly recommends that GLBT suicide and self-harm prevention adopts a multidisciplinary approach inclusive of targeted mental health promotion, suicide prevention and crisis intervention strategies, coordinated through the *National Suicide Prevention Strategy*.
- All suicide prevention and mental health promotion initiatives funded under the *National Suicide Prevention Strategy* should be inclusive of and, where appropriate, specific to GLBT people at risk of suicide and self-harm.
- For progress to occur, heterosexism, homophobia and transphobia must be addressed at the interpersonal, sociocultural, and institutional level. This will require a comprehensive approach, ranging from community education campaigns through to legislative measures to end discrimination in all areas (including marriage and parenting rights).
- The Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) to lead the development of a 'whole of school' approach to address homophobia and transphobia in education settings across Australia; building on the success of frameworks such as the Victorian Department of Education and Early Childhood's *Supporting Sexual Diversity in Schools* project. Additional areas for action in education include:
 - o Curriculum development;
 - o Professional and/or pre-service training for teachers to identify and respond to bullying and harassment on the grounds of sexual orientation and/or gender non-conformity; and
 - o Development of targeted resources through initiatives such as *MindMatters*.

- Increase resources to build the capacity of GLBT health and community service providers to undertake targeted suicide prevention and mental health promotion activities. SPA also recommends training and supporting mainstream suicide prevention, health and community services to raise awareness of issues facing GLBT Australians for the provision of culturally competent care.
- GLBT suicide prevention strategies must be inclusive and relevant to the diversity within and between GLBT communities; recognising that some groups may be at higher risk than others and that different approaches may be required for different groups.
- While the recent commitment by the Australian Government to remove discriminatory legislation against GLBT people is a positive step, SPA believes this development must be supported by an ongoing commitment by all state/territory and federal governments to improving GLBT mental health and wellbeing through data collection, inclusion in policy, and dedicated resources.
- SPA strongly recommends that a review be conducted across all government departments of pre-existing recommendations that impact on GLBT mental health and wellbeing, including those emerging from the recent *Sex Files* and the *Same sex same entitlements* reports; both prepared by the Australian Human Rights Commission.
- Provide greater capacity for the delivery of resources and support services for parents and families dealing with sexuality and gender issues.
- The federal Department of Health and Ageing (DoHA) initiate a GLBT aged care strategy that includes policies, resources and programs targeted at researching and meeting the mental health needs of GLBT older Australians.
- SPA strongly advocates that greater attention be afforded to detailed research of specific issues that will improve the evidence base and understanding of suicide prevention, such as:
 - o Rates of completed suicide among GLBT populations, disaggregated by age, rural or remote location, disability and ethnicity;
 - o Links between self-harm and suicidal behaviour in GLBT populations;
 - o Inclusion of sexual orientation and gender identity 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);
 - o The causal mechanisms underpinning suicide and self-harm behaviours in GLBT communities;
 - o Greater understanding of the extent and nature of suicide and self-harm among specific groups within GLBT communities (particularly transgender communities, older GLBT people, those living in rural and remote Australia and those who are Indigenous and/or from culturally and linguistically diverse backgrounds); and
 - o Best available practice approaches to building resilience, help-seeking and the capacity for self-help.



More information is available via the SPA website:

<http://www.suicidepreventionaust.org>

References and further reading

- Alexander, J. (2002). Queer Webs: Representations of LGBT People and Communities on the World Wide Web. *International Journal of Sexuality and Gender Studies*, 7(2-3), 77-84.
- Aguilar, A., Boerema, C., Harrison, J. (2009). Meanings Attributed by Older Adults to Computer Use. *Journal of Occupational Science* (in press).
- Australian Human Rights Commission. (2009). *Sex files: the legal recognition of sex in documents and government records*. Sydney, Australia: Australian Human Rights Commission.
- Bagley, C., & Tremblay, P. (1997). Suicidal Behaviours in Homosexual and Bisexual Males. *Journal of Crisis Intervention and Suicide Prevention*, 18(1), 24-34.
- Barrett, C., Harrison, J., & Kent, J. (2009). Permission to Speak: Determining strategies towards the development of gay, lesbian, bisexual, transgender and intersex friendly aged care services in Victoria. Melbourne, Australia: Matrix Guild Victoria Inc.
- Beautrais, A. (1998). Risk factors for Suicide and Attempted Suicide Amongst Young People. Prepared for the National Health and Medical Research Council.
- Bockting, W., Knudson, G., & Goldberg, J. M. (2006). *Counselling and Mental Health Care of Transgender Adults and Loved Ones*. Vancouver: Vancouver Coastal Health Unit, Transcend Transgender Support and Education Society, and the Canadian Rainbow Health Coalition. Retrieved March 28, 2006, from <http://www.vch.ca/transhealth>
- Bockting, W., Robinson, B., Benner, A., & Scheltema, K. (2004). Patient Satisfaction with Transgender Health Services. *Journal of Sex and Marital Therapy*, 30, 277-294.
- Bockting, W. O., & Ehrbar, R. D. (2006). Commentary: Gender variance, dissonance, or identity disorder. *Journal of Psychology & Human Sexuality*, 17, 125-134.
- Boehmer, U. (2002). Twenty Years of Public Health Research: Inclusion of Lesbian, Gay, Bisexual and Transgender Populations. *American Journal of Public Health*, 92, 1125-1130.
- Brown, G. (1999). 'Here for life' youth sexuality project. *Youth Suicide Prevention Bulletin*, 3, 28-31.
- Brown, K. (2004). 'Sistergirls' – Stories from Indigenous Australian Transgender People. *Aboriginal and Torres Strait Islander Health Worker Journal*, 28(6), 25-26.
- Burns, J., Morey, C., Lagelee, A., Mackenzie, A., & Nicholas, J. (2007). Reach Out! Innovation in service delivery. *Medical Journal of Australia*, 187(7), S31-S34.
- Cochran, S. D., Sullivan, J. G., & 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*, 71(1), 53-61.
- Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV Prevalence, Risk Behaviours, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention. *American Journal of Public Health*, 91, 915-921.
- Cline, R. J. W., & Haynes, K. M. (2001). Consumer health information seeking on the Internet: the state of the art. *Health Education Research*, 16(6), 671-692.
- Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer, W. J. (1997). Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses. *Archives of Sexual Behaviour*, 26(1), 13-26.
- Commonwealth Department of Health and Aged Care. (2000). *Promotion, Prevention and Early Intervention for Mental Health – A Monograph*. Canberra, Australia: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.
- Cooperman, N. A., & Simoni, J. M. (2003). Abuse, Social Support, and Depression Among HIV-Positive Heterosexual, Bisexual, and Lesbian Women. *Journal of Lesbian Studies*, 7(4), 49-66.
- Couch, M., Pitts, M., Mulcare, H., Croy, S., Mitchell, A., & Patel, S. (2007). *Tranznation – a report on the health and wellbeing of transgender people in Australian and New Zealand*. Melbourne, Australia: Australian Research Centre in Sex, Health and Society (ARCSHS).
- Crawford, J., Kippax, S., Rodden, P., Donohoe, S. & Van de Ven, P. (1998). *Male Call '96: National Telephone Survey of Men Who Have Sex With Men*. Sydney, Australia: National Centre in HIV Social Research, Macquarie University.
- Department of Education and Early Childhood Development. (2008). *Supporting Sexual Diversity in Schools*. Melbourne, Australia: Victorian Government.
- Department of Health and Ageing. (2007a). *Living Is For Everyone (LIFE) Framework*. Canberra, Australia: Australian Government Department of Health and Ageing.
- Department of Health and Ageing. (2007b). *Living Is For Everyone (LIFE) Research and Evidence in Suicide Prevention*. Canberra, Australia: Australian Government Department of Health and Ageing.
- Di Ceglie, D. (2000). Gender Identity Disorder in Young People. *Advances in Psychiatric Treatment*, 6, 458-466.
- Drabble, L., Keatley, J., & Marcelle, G. (2003). Progress and Opportunities in Lesbian, Gay, Bisexual and Transgender Health Communications. *Clinical Research and Regulatory Affairs*, 20(2), 205-227.
- Duggan, S., & McCreary, D. (2004). Body image, eating disorders, and the drive for muscularity in gay and heterosexual men: The influence of media images. *Journal of Homosexuality*, 47(3/4), 45-58.

- Dyson, S., Mitchell, A., Smith, A., Dowsett, G., Pitts, M., & Hillier, L. (2003). Don't ask, don't tell. Report of the same-sex attracted youth suicide data collection project. Melbourne, Australia: Australian Research Centre in Sex, Health & Society.
- Edwards, J. (2007). Coming out alone: an assessment of the needs of same sex attracted youth, their families, and service providers in Western Australia. Perth, Australia: Trinity Outreach Services.
- Faulkner, A. H., & Cranston, K. (1998). Correlates of Same-Sex Behaviour in a Random Sample of Massachusetts High School Students. *American Journal of Public Health*, 88(2), 262-265.
- Feldman, J., & Bockting, W. O. (2003). Transgender health. *Minnesota Medicine*, 86, 25-32.
- Flood, M., & Hamilton, C. (2005). Mapping Homophobia in Australia. The Australia Institute.
- Foster, S. J. (1997). Rural lesbians and gays: public perceptions, worker perceptions and service delivery. In J. D. Smith & R. J. Mancoske (Eds.), *Rural gays and lesbians: Building on the Strengths of Communities*. Binghamton, NY: Haworth Press.
- Garofalo R., Wolf, R. C., Kessel, S., Palfrey, J., & DuRant, R. H. (1998). The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics*, 101, 895-902.
- Gilman, S. E., Cochran, S. D., Hughes, D., Ostrow, D., & Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. *American Journal of Public Health*, 91(6), 933-939.
- Grierson, J., Thorpe, R., & Pitts, M. (2006). HIV futures five – Life as we know it. Melbourne, Australia: The Living with HIV Program at the Australian Research Centre in Sex, Health & Society.
- Harrison, J. (2005). Pink Lavender and Grey: Gay, lesbian, bisexual, transgender and intersex ageing in Australian gerontology. *Gay and Lesbian Issues and Psychology Review*, 1(1), 11-16.
- Harrison, J. (2006). Coming Out Ready or Not! Gay, lesbian, bisexual, transgender and intersex ageing and aged care in Australia: Reflections, contemporary developments and the road ahead. *Gay and Lesbian Issues and Psychology Review*, 2(2), 44-53.
- Hegland, J. E., & Nelson, N. (2002). Cross-Dressers in Cyber-Space: Exploring the Internet as a Tool for Expressing Gender Identity. *International Journal of Sexuality and Gender Studies*, 7(2-3), 139-161.
- Hepp, U., Kraemer, B., Schnyder, U., Miller, N., & Delsignore, A. (2005). Psychiatric comorbidity in gender identity disorder. *Journal of Psychosomatic Research*, 58, 259-261.
- Herrman, H., Saxena, S., & Moodie, R. (2005). Promoting Mental Health: Concepts, Emerging Evidence, Practice. Geneva: World Health Organisation, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne.
- Herrell R., Goldberg, J., True, W. R., Ramakrishnan, V., Lyons, M., Eison, S., & Tsuang, M. T. (1999). Sexual orientation and suicidality: a co-twin control study in adult men. *Archives of General Psychiatry*, 56(10), 867-874.
- Hillier, L., Dempsey, D., Harrison, L., Beale, L., Matthews, L., & Rosenthal, D. (1998). Writing Themselves In: A national report of the sexuality, health and well-being of same-sex attracted young people. Melbourne, Australia: Australian Research Centre in Sex, Health & Society, La Trobe University.
- Hillier, L., Kurdas, C., & Horsley, P. (2001). 'It's just easier' The Internet as a safety-Net for same sex attracted young people. Melbourne, Australia: Australian Research Centre in Sex, Health & Society.
- Hillier, L., Mitchell, A., & Mulcare, H. (2008). 'I can't do both at the same time': Same sex attracted youth and the negotiation of religious discourse. *Gay and Lesbian Issues and Psychology Review*, 4(2), 80-93.
- Hillier, L., Turner, A., & Mitchell, A. (2005). Writing themselves in again: 6 years on - the 2nd national report on the sexuality, health & well-being of same-sex attracted young people. Melbourne, Australia: Australian Research Centre in Sex, Health & Society.
- Hillier, L., & Walsh, J. (1999). Abused, silenced and ignored : creating more supportive environments for same sex attracted young people. *Youth Suicide Prevention Bulletin*, No. 3, 23-27.
- Holman, C. W., & Goldberg, J. (2006). Ethical, Legal and Psychosocial Issues in Care of Transgender Adolescents. In *Counselling and Mental Health Care of Transgender Adults and Loved Ones*. Vancouver: Vancouver Coastal Health Unit, Transcend Transgender Support and Education Society, and the Canadian Rainbow Health Coalition.
- Howard, J., & Arcuri, A. (2006). Drug use among same-sex attracted young people. In P. Aggleton, A. Ball, & P. Mane. *Sex, Drugs and Young People: international perspectives*. London: Routledge.
- Howard, J., Nicholas, J., Brown, G., & Karaçanta, A. (2002). Same-sex attracted youth and suicide. In L. Rowling, G. Martin, & L. Walker (Eds.), *Mental Health Promotion in Young People*. Sydney, Australia: McGraw Hill.
- Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *Journal of Primary Prevention*, 22, 263-298.
- Human Rights and Equal Opportunity Commission. (2007). Same-sex: same entitlements – national enquiry into discrimination against people in Same-Sex relationships: financial and work-related entitlements and benefits. Sydney, Australia: Australian Human Rights Commission.
- Keatley, J., Nemoto, T., Sevelius, J., & Ventura, A. (2004). 'Expanding mental health services for transgender people'. Poster presented at the 132nd Annual Meeting of the American Public Health Association, Washington.
- Kenargy, G. P. (2005). Transgender Health: Findings from Two Needs Assessment Studies in Philadelphia. *Health and Social Work*, 30(1), 19-26.

- Kreiss, J. L., & Patterson, D. L. (1997). Psychosocial Issues in Primary Care of Lesbian, Gay, Bisexual and Transgender Youth. *Journal of Pediatric Health Care*, 11, 266-274.
- Krieger, N. (2003). Genders, sexes, and health: what are the connections-and why does it matter? *International Journal of Epidemiology*, 32, 652-657.
- Lee, R. (2000). Health Care Problems of Lesbian, Gay, Bisexual and Transgender Patients. *Western Journal of Medicine*, 172(6), 403-408.
- Leonard, W. (2002). What's the Difference? Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians: Research Paper. Melbourne, Australia: Ministerial Advisory Committee on Gay and Lesbian Health, Victorian Government Department of Human Services.
- Levesque, M., & Vichesky, D. (2006). Raising the bar on the body beautiful: An analysis of the body image concerns of homosexual men. *Body Image*, 3, 45-55.
- Lombardi, E. (2001). Enhancing Transgender Health Care. *American Journal of Public Health*, 91, 869-872.
- Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality*, 42, 89-101.
- Macdonald, R., & Cooper, T. (1998). Young gay men and suicide: A report of a study exploring the reason which young men give for suicide ideation. *Youth Studies Australia*, 17(4), 23-27.
- Mayock, P., Bryan, A., Carr, N., & Kitching, K. (2009). Supporting LGBT Lives: A study of the mental health and wellbeing of lesbian, gay, bisexual and transgender people. Ireland: Gay and Lesbian Equality Network and BeLonG To Youth Service.
- McNair, R., Anderson, S., & Mitchell, A. (2003). Addressing health inequalities in Victorian lesbian, gay, bisexual and transgender communities. *Health Promotion Journal of Australia*, 11(1), 32-38.
- McNair, R., & Thomacos, N. (2005). Not yet equal. Report of the VGLRL same sex relationships survey 2005. Melbourne, Australia: Victorian Gay and Lesbian Rights Lobby.
- Monro, S. (2000). Theorizing transgender diversity: towards a social model of health. *Sexual and Relationship Therapy*, 15(1), 33-45.
- Morrow, D. F. (2004). Social Work Practice with Gay, Lesbian, Bisexual and Transgender Adolescents. *Families in Society*, 85(1), 91-99.
- National Institute for Mental Health in England. (2007). Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people – a systematic review. London: NIMHE.
- Nicholas, J., & Howard, J. (1998). Better dead than gay? Depression, suicide ideation and attempt among a sample of gay and straight-identified males aged 18 to 24. *Youth Studies Australia*, 17(4), 28-33.
- Ontario Public Health Association (OPHA). (2003). Trans Health Project A position paper and resolution adopted by the Ontario Public Health Association (OPHA). Ontario: OPHA.
- Pitts, M., Smith, A., Mitchell, A., & Patel, S. (2006). *Private Lives: A report on the wellbeing of GLBTI Australians*. Melbourne, Australia: Australian Research Centre in Sex, Health & Society, La Trobe University.
- Queensland Association for Healthy Communities. (2004). Aboriginal and Torres Strait Islander Lesbian, Gay, Bisexual, Transgender and Sister Girls LGBT Health Systems Project Fact Sheet. QAHC.
- Quinn, K. (2003). Rural suicide and same-sex attracted youth: issues, interventions and implications for rural counselors. *Rural and remote health*, 3(222), 1-6.
- Remafedi, G. (1994). *Death by Denial: studies of suicide in gay and lesbian teenagers*. Boston: Alyson Publication.
- Remafedi, G. (1999). Suicide and sexual orientation: nearing the end of controversy? *Archives of General Psychiatry*, 56(20), 885-866.
- Remafedi, G., French, S., Story, M., Resnick, M. D., & Blum, R. (1998). The Relationship between Suicide Risk and Sexual Orientation: Results of a Population-Based Study. *American Journal of Public Health*, 87(8), 1-4.
- Russell, C., & Keel, P. (2002). Homosexuality as a specific risk factor for eating disorders in men. *International Journal of Eating Disorders*, 31, 300-306.
- Russell, S. T. (2003). Sexual minority youth and suicide risk. *The American Behavioral Scientist*, 46(9), 1241-1257.
- Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, 91(8), 1276-1282.
- San Francisco Department of Public Health. (1999). *The Transgender Community Health Project – Descriptive Results*. San Francisco: San Francisco Department of Public Health.
- Suicide Prevention Resource Center. (2008). *Supporting GLBT lives: a study of the mental health and well-being of lesbian, gay, bisexual and transgender people*. Newtown, MA: Education Development Center, Inc.
- World Health Organisation. (2003). *Social Determinants of Health - The Solid Facts. (2nd Edition)*. Copenhagen: WHO.
- Xavier, J. M. (2000). *Final Report of the Washington Transgender Needs Assessment Survey*. Washington: Administration for HIV and AIDS, Government of the District of Columbia.