Mental Health and Suicidal Behaviours in LGBTI Populations and Access to Care in Australia: A Literature Review

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There is evidence for greater vulnerability to various mental health issues among lesbian, gay, bisexual, transgender, and intersex (LGBTI) people in Australia, depression, anxiety, and suicidal behaviours in particular. There is therefore a gap in addressing the psychological distress of LGBTI people, who experience disproportionately negative mental health outcomes in comparison with the general community, yet despite these poorer outcomes, are less likely to seek help than their mainstream counterparts (beyondblue, 2014). There are also clear barriers to change, including discrimination, social exclusion and isolation, reluctance to access help, and the failure of generic health interventions and prevention strategies to be inclusive of LGBTI people and their needs (Rosenstreich, 2013). Currently, the idea that treating everyone the same is best practice constitutes the biggest barrier to change in LGBTI mental health and recent Australian research demonstrates that such a policy reinforces the current situation and that this approach is not enough (Barrett & Stephens, 2012).

Prevalence of Poor Mental Health and Suicidal Behaviours

Studies in Australia consistently show LGBTI individuals, or a subset of these, to be at a greater risk for not only depression and anxiety, but an array of mental health issues, including suicide. A meta-analysis conducted by King and colleagues King et al. (2008) on 28 articles (25 studies carried out in seven countries in North America, Europe, and Australasia) revealed that the risk depression and anxiety disorders among gay and bisexual individuals was at least 1.5 times that of heterosexual people. Furthermore, the lifetime relative risk for suicide attempt in gay and bisexual men was over four times that of heterosexual people. Furthermore, the lifetime relative risk for suicide attempt in gay and bisexual men was over four times that of heterosexual people.

There were 5,476 gay (52%), lesbian (18%), bisexual (10%), transgendered (1%), and intersex (0.1%) participants from all Australian states and territories (65% male) in the geographically broadly representative online survey conducted by Pitts, Smith, Mitchell, and Patel (2006). Participants were recruited through Internet sites, advertisements in the media, promotional cards, and through personal email networks. Overall, 41.2% of participants reported having felt down, depressed, or hopeless in the two weeks prior. Additionally, 48.6% of males and 44.4% of females met at least one of the two criteria for a diagnosis of major depressive disorder and 24.4% of all respondents met the full criteria for the disorder. Lifetime prevalence for depression was 70% for males and 80% for females. Prevalence of the disorder decreased with age. One-third of all respondents met the criteria for dysthymia (now Persistent Depressive Disorder; American Psychiatric Association, 2013), a less severe but more chronic form of depression. Furthermore, in terms of suicidal ideation, of males 15.7%, females 14.6%, and overall 15.7% responded that they had felt that they would have been “better off dead” in the previous two weeks. Of males 42%, of females 62.2%, and overall 50.1% had seen a counsellor within the previous five years.
The follow-up to this study on the health and wellbeing of LGBT Australians (Leonard, et al., 2012) reported psychological distress using the K10 scale, which ranges from 0 to 50, higher scores indicating poorer mental health. Compared to a national average of 14.5, gay and bisexual males and trans*-males scored 18.9 and 23.3 and lesbian and bisexual females and trans* females 19.6 and 23.2, respectively. Unfortunately, this report did not report data on thoughts of death or suicide. Results were 18.8, 20.4, and 20.4 for gay, bisexual male, and other male respondents and 19.0, 21.7, and 21.3 for lesbian, bisexual, and other female respondents, respectively. A score of 22 or higher is considered “very high”; 40% of males and 55% of females aged 16-24 years scored at this level. This higher level of psychological distress only merges with that of the general population for those aged 65 and older. Results on the SF36 subscale, where higher scores indicate better mental health, showed that males and females scored lower than the national average (71.4 versus 75.3 and 68.9 versus 73.5) and that trans*-males and females scored even lower still at 64.1 and 60.4, respectively. Bisexual respondents and those preferring another identity scored lower than gay and lesbian participants (68.2, 68, and 71.6 for males and 64.6, 65.3, and 70.0 for females, respectively). In terms of anxiety, more than one-quarter of all participants had been diagnosed or treated for anxiety over the previous three years. Trans*-males were twice as likely as other males to have had such a diagnosis or treatment (45.7% versus 22.3%). Additionally, trans*-males were 2.5 times more likely than other males to have experienced an intense episode of anxiety over the previous 12 months and a similar trend was evident in trans*-females. Bisexual females were almost at twice the odds of having been diagnosed with or treated for anxiety in the previous 12 months (38.2% versus 20.9%).

In a recent study of 189 Australian transgender and gender diverse individuals aged 14 to 25 (Smith, et al., 2014), the prevalence of diagnosed anxiety, depression, and suicidal thoughts was 45%, 47%, and 25%, respectively. Of those participants who had reported having experienced abuse, harassment, or discrimination (67%), 80% had thoughts of self-harm, 70% had self-harmed, 81% had thought of suicide, and 37% had attempted suicide.

Early community-based studies from the US (using convenience samples) on young gay men reported a prevalence of attempted suicide of between 18% and 42% (Nicholas & Howard, 1998), which represents an extremely high rate, but such surveys were usually conducted on selected, highly vulnerable sub-populations of subjects. The first population-based study on the relationship between sexuality and suicidality in young males found that gay males were 13.9 times more likely than heterosexual males to have made a life-threatening suicide attempt during their lifetime (Bagley & Tremblay, 1997).

Other robust international (e.g., representative or controlled) studies have found LGB individuals to be at a higher risk for suicidal ideation (Eisenberg & Resnick, 2006; Marshal, et al., 2012; Silenzio, Pena, Duberstein, Cerel, & Knox, 2007), suicide attempt (Bolton & Sareen, 2011; Eisenberg & Resnick, 2006; M. L. Hatzenbuehler, 2011; Russell & Joyner, 2001; Silenzio, et al., 2007), and death by suicide (men only in a Danish study: Mathy, Cochran, Olsen, & Mays, 2011). LGB adolescents appear to be at particularly high risk (Russell & Toomey, 2012).

In Australia, there are no published population-based studies of suicidal behaviours in LGBTI people and the majority of the research in the field is “grey” literature. However, the Australian Bureau of Statistics holds nationally representative data on non-fatal suicidal behaviours comparing “homosexual/bisexual” with “heterosexual/sexuality not stated” males and females (ABS, 2007).
The data appear in Table 1. While non-heterosexual people have higher rates of all suicidal behaviours, strikingly elevated is the proportion of lesbian and bisexual females who have attempted suicide: almost one in five.

Data from a national Longitudinal Women’s Health study revealed similar patterns (Hughes, Szalacha, & McNair, 2010). Results appear in Table 2. Noteworthy is the higher prevalence of suicidal behaviours among those who identified as bisexual or mainly heterosexual.

A randomised study of 4,824 people from the Australian electoral role (Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002) and smaller city-based study (Abelson, Lambevski, Crawford, Bartos, & Kippax, 2006) found gay men to be at a higher risk for suicidality than heterosexual men. Bisexual men in both studies were found to be at a higher risk than gay men. More recently, a review of “the evidence base for a heightened vulnerability to suicidal behaviors” (p. 1) among Australian LGBTI populations by Skerrett and colleagues (in press) found that sexual minorities are indeed at a higher risk for non-fatal suicidality.

Gender diverse individuals have been found to be at even higher risk for non-fatal suicidal behaviours. Cross-gender role was found predictive of suicidality in a study on university students (Fitzpatrick, Euton, Jones, & Schmidt, 2005). Furthermore, against a general prevalence of suicide attempt of 4.6% in the US, much higher rates have been found among trans* individuals: one study finding 32% of respondents having attempted (Clements-Nolle, Marx, & Katz, 2006) and a larger-scale study finding even higher rates still among trans* sub-groups, such as multiracial (54%) and American Indian or Alaska Native (56%) individuals, those with only high school education (49%) or lower (48%), and an income of less than $10,000 p.a. (54%; Haas, Rodgers, & Herman, 2014). In the Australian and New Zealand context, the TranZnation report (Couch, et al., 2007) found that one-quarter of the 229 trans* individuals surveyed (90.5% from Australia) had thought that they were “better off dead” or thought of hurting themselves in the previous two weeks.

With regard specifically to fatal suicidal behaviours, it has been observed that sexual orientation is rarely noted in official documentation on death in Australia (De Leo, et al., 2010). Suicide in LGBTI populations is believed to be under-reported in Australia due to this failure to gather information on sexual orientation and gender diversity. For example, in their report on the Queensland Suicide Register (QSR) for the period 2005-2007, De Leo and Sveticic (2012) were only able to identify 12 suicides by same-sex attracted individuals from a total of 1,637 suicides.
The lack of data on the prevalence of LGBTI suicide deaths also exists in the international literature, with one noteworthy exception of a recent Danish report. In that study, Mathy and colleagues (2011) compared same-sex domestic registered partnerships to marriages using suicide data from the Danish National Board of Health. In the period 1990-2001, there were 7,637 suicides of individuals aged 18 years and older; 5,106 were or had been married at death, 2,507 had never been married, and 24 were or had been in a same sex registered partnership. Significant differences emerged in the data for men only. The age-adjusted suicide mortality risk for men in same-sex registered domestic partnerships was nearly eight times higher than that of men who were or had been married and nearly twice as high as men who had never been married. A report by the British Columbia Child Death Review Unit (2008) in Canada also found that “gay, lesbian and bisexual children and youth, as well as those questioning their sexuality, were at increased risk of suicide” (p. vii). Furthermore, Plöderl et al. (2013) reanalysed the results of a Québec study on suicide death (Renaud, Berlim, Begolli, McGirr, & Turecki, 2010) to conclude that there was an increased risk of suicide mortality in LGB cases versus non-LGB cases. Given these international findings and the elevated rates of non-fatal suicidal behaviours found in LGBTI people in Australia, we can suppose that the prevalence of LGBTI suicide death in Australia is also elevated.

**Predictive Factors**

Developmental stressors, such as self-identifying (‘coming out’) in adolescence and early adulthood, might place LGBTI people at a higher risk for psychosocial difficulties, substance abuse, and suicide attempt (Nicholas & Howard, 1998). Smith, Rissel, Richters, Grulich, and de Visser (2003) found, in a representative Australian study, that same-sex attracted men who had not acted on their desires had elevated levels of psychosocial distress and a recent US study found that suicide attempts in LGB people tend to occur at the same time as coming out milestones (Meyer, Teylan, & Schwartz, 2014).

In a study carried out on a convenience sample of attendees at various LGBTI festival events in Adelaide, South Australia, by Rogers (2007), suicide was listed by participants as the third highest health threat, following depression and HIV, for sexual and gender minorities. The main social factors contributing to health priorities nominated were discrimination under the law, in daily life, and in the media. Rejection by a family member (be it mother, father, sister, or brother) is associated with an increased incidence of self-harming behaviours, independently of history of abuse (Hillier et al., 2010). Of those that had seen a counsellor in the previous five years, 26.8%, 30%, and 25% of gay or bisexual males, trans*-males, and intersex males and 36.7%, 18.9%, and 33.3% of lesbian or bisexual females, trans*-females, and intersex females, respectively, had done so due to family problems (Pitts et al., 2006).

McKee (2000) found that exposure to and consumption of fictional media featuring positively portraying openly gay characters helped to raise self-esteem and decrease the sense of isolation among gay male participants in Perth. He posits that reducing these risk factors may act as a protective factor against suicide. Jones and Hillier (2012) found that perceived school-based policy protection in Australia was linked with decreased likelihood of thoughts of self-harm, actual self-harm, suicidal ideation, and attempted suicide in LGBTI students. Perceived policy protection was also linked with students’ feeling good about their sexuality. Hillier, Turner, and Mitchell (2005) noted that there was an increase in the number of respondents identifying as non-heterosexual in their follow-up to the initial report published seven years prior (Hillier et al., 1998). There was also an increase in the instance of respondents feeling “great” or “good” about their
sexuality (76% in the 2005 report compared to 60% in 1998). As the authors suggest, this is likely a “result of more widespread acceptance of diverse sexuality” (Hillier et al., 1998, p. vii).

Additionally, prejudice and discrimination (homophobia and heterosexism) may result in shame, hostility, and self-hatred, especially as homophobia may become internalised (McDaniel, Purcell, & D’Augelli, 2011). Victimised or bullied LGBT school students are 2.5 times more likely to engage in self-harm (Liu & Mustanski, 2012). An Australian study recently found that the experience of homophobic bullying in combination with a low level of self-acceptance among same-sex attracted and gender diverse (SSAGD) school students was predictive of depression, anxiety, and stress (Symons, Borkoles, Andersen, & Polman, 2014). Overall mean levels of depression for the SSAGD students in that study were in the moderate range, with anxiety in the moderate-severe range and stress at mild-moderate levels. Furthermore, gay individuals are at a higher risk of sexual assault and those who have suffered physical assault are at a higher risk of suicidal behaviour (Nicholas & Howard, 1998).

Rural LGBTI individuals appear to be at an even greater risk of negative mental health outcomes, with a greater experience of isolation and homophobia and lesser sense of community and support services (Quinn, 2003).

The importance of an inclusive environment that supports the mental health and wellbeing of LGBTI people was a major implication of recent research from the United States that found that the life expectancy of sexual minorities in areas of high anti-gay prejudice was 12 years lower than in areas of low prejudice and that that those that died by suicide in high-prejudice communities tended to so some 18 years younger (Hatzenbuehler, et al., 2014). This has occurred within the context of various initiatives from the United States that have endeavored to “upstream” mental health promotion by facilitating more inclusive environments at the family (Ryan, 2010) and school (Meyer & Bayer, 2013) levels, but these programs have been implemented neither uniformly nor widely across the country, underscoring the importance of coordinated national strategies such as those in Australia reported in the present report (see next section). Nevertheless, as noted, the “we treat everyone the same” attitude in the provision of (mental) health care is still the biggest barrier to inclusive practice in Australia (Barrett & Stephens, 2012) and thus efforts to promote LGBTI-specific cultural sensitivity in mainstream (mental) health care providers must be sustained and expanded if they are to be effective.

In a recent reanalysis of QSR data for the period 2000-2009, Skerrett and colleagues (Skerrett, Kõlves, & De Leo, 2014) were able to establish that LGBT individuals constitute a unique subpopulation in terms of risk factors for suicide mortality, suggestive of the need for targeted approaches to mental health promotion and suicide prevention at numerous levels. It is clear that LGBT people were at a greater risk for depression in that study, and while they were more likely to be receiving psychiatric treatment from their GP, they were less often treated as inpatients or outpatients in hospitals for mental health issues. This suggests that LGBT individuals are not receiving sufficient levels of specialised psychiatric treatment. There are at least two potential reasons for this. Firstly, there were no psychotic disorders in the LGBT suicides identified (versus 12.4% in the comparison non-LGBT cases) and this could mean that the psychological distress being experienced by these people is not as salient to medical professionals and their need for more intensive and focused treatment goes undetected.
Indeed, as the risk of suicide among people with psychotic disorders such as schizophrenia is well established (Palmer, Pankratz, & Bostwick, 2005), the non-occurrence of these in LGBT suicides in the study is telling, suggesting that there are other factors leading to very high levels of vulnerability. Secondly, the fact that the study found that LGBT people were more often getting psychiatric treatment from GPs could mean that there is a reluctance to seek specialised psychiatric treatment due to a fear of discrimination from psychologists or psychiatrists in relation to the suicidal person’s sexuality or gender identification. A rapport may have been well established already with the GP but the pathological past of “homosexuality” in psychiatry and the regular assumption of health professionals that all clients are heterosexual (Mayer, et al., 2008) may act as barriers to help-seeking in suicidal LGBT people. This issue is discussed in more detail further below.

In a similar study from Québec (Renaud, Berlim, Begolli, McGirr, & Turecki, 2010), the authors found that LGB child and adolescent suicide cases were more likely to meet the criteria for an anxiety disorder, to have seen a health professional or psychiatrist or have been hospitalised in the month prior to death, and to have seen a psychiatrist in the year prior to death.

**Prevention and Intervention**

Given the particular risk for suicidal behaviours during the teenage years and the “coming out” process, schools have been the focus of different mental illness-focused preventative activities. An evaluation of the implementation of the Massachusetts State Board of Education’s recommendations to improve the school environment for LGB students found that students in schools that did not provide “gay-sensitive instruction” were at greater risk of suicide, as well as a range of other physical and mental health concerns, including victimisation and HIV infection (Blake, et al., 2001). It would seem that a supportive school environment acts as a buffer to poor mental health among LGBTI students. Indeed, a study of Austrian gay and bisexual individuals found that suicide attempts at school were associated with a lack of acceptance, whereas positive reactions to “coming out” offset this risk (Plöderl, Faistauer, & Fartacek, 2010). Research on Gay-Straight Alliances (GSAs) in the US has supported this, finding higher levels of emotional wellbeing among sexual minority students in schools that offer this support (Lee, 2002; Rutter & Leech, 2007).

Other types of intervention that have been shown to be effective when specifically targeting sexual minorities include the use of gay-tailored cognitive behavioural therapy (CBT). While not addressing depression or anxiety directly, this form of CBT has led to a faster decrease in methamphetamine usage (Jaffe, Shoptaw, Stein, Reback, & Rotheram-Fuller, 2007) and risky sexual activity (Shoptaw, et al., 2005). In-depth interviews with gay male clients revealed that experienced and sensitive heterosexual therapists could successfully adopt a “gay affirmative” psychotherapeutic approach (Lebolt, 1999), and a Gay Affirmative Practice (GAP) Scale has been developed for mainstream mental health practitioners working with lesbian and gay clients (Crisp, 2006).

Mainstream media can also be a channel for LGBTI health promotion. An investigation of HIV/AIDS prevention publicity campaigns in the US discovered that “strategic ambiguity” was key to reaching a non-heterosexual audience (DeJong, 2001). That is, although the advertisements generally target a straight audience, it is important for sexual minorities to feel that the campaigns could also be directed at them by using actors that could be interpreted as non-heterosexual.
There is no research published on LGBTI-specific health promotion in Australia, although HIV-prevention, for example, campaigns do exist in LGBT publications and beyondblue recently launched a set of ads aimed at increasing awareness of the effect of discrimination on the mental health of LGBTI individuals (beyondblue, 2012). As part of its drive towards targeted approaches to prevention and awareness, the Australian government recently launched MindOUT! Implemented through the National LGBTI Health Alliance, MindOUT! is a national mental health promotion and suicide prevention project, the first of its kind in the world. Key elements of the MindOUT! project are the convening of two steering committees—an LGBTI Mental Health Promotion Framework Task Group and a Mental Health Working Group—nationwide training programs, a national LGBTI ‘Champions’ pilot program, and ongoing policy advocacy. The aim of the MindOUT! project is to draw together expertise about mental health and suicide prevention from leading experts in the field and disseminate programs and information in a cohesive manner across Australia.

In terms of the school environment, the Safe Schools Coalition Victoria, with the support of the State government works to reduce homophobia and transphobia in schools by providing a membership network, training, and materials (Safe Schools Coalition Victoria, no date). A similar initiative, the Proud Schools program, exists in New South Wales (Education & Communities, 2012)

**Help-Seeking Behaviours and Accessibility**

A research project involving 1,224 online participants was conducted by the National LGBTI Health Alliance for beyondblue to inform their campaign targeted at men, Beyond Barriers (see Mars & Skerrett, submitted). The aim of the study was to understand help-seeking behaviour in GBTI men, with a particular focus on perceptions of help-seeking, specific ‘enablers’, and ‘barriers’ for GBTI men. GPs were the most common source of help-seeking for depression, followed by psychologists and then talking to family and friends. The majority (52%) reported having sought help from a GP and 39% from a psychologist for anxiety. The majority of each group found help for anxiety not to have been useful, however. Talking to friends/family, medication, and general counselling were found to be effective by around one-third of respondents. With both anxiety and depression, online or printed resources alone were not considered helpful by the majority.

Most survey respondents agreed that “men are uncomfortable in talking about their feelings or personal problems”, that they “find it difficult to express feelings, especially sadness”, that they find it difficult to ask for help, that they are “reluctant to go see a professional if they have a problem”, “that a man will ask for help as a last resort”, and that “men will ask for help if they feel they will not be judged”. Most, however, disagreed with the statements “a man should be able to solve his problems by himself” and that “asking for help is a sign of weakness”.

Specific factors that would influence a man not to seek help endorsed by the majority were a negative reaction to disclosure of sexuality or gender, past negative experiences due to sexuality or gender, actual or perceived discrimination, an organisation being faith-based, being judged for aspects of GBTI lifestyle, and lack of knowledge of the lived experiences of GBTI men. Respondents were likely to use the services of an organisation, on the other hand, if it was an LGBTI community organisation, if it had a reputation as LGBTI inclusive, had accreditation as LGBTI inclusive, or had GBTI-identified men on staff.
In an other study of 1,939 LGBTI community members, 86% of respondents either agreed or strongly agreed that having LGBTI-specific mental health and suicide prevention services was important (Price Waterhouse Coopers, 2011). In the same study, it was found that less than 20% of mainstream mental health and suicide prevention services included LGBTI individuals specifically in their goals and/or strategic plan. Furthermore, the majority of LGBTI organisations were found unable to deliver mental health services and the majority of mainstream mental health services were not trained in LGBTI-sensitive practice.

This lack of LGBTI-culturally appropriate and inclusive health services appears to act as a barrier to help-seeking in LGBTI people experiencing poor mental health and suicidality. In one New Zealand study (Neville & Henrickson, 2006), more women than men reported their healthcare provider usually or always assumed that they were heterosexual, although it was the majority in both cases (83.2% and 65.8%), and most respondents indicated that the healthcare professional’s attitude towards sexuality was important to them. The majority of general practitioners (GPs) do not enquire about patients’ sexual orientation, believing it is the responsibility of the patient to disclose (Dahan, Feldman, & Hermoni, 2008), yet given the almost universal experience of discrimination among LGBTI people (McNair, Hegarty, & Taft, 2012) and the assumption of heterosexuality among practitioners, this creates barriers to disclosure and the development of an appropriate and affirming alliance with the practitioner. In their study of trans* people’s use of health services, Pitts, Couch, Croy, Mitchell, and Mulcare (2009) found that trans* patients often avoided disclosing to health professionals when the issue did not related directly to their transgender status for fear of being pathologised and stigmatised. McNair, Szalacha, and Hughes (2011), in their review of the data from the Australian Longitudinal Study on Women’s Health, found overall that sexual minority women have lower satisfaction with care received from GPs and lower continuity of GP care than heterosexual women, attributing this, at least in part, to a general lack of culturally inclusive health services. Increased disclosure, on the other hand, was shown to lead to better health care utilisation and increased satisfaction among lesbian patients in one Canadian study (Bergeron & Senn, 2003).

In addition to the assumption of heterosexuality, GPs in an Australian study (McNair, et al., 2012) often failed to facilitate disclosure due to fear of damaging the patient-doctor relationship (particularly due to a belief that patients prefer not to disclose due to the embarrassment of the stigma related to sexuality) and to concerns over revealing their inadequacies in the area. Furthermore, most of the GPs involved in the study did not see the clinical relevance of sexual orientation due to a lack of knowledge about the health inequalities of same-sex attracted individuals and a lack of formal training in the area. While not all the same-sex attracted patients in this study found disclosure to be important or necessary, as the authors noted, “creating a supportive and sensitive environment that encourages disclosure falls to the GP” (p. 215). The authors suggest that further training is required for practitioners to understand the social and clinical relevance of sexuality for patients, and elsewhere (McNair & Hegarty, 2010) note the need for evidence-based guidelines for dealing with sexual minority patients, developed in conjunction with these stakeholders, in primary care settings.

Further barriers to patient or client disclosure include the reluctance and fear LGBTI providers may experience in disclosing their sexuality or gender. Discrimination of LGB physicians by colleagues and superiors is known to occur (Druzin, Shrier, Yacowar, & Rossignol, 1998). In a telephone interview with a random sample of 500 participants from a large Canadian city (Druzin, et al., 1998), 11.8% stated that they would refuse to see an LGB physician; of those that would refuse, more than half (56%) indicated that this
was due to fear that the physician would be incompetent and 17% reported feeling that the physician would not be able to understand aspects of their (heterosexual) lifestyle. Only 5% indicated that they would not see an LGB physician for “fear of being thought of sexually” (p. 596). In a more recent nationally representative US study (Lee, et al., 2008), however, fully 30.4% of respondents indicated that they would change providers if they found out he or she was gay or lesbian and 35.4% indicated they would change practices if they found out there were gay or lesbian providers on staff. Male respondents were also 1.9 times more likely to prefer having a chaperone for genital examinations with a gay male provider.

LGBTI individuals may also experience outright discrimination from (mental) health providers (National LGBTI Health Alliance, 2012), or at the very least unhelpful therapeutic encounters related to sexual orientation or gender identity (Israel, Gorcheva, Burnes, & Walther, 2008). The expectation or fear of discrimination from health care professionals has also been shown to lead to avoidance of help-seeking (National LGBTI Health Alliance, 2012; Pitts, et al., 2009). Research from the US has even shown that those LGBT people receiving care for more severe mental health conditions in the public and community health systems experience outright hostility (Lucksted, 2004). The author notes that there is “little to no recognition of LGBT issues” in these settings and that LGBT organisations and those therapists who are LGBTI-inclusive are ill-equipped to deal with more serious psychiatric disorders. Similarly, Israel and colleagues (2008) found that helpful experiences for LGBT clients with mental health professionals tended to be with psychologists and social workers who were warm, respectful, and affirming of sexual orientation and gender identity. Unhelpful experiences, on the other hand, tended to occur with psychiatrists. These were characterised by therapy that was cold and disengaged and could involve negative bias in relation to sexuality and gender identity, as well as forced use of medication and hospitalisation. While the majority of Australian GPs surveyed in a study by Khan, Plummer, Hussain, and Minichiello (2008) reported being comfortable managing sexually transmitted infections in heterosexual patients, less than half were comfortable doing so with gay and lesbian patients. Koh, Kand, and Usherwood (2014) also recently found that Australian LGBT adults often divided care between different health providers, particularly for sexual health concerns, citing real or perceived discrimination as a primary concern. There is also evidence of mixed experiences from mainstream crisis lines in terms of their ability to effectively engage with LGBTI callers (National LGBTI Health Alliance, 2012).

Conclusions

There are several main conclusions to be drawn from this review. Firstly, LGBTI individuals are at a high risk for an array of poor mental health outcomes, particularly depression, anxiety, and suicidality, both internationally and in the Australian context. Rates of suicide attempt among trans* individuals are particularly elevated. While there is no research to support a higher incidence of LGBTI suicide mortality in Australia (due to a lack of reporting of sexuality and gender diversity on death), given the higher rate of non-fatal suicidal behaviours and the evidence for an increased vulnerability internationally, it can be presumed that risk of death by suicide among LGBTI people is indeed increased.

Secondly, research suggests that there are specific risk factors related to poor mental health outcomes in LGBTI people. Chiefly, these relate to lack of acceptance at different social levels: the family, the school, and society in general. On the other hand, a tolerant and accepting environment serves as a protective factor.
Thirdly, prevention and intervention initiatives that have an evidence-base for their effectiveness in reducing poor health outcomes across an array of domains are those that are inclusive and affirming of sexual and gender diversity. This includes various therapies, schooling, and society in general. Many of these have begun to be introduced in Australia.

Finally, utilisation of health services appears to be largely contingent on the real or perceived experiences of LGBTI people of acceptance, on the one hand, and discrimination, on the other, on the part of health practitioners, particularly for more severe mental health conditions. It seems that health professionals that promote an inclusive environment which facilitates disclosure of sexuality or minority gender identity, should the LGBTI client wish to disclose, are the most effective in promoting help-seeking and continuity of care. It may also be that LGBTI practitioners themselves need assistance in feeling more comfortable with disclosure to clients, particularly in the cases where this would be conducive to establishing a more inclusive alliance. LGBTI people are willing to seek help, but barriers remain. Mainstream organisations require upskilling of staff in LGBTI-specific cultural competence to create sensitive and supportive therapeutic environments. Services also need to develop a reputation (and possibly acquire accreditation) for being LGBTI-inclusive in order to promote help-seeking in LGBTI populations.
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