

Position Statement 83

Recognising and addressing the mental health needs of the LGBTI population

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The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is concerned that a disproportionate number of Australia and New Zealand's lesbian, gay, bisexual, transgender and intersex (LGBTI) population experience mental illness and psychological distress. Evidence shows that the discrimination and marginalisation experienced by the LGBTI population increases the risk of developing mental health issues, and also creates barriers to accessing supportive services. This position statement provides an overview of some of the key issues relevant to mental health and LGBTI identity, and makes recommendations for enhancing the mental health sector's responsiveness to these.

Definition

The RANZCP acknowledges the importance of using appropriate terminology when discussing issues of sexual, sex and gender identity (Smith et al., 2014). Inclusive language engenders respect and promotes visibility for important issues, and this is integral to improving the health of the LGBTI population (AHRC, 2015). The text box below provides an overview of some key terms used in Australia and New Zealand. Clinicians should however be mindful of the rapidity with which language and terminology can change and develop in this area, and should undertake additional research or inquiry with the appropriate organisations as appropriate (please refer to the list of resources below for more information).

Key terminology in Australia and New Zealand

- The acronym **LGBTI** refers collectively to people who are lesbian, gay, bisexual, transgender, and/or intersex.
- **LGBTIQ** is also sometimes used, the 'Q' referring to people who identify as queer (see below) or questioning (those who are exploring their orientation and identity).
- The word **queer** can be used to refer to a sexual or gender identity that is non-binary. The term has been used variably throughout history, as a derogatory word, and also as a political term used to resist homophobia. People may therefore have varying relationships to the word, and some may find it offensive (Smith et al, 2014).
- Sexual diversity can include people who are **lesbian, gay** or **bisexual**, as well as a range of other expressions of sexuality. This may include people who identify as **asexual** (experiencing an absence of sexual attraction, distinct from celibate) or **pansexual** (experiencing sexual or romantic attraction that is not based on gender identity or sex) (Smith et al, 2014).
- **Transgender** or **trans** is commonly used to describe a broad range of non-conforming gender identities or expressions. The term **gender diverse** or **transsexual** may also be used to refer to a person who has an internal sense of gender that differs from their birth sex. This includes people who are **MTF** (male-to-female) or **FTM** (female-to-male). Non-binary gender identities can also include people who identify as **agender** (or having no gender), **bigender** (identifying as both a woman and a man), or **non-binary** (neither woman nor man). The term **genderqueer** or **gender fluid** is also used to refer to shifting gender identity.
- Some Aboriginal and Torres Strait Islander peoples use the term **sistergirl** to refer to male-assigned people who live partly or fully as women and **brotherboy** to refer to female-assigned people who live partly or fully as men (Smith et al, 2014).
- **Takatāpui** as a self-descriptor is often used by Māori to describe non-binary gender and/or sexual identity. Specific meaning can vary depending on context (Henrickson, 2006).
- People born with **intersex variations** encompass a diversity of experiences. Intersex traits are a naturally occurring biological phenomenon, with at least 40 different variations. People may use diagnostic or chromosomal labels for their variations, including **XXY**, **Complete Androgen Insensitivity**, **XY Woman**, **Swyer Syndrome** or **Turner Syndrome** (OII Australia, 2009)

Statistical information about LGBTI populations in Australia and New Zealand is limited. It is estimated that 9% of Australian men and 15% of Australian women report same-sex attraction (Rosenstreich, 2013). At the 2011 Australian Census there were around 33,700 same-sex couples, representing around 1% of all couples in Australia (ABS, 2011). Equivalent statistics are not currently available for New Zealand, however, sexual identity is being considered for inclusion in the 2016 census (Statistics New Zealand, 2008).

Statistical information on gender diversity in Australia and New Zealand is scarcer still, however a study of New Zealand high school students found that approximately 1.2% identify as trans (Hyde, 2014). There are no firm figures for people with intersex variations, and estimates range considerably, however 1.7% if the population is broadly accepted as an evidence-based approximation (Oll, 2013).

Background

LGBTI identity has historically been criminalised, pathologised or invisibilised by the legal and medical institutions of Australia and New Zealand. Many gay or bisexual Australian and New Zealander men have a lived experience of sodomy laws, which were repealed in 1986 in New Zealand and between 1975 and 1994 in the various jurisdictions of Australia (Cramer et al., 2015). Approximately 80 countries worldwide continue to legislate against homosexuality.

Many LGBTI people also have a lived experience of their sexual identity being defined as a mental disorder or abnormality. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) included homosexuality in its diagnostic classifications until 1973, and 'ego-dystonic homosexuality', indicated by a persistent lack of heterosexual arousal causing distress, until 1987 (Mendelson, 2003). Similarly, the *International Statistical Classification of Diseases and Related Health Problems* (ICD) previously included homosexuality as a 'sexual deviation' or 'mental disorder'. *ICD-10*, published in 1992, includes diagnosis code F66, 'sexual maturation disorder'; indicated by experience of uncertainty about gender identity or sexual orientation which causes anxiety or depression (Mendelson, 2003). A working group was formed to consider this issue for the upcoming *ICD-11*, and has recommended that F66 be removed entirely, stating 'it is not justifiable from a clinical, public health or research perspective for a diagnosis classification to be based on sexual orientation' (Cochran et al, 2014).

Legal and medical institutions are becoming increasingly inclusive. Same-sex marriage was legalised in New Zealand in 2013 but is not currently legal in Australia. The RANZCP supports marriage equality based on the evidence that legislative inequality has a significant and deleterious impact on mental health (beyondblue, 2015; Obergefell v. Hodges, 2015) and conversely, that there is a strong link between improved health outcomes and legislation change of this sort (Kealy-Bateman and Pryor, 2015; PHAA, 2015). Further, sexual orientation change efforts, or often non-consensual therapies intended to change the sexual orientation of a person, are now broadly understood to be harmful and unethical (RANZCP, 2015).

There is still a significant amount of work to be done in fostering more inclusive institutions however, and this is discussed below in more detail. Greater awareness of intersex and gender diverse identities in particular is urgently needed to begin to address the high vulnerability and low mental health outcomes of these groups.

Evidence

People who identify as LGBTI are at increased risk of exposure to institutionalised and interpersonal discrimination and marginalisation which in turn increases vulnerability to mental illness and psychological distress (King & Nazareth, 2006). Mental health outcomes for the LGBTI populations of Australia and New Zealand are amongst the lowest of any demographic (Chakraborty et al., 2011).

In Australia, LGBTI people have very high rates of suicidality, with 20% of trans people and 15.7% of lesbian, gay and bisexual people reporting current suicidal ideation (Rosenstreich, 2013). Same-sex attracted people are up to 14 times more likely to attempt suicide, twice as likely to experience anxiety disorders and three times more likely to experience affective disorders compared with the broader population (Rosenstreich, 2013; ABS, 2007).

In New Zealand, LGBTI people are similarly vulnerable. Gay men experience mental health problems at over five times the rate of opposite-sex attracted men, with an estimated 28.6% of same-sex attracted men having attempted suicide and 71.4% reporting suicidal ideation, compared with 1.6% and 10.9% of

heterosexual men respectively (Adams et al, 2013). A survey of New Zealand secondary students found that 20% of same-sex attracted students had attempted suicide in the past year, compared with 4% of their opposite-sex attracted peers (Rossen et al, 2009).

The birth of an intersex child continues to be treated as a 'psychosocial emergency', leading to non-essential medical interventions from infancy (Latham & Barrett, 2015). Across Australia and New Zealand it has been found that intersex adults exhibit psychological distress at levels comparable with traumatised non-intersex women, such as those who have experienced severe physical or sexual abuse (Rosenstreich, 2013).

Considerations for mental health policy and practice

1. Diversity of experience

Concern that medical professionals will not have an understanding of LGBTI identity is commonly identified by LGBTI people as one of the key barriers to accessing timely supports (Smith et al., 2014). Psychiatrists who work with LGBTI people should maintain an up-to-date understanding of the key issues for this population, including an understanding of the prevalence of mental health issues, as well as the importance of making sensitive enquiry, avoiding assumptions, and using inclusive language.

Different groups will have various specific needs and sensitivities linked to personal and historical backgrounds. For example, international research shows that bisexual people have the highest rate of mental health issues of any sexual identity group, and often experience marginalisation and discrimination in ways distinct from people who are gay or lesbian (Barker et al., 2012).

2. Children and adolescents

During adolescence, young people undergo biopsychological development phases where they must establish their social and sexual identities. This can be a particularly challenging period for young people who identify as LGBTI, and a time of heightened vulnerability to mental health issues (Smith et al., 2014).

At this critical juncture, experience of homophobia, transphobia and heteronormativity can be devastating (Robinson et al, 2014). An Australian survey of gender variant and sexually diverse young people found that almost two thirds had experienced homophobia and/or transphobia, and that more than two in five young people interviewed had had thoughts of self-harm (41%) and/or suicide (42%). In addition, 33% of respondents reported having self-harmed in the past, and 16% had attempted suicide (Robinson et al., 2014). LGBTI young people are at particular high risk of suicide in the period prior to 'coming out', or identifying oneself as LGBTI to others (Rosenstreich et al., 2013). Family support and acceptance can enhance outcomes for LGBTI children and adolescents across a range of indicators (Smith et al., 2014).

For children and adolescents experiencing gender dysphoria, puberty can be a time of particularly severe emotional distress. Child and adolescent psychiatrists are the primary care managers and decision makers for this group, in collaboration with other specialists, such as paediatric endocrinologists (Australian Paediatric Endocrine Group, 2010). International consensus guidelines recommend that adolescents who fulfil eligibility and readiness criteria undergo treatment to (reversibly) suppress puberty, generally with the use of gonadotrophin releasing hormone (GnRH) analogues (Hembree et al., 2009). Current evidence suggests good outcomes associated with this approach (Wallien and Cohen-Kettenis, 2008). In New Zealand, treatment such as this can be undertaken following rigorous assessment and diagnosis, and after obtaining informed consent (Counties Manukau District Health Board, 2012). Australia is the only country in the world where authorisation for such treatment must be obtained from the Family Court. Research shows that the complexity and cost of the legal proceedings leads some families to have to forgo this course of treatment (Hewitt et al., 2012).

Mainstream health services may not always seem relevant or accessible to LGBTI children and adolescents, many of whom report feeling uncomfortable about approaching, and having to 'come out' to, health professionals (Robinson et al., 2014). One study of gender diverse and transgender young people in Australia found that over half had experienced at least one negative experience with a healthcare professional, and one quarter of the participants avoided medical services due to their gender presentation.

3. LGBTI identity and ageing

Many older LGBTI people have a lived history of direct discrimination by legal and medical institutions, as discussed above. These experiences can create ongoing barriers to accessing aged care, mental healthcare and other supports (Brown et al., 2015). Older LGBTI people experience anxiety regarding

whether their needs will be met in a dignified manner as they age, and some report feeling forced 'back into the closet' due to the lack of availability of inclusive services (Latham and Barrett, 2015).

With an increasing portion of the populations of Australia and New Zealand aged over 65, mental health and aged care facilities must carefully consider the needs of the ageing LGBTI population. This includes how LGBTI-specific identity and support needs intersect with dementia, personal care needs, end-of-life decision-making and advance care plans (Barrett et al., 2015; Hughes and Cartwright, 2015).

4. *Visibility in data and research*

There are many gaps in administrative data and generic research relating to LGBTI populations. More consistent statistical information is required, as well as more research into LGBTI mental health, including protective factors, comorbidity, effective interventions and specific issues faced by high risk population groups (Rosenstreich, 2013). Enhanced statistics and research must however be carefully balanced with the entitlement of each person to privacy and dignity.

5. *Sexual and family violence*

Statistics indicate that LGBTI people experience family and sexual violence at rates similar to, or higher than, heterosexual women (Fileborn & Horsley, 2015). Despite this, current policy and program responses to family violence tend to be geared towards heterosexual relationships, with some notable exceptions (see additional resources below). A Senate inquiry into family violence in Australia found a lack of data, reporting and understanding of the impact of violence in the LGBTI community as well as a lack services and programs. Of particular concern is the acute shortage of appropriate housing for LGBTI survivors of family violence (SFPAC, 2015).

6. *Aboriginal and Torres Strait Islander and Māori LGBTI peoples*

People from Aboriginal and Torres Strait Islander or Māori backgrounds who are LGBTI must often face particularly complex layers of discrimination and identity (Tovey, 2015). A small number of remote, traditional Aboriginal and Torres Strait Islander cultures, such as the Tiwi Islands, have traditionally included and supported people of diverse gender identities. However, many other LGBTI Aboriginal and Torres Strait Islander peoples and Māori experience multiple levels of marginalisation and discrimination (National LGBTI Health Alliance, 2013). Some may face rejection from their community, or alternatively be required to renegotiate cultural and spiritual standing, including gender-specific roles in ceremonies and the community, and the passing on of knowledge (Creative Spirits, 2015).

Recommendations

- The RANZCP supports marriage equality, in recognition of the link between improved health outcomes and legislative change of this sort for both same-sex attracted people and their children (Commissioner for Children Tasmania, 2015). The RANZCP emphasises the importance of ongoing, respectful dialogue with those on both sides of the marriage equality debate in Australia.
- Psychiatrists should maintain an up-to-date understanding of LGBTI issues, including appropriate referral pathways should specialised support be required. Psychiatrists should be mindful of balancing the sometimes diverse views of the consumer and their family or carer.
- In undertaking clinical assessment and interviews, psychiatrists should ensure enquiries into LGBTI identity are undertaken with sensitivity, avoiding assumptions in language and approach.
- Psychiatrists should have access to opportunities to develop and enhance their understanding of LGBTI issues, including via professional development (Latham & Barrett, 2015).
- Health, aged care, child and adolescent, family violence and other services should take steps to promote inclusiveness and cultural safety for LGBTI people (Cramer et al., 2015). This includes ensuring assessment forms, databases and other mechanisms for collecting information avoid assumptions and discriminatory language (Ansara, 2015). Services should also consider registering with relevant LGBTI health directories and displaying inclusive signage.
- Health, aged care, child and adolescent, family violence and other services should make reasonable steps to accommodate the needs of LGBTI consumers, including recognising partners, addressing personal care issues and ensuring privacy.
- Services for older people should consider the intersection of LGBTI identity with issues such as dementia, end-of-life decision-making and advanced care plans.

- Services for children and adolescents should maintain an awareness of the particular stressors faced by LGBTI young people, including issues to do with ‘coming out’, experience of bullying and the potentially traumatic experience of puberty for gender diverse young people.
- Enhanced statistical information and research into LGBTI mental health is required, however this should be undertaken with sensitivity and awareness (Irlam, 2012).
- Free 24 hours, 7 day a week services for LGBTI people experiencing sexual and family violence, such as Another Closet, should be supported with ongoing funding.
- Services working with Aboriginal and Torres Strait Islander peoples and Māori who identify as LGBTI should in particular consider the intersection of LGBTI identity with issues such as traditional gender roles, community acceptance and the impact of multiple layers of discrimination.

Additional resources

- [Australian and New Zealand Professional Association for Transgender Health](#): peak body actively promoting communication and collaboration amongst professionals involved in the health, rights and wellbeing of people who experience difference in sexual formation and/or gender expression.
- [American Medical Association’s LGBTI resources](#): including resources for promoting inclusiveness in health services and information for health practitioners.
- [Australian Government Guidelines on the Recognition of Sex and Gender](#): guidelines for incorporating LGBTI-awareness into data collection.
- [Mental Health Professional Online Development](#): includes a topic on ‘Mental health for same sex attracted persons’.
- [Australasian Journal on Ageing](#): Special Issue: LGBTI Ageing and Aged Care Special Edition, Volume 34, Issue Supplement S2, pages 1-44.
- [National LGBTI Health Alliance](#): Peak health organisation in Australia, providing health-related programs, services and research.
- [Another Closet](#): An online resources for people in LGBTI relationships who are, or may be, experiencing domestic and family violence.

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Disclaimer

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