Submission: Suicide prevention and response strategy

29 August 2022

Thorne Harbour Health

Thorne Harbour Health is one of Australia's largest community-controlled health service providers for people living with HIV, and the lesbian, gay, bisexual, trans and gender diverse, and intersex (LGBTI) communities. Thorne Harbour Health primarily services Victoria and South Australia, but also leads national projects. Thorne Harbour Health works to protect and promote the health and human rights of LGBTI people and all people living with HIV.

Thorne Harbour Health provides the following services to support the mental health of LGBTI people:

- Counselling services for people affected by or at risk of HIV (many of whom in Victoria are men who have sex with men) as well as people from LGBTI communities.
- Alcohol and drug counselling, care coordination and therapeutic group services for LGBTI people and people living with HIV.
- Family/intimate partner violence programs for LGBTI people and people living with HIV.
- LGBTI inclusive general practice and specialist care for people living with HIV or hepatitis C, and bulk billing general practice services to the trans and gender diverse community.
- The Positive Living Centre, a psychosocial support program for people living with HIV.
- Housing Plus, a state-wide program supporting people living with HIV who are homeless or at risk of homelessness.
- Volunteer participation and community events which promote acceptance, validation, visibility and community connection.

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Vision

1a. The Royal Commission suggested 'towards zero suicides' as a vision for the strategy. Is this appropriate? (Yes/No)

Yes

1b. If not, what vision for suicide prevention and response would you like to see Victoria work towards?

N/A

Priority populations

2a. In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate? (Yes/No)

Yes

2b. If not, which other higher risk groups do we need to prioritise for targeted and comprehensive action now?

N/A

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Priority areas

3. What priority areas should be included in the strategy to create the greatest impact and help us achieve our vision?

From the perspective of THH, bolstering better availability and accessibility to appropriately competent, knowledgeable and safe medical services for the LGBTIQ+ community is essential.

Whilst many lesbian, gay, bisexual, transgender, intersex, queer people and other sexuality and gender diverse people (LGBTIQ+) individuals live healthy, productive and fulfilling lives, underlying discrimination, social exclusion and vilification from wider society continues to permeate and degrade mental health and wellbeing outcomes of the diverse range of individuals within this community.

Conservative estimates show at least 3-4.5% of the population identify as lesbian, gay or bisexual, and is higher among people under the age of 25.[1] Approximately 1% of people identify as transgender, and 1.7% of people are born with an intersex variation. While other identities such as 'queer', 'pansexual' or 'asexual' have not been included in existing research looking at populations size, younger people are increasingly identifying at not heterosexual and not cisgender. Cumulatively, the LGBTIQ+ population makes up at least 7.2% - 10% of Victoria's population[2].

Research has consistently concluded that the LGBTIQ+ population both in Australia[3] and Victoria[4] disproportionately suffer from poorer mental health outcomes and have higher risk of suicidal behaviours and rate of suicide compared to any other population group,[5] some studies even suggesting that within the past 12 months, over 50% of LGBA+ individuals

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[1] Carman et al., 'Research Matters: How many people are LGBTIQ?' (Rainbow Health Victoria, 2020); Christopher M Fisher et al., '6th National Survey of Australian Secondary Students and Sexual Health 2018' (Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, 2019).

[2] 'The cost of adverse mental health outcomes in the LGBTIQ+ Victorian adult population' (Deloitte, Thorne Harbour Health, March 2022).

[3] See, e.g., 'Snapshot of Mental Health and Suicide Prevention Statistics for LGBTIQ+ People' (LGBTIQ+ Health Australia, 2021); Hill et al., 'Writing themselves in 4: The health and wellbeing of LGBTQA+ young people in Australia - National report, monograph series number 124' (Australian Research Centre in Sex, Health. and Society, La Trobe University, 2021); Hill et al., 'Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. ARCSHS monograph series number 122' (Australian Research Centre in Sex, Health and Society, La Trobe University, 2020) ('Private Lives 3'); Taylor et al., 'Bisexual mental health: 'Findings from the Who I am study' (2019) 48(3) *Australia Journal of General Practice* 138; Corboz et al., 'Feeling queer and blue: A review of the literature on depression and related issues among gay, lesbian, bisexual and other homosexually-active people' (Australian Research Centre in Sex, Health and Society, La Trobe University, December 2008); National LGBTI Health Alliance, 'Snapshot of mental health and suicide statistics for LGBTI people' (Report, February 2020).

[4] See, e.g., Hill et al., 'Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia. Victoria summary report, ARCSHS monograph series number 127' (Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne, 2020); 'Suicide prevention and response strategy – Discussion Paper' (Victoria State Government, Department of Health, 2022), p. 25 ('Discussion Paper').

[5] Royal Commission into Victoria's Mental Health System, Thorne Harbour Health, Rainbow Health Victoria and Switchboard, Submission to the RCVMHS:SUB.0002.0028.0150, 2019, p. 10. 'Strategic Framework for Suicide Prevention in NSW 2018-2023' (NSW Mental Health Commission, 2018), p. 5.

reported suicidal ideation.[6]

Three-fifths of LGBTIQ+ people have been diagnosed with depression and almost half have been diagnosed with generalised anxiety disorder at some point.[7] Almost three-quarters of LGBTIQ people have considered attempting suicide.[8] Two-fifths have considered suicide in the last 12 months.[9] Almost one-third have attempted suicide at some point in their lives and 1 in 20 have attempted suicide in the last 12 months.[10] Despite these horrifying statistics, the coroner's court still doesn't record LGBTIQ suicide statistics, reducing their visibility.

Concernedly, another significant interlaced risk factor conducive to higher rates of attempted suicide was the experience of abuse and violence. In a study of young LGBT Australians, attempted suicide was reported by twice the number of respondents who had experienced verbal abuse, and by four times the number who had experienced physical abuse, compared to those who had not experienced abuse.[11] In another Australian study, two thirds of trans and gender diverse young people had experienced verbal abuse, and over 90% of young people who experienced physical abuse thought about suicide as a result.[12] In this regard, literature has expressed that "[s]topping discrimination is critical: the single strongest and most consistent predictor of poor mental health and wellbeing among LGBTIQ+ communities is experiences of abuse, harassment or assault."[13]

Similarly, experiences of conversion practices remain a distinct and unique form of abuse of LGBTIQ+ individuals that has been condemned by international experts are 'degrading', 'inhuman', even tantamount to 'torture'[14]. In this regard, it is not surprising that conversion practices increase risk of suicide, and therefore requires ongoing commitment from Government to address following the *Change or Suppress (Conversion) Practice Prohibition Act*.

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[6] Hill et al., 'Suicidal Ideation and Suicide Attempts Among Lesbian, Gay, Bisexual, Pansexual, Queer, and Asexual Youth: Differential Impacts of Sexual Orientation, Verbal, Physical, or Sexual Harassment or Assault, Conversion Practices, Family or Household Religiosity, and School Experience' 2022 9(5) *LGBT Health* 313-324. The study concludes that overall, 56.4% of participants, (4370 cisgender LGBA+ persons), reported suicidal ideation, and 8.9% a suicide attempt in the past 12 months.
[7] Private Lives 3 (n 3), p. 15, 58.
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Hillier et al., 'Writing Themselves in 3: The Third National Study on the Sexual Health and Wellbeing of Same Sex Attracted and Gender Questioning Young People' (Australian Research Centre in Sex, Health & Society, La Trobe University, 2010).
[12] Smith et al., 'From Blues to Rainbows: Mental health and wellbeing of gender diverse and transgender young people in Australia' (Australian Research Centre in Sex, Health & Society, La Trobe University, September 2014).
[13] See, Dolan et al., 'Misgendering and experiences of stigma in health care settings for transgender people' 2020 212(4) *Medical Journal of Australia*, 150-151; 2020; Strauss et al., 'Mental Health issues and complex experiences of abuse among trans and gender diverse young people: findings from Trans Pathways' 2020 7(3) *LGBT Health* 128-136.
[14] 'Practices of so-called "conversion therapy", Report on the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity' Human Rights Council, (1 May 2020) A/HRC/44/53), para [65].

As demonstrated from the *Victorian Population Health Survey 2017*,[15] *Private Lives 3*,[16] and *Writing Themselves In 4*[17], it is now inarguable that LGBTIQ+ communities are being dramatically underserved as it relates to available, accessible, affordable, culturally safe, and quality mental health care by competent and knowledgeable medical practitioners, resulting in significant health inequities.

Similarly, compounding global events such as COVID-19 has only served to further negatively impact on LGBTIQ+ mental health outcomes[18]. Despite lockdowns exacerbating loneliness and isolation for everyone, when connection to community is often centred around physical spaces such as clubs dedicated to LGBTIQ+ clientele, isolation can be profoundly worse for a community that is largely reliant on their 'chosen family' in absence of family support. Similarly, lack of family support during these lockdowns can further inflame issues pertaining to family violence perpetrated by homophobic family members.

Whilst research identifying LGBTIQ+ populations as a priority mental health population within the circulated *Discussion Paper*[19] and the foreword of *Pride in our future: Victoria's LGBTIQ+ strategy 2022-3,*[20] Thorne Harbour welcomes the updating of the Victorian Government Suicide Strategy to better reflect contemporaneous lived reality of priority populations in Victoria and how best to assist those in crisis.

Likewise, discrimination of the LGBTIQ+ is not a new phenomenon. Studies have since concluded that LGBTIQ+ related discrimination is a fundamental cause for adverse mental health outcomes, specifically suicidal ideation.[21]

Individuals cannot focus on wellbeing and recovery when experiencing stigma, discrimination, violence, or vilification.

Despite well intentioned reform pushing for improved capacity building of providers to the LGBTIQ+, this in isolation will not act as the panacea of the tragedy that is the LGBTIQ+ mental health paradigm, and must form a part of a coordinated, comprehensive response across society to tackle LGBTIQ+ mental health and wellbeing.

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[15] 'The Health and Wellbeing of the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer Population in Victoria: Findings from the Victorian Population Health Survey 2017' (Victorian Agency for Health Information, 2020).
[16] Private Lives 3 (n 3).
[17] Writing Themselves in 4 - Australia, (n 2).
[18] See, e.g., Zwickl et al., 'The impact of the first three months of the COVID-19 pandemic on the Australian trans community' 2021 *International Journal of Transgender Health.*
[19] Discussion Paper (n 4), p. 25.
[20] 'Pride in our future: Victoria's LGBTIQ+ strategy 2022-23' (State Government of Victoria, Department of Families, Fairness and Housing, 2022) p. 4 ('LGBTIQ+ strategy'). In the foreword, Daniel Andrews states: "LGBTIQ+ Victorians continue to face disproportionately higher levels of poor mental health, suicidal thoughts and attempts, homelessness, harassment and abuse, and an increased risk of drug and alcohol abuse".
[21] Sutter M, Perrin PB, 'Discrimination, mental health, and suicidal ideation among LGBTQ people of color' 2016 63(1) *Journal of Counselling Psychology* 98-105; Similar outcomes were found for discrimination generally, see, e.g. Khan, M., Ilcisin, M. & Saxton, K. 'Multifactorial discrimination as a fundamental cause of mental health inequities' 2017 16 *International Journal of Equity Health* 43; Royal Commission into Victoria's Mental Health System. Chapter 11: Supporting good mental health and wellbeing in the places we work, learn, live and connect', Witness Statement of Commissioner Ro Allen, para [32]. Here, commissioner Allen emphasised that these impacts on mental health are not felt by LGBTIQ+ communities by virtue of their identity, but rather because of experiences of discrimination and social exclusion.

Discrimination, hate speech, or vilification can lead to social isolation, a factor that has been identified as further inflaming poorer mental health outcomes in LGBTIQ+ individuals.[22] Isolation is a particularly frequent and perennial phenomena amongst the LGBTIQ+ community, older LGBTIQ+ individuals, those who are living with a disability, or those who have experienced familial rejection.

Therefore, addressing societal prejudice is arguably the best prevention measure for LGBTIQI+ suicide that can be achieved.

With respect to LGBTIQ+ community, Thorne Harbour Health (THH) perceives the priority areas with respect to developing this strategy, specifically as it pertains to those within the LGBTIQ+ community to be the following:

a. **Improving overall service system accessibility and availability of culturally appropriate mental healthcare for the LGBTIQ+ community;**

b. **Intersectional and targeted approaches for groups disproportionately affected by suicide;**

c. **Placing higher emphasis on LGBTIQ+ community-controlled mental health services, and recognising the impact these services; and**

d. **Enhanced capacity building of medical professionals, allied health clinicians and broader clinical services in assisting the LGBTIQ+ community.**

a. Improving overall service system accessibility and availability of appropriate mental healthcare for the LGBTIQ+ community

As correctly raised in the *Discussion Paper,* "[s]ome of the ways to improve LGBTIQ+ experiences include ensuring access to: … LGBTIQ+ suitable health care"[23].

Appropriate preventative mental healthcare is integral for reducing suicides of priority populations.

LGBTIQ Victorians currently only have access to a limited range of LGBTIQ specific mental health services that are largely centralised to inner-metropolitan Melbourne. This is despite a recent report published by the Victorian Government concluding that there are significant populations of LGBTIQ people in non-metropolitan areas across the state, including Mount Alexander Shire and the cities of Ballarat and Greater Bendigo among others.[24] These populations remain underserved by existing appropriate mental health infrastructure.

The word 'appropriate' here connotes that medical services accessed by LGBTIQ+

[22] Lyons et al., 'Demographic and psychosocial factors associated with recent suicidal ideation and suicide attempts among lesbian, gay, bisexual, pansexual, queer, and asexual (LGBQ) people in Australia: Correlates of suicidality among LGBQ Australians' 2022 296 *Journal of Affective Disorders* 522-531.
[23] Discussion Paper (n 3), p. 33.
[24] Victorian Agency for Health Information (n 15), p. 34.

consumers are provided by competent and knowledgeable medical providers, where the environment is perceived as safe by the consumer insofar as they are comfortable in disclosing potentially medically pertinent information relating to their sexual orientation, identity, or innate sex characteristics and hosting concomitant discussions with respective providers.

Whilst it has been noted that mainstream health and mental health services were the most frequently accessed by LGBTIQ+ people, mainstream services were also reported to be least likely to respect LGBTIQ+ individuals.[25] This lack of respect can culminate in intentional or unintentional misgendering, stigmatising language, discrimination, hate speech, vilification, even violence, that may engender poorer mental health outcomes for the LGBTIQ+ consumer that can operate as an effective deterrence in seeking future mental health treatment.

Similarly, many mainstream service providers in Victoria are faith-based organisations. These organisations and the religious institutions they are affiliated with, have protracted histories of homophobic discrimination, vilification and persecution. Understandably, this can undermine trust and willingness of LGBTIQ+ people to engage with these services. Internal policies aimed at improving inclusion, or external accreditation such as the Rainbow Tick, are steps in the right direction, but cannot easily undo the mistrust these organisations have cultivated within the LGBTIQ+ population. Simply put, many LGBTIQ+ will not attend faith-based services at all because of anticipated discrimination, thereby highlighting the importance of LGBTIQ+ community-controlled health services.

Therefore, if an LGBTIQ+ individual is not comfortable in disclosing particular innate characteristics about themselves during medical consultations due to perceptions of possible reprisal, this may, in effect, lead to poorer mental health outcomes, as the clinician cannot appropriately tailor treatment to alleviate symptoms.

Accordingly, studies have concluded that half of LGBTIQ+ individuals indicated they would prefer to access a medical or support service that is known to be LGBTIQ+-inclusive,[26] noting that particularly for transgender young people, it was common to encounter inexperienced or transphobic service providers in light of long waiting lists to see 'trans-friendly' providers.[27]

b. Intersectional and targeted approaches for groups disproportionately affected by suicide

It is important to note that the LGBTIQ+ experience is not solely bound to identifying within this community, and that intersectional considerations may compound discrimination, leading to even worse mental health outcomes and higher rates of suicidal ideation and suicide attempts.[28]

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[25] Private Lives 3 (n 3), p. 58.
[26] Ibid; Also see Royal Commision into Victoria's Mental Health System, Witness Statement of Commissioner Ro Allen, paras. 80–82.
[27] Strauss et al (n 13).
[28] See, Royal Commission into Victoria's Mental Health System, Volume 3, p. 5: "People who identify as LGBTIQ+; refugees; asylum seekers; people living with disabilities; and people from culturally diverse backgrounds are exposed to a range of factors, including stigma and discrimination that increase the likelihood they will have poor mental health outcomes."

In this regard, an intersectional approach to addressing suicides within priority populations must be a formative aspect in leading the strategy.

For the purposes of this submission, the Victorian Government has defined 'intersectionality' as referring to 'the ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation that relates to aspects of a person's identity can include social characteristics such as:

- Aboriginality
- gender
- sex
- sexual orientation
- gender identity
- ethnicity
- colour
- nationality
- refugee or asylum seeker background
- migration or visa status
- language
- religion
- ability
- age
- mental health
- socioeconomic status
- housing status
- geographic location
- medical record
- criminal record'[29]

The Victorian Government goes on to conclude that, '[w]hen these aspects or characteristics combine: '…people find it harder to get the help they need due to systemic barriers'[30]. As mentioned by the Discussion Paper, '…a young person from the LGBTIQ+ community living in a regional area may be more likely to face stigma and discrimination and experience barriers to receiving safe and appropriate mental health and healthcare, compounding their risk of suicide.'[31]

In fact, this statement has been affirmed studies that have noted that LGBTIQ+ people who are part of intersectional minorities are more at risk of experiencing poorer mental health outcomes compared to their peers. Germane to the LGBTIQ+ experience, studies have noted that some of these intersectional considerations include, *inter alia*, living rurally, being under 18, experiencing violence on the basis of sexual orientation or gender identity, those with religious family members, or those who had experience conversion practices in the past 12 months[32].

It is therefore critical that the strategy recognises and reflects the importance of

[29] 'Understanding intersectionality' (Victorian Government) <https://www.vic.gov.au/understanding-intersectionality>.
[30] Ibid.
[31] Discussion Paper (n 3), p. 24.
[32] Hill et al. (2022) (n 6).

intersectional disadvantage that increases the likelihood in delaying avoiding or prematurely ceasing mental health care.

The effectiveness of this strategy will depend on intersectional needs being recognised and addressed during service delivery to priority populations.

Ideally, targeted services to serve those from priority and intersectional backgrounds will be led by, or will have employed strategies, policies, and procedures previously curated and approved by their respective community after active consultation by clinical providers. This would manifest in examples such as, including, *inter alia*, culturally respective and appropriate services for those who are Aboriginal or Torres Strait islander led by the same community these services are targeted to assist.

c. Enhanced capacity building of medical professionals and clinical services;

With many LGBTIQ+ individuals having to self-refer, self-advocate, or even educate clinicians whilst in crisis, building capacity of a skilled, competent, and knowledgeable workforce is essential to provide adequate services to LGBTIQ+ individuals during periods of crisis and to assure that accessing mainstream mental health services is safe.

For example, as identified in the *Trans Pathway* study, 42.1% of trans young people encountered mental health and other medical services who "did not understand, respect or have previous experience with gender diverse people."[33]

A lacunae of appropriately trained and experienced medical providers dealing with priority populations that are disproportionately affected by suicide is an extremely dangerous and worrying paradigm.

Whilst there have been significant improvements with respect to the Rainbow Tick[34] initiative, providing LGBTIQ+ training to medical professionals, there remains a further need to finance a specialised position within an LGBTIQ training organisation, such as Rainbow Health Australia, to provide ongoing consultation, capacity building and advice to organisations that receive the Rainbow Tick and to coordinate peer-to-peer learning through an ongoing community of practice.

Proactive training or professional development must enhance capacity in assisting diverse clientele is required at all strata of mental healthcare provision, inclusive of *inter alia*, primary healthcare services, accident and emergency department, and in-patient mental health services. Similarly, staff should be knowledgeable and be supported by approved policies and procedures to attend to safety concerns and address discrimination perpetrated by fellow patients/clients and staff. This could take the form of tailored LGBTIQ+ Mental Health First Aid that would, in effect, facilitate better access to desired services.

Capacity building of medical professionals, as it pertains to assisting LGBTIQ+ consumers, should at a minimum seek to:

- Raise awareness of LGBTIQ+ issues;

[33] Strauss et al., 'Trans Pathways: The mental health experiences and care pathways of trans young people. Summary of results' (Telethon Kids Institute, Perth, 2017), p. 97.
[34] See, Jones et al., 'Rainbow Tick Standards' *Rainbow Health Victoria* (2020).

- Identify the protective factors for LGBTIQ mental health as well as drivers of poor mental health;
- Foster empathy and self-reflection;
- Emphasise the importance of cultural safety and intersectionality;
- Provide opportunities to acquire and practice specific affirmative practice tools and skills;
- Explain how to identify and respond to homophobic, biphobic, transphobic or intersex related family violence;
- Detail relevant legislative requirements;
- Promote a person-centred and trauma and violence informed model of care;
- Encourage collaboration and shared learning across disciplines;
- Build pathways for specialisation in LGBTIQ mental health; and
- Address the needs of specific cohorts such as intersex people, trans and gender diverse people, disability bisexual people, younger people and older people.

Activities could include, *inter alia,* training interventions and learning resources, practice guidance tools and frameworks, clinical practice guidelines, practice and workforce qualification benchmarking, or policy statements from Peak bodies such as Australian Medical Association or the Royal Australian College of General Practitioners.

Inclusive practice training similar to what has been described above will operate to counter unconscious and explicit LGBTIQ+-specific bias, reduce assumptions made prior to engagement that can lead to misgendering or stigmatising interactions based on appearance alone, and create better understanding of the complex nature of identity in clinical services. Paired with this, incentives should be funded and promulgated for relevant clinicians to undertake this type of training.

As there are diverse experiences within the LGBTIQ+ community, it is essential that any training provided cannot consider LGBTIQ+ as a homogenous group, or that promulgates the assumption that all individuals who fall within the LGBTIQ+ community have the same experiences.

Similarly, in absence of competent clinicians, peer workers operate as a useful support for LGBTIQ+ individuals in identifying culturally safe and inclusive services. With the need of the LGBTIQ+ being so pronounced, it would be prudent to develop content in the form of a formal qualification for health workers to reflect LGBTIQ+ needs. As individual qualification frameworks provide inconsistent and often insufficient levels of training in affirmative practice and diversity inclusion, with little input from LGBTIQ+ health experts or the communities in question, a LGBTIQ+ affirmative practice competency framework that can be scaled for all qualification levels across all disciplines is required to ensure a consistent and enduring shift in attitudes and skills to drive greater system-wide cultural safety.

Germane to our discussion of advocacy of lived experience below, there remains an opportunity for the funding of targeted scholarships and training for LGBTIQ+ individuals, in recognition of some LGBTIQ+ experiencing a range of barriers employment finding it more difficult to complete school or tertiary education. This, in effect, would allow for better representation and diversity and voice across mental health to cater for this priority population.

Likewise, there is a need for safe and competent interpreters with accredited medical

translation and LGBTIQ+ training, as LGBTIQ+ individuals may be hesitant to agree to the use of interpreting services due to stigma attached to culture. Furthermore, the tripartite matrix of minority stress, substance use, and suicidality must be an additional consideration when discussing capacity building initiatives to support medical clinicians providing assistance to LGBTQI+ mental health consumers.

Research has concluded that LGBTQI+ individuals suffer from significantly higher substance abuse rates compared to their heterosexual counterparts.[35]

As substance abuse can be regularly deployed as a common means of managing psychological distress or alleviating ones' feelings of anhedonia, the adaptive nature of substance abuse must be concomitant consideration when discussing the bolstering of capacity building initiatives of providers providing assistance to LGBTQI+ individuals in psychological distress.

However, unfortunately due to the subtle confluence of comorbidities of substance abuse and mental illness, there remains significant lacunae in medical professional competency in identifying dual diagnoses.

In this regard, substance abuse must form an integral part of a clinician's/allied health professionals toolkit when providing clinical services to LGBTQI+ in psychological distress, and thus, must at a minimum be mentioned in any prospective training material or capacity building initiatives.

In essence, capacity building initiatives must be a coordinated, comprehensive, sector-wide response, so as to elevate capacity building beyond that of an individual and serve to induce pervasive competency of all mental health professionals in providing appropriate care to priority and intersectional populations. In turn, this creates lasting solutions for improving the availability and accessibility of appropriate care to these populations.

d. Place higher emphasis on community-controlled LGBTIQ+ mental health services and recognising the impact these services.

As a premise, it is important to remember that formal clinical medical interventions are not always the definitive answer in engendering improved mental health outcomes.

'Community-controlled' organisations are initiated and operated by and for their communities and have governance structures to ensure the organisation is accountable to members of those communities. Being community-controlled enables LGBTIQ+ and HIV organisations to deliver trusted, safe, holistic, and culturally appropriate services to the communities they serve, while also advocating for solutions that advance the quality of life of LGBTIQ+ people and people living with HIV and reducing health disparities experienced by LGBTIQ+ communities.

The role of community-lead organisations was recognised in the Royal Commission, noting that 'the non-government, peer led nature of many community led organisations can be

[35] 'Alcohol, tobacco & other drugs in Australia – People identifying as lesbian, gay, bisexual, transgender, intersex or queer' (Australian Government, Australian Institute of Health and Welfare, April 2022) <https://www.aihw.gov.au/reports/phe/221/alcohol-tobacco-other-drugs-australia/contents/population-groups-of-interest/patterns-of-consumption-by-drug-type>.

empowering for community members, particular for people who, for a range of reasons, have been unable to access care or who have not experiences safe, responsive and inclusive care in government services"[36]

With the Victorian Government's announcement of 50-60 local area mental health and wellbeing hubs, it is essential that a series of these hubs are dedicated to LGBTIQ+ individuals in priority geographic areas that operate as an alternative to clinical interventions and allow for flexibility of consumer choice in non-mandated mental health service.

Therefore, the strategy must acknowledge and recognises the role these community-controlled organisations play, especially as it relates to the LGBTIQ+ community.

[36] Royal Commission into Victoria's Mental Health System. Chapter 11: Supporting good mental health and wellbeing in the places we work, learn, live and connect'; Also see, Embracing Equality, 'Charter' (2021): "[e]nsuring consumer choice and access to culturally safe, sustainably funded community-controlled LGBTIQ+ services is essential to improving health and wellbeing outcomes for LGBTIQ+ people in Victoria".

Principles

4. What principles should guide the development and implementation of the strategy?

THH submits that the following interrelated and interdependent four principles should be fundamental in guiding the development and implementation of the strategy to specifically improve LGBTIQ+ suicide rates and mental health outcomes:

a. Valuing lived experience;

b. Availability, accessibility, acceptability and quality of appropriate preventative mental healthcare and aftercare to priority and intersectional communities;

c. Trauma-informed models of care; and

d. Promotion of evidence-based practice.

a. Valuing lived experience

Lived experience is already recognised as a core tenant and key commitment of the Victorian Government in improving mental healthcare for the LGBTIQ+ community, as demonstrated within such documents as Victoria's *Mental health lived experience engagement framework*[37] and Victoria's *LGBTIQ+ Strategy 2022-23*[38].

In fact, the Victorian Government has stated, '[t]he people who use our services are in an ideal position to shape them. Participation by the people who use our services is integral to ensuring that we develop, implement and evaluate services and policies that best support Victorians to be healthy, safe and able to lead a life they value'[39], indicating that marginalised groups "that many people with lived experience (carers) providing informal supports experience barriers to inclusion in the recovery journey of the person they support … particularly true for those from marginalised groups" [40], these groups requiring "a tailored and integrated response"[41].

Australia's ratification of the International Convention on the Rights of Persons with Disabilities (ICRPD) requires that the voices of persons with disabilities[42], and their representative organisations be heard, that persons with disabilities should be closely consulted and actively involved in the development and implementation of legislation and

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[37] 'Mental health lived experience engagement framework' (State Government of Victoria, Department of Health and Human Services, 2019) ('Lived Experience Framework').
[38] LGBTIQ+ strategy (n 20) p. 33: **"**The most successful programs are those that include the expertise and lived experience of community within design and delivery".
[39] Lived Experience Framework (n 37) p. 5
[40] Ibid, Foreword, Marie Piu.
[41] Ibid, Foreword, Marie Piu.
[42] UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly, (24 January 2007) A/RES/61/106, Article 1 ('ICRPD'): "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."; Also see, Art 3(c), 29.

policies to implement the Convention and in other decision-making processes concerning issues that affect them[43]. This requirement has been translated into domestic legal frameworks, culminating in the espousal of this obligation under the *Charter of Human Rights and Responsibilities Act 2006,* which states that every person in Victoria has the right to participate in the conduct of public affairs, be included in community consultation with government and participate in public debate and dialogue with representatives, either as an individual or as part of an organisation[44].

Valuing lived experience connotes the active consultation, collaboration, and elevation of those with lived experience of mental illness and/or suicide to decision making positions. THH submits that valuing lived experience must represent a core tenant of principles that guide the strategy so as to position priority populations at the forefront of strongly influencing future policy outcomes that will directly affect and best serve them.

In essence, invisibility and inequality are mutually reinforcing concepts that has been historically emblematic of the LGBTIQ+ experience.

Valuing lived experience and translating this into practical applications can operate to readjust the balance of power that usually uniquely tilts against consumers via the means of safe and meaningful engagement.

Provision of a platform to those with lived experience is vital for creating opportunities for dialogue with consumers and carers throughout the decision-making process so that consumer and carer perspectives are understood and translated into action. Similarly, collaboration with those who will be effected by any prospective framework allow for the engendering of trust within priority populations that have historically targeted, pathologised, and discriminated by authoritative systems.

b. Availability, accessibility, acceptability of preventative mental health care and quality aftercare to priority and intersectional communities.

Despite the *Royal Commission* recommending that 'mental health services are accessible to everyone in the community', including LGBTIQ+ people, THH submits that this must be expanded.

All LGBTIQ+ people deserve to live happy and healthy lives, and to enjoy the benefits of a mental health system that is safe, affirming and supportive. It is therefore essential that any prospective strategy enshrines and promulgates the principle that all preventative and aftercare must be:

1. Available to all Victorians within a reasonable time period no matter location and of sufficient quantity;
2. equitability and economically accessible;
3. perceived as culturally and equitably acceptable; and
4. of good quality.

[43] Ibid, Art 4(3).
[44] Charter of Human Rights and Responsibilities Act 2006, s 18 ('Victorian Charter').

Despite preventative mental healthcare forming a key tenant of informing reducing suicide in Victoria, the same standards must apply to aftercare for those who have attempted suicide.

These principles should not operate as mere window dressing, rather be recognised as goals to be progressively realised within the Victorian mental healthcare system.

Availability

i. Geographical considerations

As espoused by the Victorian Government, "LGBTIQ+ people must be able to access the services that meet their needs. Their experience through Victorian Government services should result in improved life outcomes."[45]

As discussed above, LGBTIQ+ Victorians currently only have access to a limited range of LGBTIQ specific mental health services. These programs target low-intensity, high-prevalence mental health issues such as depression and anxiety, as well as providing a range of individual and group-based interventions to address internalised homophobia, biphobia and transphobia; treat trauma; deliver psychoeducation around identity, self-care and health; and build connections with community.

Unfortunately, as discussed above, intersectional disadvantages can operate as individual, independent exacerbating factors, or operate in tandem to create increased absence of available and appropriate services for priority populations.

For example, trans and gender diverse people have extremely limited service options or safe spaces, rendering choice to the 'best worst option' of providers.

For example, research has concluded that LGBTIQ+ Australians who reside rurally find it difficult in locating the right care due to reasons of their location[46], further saddled with the burden of issues of privacy due to knowing staff where services are provided.

For example, LGBTIQ+ and multicultural services often face mirrored problems; multicultural services needing to be more LGBTIQ+ inclusive, and LGBTIQ+ services needing to be more multiculturally attuned.

For example, culturally and linguistically diverse (CALD) LGBTQI+ individuals may not have English adequate enough to understand complex medical terms, yet even where an LGBTIQ+ service is able to provide a translator, there remains inherent risk for fear of knowing the person translating or being outed within their community.

These examples can understandably act as barriers in accessing understandable and practical information.

It is simply not acceptable for appropriate and essential mental healthcare to be available to only those who fit certain criteria that is largely out of their control.

The only solution to this problem is for mainstream mental health program to be as inclusive as possible and represent diverse lived experiences to support flexibility and consumer choice. As it relates to LGBTIQ+ individuals, these would ideally be co-designed with LGBTIQ+ individuals with lived experience of living with an adverse mental health condition,

[45] LGBTQI+ strategy (n 20), p. 33
[46] Bowman et al., 'Virtually caring: a qualitative study of internet-based mental health services for LGBT young adults in rural Australia' 2020 20(1) *Rural and Remote Health* 5448.

ensuring that the principle of lived experience, as espoused above, is adhered to.

ii. Reasonably timely

Even when an individual is physically surrounded by available services, wait lists for these services are often extremely long, with some services having to intermittently close their books due to overwhelming demand, or choose not to promote their services due to lack of capacity.

For clarity, merely stating that services must be 'timely' is an unreasonable ask for an already heavily burdened system, straining under the weight and indirect impact COVID-19 has had on the Victorian population's mental health. In this regard, THH has opted that availability of services must be 'reasonably timely', recognising that not everyone can be seen, assessed and treated immediately, yet individuals who are expected to wait months for appropriate services would likely be deemed 'unreasonable' practice by assessment of a lay member of the public.

Despite evidence clearly indicating that LGBTIQ+ people are to be considered a priority in suicide prevention services,[47] the provision of reasonably timely, high-quality, culturally-safe, affirming, acceptable, and uninterrupted services is not often a reality for LGBTIQ+ individuals due to being booked out for long periods of time, resulting in absence of access during periods of crisis.

Likewise, there remains no acute, bed-based or forensic services available that specialise in supporting LGBTIQ+ Victorians.

As discussed above, to ensure that people do not 'fall through the gaps' in the Victorian mental health system, enacting a state-wide LGBTIQ+ community-controlled HOPE program, the development of community-controlled services, and/or development of mental health Prevention and Recovery Care services, therefore present as solutions so as to ensure that reasonably timely assistance to the LGBTIQ+ populations in crisis is provided.

Accessibility

LGBTIQ+ individuals must be ensured equitable and economic access to appropriate mental healthcare.

i. Equitable accessibility

Equitable accessibility connotes that all LGBTIQ+ individuals should have the inalienable freedom to not be turned away on the basis of their immutable characteristics, such as sexual orientation, gender identity, or innate sex characteristics.

Despite a series of domestic legal frameworks already entrenching this principle[48], it is essential that the strategy captures this in light of evidence indicating that mainstream mental health services are unlikely to respect LGBTIQ+ individuals[49] that has resulted in a clear preference by a LGBTIQ+ individuals in accessing LGBTIQ+-inclusive services[50].

[47] See, (n 3-10).
[48] See, e.g. *The Disability Discrimination Act 1992*, s 24; Victorian Charter (n 44) s 8(2).
[49] Private Lives 3 (n 3) p. 58.
[50] Private Lives 3 (n 3) p. 58.

In simple terms, an individual in crisis should not be subjected discrimination that is likely to inflame their condition from a service designed to assist them that can result in early exits from programs or even engage initial intake procedures.

Availability and accessibility therefore present themselves as mutually reinforcing principles for priority populations and must form a core tenant of any prospective strategy.

ii. Economic accessibility

Moreover, accessibility connotes economic accessibility.

With the rising cost of living, interest rates, and inflation, many Victorians are finding it increasingly difficult to make ends meet.

Despite Medicare providing financial support to Victorian mental health consumers, requirements for cumulative appointments and specialist consultations can create untenable financial strain, resulting in apprehension of seeking help, or refusing it altogether by sole virtue of absence of available personal finance.

Personal finance should not and cannot act as a stalwart barrier or deterrent for Victorians seeking mental healthcare.

Is it therefore why THH submits that this strategy must take into account and be guided by the contemporary reality that economic accessibility to mental healthcare is becoming increasingly difficult.

Acceptability

As it pertains to the LGBTIQ+ experience, the principle of 'acceptability' bifurcates into two key areas: perception of culturally safe services, and the provision of equitable services.

i. Perceived and manifest cultural safety of services

Trusted access points and safe spaces for the LGBTIQ+ population are critical.

LGBTIQ+ people are more likely to access and benefit from services that they see as being culturally safe. Building effective models of treatment and care for LGBTIQ+ people mean ensuring access to mainstream services and treatment pathways that are also safe and inclusive.

The Australian Human Rights Commission defines Cultural Safety as; 'an environment that is safe for people: where there is no assault, challenge or denial of identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and true listening.'[51]

As discussed above, if an environment is not perceived as safe, LGBTIQ+ individuals may be disinclined to disclose medically pertinent information to respective adverse mental health conditions due to fear of reprisal, discrimination or vilification by medical staff or fellow

[51] Australian Human Rights Commission, *Social Justice Report* (October 2011).

patients. This can therefore result in suboptimal mental health outcomes and impair successful long-term treatment outcomes.

This fear is not ephemeral. Almost three-fifths of LGBTIQ+ people, and more than three-quarters of trans and gender diverse people report being treated unfairly in the last 12 months based on their sexual orientation or gender identity, respectively.[52] Likewise, more than a third of LGBTIQ people have been verbally abused, almost a quarter harassed (including offensive gestures or being spat at), more than 1 in 10 sexually assaulted, and almost 4 in 100 physically attacked or assaulted with a weapon in the last 12 months based on their sexual orientation or gender identity.[53]

In this regard, when LGBTIQ+ individuals access mainstream health services, despite health services having a positive duty to accommodate different standards of care in the provision of services under the *Equal Opportunity Act* 2010 (VIC), perceived and manifest safety must form part of the core tenants in informing this strategy.

Over-reliance on mainstream services for LGBTIQ+ individuals remain unacceptable, especially when faith-based services retain their ability to legally discriminate against LGBTIQ+ people on the basis of religious doctrine, understandably resulting in LGBTIQ+ feeling unsafe accessing their services.

No matter how well trained and affirming mainstream services are, there will always be a portion of LGBTIQ+ community members who prefer to use trusted community-controlled services[54].

Perception of consumers in accessing mental healthcare is essential. Even where clinical services present themselves as having requisite accreditation demonstrating they are 'LGBTIQ+ friendly', consumer perception of service, including of unintentional stigmatisation or discrimination by service providers, can result in the unacceptable early exit of consumers from programs.

In the absence of trusted referral databases or LGBTIQ+ liaison services, word of mouth remains often the only mechanism to hear about services that are considered safe and welcoming to LGBTIQ+ people. This can be an exhausting process for those already in crisis.

Moreover, research has concluded that previous and anticipated experiences of stigma and discrimination from service providers deter and delay seeking prevention and treatment,[55] such as crisis support lines[56].

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[52] Private Lives 3 (n 3), p. 14.
[53] Ibid, p. 14.
[54] See, Ibid, p. 58.
[55] Carman et al., 'Research Matters: Why do we need LGBTIQ-inclusive services?: A fact sheet by Rainbow Health Victoria' (Rainbow Health Victoria, 2020).
[56] Lim et al., 'The experiences of lesbian, gay and bisexual people accessing mental health crisis support helplines in Australia' 2021 *Psychology & Sexuality.* This study concludes that while most responses indicated some familiarity with available services, only 30% (*n*=75) of participants had accessed a helpline service during a time of crisis. Despite a low rate of service uptake, many of those who had used a service evaluated it positively. The low rate of overall engagement was attributed to a fear of being discriminated against by helpline workers or arose from a concern that they would have insufficient understanding of LGBT-specific concerns to be able to render meaningful

Furthermore, aboriginal and Torres Strait islander individuals must similarly receive comprehensive and culturally appropriate, holistic, and responsive care, ideally modelled from documents that have demonstrable history in engaging aboriginal and Torres Strait islander communities for their perspectives on this issue, such as the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*[57].

This framework advocates for clinicians to be provided with capacity building initiatives that promote aboriginal-led strategies, and that all mental health professionals providing care recognise the principles of self-determination, community governance, and family and kinship. Similarly, any health professional providing care must recognise the intergenerational trauma that has stemmed from colonisation acting as a central disruptor to aboriginal and Torres Strait islander people's cultural wellbeing, and the consequential westernisation of mental healthcare.

Likewise, in terms of the practical provision of care, care must be provided holistically that encompasses mental, physical, cultural and spiritual health, whilst further tailoring care for intersectional considerations, such as identifying as LGBTIQ+.

ii. Equitable but tailored treatment

International experts have concluded that all countries have a duty to "create and sustain enabling environment that incorporates a rights-based approach to mental health, promoting a life of dignity and well-being for all people, including LGBTQI+ people, throughout their lifetime".[58]

Australia's ratification of ICRPD obligates governments to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'[59]. This resonates with Victoria's current legal framework, particularly the *Charter of Human Rights and Responsibilities Act 2006*, obligating governments and public authorities, such as public hospitals and health services, to consider, protect and promote human rights[60].

LGBTIQ+ individuals must be treated equally, connoting both a human rights and intersectional approach, in essence, ensuring that tailored and culturally appropriate services are provided to priority and diverse populations, based on understanding how intersectionality contributes to individual mental health outcomes.

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support; Also see, Waling et al., 'Understanding LGBTI+ Lives in Crisis' (Bundoora, VIC & Canberra, ACT: Australian Research Centre in Sex, Health & Society, La Trobe University & Lifeline Australia, 2019). This study concluded that '71% of participants chose not to use a crisis support service during their most recent personal or mental health crises' due to 'anticipation of discrimination, burden narratives, lack of awareness of mainstream crisis support services and LGBTI+ specialist counselling and mental health support services, and physical access, technological, and financial barriers'.

[57] 'National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023' (Australian Government, National Indigenous Australians Agency, October 2017.

[58] 'Right of everyone to the enjoyment of the highest attainable standard of physical and mental health - Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' United Nations General Assembly, Human Rights Council, A/HR/41/34 (12 April 2019), Summary, p. 1.

[59] ICRPD (n 42) Art 1.

[60] Victorian Charter (n 44) 1(c).

In fact, the Victorian Government already acknowledges that diversity and inclusivity remains a central tenant of values of lived experience engagement[61], whilst further noting the importance of understanding, respecting and responding to diversity whilst promoting inclusivity[62].

However, although LGBTIQ+ individuals must be treated equitably when receiving mental health treatment, including the respect of bodily integrity and autonomy, it is important that this standard is not a 'one-size fits all' when it comes to providing treatment. As the LGBTIQ+ community comprises multiple distinct and overlapping communities, there remains intersecting risks and disadvantages that results in differing levels of need, thus requiring individualised tailoring to respective treatment provided.

Quality

The last principle, albeit fairly self-evident, should prescribe that those who are recipients of mental health care in Victoria should receive high quality of care that serves to protect their mental health and wellbeing.

Services should be scientifically and medically appropriate, requiring, *inter alia*, appropriately trained medical personnel in delivering services to priority populations, scientifically approved equipment, and the administration of unexpired pharmacotherapy as directed by relevant medical professionals.

c. Trauma and violence-informed model of care

Trauma-informed care is based on the principles of safety, choice, collaboration, trustworthiness and empowerment. Trauma experienced by the community must be recognised and how trauma underpins a vast part of the LGBTIQ+ experience.

All interventions for LGBTIQ+ mental health must be trauma-informed, strengths-based, and depathologising[63] that operates to address the cumulative impact of discrimination, marginalisation and violence upon individuals, families and communities.

For example, despite reform by the World Health Organisation to remove being trans or gender diverse from the chapter dedicated to Mental Disorders, the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) prescribes being trans with experiencing gender dysphoria, in effect, instructing that the trans experience is a mental illness rather than reflecting innate human diversity.

Trauma-informed care is fundamental to providing a person-centred, safe, and affirming service to vulnerable populations with a higher rate of trauma who are experiencing mental health issues and/or exhibiting suicidal ideations or concomitant behaviours.

The medical model of mental health centres diagnosis and pharmaceutical treatment options, often failing to effectively identify and treat trauma or the broader psychosocial needs of the individual. This medical model has itself been, and continues to be, a source of significant trauma for many LGBTIQ+ people who historically had their bodies, genders and

[61] Lived Experience Framework (n 37), p. 8.
[62] This echoes the Lived Experience Framework (n 37), p. 8; See also, 'Victoria's 10-year mental health plan' (Victoria State Government, Department of Health and Human Services, 2015) p. 21.
[63] The depathologisation of healthcare is particularly germane to intersex people: see, e.g. 'Malta Declaration' (Intersex Human Rights Australia, 2013).

sexualities pathologised and dehumanised; their bodily autonomy violated; been verbally, physically and sexually abused within treatment spaces such as wards and rehab; and/or been subject to violent and harmful conversion practices. The experience of having your name, gender, pronouns, or relationships and family structure discounted can also be traumatising.

Previous incidents of trauma are another further important consideration in informing the guiding of the strategy. Many LGBTIQ+ people do not feel safe to call police or service providers due to a history of medical or legal trauma.

Intersex, trans and gender diverse communities especially experience histories of medical trauma and negative experiences of health services which might be aided by better coordinated services for them, peer navigators and workers adopting a self-determination approach where the person directs their own care.

d. Promotion of evidence-based practice

This strategy must prioritise evidence-based practice, including prescribing the amassing of disaggregated data on LGBTIQ+ mental health. Disaggregation is essential to reflect more effective, nuanced, and practical policy that operates to actually serve the community than positioning itself as mere window dressing.

The traditional approach of amassing aggregated data on the LGBTIQ+ community fails to capture and compare rates and the burden of mental illness and suicidal behaviours between Lesbian, Gay, Bisexual, Transgender, Intersex, and non-LGBTI populations. It is illogical to enact any type of framework without collecting appropriate data on a priority population.

If data is continued to be collected in an aggregated manner, policy makers are rendered to rely on pure assumptions regarding sexuality, intersex variations, gender and other social determinants and how they intersect with other minority populations involving culture, disability, faith or location.

In this regard, the disaggregation of data, including considerations pertaining to sexuality and gender identity should be a requirement across all mental health service providers, and should extend to all intake procedures or forms that are provided to consumers include LGBTIQ+ considerations. It is important that this process should not be a ‘box ticking’ exercise, rather inform providers of medically pertinent information to adequately tailored services to those seeking it.

Suicide prevention and response initiatives and actions

5a. In addition to the Royal Commission's recommended initiatives, what other initiatives should be included in the strategy?

Thorne Harbour submits the following initiatives that should be included in the strategy:

Recommendation 1

Fully resource the development of an LGBTIQ+ Mental Health Prevention Framework that reflects the social realities of LGBTIQ+ people and included specific protective factors that promote mental health resilience.

Recommendation 2

Fully resource the development of targeted prevention strategies for particular priority populations, such as for trans and gender diverse people within the LGBTIQ+ community, and aboriginal and Torres Strait islander individuals.

Recommendation 3

Fund the development of a framework for early intervention and entry into care for LGBTIQ+ young people encompassing the family and social support services provided through HEY and mainstream mental health early intervention services for young people.

The Prevention Framework should:

- Clearly define the issue, using research evidence, and a collective call to action;
- Analyse the structural drivers of poorer mental health;
- Identify protective factors that promote resilience and mental health for individuals, families, and the broader community;
- Emphasise approaches based on valuing and affirming gender and sexual diversity, not just tolerance;
- Examine the different settings, models and achievements of existing interventions;
- Outline principles and strategies for effective community engagement both to and between LGBTIQ communities and wider society;
- Identify synergies with existing gender violence prevention work frameworks, systems and interventions;
- Analyse sector capacity needs and workforce development plan;
- Provide an evaluation framework based on measurable outcomes; and
- Define a set of staged actions, and a plan for review and renewal of the framework in line with emerging evaluation evidence.

The Framework would need to be developed through extensive consultation with key stakeholders in government, non-government organisations, community, service providers, and across the sectors engaged in LGBTIQ+ health and mental health.

The Prevention Framework should outline a three year, five year and twelve year plan to be reviewed at these intervals, acknowledging that generational change of this nature requires a long-term commitment.

Recommendation 4

Develop and implement an intersectionality framework similar to *Everybody Matters* in the family violence sector to identify how multiple and overlapping disadvantages impact on people with mental illness, LGBTIQ+ status, and other intersecting minority positions, and address barriers to inclusion through an integrated policy framework and associated organisational toolkits.

Recommendation 5

Require key mental health services in each geographic region of Victoria to achieve the Rainbow Tick and provide the assessment and staffing costs to facilitate this within three years. Further expansion of this network should then be funded to occur until all services in the system achieve the Rainbow Tick.

Recommendation 6

Require all mental health early intervention, crisis response and treatment services to attend the HOW2[64] program over a five-year period.

Recommendation 7

Fund a specialised role within an LGBTIQ+ training organisation such as Rainbow Health Victoria to provide ongoing consultation, capacity building and advice to organisations mandated to receive the Rainbow Tick and to coordinate peer-to-peer learning through an ongoing community of practice.

Recommendation 8

Fund a workforce training needs analysis to inform the development of a whole of sector LGBTIQ+ inclusive practice capacity building strategy. This should be integrated with the rollout of the HOW2 and Rainbow Tick.

Recommendation 9

Fund the authorship of an 'LGBTIQ Affirmative Practice Training Package' in conjunction with Service Skills Organisations. This would establish a Unit of Competency, a Qualification Framework, and Assessment Guidelines to ensure consistency in embedding LGBTIQ+ Affirmative practice into the skills and qualifications of the mental health sector workforce going forward.

Recommendation 10

Adopt a sector-wide trauma-informed model of care. This must include a focus on cultural safety for those communities who experience higher levels of trauma such as LGBTIQ+ people and be co-designed with these communities.

Expand the Hospital Outreach Post-Suicide Engagement (HOPE) program across the state. This program must include an LGBTIQ+ specific HOPE service, provided by an LGBTIQ+

[64] The HOW2 program helps organisations to embed LGBTIQ inclusive practices within their workplace and services, creating lasting cultural change. The program takes participants from different organisations through a series of practical steps to help them develop and begin to implement a plan for inclusive practice specific to their organisation.

community-controlled organisation, with experience delivering phone and group-based suicide postvention activities.

Recommendation 11

Require and resource the mainstream mental health, coronial systems and other services adjacent to mental health services to gather and disaggregate accurate, reliable and timely data that represents the experience of LGBTIQ+ people and expand existing outcome frameworks to measure the experiences of LGBTIQ+ Victorians across a broader range of domains.

Recommendation 12

Develop strategies, policies and procedures for use in acute care and crisis intervention response services that are inclusive of and responsive to the needs of LGBTIQ+ populations that includes periodic evaluation, ideally in line with Recommendation 1, above.

Recommendation 13

Identify, recognise and fund LGBTIQ+ suicide prevention as a categorical priority within mental health services.

Recommendation 14

Provide an ongoing commitment to follow the *Change or Suppress (Conversion) Practice Prohibition Act*.

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5b. What opportunities should be created for the Victorian community to be part of the change to reduce the stigma associated with suicide, increase understanding and awareness, and prevent suicide?

Despite a legal and social environment that is increasingly supportive of LGBTIQ+ people, harassment and discrimination driven by homophobia, biphobia and transphobia still occurs and operates to devalue LGBTIQ+ people. In order to reduce the stigma associated with suicide and increase awareness, especially as it relates to the LGBTIQ+ community, a comprehensive, coordinated response by multiple sectors is required.

Moreover, greater frequency in exposure to negative media messages has been found to be associated with greater psychological distress.[65]One example of how this impacts mental health is the recent debate around marriage equality, where recent studies have concluded that the debate have rendered LGBTIQ+ young people more vulnerable to discrimination[66], whilst 80 per cent of LGBTIQ+ people in other studies highlighted that the debate was 'considerably' or 'extremely' stressful[67].

In the eyes of the law, the freedoms and human rights of LGBTIQ+ are inalienable and axiomatic.

Yet in the eyes of the public, the natural reflexive action is still to fundamentally question the validity of LGBTIQ+ individual's valid and equal participation in society, demonstrated in contemporary examples as the *Religious Discrimination Bill* and the involvement of transwomen's involvement in sport.

Government and policy makers

Recommendation 1

Advocate for the needs of people impacted by suicide, highlighting the disproportionate poorer mental health outcomes of LGBTIQ+ people, by engaging local, state and federal governments to ensure relevant representatives are informed about postvention and the impact of suicide.

Education

Recommendation 2

With studies having noted that support from *inter alia* schools support resilience that optimises LGBTIQ+ mental health[68], the Victoria Government should build the capacity of schools and education institutions to support LGBTIQ+ students, so as to address bullying and respond to those presenting at risk or experiencing suicidality.

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[65] Verrelli et al, 'Minority stress, social support, and the mental health of lesbian, gay, and bisexual Australians during the Australian Marriage Law Postal Survey' (2019) 54(4) *Australian Psychologist* 1.
[66] Gerber, P., & Lindner, P. I, 'Educating children about sexual orientation and gender identity post-marriage equality in Australia' 2022 5(2) *Human Rights Education Review* 4–31.
[67] 'Preliminary results of the Coping with marriage equality debate survey' (The Australia Institute, LGBTI National LGBTI Health Alliance, 2022).
[68] Wilson, C., Cariola, L.A, 'LGBTQI+ Youth and Mental Health: A Systematic Review of Qualitative Research' 2020 5 *Adolescent Research Review* 187–211.

LGBTIQ+ crisis support promotion

Recommendation 3

Ensure the availability, visibility and accessibility of crisis and care support options promoted on hook-up/dating apps and other online platforms that are frequented by priority populations.

LGBTIQ+ health promotion

Recommendation 4

To enhance the resilience of individuals, families and communities to respond to suicide via capacity building initiatives, supporting education and awareness campaigns relevant to local communities regarding priority communities, and promote help seeking behaviours in the community.

Recommendation 5

Enact and promote postvention services and training that is LGBTIQ+ inclusive.

Workplace

Recommendation 6

Encourage safe and appropriate conversations around mental health, suicide, and the impact of suicide across all strata and sectors of society.

Media

Recommendation 6

That sexuality and gender language guidelines, such as the Mindframe media reporting guidelines, are utilised by Victorian media to prevent stigmatised LGBTIQ+ suicide reporting.

Recommendation 7

Fund and promote advertising campaigns involving the visibility of priority communities, such as the LGBTIQ+ population, in order to encourage open discussions to lessen stigma attached with suicide and increase awareness.

Multi-sector response

Recommendation 8

Provide clear, written suggested guidelines to sectors, including, *inter alia*, media, government, and sporting bodies regarding how to appropriately publicly speak about trans and gender diverse individuals.

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5c. In addition to training, what else is needed to support frontline workforces and other social and health services workforces to respond compassionately to: people experiencing suicidal thoughts and behaviour; suicide attempt survivors; and families and carers?

Recommendation 1

Enact LGBTIQ+ specific acute mental health and rehab beds that offers LGBTIQ+ people the option to decide for themselves where they feel most safe and comfortable.

Recommendation 2

Invest in specific mental health services for both young trans and gender diverse people and adults attached to LGBTIQ+ community-controlled organisations, with the ability to provide short, medium, and longer-term support.

Recommendation 3

Support the growth of the specialist clinical mental health workforce delivering care for trans and gender diverse people through the provision of specific training pathways and standards, clinical practice guidelines and communities of practice.

Recommendation 3

Develop specific psychosocial support models for intersex people as part of the development of, and to be integrated with, the standards of care for intersex people.

Recommendation 4

Expand the Hospital Outreach Post-Suicide Engagement (HOPE) program across Victoria that includes an LGBTIQ+ specific HOPE service, provided by an LGBTIQ+ community-controlled organisation, with experience delivering phone and group-based suicide postvention activities.

Recommendation 5

Encourage financial incentives and further promotion of Rainbow Tick accreditation amongst services providers in Victoria.

Recommendation 6

Adopt a sector-wide trauma-informed model of care. This must include a focus on cultural safety for those communities who experience higher levels of trauma such as LGBTIQ+ people and be co-designed with these communities.

Recommendation 7

Require all providers of mental health care to maintain policies that prescribe what staff are required to do to address discrimination perpetrated by fellow patients, clients, or staff.

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Ideally such policy would be enacted after having consulted with an employee or stakeholder with lived experience of mental illness from a diverse, intersectional background.

Recommendation 8

Reduce the over-reliance on hospital-based care for young trans people, and further fund and promote LGBTIQ+ community-controlled and based mental health provision.

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5d. How can we better educate and build the capacity of workplaces to reduce the risk of suicide and better support staff? What capabilities or supports are required?

As discussed above, capacity building of medical professionals to cater to LGBTIQ+ individuals operate to not only provide adequate service to LGBTIQ+ individuals during this stressful period, but to further assure communities feel safe when accessing mainstream medical services.

Recommendation 1

Further promote Rainbow Tick accreditation amongst services providers in Victoria.

Recommendation 2

Decrease Victoria's reliance on mainstream faith-based mental health providers providing assistance to LGBTIQ+ consumers.

Recommendation 3

To finance a specialised position within an LGBTIQ+ training organisation, such as Rainbow Health Australia, to provide ongoing consultation, capacity building and advice to organisations that receive the Rainbow Tick and to coordinate peer-to-peer learning through an ongoing community of practice.

Recommendation 4

Enact proactive training or professional development modules in assisting diverse clientele is required at all levels.

Recommendation 5

Require all providers of mental health care maintain policies that prescribe what staff are required to do to address discrimination perpetrated by fellow patients, clients, or staff, ideally enacting this policy after having consulted with ideally having consulted an employee with mental illness from a diverse background.

Recommendation 6

Enact targeted scholarships for LGBTIQ+ individuals entering mental healthcare.

Recommendation 7

Ensure interpreters utilised in medical settings are provided with training regarding LGBTIQ+ clients.

Recommendation 8

Further finance LGBTIQ+-specific peer worker initiatives within mental health.

Recommendation 9

Draft and enact mental health policy, ideally lived experience of mental illness and/or

suicide.

Recommendation 10

Ensure that there is available and accessible counselling and support that is afforded to all mental healthcare providers at all levels of employment throughout the duration of their employment.

Recommendation 11

Develop and enact an LGBTIQ+ competency framework for mental health service providers.

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5e. What higher risk industries/workplaces should we prioritise for immediate suicide prevention action and why?

THH submits that healthcare workers should be prioritised for immediate suicide prevention action.

With the World Health Organization designating 2021 as the 'International Year of the Health Worker', poorer mental health outcomes of healthcare workers are increasing in frequency and severity.

Healthcare workers already suffer from poor mental health and increased rates of occupational burnout, anxiety, depression and suicide than other occupations.[69] Additionally, the healthcare system is already under significant, historical strain that is impacting on the mental health and wellbeing of healthcare workers.

Acknowledge the impact of working within the field of suicide and be aware of and know how to recognise compassion fatigue, burn out and vicarious trauma, especially after the impact COVID-19 that brought increased workplace stressors and associated risks.

Studies have concluded that during the height of COVID-19, Australian frontline healthcare workers had higher prevalence of mental health conditions, including symptoms of anxiety 59.8%, burnout (emotional exhaustion) 70.9% and depression 57.3%, despite participants having very high resilience scores.[70]

[69] De Cieri H et al., 'Effects of work-related stressors and mindfulness on mental and physical health among Australian nurses and healthcare workers' 2019 51 *Journal of Nursing Scholarship* 580–9; Imo UO, 'Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors' 2017 41 *BJPsych Bulletin* 197–204.
[70] Smallwood et al., 'High levels of psychosocial distress among Australian frontline health workers during the COVID-19 pandemic' 2021 72 *General Psychiatry* 124–30.

5f. For people who have been bereaved by suicide, what are the most compassionate and practical responses we can implement? How might this differ across various communities/groups?

At its core, the efficacy of postvention relies heavily upon practical and intensely personal relationships and engagement between people and their communities to process a profoundly significant life event. The importance of 'chosen families' for LGBTIQ+ people cannot be overstated, particularly those with strained relationships with biological families.

Existing research evidence indicates that social networks, supportive relationships, and a feeling of belonging or connectedness are important protective factors. For LGBTIQ+ people, connection and belonging to LGBTIQ+ and mainstream communities and family are predictors of improved mental health.[71]

It was important that service providers understand and value that LGBTIQ+ people may have diverse support networks. It is essential that those who are or have been bereaved by suicide are aware that not only that support is available, but also that support will endure to be available until no longer required.

In this regard, a concomitant principle must be considered, that is, to build safe, strong and sustainable communities, and promote visibility and inclusivity of priority populations, such as the LGBTIQ+ community.

Yet concernedly, evidence suggests that those bereaved by suicide have higher risks of adverse mental health disorders[72], or even exhibiting suicidal behaviour[73] after the loss of someone they know to suicide. Thus, effective postvention presents itself as additional avenue of suicide prevention.

Therefore, THH submits the following recommendations:

Recommendation 1

Provide information to those bereaved of suicide that is clear, appropriate, available, accessible, accurate, practical and useful.

Recommendation 2

Ensure that assistance provided to those bereaved of suicide is identifiable, locatable and navigable.

Recommendation 3

The 'no wrong door' approach is followed to facilitate referrals to other more appropriate services, ensuring that the bereaved, carers are supported in finding the right services. This

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[71] Marina Carman et al, 'Falling through the cracks: the gap between evidence and policy in responding to depression in gay, lesbian and other homosexually active people in Australia' (2012) 36(1) *Australian And New Zealand Journal Of Public Health* 76; Julia Taylor et al, 'Bisexual mental health: 'Findings from the Who I am study' (2019) 48(3) *Australia Journal of General Practice* 138; Anthony Lyons et al, 'Rural-Urban Differences in Mental Health, Resilience, Stigma, and Social Support Among Young Australian Gay Men' (2015) 31(1) *Journal of Rural Health* 89.

[72] Spillane et al., 'What are the physical and psychological health effects of suicide bereavement on family members? An observational and interview mixed-methods study in Ireland' 2018 8 *BMJ Open* e019472.

[73] See, 'Pitman et al., 'Effects of suicide bereavement on mental health and suicide risk' 2014 1 *Lancet Psychiatry* 86-94.

includes the facilitation of referrals to relevant support groups, noting the inherent value of connecting with others (following WHO and Lifeline guidelines).

Recommendation 4

Time is of the essence: ensure that information is provided promptly and connection to services is conducted quickly as possible.

Recommendation 5

Ensure availability of differing modalities in providing assistance to those bereaved of suicide (in-person and virtual).

Recommendation 6

Enact a state-wide referral database to enhance coordination and connections between service providers.

Recommendation 7

Ensure crisis mental health and support lines (Switchboard, Lifeline, Kidsline, QLife, Suicide Call Back Service) are LGBTIQ+ inclusive and available outside of business hours.

Recommendation 8

Implement a flexible approach to service delivery including undertaking both passive and proactive methods of assistance to those bereaved of suicide.

Recommendation 9

Ensure counselling and/or therapeutic work is accredited specific, diverse, intersectional and culturally sensitive. This includes tailoring services and assuring sensitivity in providing services for factors such as gender, sexual orientation, age, kinship type of the bereaved, ethno-racial considerations, Aboriginal and Torres Strait Islander people. Throughout this process, it should be encouraged to utilise appropriate language to avoid engendering any stigma of service users.

Recommendation 10

Recognise the need of priority populations that are prone to higher risk of adverse mental health outcomes, such as the LGBTIQ+ community, adolescents, or those seeking help electronically via internet.

Recommendation 11

Understanding diverse needs and changing needs during the bereavement process.

Recommendation 12

Enacting specific bereavement postvention programs for LGBTIQ+ people who have been affected by loss following a death by suicide, ideally following or taking inspiration from the framework as espoused by Switchboard's *LGBTIQA+ Suicide Postvention Response Plan: Preliminary Findings*[74].

[74] 'LGBTIQA+ Suicide Postvention Response Plan: Preliminary Findings' (Switchboard, Pride Foundation Australia, PHN, University of New England, November 2020).