don't ask don't tell

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Hidden in the crowd:
the need for documenting links between sexuality and suicidal behaviours among young people

Report of the same-sex attracted youth suicide data collection project

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AUSTRALIAN RESEARCH CENTRE IN SEX, HEALTH AND SOCIETY

LA TROBE UNIVERSITY

A COLLABORATING CENTRE TO THE NATIONAL CENTRE IN HIV SOCIAL RESEARCH

COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING

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Definitions and terminology

Suicide: Death due to other than natural causes resulting from a deliberate act to end one's own life. In common use the term 'to commit suicide' is used but completed suicide is the preferred term.

Attempted suicide: An incomplete suicide. Any act that has suicidal intent.

Parasuicide: a term coined by Kreitman (1997) to describe "all non-fatal approximately suicidal acts irrespective of intent".

Deliberate self-harm: Also called intentional self-harm.

Suicidal behaviour: Any behaviour that is life threatening; self-harming behaviour that results in death; attempted suicide, parasuicide, deliberate self-harm, self mutilation and a range of other self destructive behaviours.

Self-mutilation: Behaviour that may or may not have suicidal intent that involves cutting, burning and other forms of intentional physical injury.

Self-destructive behaviours: Behaviours that may have intended or unintended long term fatal outcomes. This can include injecting drug use, sharing needles, eating disorders, unsafe sex and single vehicle accidents.

Suicidal ideation: Self reported thoughts of wanting to commit suicide. Includes expressing a desire to end one's own life and making plans to carry out this desire.

Hospitalised self-harm: Those acts of deliberate self-harm that are attended to in hospital.

Sexual orientation: "an enduring emotional, romantic, sexual or affectionate attraction to individuals of a particular gender" (Fordham, 1998: 14)

Same-sex attracted: Anyone who is romantically, sexually or affectionately attracted to members of the same gender. This will encompass those who are questioning their sexuality, acknowledging feelings of attraction to both genders, identifying as gay, lesbian or bisexual.

Transgender: Anyone who transgresses gender for whatever reason. This includes transsexuals, transgender and intersex people, cross dressers and drag queens. In this report the term is used to describe anyone who is experiences discomfort with the gender that they are currently assigned for whatever reason.

Homophobia: The irrational fear and hatred of homosexuality. Homophobia occurs at a number of different levels: including personal, interpersonal and institutional (or societal). The outcome of homophobia can vary from discrimination to violence, abuse and even murder. It is important to acknowledge the range of ways it plays out in society.

Heterosexism: The assumption that heterosexuality is the norm and that everyone is heterosexual. The terms heterosexism and homophobia will generally be used in this report.

Homonegativity: The range of negative attitudes and behaviours towards people who are perceived to be non-heterosexual.

Executive Summary

Project Aims and Objectives

This project was commissioned to establish whether agencies and services collected qualitative or quantitative data that might demonstrate links between suicidal behaviours and issues of sexuality for young people. Funding was received for the project under the Victorian Department of Human Services (DHS), Gay and Lesbian Youth Suicide Data Research Project. The work was carried out by the Australian Research Centre in Sex, Health and Society at La Trobe University.

Project terms of reference:

1. To identify the range of data currently collected in relation to youth suicide, suicidal ideation, parasuicide and self-harm, where sexuality may be an issue, with particular focus on the:
   - Extent of such collection;
   - Nature and types of information, both qualitative and quantitative;
   - Quality, reliability and validity of this information.
2. To identify situations in which such data might be collected, the nature of the data to be collected and how this might appropriately occur.
3. To provide population based public health rationale for the planning, development and delivery of prevention and early intervention services to better meet the mental health needs of same-sex attracted young people.

Project aims:

1. To document the source, scope and nature of any data that is currently collected that links youth suicide and deliberate self-harming behaviours with sexuality and gender identity.
2. To obtain, analyse and aggregate any existing data with a view to developing a comprehensive and descriptive overview of the situation.
3. To comment on the usefulness of existing data.
4. To identify any gaps in data collection.
5. To identify issues concerning the information, referral and training needs of those workers at data collection points.

Methodology

In the course of the project a review of current Australian and international literature was undertaken, and contact was made with over 100 agencies, services and organisations. Rapid assessment techniques were used to map which sectors have contact with same-sex attracted young people, identify key informants, what is currently happening across a range of service sectors, and whether any qualitative or quantitative data was being collected in relation to suicidal and self harming behaviours with this population. Contacts were made with schools and educational institutions (14), legal/ juvenile justice agencies (5), health services (15), mental health and counselling services (13), alcohol and drug services (2), welfare/ housing and homelessness agencies (19) and youth workers, including workers from support groups with same-sex attracted young people (19). In addition gay and lesbian community organisations and groups were contacted (6) as well as a range of other miscellaneous organisations, including some from interstate (14).

Literature review

A review of international and Australian literature was carried out, with a dual focus on both suicidal behaviours and sexuality. Establishing the links between sexuality and suicidal behaviours is difficult because young people who are confused or undecided about their sexuality are a difficult group to identify for obvious reasons. They are not ready to seek help or support, for fear of being judged or outed, and are in every way indistinguishable from other young people. This may well be why none of the literature reviewed was able to document conclusive links between suicide and same-sex attraction

There has been some controversy between mainstream researchers and those who focus on same-sex attracted young people, about whether there are links between sexual orientation and suicidal behaviours. Mainstream researchers maintain there is inadequate evidence to substantiate an independent link between suicide risk and sexual orientation, while worker advocates and researchers of sexuality issues assert that same-sex attracted young people are underrepresented in mainstream research, and cite more qualitative and anecdotal evidence of a connection.

However, a growing body of research was found to demonstrate that same-sex attracted young people are significantly *at risk* of self destructive and suicidal behaviours, and that they experience many of the factors shown to have an influence on such behaviours.

Interview findings

Many Government funded services and programs have mandatory electronic data collection processes. These include juvenile justice, health services, school nurses, mental health services, alcohol and drug agencies and a range of welfare, housing and homelessness services. In spite of the widespread and extensive data collection processes that exist, only one of the agencies contacted actually collects any data that is able to establish a connection between sexuality, gender non-conformity and suicidal behaviours.

While very little useful data was identified to establish that these links do exist, workers generally confirmed the findings of the literature review, in which a growing body of research was found to demonstrate that same-sex attracted young people are significantly at risk of self destructive and suicidal behaviours. Those workers in this study who work with same-sex attracted young people reported significant levels of suicidal ideation, deliberate self-harm and self-destructive behaviours in their clients. They have also heard retrospective accounts of such experiences from gay and lesbian young people with whom they worked. There was general acknowledgement that sexuality is not a cause of suicide any more than any of the other risk factors identified, however, for many young people, doubts or questions about sexuality or gender can compound social and emotional risk factors for suicide.

While workers in mainstream agencies demonstrated during interviews that they are concerned about this group and recognise the risk factors, they also say that they feel at a loss to know how to address these issues, or even to convince funding bodies and management about their concerns. Training to address these issues was a clear need identified in the interviews.

It is clear from the interviews that data collection can be difficult for a number of reasons, not the least of which is resistance from workers. Data collection is seen as a futile activity that adds a burden to an already full work load. Few workers appreciate the value of high quality data or have the opportunity to review their practice based on the analysis of data that arise from their experience. Data collection relating to sexuality and suicidal behaviours can also be problematic as not all workers have the skills or qualities needed to elicit this kind of sensitive information from young people. Many workers also have concerns about the privacy and confidentiality of the records they keep and they see information relating to sexuality and suicide as both being highly confidential and not belonging in the public domain. Workers at times also expressed concerns about the appropriateness

and safety of young people disclosing feelings of same-sex attraction in some environments where they worked.

Most services have some form of electronic data collection system, and many of these systems have the capacity to have modules added so that different kinds of data can be collected, in addition to that which is relevant to their mandatory reporting responsibilities. Many of these systems also include brief narrative descriptive fields. With modifications to existing data bases made in consultation with workers, combined with ongoing training and support, it can be projected that high quality data could potentially be collected in the future.

Data analysis

In all, six organisations were identified as potentially having useful data, based on existing patterns of service use, existing data collection and assumptions about services that might have contact with same-sex attracted people or those who exhibit suicidal behaviours. None of these were found to collect data that intentionally seeks information about sexuality and suicidal behaviours. Where links are identified through the data it is by chance, therefore must be seen as having questionable reliability. None of the data obtained and analysed for the purpose of this study were found to have a potential use in documenting this link.

In spite of the paucity of quantitative data, the interviews with workers uncovered a rich source of qualitative information concerning suicidal behaviours among same-sex attracted young people.

Future Directions

To support the increasing body of research that indicates links between suicidal behaviours and same-sex attraction, empirical evidence is needed. There is a great deal of anecdotal information about this issue, and it can only become evidence if processes are put in place to promote the collection and recording of high quality data that informs future practice. In developing systems that do this while protecting confidentiality and privacy, the focus needs to be taken off individuals and placed on typologies of observed behaviour that may be indicative of suicide risk. Such typologies would need to be take into account sexual and gender diversity, disclosures and biopsychosocial risk factors for suicide. By reflecting on the narrative that emerges from the data on a regular basis, rather than on individual cases, organisations could learn about the degree to which these issues pose a problem for the young people they work with and develop appropriate

responses in their practice. In this way, the organisation can recognise the issues, while only relevant workers need to have knowledge about particular clients.

To collect high quality data that informs ongoing practice, all workers need to have access to appropriate training to develop the skills and expertise they need in order work with young people, identify possible risk factors, elicit information in a sensitive manner and record it effectively.

Don't Ask Don't Tell

Hidden in the Crowd: Documenting the links between sexuality and suicidal behaviours among young people.

Introduction

Suicide is one of the leading causes of death among 15 - 24 year olds in Australia (Statistics of Suicide Among Young Western Australians, 2001; A Dying Shame, 2000). Despite the fact that the suicide rate has dropped in recent years, the rate for 20 – 29 year olds remains high (Steenkamp, 2000). With suicide statistics for young people reaching alarming proportions in recent years, efforts have focused on preventing suicide and self-harming behaviours among young people. The National Youth Suicide Prevention Strategy (YSPS) allocated $31 million to eighty eight projects across Australia between 1995 and 1999, for a range of suicide prevention strategies. In the first round, only one of these projects was gay and lesbian specific, the Here For Life Youth Sexuality Project in Perth, which received $250,000. In 2001/2 the YSPS was expanded to become the National Suicide Prevention Strategy (NSPS) that covered all age cohorts. A further 3 projects were funded in Victoria by the Commonwealth Government under the NSPS, and several other major projects were also funded by philanthropic trusts and the Department of Human Services.

Research in Australia has identified that same-sex attracted young people may be up to six times more likely to attempt suicide than the population in general, with those in rural areas being particularly at risk. The average age for same-sex attracted young people to attempt suicide is between 15 and 17 years, with most attempts occurring after self identifying as gay but prior to having a same-sex experience (Nicholas, 1998).

In recent years there have been a number of studies that have focused on young people who do not conform to heterosexual stereotypes and the pervasive threat of physical and emotional violence and discrimination that they experience. In a major nation-wide Australian survey of 750 young people aged between 14 and 21, same-sex attracted young people identified schools as particularly unsafe (Hillier, 1998). In a number of studies, young people who do not conform to gender and sexual norms have been found to be more likely to experience bullying, homophobia and victimisation (Remafedi, 1991; D'Augelli, 1993; Bagley, 2000). Feelings of sexual guilt, shame, social isolation, depression, and hopelessness are all common among former victims of homophobic bullying, and these factors have all been linked to suicidal behaviours and feelings (Rivers, 1995).

In 2000, the Victorian Minister for Health convened the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) in recognition of the specific health and access issues experienced by the lesbian, gay, bisexual and transgender communities. The principle role of this committee was to provide advice on health issues to the Government through the Minister for Health, and while there are significant physical health issues it was the social context of health for these communities that were of particular relevance to the Committee. The MACGLH has developed and endorsed a set of principles for proposed initiatives with the gay and lesbian community.

Concerns were raised about the suicide risks facing same-sex attracted young people as a result of the work of the MACGLH. As a result, the Department of Human Services, Mental Health Branch called for tenders and ultimately funded La Trobe University's Australian Research Centre in Sex, Health and Society (ARCSHS) to undertake this six-month project. The terms of reference for the project were to:

- Identify the range of data currently collected in relation to youth suicide, suicidal ideation, parasuicide and self-harm, where sexuality may be an issue, with particular focus on the:
    - Extent of such collection
    - Nature and types of information, both qualitative and quantitative;
    - Quality, reliability and validity of this information.
- Identify situations in which such data might be collected, the nature of the data to be collected and how this might appropriately occur.
- Provide population based public health rationale for the planning, development and delivery of prevention and early intervention services to better meet the mental health needs of same-sex attracted young people.

Project Aims

- To document the source, scope and nature of which data is currently collected that links youth suicide and deliberate self-harming behaviours with sexuality and gender identity.
- To collect and aggregate any identified data with a view to developing a comprehensive and descriptive overview of the situation.
- To comment on the usefulness of existing data.
- To identify any gaps in data collection.
- To identify issues relating to the information, referral and training needs of those workers at data collection points.

Methodology

Project Management

A Project Steering Committee comprising six researchers from ARCSHS was formed to manage the research and met on a regular basis to monitor the progress of the project. The Project Officer was Sue Dyson.

A community reference group was convened to identify key informants and provide expert input to the project at the beginning and again towards the end, to involve them in framing possible responses to the project findings. This group was comprised of representatives from Police Victoria (2), The Department of Education and Training (2), Family Planning Victoria Action Centre, The Youth Affairs Council of Victoria (YacVic) and the Royal Children's Hospital Gatehouse Centre.

A reference group was also convened at DHS with representatives from Rural Health, Mental Health, Acute Health and the Ministerial Advisory Committee and Gay, Lesbian and Bisexual Health.

Ethics

There was no direct contact with young people during this project. Ethics approval was obtained to carry out interviews with workers from agencies and services working with young people, to establish whether such data exists. Because some data might carry identifying information or be identifiable due to the circumstances surrounding an event, separate Ethics approval was obtained for each data source that was identified. No data containing any identifying information was used in this project and workers who contributed were offered the opportunity to withdraw at any time up to the publication of the final report.

Literature Review

In order to develop an understanding about issues concerning same-sex attracted young people and suicidal behaviour, a review of the recent literature concerning both suicide and sexuality was undertaken. Because of the complexity of the issues and the paucity of epidemiological data concerning gay, lesbian and transgender youth suicide, it was considered necessary to review both current Australian and International literature.

Interviews

Rapid assessment techniques were employed to map the sectors, organisations, agencies and services that might have contact, or be working with young people who are same-sex attracted, or who display suicidal or self-harming behaviours. Telephone, email and networking processes were employed to make initial contact and establish whether any data relevant to the project is being collected as well as to elicit anecdotal information. Semi structured interviews were then carried out with people in different sectors who were identified as key informants. In all 110 contacts were interviewed and of these 25 were identified as key informants.

Data sources that were identified in this process were obtained and analysed in order to establish whether there were in fact demonstrable links between same-sex attraction and suicidal or self-harming behaviours.

Literature Review

Perspectives on suicide

In Western societies like Australia, suicide is seen as a complex, confronting and tragic event for everyone concerned. Until the last half of the Twentieth Century suicide was defined in Australia as a criminal matter by the Legal System and as a sin by Christian Churches. It is an act that results in shame not only for the deceased, but also for those who survive suicide attempts and their families. In spite of the fact that it is no longer a crime, the stigma associated with suicide continues to influence community attitudes, and this extends to how it is discussed, researched, recorded and dealt with at all levels of society [Commonwealth Department of Aged Care, 1999].

Sexuality and Suicide

Cultural and religious mores are frequently incompatible with any behaviour that doesn't comply with the heterosexual norm (Farnan 2001). Same-sex sexual attraction, orientation and gender non-conformity are generally socially unacceptable and many young people experience shame, fear and confusion if they feel they don't conform to the narrow societal norms for gender or (hetero)sexuality. Young people who disclose or act on same-sex attraction or discomfort with assigned gender roles, may experience rejection, violence and discrimination. Those who are not perceived to be exclusively heterosexual are often the target of bullying and harassment. In recent research with young same-sex attracted people 46 per cent reported being verbally abused, and some had also been physically abused (Hillier, 1998). In British studies same-sex attracted young people have been found to attempt suicide because of their sexual orientation (19% once and 8% more than once), however significantly more (30%) have been found to be likely to attempt suicide if they have also been bullied at school (Rivers, 2000). In Australian research, the rate of suicidal behaviours in same-sex attracted young people was found to be between 6.2 and 50%, with those young women and men who are confused or undecided about their sexual orientation having the highest rate of deliberate self harm (Nicholas and Howard, 2001).

There is some disagreement between researchers who focus on same-sex attracted young people and mainstream researchers about whether links exist between sexual orientation and suicidal behaviours, A recent Australian literature review concerning youth suicide identified a number of studies comparing suicidal behaviours in the general population of young people with gay, lesbian and bi-sexual young people

and concluded that, while there does appear to be an increased risk of attempted suicide, there is no correlation with completed suicides. The review suggests that based on the available evidence, claims of high levels of suicides amongst gay and lesbian young people are based on anecdotal information and calls for the development of a series of well-designed studies of large samples to replicate, extend and validate the current evidence [Setting the Evidence Based Research agenda for Australia (a literature review) 1999).

Debate about the link between suicide and sexuality was first brought into the mainstream in 1986 in the USA when *Gay Male and Lesbian Youth Suicide: Report of the Secretary's Task Force on Youth Suicide* first appeared. This report suggests that:

> *"Gay youth are 2 to 3 times more likely to attempt suicide than other young people. They may comprise up to 30 per cent of completed youth suicides annually"* (Gibson, 1986).

This report has been criticized as being based on biased samples and subsequent studies that have consistently found the rate of attempted suicide among gay and lesbian young people to be in the range of 20 to 42 per cent have also been criticized. Remafedi (1999) has suggested that the discrepancies arise because studies are based on convenience samples. Furthermore Muehrer (1995) concludes that:

> *"… limitations (exist) in the research literature on suicide and sexual orientation: a lack of consensus on definitions of fundamental terms such as "suicide attempt" and "sexual orientation"…. non-representative samples, and a lack of appropriate control groups."* (Quoted in Life, Living is For Everyone, 1999].

In Australian research, Nicholas and Howard (2001) found that young gay men and lesbian women have consistently higher rates of deliberate self-harm than their heterosexual counterparts. Among young gay men 20.8 per cent were found to have self-harmed, compared to 4.5 per cent for young heterosexual men and for young lesbians 28 per cent were found to have self-harmed compared to 8.3 per cent for young heterosexual women. Young people who are bi-sexual or uncertain have even higher rates than those who have come to terms with their sexual orientation, with 29.4 per cent of males and 34.9 per cent of females in this group exhibiting suicidal behaviours. Studies of suicidal ideation also show significantly higher rates among gay and lesbian youth compared to heterosexual youth [A Dying Shame, 2000]

Establishing the links between sexuality and suicidal behaviours is difficult because young people who are confused or undecided about their sexuality are a difficult group to identify for obvious reasons. They are not ready to seek help or support for fear of being judged or outed and are indistinguishable from other young people.

The first round of the Commonwealth Government's Youth Suicide Prevention Strategy promoted evidence based practice and funded a number of major research projects, in addition to the 88 funded prevention projects, to establish an evidence base for suicide prevention. None of these research projects included reference to same-sex attracted young people. The evaluation of the strategy, Valuing Young Lives, suggests that the epidemiological evidence-based approach to the Strategy has some shortcomings that may miss the social implications of risk factors and calls for a dual approach that incorporates both population and biopsychosocial approaches to suicide prevention (Mitchell 2000).

Penny Mitchell, author of the four volume evaluation of the Strategy, commented in the Sydney Gay Press:

> *". Lack of data is likely to enforce silence about sexual difference. Links between sexuality and suicide have not to date been demonstrated to be risk factors" (Bacon 2001).*

As previously identified, a number of suicide prevention projects that focus on same-sex attracted and transgender young people have been funded as part of the NSPS, although none have a research focus.

Defining Suicidal Behaviours

Because of the shame associated with suicide, the language used to describe and define the range of suicidal behaviours can be problematic. Terminology that is used to describe suicidal behaviours includes suicide, completed suicide, parasuicide, attempted suicide, deliberate self-harm, intentional self-harm, self-mutilation and self-destructive behaviours.

While such language as "commit suicide" and "attempted suicide" are in common use, they have been criticised because of the connotations of sin and illegality that are associated with them. Teehan and Murray (1996:5) argue that the term 'attempted suicide' has a wide variation of meanings and it is more appropriate to

use the term 'suicidal behaviour' when analysing completed and attempted suicides, as the two behaviours overlap consistently. The term 'completed suicide' is preferred to 'commit suicide' and the range of behaviours that are self destructive or suicidal are more accurately described by the use of 'deliberate self-harm' or 'intentional self-harm' (Setting The Evidence Based Research Agenda For Australia (A Literature Review) 1999).

In this report suicide, attempted suicide and deliberate self-harm will be used to describe the different manifestations of suicidal behaviours. Self-mutilation will be used to describe behaviour that may or may not have suicidal intent where slashing, burning or other forms of self-mutilation is involved. Self destructive behaviour will be used to describe those behaviours that may have unintended or long term fatal outcomes.

Suicidal behaviour leading to death

Suicidal behaviours can include deliberate self-harm that is fatal or non-fatal as well as a range of other self-destructive behaviours. Suicidal behaviour that leads to death is defined as suicide or completed suicide. Suicide has been defined as "a problem-solving act to end one's life" (Teehan, 1996) and "a conscious act of self induced annihilation" (Shneidman, 1996). To be classified as suicide, death must be due to other than natural causes. The Coroner must establish that death resulted from a deliberate act with the intention of taking ones own life [A Dying Shame, 2000]. The Taskforce on Suicide in Canada has identified that suicide is not an illness but:

> *"the end result of a complex interaction of a number of neurobiological, psychological, cultural and social factors that have an impact on a person"* [Health Canada, 1994).

Non-Fatal Suicidal Behaviour

Parasuicide is a term coined by Kreitman to include "all non-fatal approximately suicidal acts irrespective of intent", however it has been widely misused to imply that it includes only those self-harming behaviours that intend outcomes other than death, for example a cry for help (Kreitman, 1977). Suicidal behaviours can be interpreted as

> *"a manifestation of distress associated with loss and abandonment, a release from despair, an appeal for help, a wish to test fate or be reunited with a loved one or a response to a disordered thinking of a psychotic illness or drug intoxication"* (Davis 1992).

Apart from Kreitman's attempt to define non-fatal suicidal behaviour with the term parasuicide, no other clear definition appears to exist, although "attempted suicide" is commonly used to describe this phenomenon.

Self-destructive behaviours may encompass any acts that have longer-term harmful results, some of which may mask suicidal behaviours. These can include self-mutilation, single vehicle accidents, alcohol and drug-abuse, sharing needles, unsafe sexual practices and eating disorders. It has been suggested that definitions of suicidal behaviours should encompass the entire range of these self-destructive behaviours. Suicide can be viewed as the end result of a range of self-destructive behaviours and any act which falls short of death should be taken seriously as having possible suicidal intent (Life: Living is For Everyone: Learnings About Suicide 1997; Teehan, 1996).

According to Cantor and Baume (1997:8) the term suicide attempt "implies reliable determination of the intent of the behaviour, which is notoriously unreliable". This raises the issue of whether a person who deliberately self-harms is in a cognitive state to be aware of the consequences of their behaviour, thus questioning the intentional nature of the act (quoted in Horn, 1998:4).

Suicidal Ideation

Suicidal ideation refers to self reported thoughts of wanting to commit suicide (Mitchell 2000). This can include not only thoughts about suicide but also expressing a desire to end one's life and having a plan to do so (Horn, 1998). Studies have shown significantly higher rates of suicidal ideation among same-sex attracted young people compared to heterosexual young people [A Dying Shame, 2000]

Hospitalised Self-harm

The extent and scope of deliberate self-harm is an unknown quantity. Death will be the result of some acts of deliberate self-harm, others will be attended to in hospital accident and emergency departments and some of these will be admitted to hospital, while still others will never seek medical help.

Estimating the number of people actually presenting or admitted to hospital as a result of deliberate self-harm is complicated by reluctance on the part of patients to admit that they intended to harm themselves, and by clinicians who may avoid classifying injury as deliberate because of the associated stigma and disapproval. It may also be assumed that clinicians avoid or ignore exploring issues about sexuality when attending to a patient who presents as a result of suicidal behaviour for

similar reasons. No register exists to provide accurate information concerning deliberate self-harm, even for those hospitalised as a result of these behaviours [A Dying Shame, 2000].

Defining sexual orientation

The American Psychological Association defines sexual orientation as "an enduring emotional, romantic, sexual or affectionate attraction to individuals of a particular gender" [Fordham, 1998: 14]. Many young people experience both same-sex and opposite sex sexual attraction, and for some feelings of same-sex attraction may be confusing and troubling.

The lack of consensus concerning definitions means that different studies use different criteria to define sexual orientation, which may account for variations in findings between studies. For example "*Writing Themselves In*" used self-defined same-sex attraction as a criterion, and estimated that between 8 and 11 per cent of young people may experience same-sex attraction [Hillier, 1999]. However, a longitudinal study in New Zealand (the Christchurch Study), which aimed to quantify the number of people in a birth cohort who would identify as gay, lesbian or bisexual by age 21, defined same-sex sexual orientation as either self reported gay, lesbian or bisexual relationships or same-sex sexual activity since age 16. In the Christchurch study only 2.8 per cent were classified as gay, lesbian or bi-sexual (Fergusson, 1999).

Until coherent definitions of both sexual orientation and suicidal behaviours are accepted and used consistently, there will continue to be confusion concerning links between suicide and sexuality. This report will use the term same-sex attraction to include gay, lesbian, bisexual and people who are confused or questioning their sexuality.

Gender Non-Conformity

There is a paucity of literature on gender identity issues for young people, and few references were found concerning suicidal behaviours among this group. The majority of literature relating to issues for transgender people is of a clinical nature and relates to gender reassignment, and does not deal with young people. Among young people, particularly young men, there is a narrow range of acceptable heterosexual gender behaviour. In his work on suicidal behaviours with non-heterosexual young people Remafedi (1999) found that suicide attempts were

significantly associated with gender nonconformity. It may be more constructive to focus on the result of these restrictions and the consequent bullying experienced by those who do not conform, rather than on gender identity issues in suicide prevention efforts.

In 1953, Hamburger et al identified the difference between cross-dressing and gender-crossing (University of NSW School of Sociology, 1994). There has been widespread gender crossing across cultures and reference is found to cross dressing and gender crossing as acceptable social behaviours in a number of ancient cultures. Contemporary society is however less tolerant of variations in gender norms and young people who do not conform to these narrowly defined norms are likely to become the target of bullying. The term "transgender" is increasingly being used to describe anyone who transgresses gender for whatever reason. This includes transsexuals, people who identify as transgendered, cross dressers and drag queens.

Transgender issues have been of less interest to social researchers than medical and clinical researchers [NSW University, School of Sociology, 1994]. The medical perspective on this issue has been to focus on finding a cure for transexualism, through therapy and surgery. The rate of suicide and suicidal behaviours among transgender people is unknown but is assumed to be quite high. In a study in Sydney with transgender people of both sexes 50 per cent were found to have attempted suicide [Perkins (1991: 53) quoted in School of Sociology, 1994]

A retrospective study of a cohort of 425 transsexual patients given hormone treatment found five times more deaths in male to female transsexuals than expected (Asscheman, Gooren and Eklund, 1989). Another unpublished retrospective study from the USA found that 50% of post-operative women reported considering suicide and 7.7% had actually attempted suicide. Self-mutilation, including that of genitals, may also occur, particularly in times of extreme frustration and in association with substance abuse (Denny, 1997).

Some transgender youth are known anecdotally to be sex workers and it is likely that they may be exposed to unsafe sex practices. A San Francisco survey of transgender sex workers showed a 70% incidence of HIV infection (Denny 1997).

Precipitating Factors for Suicidal behaviours

Risk factors for suicide are not clear and difficult to predict (Mitchell 2000). A number of precipitating factors are identified in the literature including loneliness, low self

esteem, criminal activity, alcohol and drug abuse, financial problems, health, relationships, employment and work related stress, physical abuse, psychiatric illness, poor family interaction, lack of a sense of purpose or belonging, being a victim of bullying, depression, lack of coping skills and negative attitudes towards ones self (Tobin, 1999; Tiller et al, 1997; Proctor, 1994].

Other risk factors include "some personality traits such as perfectionism, social and cultural factors, family stresses, prior suicidal behaviour, mental illness, behavioural factors, biochemical and genetic factors, exposure to attempted or completed suicide and stressful life events" (Life: Living is For Everyone: Learnings About Suicide, 1997).

Bullying is also a significant factor for suicidal ideation and behaviours. Rigby (1997) found in Australian research that where a young person is repeatedly bullied at school there is an increased risk of deliberate self-harm [quoted in Rivers, 2000: 87]. Former victims of bullying have been found to experience feelings of guilt, shame, social isolation, depression, feelings of hopelessness and have also been found to engage in self-harming and suicidal behaviours. It is not surprising that the outcome of bullying for victims correlates closely with risk factors for suicide.

Askew and Ross (1992) found that a considerable amount of bullying among teenage boys is homophobic. Internalised homophobia is a potentially life threatening experience for many same-sex attracted young people. The fear of disclosure to parents and teachers promotes feelings of hopelessness and despair that may ultimately lead to self-harm or suicide (quoted in Rivers, 2000).

Other precipitating factors that are identified include early awareness of homosexuality, stress, violence, lack of support, school drop-out, family problems, suicide attempts by acquaintances, homelessness, substance abuse and some psychiatric symptoms (Remafedi 1999).

It is apparent that many of the precipitating factors for suicidal behaviours also correlate with the experience of coming to terms with same-sex attraction in a hostile and homophobic environment. Young people can experience deep shame and fear when they experience same-sex attraction, question their sexuality or experience confusion concerning gender and this can lead to diminished self esteem, distancing from peers, attempts to avoid disclosure, distortion of nearly all relationships including family, an increasing sense of isolation, inferiority and self loathing (Nicholas and Howard, 1998).

Findings from Project I, a five year study into homeless young people in Melbourne and Los Angeles, indicate that while few young people self identify as gay/ homosexual or lesbian, approximately 14% either think of themselves as bisexual, or are undecided about their sexuality (Rossiter, 2003). This group, who are uncertain about their sexuality, may be the greatest cause for concern. It has been suggested that because of a series of social processes that centre on homophobic attitudes young people who are same-sex attracted, or who step outside acceptable gender norms, are exposed to personal stresses that increase the likelihood of suicidal behaviours (Fergusson, 1999). There is however, an important distinction to be made when discussing risk or precipitating factors:

> *"Sexuality does not cause suicide any more than any of the risk factors that have been identified do, rather they are factors that are mediated by discourses that shape individual experience."* (Fullagar, 1999).

Service Sector Issues

While all service sectors are likely to have some contact with same-sex attracted young people, some have greater contact than others. While it is outside of the scope of this study to analyse service delivery in detail, the literature draws our attention to some significant issues.

Schools

Schools have been identified as a major site for bullying (Rivers, 2000; Hillier, 1999). this was cited as one of the main themes for callers to Kids HelpLine about sexuality related issues [KHL, 2001]. Anyone who is openly gay (or does not conform with gender norms) is open to social exclusion and psychological and physical persecution at school. Same-sex attracted young people must either hide their feelings from others for many years or risk 'coming out' to family and peers. Either is a perilous course. One consequence of identity confusion in a climate of intense intolerance and victimization may be suicidal behaviours. Research in the UK, New Zealand, the USA, Canada and Australia found that schools have consistently allowed a climate of homophobia to persist and provide limited assistance to same-sex attracted young people (Bagley 2000; Rivers, 1995). The young people who appear to be at the highest risk for suicide are those who are least likely to reveal their sexual orientation to anyone. It has been suggested that suicide may be a way of making sure no-one ever knows [Blumenfeld 1998]. The VicHealth Sexual Diversity projects in Victoria identified bullying and homophobia in schools and

other community settings as major obstacles for same-sex attracted young people (Frere, 2001). Work in schools in the UK has identified being labelled as gay by ones peers, regardless of the validity of the label, as damaging for young people and many attempt to prove themselves heterosexual by inventing boy or girl friends or becoming sexually active with opposite sex partners, thus increasing their risk of contracting or transmitting sexually transmitted infections (Rivers, 1995).

Housing and Homelessness

Many same-sex attracted young people become homeless and homelessness has also been identified as a social risk factor for suicide (Farnan, 2001). All of the social and psychological risk factors identified earlier in this report are issues for young homeless people. In a study in the USA and Canada same-sex attracted young people were found to be hidden and invisible to service providers and likely to experience greater social discrimination, depression, isolation, low self esteem and violence than their counterparts. All of these factors 'exacerbate desperation and augment the risk of suicide'. Refuges and homelessness programs need to be sensitive to these issues and possibility that sexuality issues will be significant for many of the young people with whom they are working (Proctor, 1994). Closer to home Project I, found that in the Melbourne arm of the study, approximately 10% of young people who have newly left home rate sexual identity issues as a major factor. Large numbers also state that conflict with family is a major reason, however underlying these conflicts may be a range of other issues including sexuality. This can lead service providers to ignore the underlying reasons for young people becoming homeless (Myers, 2001). External pressures on same-sex attracted young people include family conflict, religion, bullying, homelessness, premature independent living, alienation and discrimination. Internal pressures include hopelessness, ambivalence and self-blame (Hazell, 1998).

Health

While youth health services and outreach health workers who have contact with homeless young people have no doubts about the over representation of same-sex attracted young people in their care and their risk of suicidal behaviours, mainstream health services are less aware. Health workers may be confronted with self-harm and suicidal behaviours and sexual and gender diversity within their working environment. These can be difficult issues to approach with no appropriate training or background experience.

Morgan and Evans (1994) found the attitudes of health professionals to be generally negative to deliberate self-harm and a considerable number did not believe suicide prevention to be a feasible or appropriate part of their work (noted in Tobin, 1999). In a survey of Victorian hospitals Bailey (1994) also found staff attitudes to deliberate self-harm to be generally negative and respondents indicated that they did not enjoy caring for parasuicide patients [noted in Tobin, 1999]. Suicide attempts are often perceived as attention seeking or manipulative by health professionals. According to Cantor these terms unfortunately "trigger a dangerous sequence of thinking " which implies that the young person has engaged in negative behaviour and has done so purposefully, as opposed to responsively (Cantor, 1999). Given the reluctance of clinicians to make reference to suicide a clear definition is much needed.

In a UK study that investigated the frequency, response to and pathways in care of young persons under 16 presenting to a hospital accident and emergency (A and E) department following deliberate self-harm, over a 12 month period, 60 young people were identified from the department's records. The study found that one third of them did not receive specialist assessment in spite of hospital guidelines, and one fifth were not referred for follow up care. There was also a low frequency of recording relevant history, particularly former attempts at self-harm. Following this evidence of inadequate or inappropriate care, improvements were implemented across departments including the design of protocols for assessment and after care (Clarke 2001). While this study did not focus on sexuality and gender among the target group of young people, it does have broader implications for hospitals in Australia.

The societal taboos against both homosexuality and suicide can play out for same-sex attracted young people presenting to a health service in ways that leave them feeling alone and without support at best. Young people who are troubled by feelings of difference are likely to keep silent and avoid disclosure for fear of judgement or negative responses and may therefore remain undetected and slip through the cracks in the system. Workers who feel discomfort with sexuality issues may compound existing issues by allowing their discomfort to be communicated.

Drug and Alcohol Services

Given the implications of substance abuse for suicidal behaviour in same-sex attracted and transgender young people it is important for these services to develop a greater awareness of the issues [Barbeller 1992; Millard, 1995; Brown, 1996; Emslie, 1996; Teehan, 1996; Farnan, 2001).

Data Issues

In addition to difficulties with definitions of suicidal behaviours and sexual orientation, there are major problems identified in the literature for the collection of demographic and descriptive data concerning the motives behind completed suicides. Each State and Territory in Australia has its own Coronial Act and procedure with no agreed definition of suicide or consistent reporting mechanisms between States and across Coroners Jurisdictions, which may affect the accuracy of suicide data. This is problematic as this data forms part of the basis for funding suicide prevention programs.

In Victoria, Coroners are not required to enter a finding of suicide and rulings of death by suicide are infrequent (Setting The Evidence Based Research Agenda, 1999: 13). Coroners may be reluctant to enter a finding of suicide because the intentions of the deceased are unclear or they may be motivated by a desire to protect grieving family members from the stigma attached to suicide (Cantor 1999). Issues about sexuality may be avoided for similar reasons (Youth Suicide in Australia, A Background Monograph, 1997).

The Commonwealth Government's commissioned literature review, Setting the Evidence Based Research Agenda (1999) suggests that the ABS may under-estimate the true suicide rate and also identifies problems with the timeliness of data. Recent increases in undetermined or accidental deaths, particularly from drug overdoses, may conceal the actual suicide rate, although researchers have paid minimal attention to this. The report calls for further investigation of these phenomena, as death by drug overdose is the predominant method used by women and suicide may also be implicated in the deaths of young men in single vehicle accidents.

Research Findings

In the absence of easily identifiable quantitative data concerning same-sex attracted young people and suicidal behaviours, the project set out to collect qualitative data through interviews with workers. The aim of these interviews was to identify existing quantitative data sources, gain an understanding about what is currently happening and whether suicidal behaviours and sexuality issues are, or could be, documented in any consistent way.

The service mapping identified a range of sectors that currently come into contact with young people who are suicidal or at risk of deliberate self-harm, as well as a number of services and agencies that have regular contact with same-sex attracted young people. As a result of the service mapping, the following broad categories of services, agencies and institutions were identified and workers contacted for interviews. These include:

- Schools and educational institutions (14),
- Legal/ juvenile justice (5),
- Health services including community health, hospital, division of general practice and specialty services such as Family Planning Victoria, the Royal District Nursing Service, women's health services and speciality youth health services (15)
- Mental health and counselling services (13)
- Alcohol and drug services (2)
- Welfare/ housing and homelessness (19)
- Youth work (19)
- Gay and lesbian community organisations (6)
- Projects and services other categories in Victoria and interstate (14)

In all, over 100 contacts were made with representatives from all these sectors. The interviews ranged from telephone and email discussions (87) to in-depth, semi-structured interviews (20).

At the time of interviewing no services were collecting qualitative or quantitative data that identifies sexuality issues for clients and many do not have the capacity to register suicide attempts or self-harming behaviours. In the course of the service mapping and literature review several data sources were identified and services approached to request access to de-identified data sources. The data sources include Kids Helpline, The National Coroners Information Service and The Gay and Lesbian Switchboard. In addition, two projects in Victoria (Project I and Hanover Young Adult Services) had recently specifically sought information on these issues as part of their research and these were also included. The Victorian Emergency Room data was also reviewed to see if any information on people presenting for deliberate self harm could be tied to issues of sexuality, but due to the fact that very little descriptive data is collected and fields do not exist in the data base to collect such information, this was not found to be useful.

Interview Findings

While few actual quantitative data sources were identified, the interviews provided a rich source of anecdotal information concerning same-sex attracted young people and suicidal behaviours. The issues differ across and between sectors, and will be addressed below by sector. There was agreement from many workers across a variety of sectors, that while data collection is seen a chore, it would be highly desirable to have empirical information to both inform practice and provide evidence, in order to argue for improved funding and programs.

School and Educational Institutions

Fourteen interviews were carried out with workers from a range of educational institutions. Teachers and student welfare co-ordinators reported very limited knowledge of same-sex attracted young people in their schools and few had experience with students who have self-harming or suicidal behaviours. The general feeling among teachers and student welfare officers is that young people are unlikely to disclose this information at school.

> *"Kids are unlikely to disclose at school. I have only known of 2 who have disclosed in the past few years. It is not an issue that our school is aware of. Kids disguise issues and don't come out at school. It's a safety issue." (Teacher)*

School nurses in Victoria, who have only been in schools since the beginning of the 2001 school year, similarly report seeing few same-sex attracted young people. While they are still relatively new in schools, there does appear to be a greater likelihood of disclosure to school nurses than to teachers, given that they have an ethical responsibility to maintain confidentiality and the level of trust in the community for nurses. No data collection occurs in schools, but school nurses now have an electronic data collection system (SNIS). At the times of interviewing, the system did not include information about sexuality or suicide although a descriptive narrative (e.g. presenting issue) can be entered and another field that allows "outcomes" to be recorded, but in practice appear to be seldom used.

> *I have seen 3 same-sex attracted boys in the six months I have been working at the school, but I think that quite a few more who come to see me might have sexuality issues. I also see quite a bit of self harming." (School Nurse)*

Most tertiary institutions have a department for people who identify as non-heterosexual as part of their student services (eg Queer Departments). The service provided is essentially peer support although workers may be employed. Students use these services as a meeting place, drop in centre and information service. Workers report seeing young people who are confused or questioning their sexuality and some that express suicidal thoughts or wishes. Workers do not keep any records and are protective of the privacy of those who attend. If anyone is thought to be seriously at risk they are either referred to the student counselling service or external counsellors.

Legal/ Juvenile Justice

The police keep no records on sexual identity in relation to self-harm/ suicide, although standing orders are that reports should be filed in the case of suspected suicide. The police do have protocols for identifying sexuality issues from narrative reports in relation to hate crimes, but this does not extend to reports on suicide and self-harm incidents to which they are called.

Youth counsellors and Streetwork outreach workers with juvenile justice clients do not collect data on same-sex attracted young people. The Streetwork Program collects data on the "CASSIS" electronic system. This program includes sensitive case notes and while sexual identity maybe mentioned in narrative form, there is no way of extracting data about suicide or sexuality.

> *"Sexuality is a completely concealed issue among our clients" (Juvenile Justice Worker).*

Health Services

Health services contacted included community health, women's health, youth health, hospital, family planning and the youth health section of several Divisions of General Practice. While all of these services indicated that they are working with same-sex attracted young people to some extent, none of those interviewed collect data on sexuality and few raise questions about sexuality during consultations. One rural health worker who was involved in one of the VicHealth Sexual Diversity Dissemination Projects reported:

> *"Our project would suggest that health practitioners make little or no attempt to specifically identify whether a client is same-sex attracted, bisexual, or*

transgender and this is one issue that we will be taking up in our "best practice" protocols".

A variety of data collection systems are in use throughout the health service system, many of which are capable of having modules added to include extra information, however no information on sexual identity is collected at present.

Youth health outreach workers report large numbers of same-sex attracted young people among the homeless population. Many of these young people have anecdotal histories of significant self-harm and present serious suicidal concerns for the workers. With this group, private case notes are often kept by the worker in narrative form and information on sexuality and suicide could not be extracted without potentially breaching confidentiality. Many are also wary about entering data about same-sex attraction or gender confusion as they see it as breeching confidentiality and potentially stigmatising the subject in the future.

"'Co-factors' such as marginalisation and rigid gender confines are more serious issues than the fact that a young person is same-sex attracted." (Youth Health Worker)

Mental Health/ Counselling

Most telephone counselling services do not seek or record information about sexual identity in relation to suicidal or self-harming behaviours, the notable exception being Kids Helpline (KHL).

Mental health services working with homeless young people and older adolescents reported frequent contact with same-sex attracted young people and expressed concerns about observed suicidal and self-harming behaviours in this group, however no organisation collects data about these issues.

A counsellor who works with family members in rural and regional Victoria after a suicide in the family, reported that in her experience any hint of homosexuality is a cause for fear among survivors. In her experience homophobia is not an uncommon response if there is any suggestion of sexuality being an issue.

Regional Mental Health Promotion Officers (MHPOs) have focused on same-sex attracted young people and suicide prevention in recent years. Extensive suicide

prevention and mental health promotion training has been carried out in each region for workers with same-sex attracted young people through the Statewide Training and Education in Youth Suicide Prevention (STEP) project. Both urban and rural MHPOs report a gap between the responses of workers to training sessions and how this is translated in their day to day practice. Several commented that there appears to have been little change in clinical practice as a result of this training.

> *"… clinicians aren't very good at asking questions about sexual orientation" (MHPO)*

While seeking information concerning sexual orientation is difficult for many workers, especially when a young person is confused or uncertain, some workers appear to be more skilled in this than others. While many workers reported reluctance on the part of young people to disclose and the difficulty in discussing these issues, several youth mental health counsellors described better results. They emphasised both the importance of establishing rapport with the client and the need for the counsellor to be very comfortable with the subject area, but had also developed their own processes for raising these difficult questions. It is beyond the scope of this study to analyse the processes used by these workers but they may provide a useful basis for education and training with mental health and other workers in the future.

Privacy and confidentiality were mentioned frequently by workers who fear that data collection could compromise their professional relationship with clients. Several reported that young people had expressed fears about anything being written in their patient records for others to see.

> *A worker reported: I wondered about whether a suicidal young man I was working with had any sexuality issues, so I made a note on his case notes to remind myself. Later, he asked to see his file. When I showed it to him he was really upset and said 'what do you think I am, a poof or something'.*

Drug and Alcohol Services

None of the services interviewed collect data on sexual identity or reported any knowledge of same-sex attracted young people among the young people with whom they work. It might be surmised that given this lack of knowledge among drug and alcohol workers within this study, that same-sex attracted young people with alcohol and drug issues may be discussing sexuality issues with health or

counselling workers in other fields. Given the difficulty the project experienced in making contact with drug and alcohol services, this is an area that needs further investigation.

Welfare/ Housing/ Homelessness

Same-sex attracted people appear to have a significant chance of becoming homeless, particularly where family conflict arises because of their sexual orientation. Unlike youth health services, that reported a high level of contact with homeless young people who are same-sex attracted, the youth refuges and supported housing services interviewed reported little knowledge of same-sex attracted young people in their client base. One worker commented that it is not relevant for them to know about sexuality issues when providing housing services.

> *"Young women are more likely to self-harm, we find slashing and taking pills more common among young women" (Refuge Worker).*

Many refuges and supported accommodation services are funded by the Supported Assistance and Accommodation Program (SAAP), which requires data to be collected using an electronic system known as "SMART" data. This system is capable of having additional modules added beyond the basic SAAP data requirements.

The National Reconnect Program funds a number of services that aim to reunite young homeless people with their families. Reconnect is a national program and one service in Brisbane has recently been funded to work with gay, lesbian, bisexual and transgender young people. Workers in Reconnect Services reported that a significant number of the young people they work with are same-sex attracted. This program has a common data collection system known as 'RECONNECT', but sexual identity and suicidal and self-harming behaviours are not included in the data collected.

Youth Services

In recent years support groups for same-sex attracted young people have proliferated in Local Government Areas and in welfare organisations across the state. In early 1999, there were two groups operating, one at the Action Centre in the Melbourne CBD and another (with support from the Action Centre) in the Knox LGA. Since then, similar groups have sprung up across the state, some auspiced by local Government, others by welfare agencies. At the time of writing there are approximately 25 services working directly with same-sex attracted young people in

urban, suburban, regional and rural areas. Some of these are facilitated by youth workers and others rely on volunteer support. Several of these services have recently received significant funding and others scrape by without any financial support. Several worker support networks have been established around the state for workers with responsibility for these groups.

> *"Many members of our group are suicidal or self harming. They talk freely in the group setting. In addition to their sexuality, may have experienced family abuse, bullying, homelessness and mental illness."*

Young people are referred to these groups from schools, health services and peers. The groups do not provide counselling or crisis services and a number specifically exclude anyone who is self-harming or suicidal. The STEP manual includes a policy model originally developed by the City of Booroondara that excludes suicidal young people. A number of groups have used this as a model for their own policy development. None of the workers are experienced counsellors and none of those interviewed feel qualified to deal with someone who is displaying self-harm or at risk of suicide.

> *"I tell them, I am not a counsellor and there are things I don't need to know as a group leader. I need to make it clear to young people who come to the group that if they have issues I will refer them to a counsellor or other kind of one to one support.*

None of these groups collect data and most do not keep any kind of records. When workers come into contact with a young person who is suicidal or self-harming they call the Crisis Assessment Team (CAT) or refer them to counselling or a mental health service.

> *"There is a fair bit of slashing and cutting, but mostly they try to cover it up. I think they feel ashamed or embarrassed about it".*

A common theme that emerged from interviews with workers in these groups is that they do an initial intake interview with a young person who expresses interest in joining the group, during which there is no disclosure made about suicidal feelings. The young person subsequently joins the group and after a few months of belonging may report to the worker retrospectively that belonging to the group has helped them to overcome feelings of hopelessness and even suicidal ideation.

Under the VicHealth Mental Health Promotion Plan (MHPP) same-sex attracted young people were identified as facing significant mental health challenges in relation to disclosure of their sexual identity, suicide, experiences of victimisation and bullying, violence, harassment and homophobia at school and in other community settings. As a result, twelve rural services were funded in 2000/ 2001 by VicHealth, under the Sexual Diversity Grants Scheme to develop programs to address these mental health challenges. The twelve projects covered a broad geographic area and were diverse in their strategies. A number of key learnings emerged from the projects, however none of them collected data sexuality and suicide risk factors concerning the young people in their target group. What is clear from these projects is that all of the issues faced by services, workers and young people in city areas are far more sensitive and complex in rural areas.

Data Analysis

Several sources of data were identified as potentially being relevant during the service mapping and informant interviews. These included Kids HelpLine (KHL), National Coroners Information Service (NCIS) and the Gay and Lesbian Switchboard. With the agreement of these agencies and ethics approval, access was gained to their raw data to determine if links could be established.

Kids HelpLine is a telephone counselling service providing young people with 24 hour access to trained counsellors. Between May 10th 1998 and December 31st 2001, Kids Help Line (KHL) received 333,026 telephone calls of which 73% were female.

Calls that included some mention or theme of suicide accounted for 3.5% of all calls and they were more likely to come from females than males: females accounted for 73% of all calls and 83% of those about suicide.

Calls in which sexual orientation was the main concern accounted for 1.5% of all calls and males were over represented in this category of calls: males account for 17% of all calls but 48% of calls where sexual orientation was the main concern.

Calls about sexual orientation were less likely to include a mention of suicide than other calls. Of all calls, 3.5% included some mention or theme of suicide and of those calls about sexual orientation 1.6% included a reference to suicide. Of all calls where there was a mention of suicide, sexual orientation was mentioned in 0.47% of calls compared sexual orientation being mentioned in 1.5% of all calls.

Overall, it appears that callers concerned about suicide were less likely than other callers to also mention sexual orientation. Similarly, those callers concerned about sexual orientation were less likely to mention suicide that other callers. However, this general pattern obscures an important gender difference. When looking at all counselling calls, 1.0% of calls from female callers were about sexual orientation compared to 2.7% of calls from males. In contrast, in calls where suicide is mentioned, only 0.4% of calls from female callers were about sexual orientation compared to 2.1% of calls for males. It would appear from this data that sexual orientation and suicidal behaviours are more closely linked for males than from females.

The KHL data was the only data source that provided any reliable data relevant to the project aims.

The Gay and Lesbian Switchboard provides a free telephone information and referral service to the gay and lesbian community, with limited hours of opening. Counsellors are trained volunteers and a toll free number is provided for country callers. A review of the Gay and Lesbian Switchboard data in 2001 showed no calls concerning suicide. Switchboard acknowledges problems with data collection and entry and are currently taking steps to improve this. Given the advertised nature of the service it is not surprising that callers do not contact them seeking crisis intervention.

National Coroners Information System contains records of 917 deaths of Victorians aged 10-30 years notified between 1 January 2000 and 31 December 2001. Of those, intentional self-harm was identified as the cause of death at the time of notification for 182 of these cases. Text searches were performed on the autopsy reports, coronial findings and the findings of the police inquiries for references to “gay”, “lesbian”, “transgender”, “bisexual”, “homosexual”, “homophobic” and “homophobia”. Those searches identified three cases. One of those cases was closed and examination of the documents demonstrated that sexuality may not have been a major contributor to the death. The remaining two cases are still open and it was not possible to access the documents associated with them.

The Victorian Emergency Minimum Dataset (VEMD) contains de-identified data detailing presentations at Victorian public hospitals with 24-hour Emergency Departments. A review of a random sample of 100 cases presenting with deliberate self harm revealed no reference to sexuality, homophobia, bullying or any other data that might be useful in establishing a link. The only place where such information

might be recorded is in a text field where narrative can be recorded describing the circumstances surrounding presentation, but this field is seldom used in practice. As a result of this and time constraints, it was decided not to proceed with obtaining more extensive data sets for analysis.
Two research projects were also identified as having data relevant to the project.

Project I is a five year study of homeless young people in Melbourne and Los Angeles that focuses on young people aged between 12 and 20 who have recently become homeless. It is looking at young people's pathways into homelessness, service provision and government policy that impacts on homeless young people. This project is still in progress.

Of the 390 young people in the study, 35.9% report having engaged in self-harm. Compared with heterosexual young people, non-heterosexual young people (gay, lesbian, bisexual and unsure) were more likely to report self-harm (58.5% versus 31.4%), ever having attempted suicide (49.0% versus 34.5%) and having attempted suicide in the previous three months (23.1% versus 8.6%). Among those young people who had ever attempted suicide there was no difference between heterosexual young people and non-heterosexual young people in whether they had told anyone about the suicide attempt (72.1% versus 75.0%).

Non-heterosexual young people were more likely than heterosexual young people to report being bothered in the previous week by thoughts of death or dying (43.1% versus 29.5%) or of ending their life (43.1% versus 19.6%).

Hanover is a welfare agency that provides a range of services, including accommodation, financial and material aid, counselling, education and training to homeless people in Melbourne. Hanover also conducts research and advocates on behalf of homeless people. In 1997 Hanover studied 205 individuals with reported suicidal behaviour or serious self harm compared with a comparison group of 57 clients experiencing homelessness.

The findings of the study are indicative due to the nature of the study and the sampling frame. Sixteen per cent of those reported to have one or more categories of suicidal behaviour were gay/ lesbian compared to 7 per cent of the comparison sample of adults experiencing homelessness. Examining the study group reported to have suicidal behaviours, those with same-sex preferences reported significantly higher levels of suicide attempts, to be more likely to have had a plan to suicide and more likely to self harm. No differences were noted in the experience of

homelessness between gay/ lesbian and heterosexual client groups and no differences were noted in the prevalence of psychiatric disorders between these groups. There was however, a significantly higher level of past personal abuse or violence and of substance abuse among the gay/ lesbian group (Horne, 2000).

Discussion

While at a population level same-sex attracted young people are not recognised as being at significant risk of self-harm, there is ample evidence from both Australian and international studies, anecdotal accounts from workers and retrospective accounts from gay, lesbian, bisexual and transgender people, that the risk real and significant. It is not surprising, in a climate where unease is experienced about both suicide and homosexuality, that workers and institutions avoid issues concerning sexuality with the people with whom they work. We live in a society that avoids dealing with these issues and workers are products of this system by avoiding the issues the potential embarrassment, fear and shame of having to deal with these issues can also be avoided.

It is clear from both the interviews and the literature that a significant proportion of young people who are same-sex attracted, or do not conform to traditional gender norms, are at risk of a number of internal and external pressures. These include being bullied, experiencing family disruption, becoming homeless and feelings of fear, shame, embarrassment and confusion. None of these pressures stem from the nature of their sexual or gender diversity, but from the experience of living in a world that pathologies sexual expression and consequently marginalises them through all the institutions that are important in the lives of young people. These institutions include the family, schools, health services, welfare services, religious institutions, sport and recreation organisations, literature and the media.

The experience of growing up in a climate that vilifies and trivialises sexual diversity leads to young people incorporating these societal prejudices to the extent that they can internalise homophobia. As a result they may learn to dislike their own natural feelings of attraction and desire and begin experiencing feelings of shame, fear and exclusion. This can be compounded by lack of positive images with which to identify, lack of access to appropriate support and geographic isolation.

Same-sex attracted young people who experience internalised homophobia usually try to continue to operate within their usual social setting including family, school, church or religious institution, recreation and social activities. All of these institutions can compound fears about being or feeling different when they do little

to intervene when bullying and other forms of violence occur. It appears that few of these institutions challenge overt homophobia and may even promote it in subtle forms of homophobia. . Non-heterosexual feelings or behaviours can be rendered invisible, through the assumption that everyone is heterosexual and as a result feelings of isolation become compounded for anyone who feels they do not fit the societal norm. The end result for young people who are uncertain, confused, questioning or identifying as gay, lesbian, bisexual or who have non-traditional gender roles can be low self esteem, alienation from friends and family, depression, despair and a desire to escape from an unbearable situation. This escape may be achieved through using drugs and alcohol, leaving home, becoming sexually active at an early age (often with multiple partners), dropping out of school, self-harming (cutting, burning etc), self destructive behaviours or attempting suicide.

The degree to which these self-destructive behaviours have suicidal intent is questionable and may be unclear to both the young person and the workers with whom they come into contact. The myth that self-harm is attention seeking or insignificant is still prevalent and as a result may be ignored. Some young people may develop eating disorders, participate in unsafe sex, drink alcohol to excess, take up injecting drug use and share needles or drive dangerously; others may self-harm themselves repeatedly through self-mutilation. Some of these behaviours will lead to serious harm and even death. Other young people might express a wish to die and start to make plans to carry out this wish. For some this may happen, while others will attend a hospital emergency room to be assessed or referred for further treatment, hospitalised or discharged. The majority of young people who deliberately self-harm will not attend any emergency or medical centre and will resolve their crisis alone or with the help of friends or family.

The implications for data collection and evidence-based practice are that an inestimable level of suicidal and self-harming behaviour probably occurs but is never recorded. All suicidal behaviour, regardless of the perceived intent, is serious. For same-sex attracted young people, suicide may be seen as a way to ensure no-one ever knows.

Privacy Legislation

The Victorian *Information Privacy Act 2000* has implications for data collection processes. The Act regulates the collection, handling and disclosure of personal information by the Victorian Public Sector and complements the Commonwealth Privacy Act 1988, which covers the Commonwealth Public Sector. Personal information is defined as:

> *"Information or an opinion (including information or an opinion forming part of a database), that is recorded in any form and whether true or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion …"*

Personal information that is also health information is also regulated by Health Privacy Principles, which are contained in the *Victorian Health Records Act 2001.* The principles are designed to ensure that organisations are responsible for ensuring that individuals are aware that information about them is being collected, that they know who is collecting it and to whom information might be disclosed. Individuals also have the right to gain access to any data that relates to them.

Organisations that collect data about service users will need to be familiar with and comply with these principles.

Issues For Young People

Young people who are probably at the highest risk of self harming and suicidal behaviours are those who have never disclosed their thoughts or feelings about themselves to anyone. They can experience their feelings of difference in an environment that is homophobic and heterosexist and may see few challenges to this at either a personal or institutional level. This can lead them to believe that their feelings and thoughts are pathological. To risk disclosure carries the threat of becoming the target of rejection or homophobic bullying. Schools, services, social and recreation organisations and families that accept intolerant attitudes towards gender and sexual diversity and encourage a narrow range of acceptable role models, are implicit in creating an environment that fosters self doubt in those who are different or confused and may contribute to their suicide risk.

Issues for Workers

There are two difficult issues that workers with same-sex attracted young people face, for which most have had little or no personal experience or training. Workers have been socialised in the same homophobic and heterosexist environment as the young people with whom they work and have incorporated societal fears and prejudices about suicidal behaviours. These issues are seldom addressed to any great extent in undergraduate and post-graduate training and personal biases and beliefs remain unchallenged. This is compounded by the relatively small numbers of young people who they know to be same-sex attracted or suicidal. The secrecy and

silence that is maintained about both of these issues, combined with lack of openness, keep them unacknowledged.

Expectations for workers vary in different disciplines and professions. For example workers who deal with the intimate aspects of human lives from whom privacy and confidentiality are required (for example counsellors, doctors and some specialist health workers), might be expected to have greater understanding and be more readily able to provide support and assistance when these issues arise. Young people might be expected to feel more comfortable to be open and honest with these workers about their innermost feelings and fears. On the other hand, workers who operate at a more superficial level, for example youth and recreation workers, teachers and emergency room staff, might be expected to be less trusted with private and confidential information. But it is the workers (e.g. youth workers) who have regular and frequent contact with young people and who build up trusting relationships, who appear to be most likely to be approached first. When it comes to same-sex attracted young people disclosing their thoughts and feelings, these are the workers they appear to most readily approach.

In many organisations it is the gay or lesbian worker who is expected to provide support for same-sex attracted young people, and who may do this without organisational support because they have an appreciation of the issues from personal experience. This can put considerable pressure on these workers. Caring for young people is a community responsibility and not the domain of a select few who have learned from personal experience what it means to be marginalised because of sexual or gender orientation. All workers in schools, recreation and sporting clubs, health and welfare services have an equal responsibility to provide understanding and support for a young person in their care.

Issues for services

Organisations and institutions that are entrusted with responsibility for young people are anecdotally known to be sites where narrow sex and gender roles are played out. These may be enforced between peers and accepted by workers through curriculum or activities in the organisation. Tolerating homophobic bullying (whether physical or verbal), failing to challenge these forms of discrimination and prejudice and assuming everyone to be heterosexual are all behaviours that foster an atmosphere that is hostile and contributes to marginalising young people who are not exclusively heterosexual.

All services need to review their environment, develop a deeper understanding of how they contribute to prejudice, develop policies and procedures to address practices that promote intolerance of difference and undertake training to ensure that homophobia and heterosexism are not normalised within their communities. Services sectors come into contact with same-sex attracted young people in different ways and respond differently to them. Policy, training and service delivery need to be addressed in different ways in different sectors.

Future Directions

There is a pressing need for empirical evidence to support the findings of both Australian and international research, and anecdotal information from workers, that there is a connection between sexuality and suicidal behaviours among young people.

As this project has found, young people who have personal issues about sexuality and suicidal or self harming behaviours can be difficult to identify and reach. Many conceal their innermost feelings because of shame and fear and in the course of this research; only a few workers were identified that felt they have the skills and expertise to reach them. Sound data collection relies not only on recording information that is forthcoming but also on knowing which questions to ask and how and when to ask them. This differs according to the nature of the work and relationship the worker has with young people. However, there is potential for infringing privacy and loss of trust, unless the worker is sensitive to the issues and trained to approach them appropriately.

To ameliorate the problems experienced by same-sex attracted young people as a result of negative attitudes towards homosexuality and its consequent prejudice and discrimination, it is first important to gain a clear understanding of the issues. High quality data collection can contribute to this through the establishment of an evidence base that has the capacity to impact on and inform reflexive practice.

The aim of data collection that seeks to demonstrate the connections between sexuality and suicidal behaviours needs to inform the development of strategies that move away from pathologising young people who are confused or uncertain about their sexual attraction or gender orientation, towards making interpersonal and institutional homophobia unacceptable and supporting young people who are in need.

In order to improve data collection systems so that they are not only clear, simple to use and accessible but also collect high quality information about sexuality, gender and suicidal risk factors, it is important that extended periods of piloting are considered with the input of workers around these issues being critical. They need to feel confident that data can be collected in a simple and sensitive manner and that it will provide useful and practical information to inform their future practice.

This report offers two resources that may assist workers and services to develop processes for reflecting on practice and collecting empirical data. The graphic depiction of Homophobia and Suicide Risk factors on page 46 shows the ways in which homophobia can affect same-sex attracted young people, the potential resulting risk factors and pathways that may result. The Provisional Inventory of Suicide Risk Factors for Same-sex Attracted Youth on page 45, suggests a typology of sexuality, social, emotional and verbal risk factors that may be indicative of suicide risk.

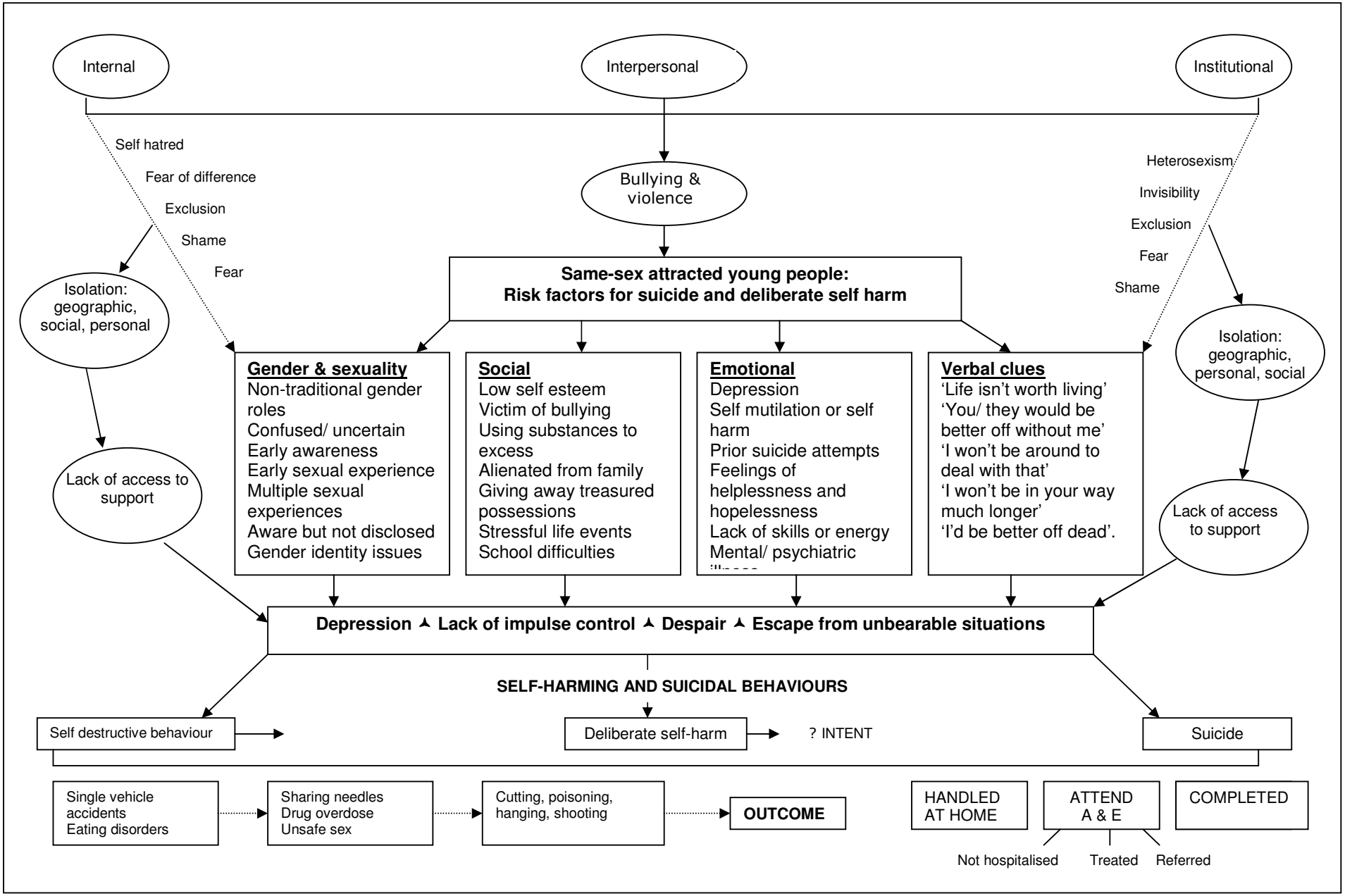
These tools must be used with caution however, as all young people will display some of these risks from time to time. When they are of an enduring nature, or when a number of factors cluster together, they may however represent clues to a serious risk for suicide or self harm.

All workers in services that have contact with young people should understand these risk factors and pathways. By coming together with other workers to reflect on the incidence of these behaviours among their clients, and developing systems to document this information, services can develop a clearer understanding about suicide and self harm risk factors and contribute to improving the knowledge base.

Appendix 1. Provisional Inventory of Suicide Risk Factors for Same-sex Attracted Youth

Gender / sexual orientation	**Social**	**Emotional**	**Verbal clues**
❑ Non-traditional gender roles ❑ Confused or uncertain about sexual attraction or orientation ❑ Early awareness of same-sex sexual attraction/ orientation ❑ Early sexual experience ❑ Multiple sexual experiences ❑ Feeling different ❑ Aware of same-sex attraction/ orientation but not disclosed ❑ Gender identity issues ❑ Victim of homophobic abuse ❑ Victim of homophobic violence	❑ Low self esteem ❑ Victim of bullying (peer, teacher, family) ❑ Victim of peer violence, family violence or sexual abuse ❑ Using alcohol/ drugs and other substances to excess ❑ Alienated from family ❑ Lack of support systems ❑ Dropping out of school ❑ Homelessness ❑ Suicide of a friend or role model or strong interest in celebrity suicides ❑ Exposure to HIV ❑ Unemployment ❑ Stressful life events ❑ Family stresses ❑ Giving away prized possessions ❑ School difficulties ❑ Change in sleeping patterns ❑ Withdrawal from friends or family ❑ Engaging in prostitution ❑ Geographic isolation ❑ Fear of abandonment or being alone, ❑ Unstable and intense personal relationships ❑ Impulsive or risky behaviours (unsafe sex, reckless driving and binge eating)	❑ Depression ❑ Self mutilation or self-harm ❑ Prior suicide attempts ❑ Poor impulse control ❑ Despair ❑ Desire to escape from unbearable situations ❑ Feelings of helplessness and hopelessness ❑ Negative attitudes about self ❑ Lack of the skills or energy needed for coping ❑ Personality traits e.g. perfectionism ❑ Mental/ psychiatric illness ❑ Suicidal threats or gestures ❑ Eating disorders	❑ 'Life isn't worth living' ❑ 'Family/ friends would be better off without me' ❑ 'I won't be around to deal with that' ❑ 'I won't be in your way much longer' ❑ 'I'd be better off dead'

Appendix 2: Possible outcomes of homophobia



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