

Lesbian, Gay, Bisexual, Transgender and Intersex health policy in South Australia:

An exploration and jurisdictional analysis

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47 King William Road
Unley, SA, 5061 Australia
Ph (08) 8305 4222
Fax (08) 8272 9500
Email: sacoss@sacoss.org.au
Website: www.sacoss.org.au

Written by Richard Cannon and Amy Kaim, South Australian Council of Social Service, with intellectual property contributed by Shane Dinnison, AIDS Council of South Australia.

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GLOSSARY OF ACRONYMS

AAC	The AIDS Action Council of ACT
ACON	The AIDS Council of New South Wales
ACSA	AIDS Council of South Australia
AIDS	Acquired Immunodeficiency Syndrome
CALD	Culturally and Linguistically Diverse
DSH	Deliberate Self Harm
HIV	Human Immunodeficiency Virus
LGB	Lesbian, Gay and Bisexual
LGBT	Lesbian, Gay, Bisexual and Transgender
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MAC	Ministerial Advisory Council
MSM	Men who have sex with men
NTAHC	Northern Territory AIDS Council
QAHC	Queensland Association for Healthy Communities
SDOH	Social Determinants of Health
SSA	Same Sex Attracted
SF-36	SF-36 General Health Scale
TasCAHRD	Tasmanian Council on AIDS, Hepatitis and Related Diseases
VAC	Victorian AIDS Council
WAAC	Western Australian AIDS Council

GLOSSARY OF TERMS

Gender diversity	Gender, put simply, can be thought of as a person looking, dressing, acting or identifying as male or female. Some people are born not identifying with, or feeling connected to, either a male or female persona. Some common terms for people who are sex and gender diverse include transgender, transsexual or intersex (HREOC, 2008).
Heteronormativity	The powerful heterosexual social and political structures and normative principles that we are immersed in from early on in life. This social construct contributes to and maintains the assumption that the human population is heterosexual, that heterosexuality is the norm, and any other sexuality/relationship is deviant and/or immoral (Rondahl, 2005).
Heterosexism	An ideological system that denies, denigrates, oppresses and stigmatises any non-heterosexual behaviour, self identity, community or relationship (Herek 1995, cited in Langley 2001).
Homophobia	An irrational fear or hatred for homosexuals and homosexuality (Brown, 1993: 1254, cited in Plummer 2001).
Internalised homophobia	The feelings of self-loathing sometimes felt by same sex attracted individuals, usually contributed to by the negative social constructs of the LGBTI community (Langley, 2001, cited in Cannon, 2006).
Institutional homophobia	Homophobia that exists, implicitly or explicitly, within the systems and institutions of a society.
Intersex	Someone who possesses from birth genitalia or reproductive anatomy that is difficult to label as either female or male.
Suicide	A fatal, self-inflicted act where the intent was on taking one's own life (Bridge, Goldstein & Brent, 2006, cited in Cannon, 2006).
Suicide ideation	A psychological state consumed with thoughts of harming or killing oneself (Bridge, Goldstein & Brent, 2006).
Suicidality	All suicide-related behaviours or thoughts about suicide including suicide ideation, attempting to kill oneself, or actually taking one's own life (Bridge, Goldstein & Brent, 2006, cited in Cannon, 2006).
Transgender	An umbrella term used to describe those whose gender identity (the gender that a person identifies with regardless of their biological gender) is opposite to their biological sex. This definition includes transsexuals and crossdressers (Transgender Victoria, n.d).
Transphobia	The fear of trans people, or those who do not fit traditional male/female gender roles. Intersex people may also experience this form of phobia (LGBT Health Alliance, 2009a).

Executive Summary

The purpose of this report is to investigate the experience of health and wellbeing for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) populations and how the South Australian government is responding to disparate health issues within this group. Juxtaposed against this will be an analysis of how each state and territory government responds to health inequities within these communities and whether any formalised LGBTI health policy or strategy exists in each jurisdiction.

Australian and overseas research indicates a significant disparity in the experience of health and wellbeing between LGBTI populations and the rest of society. Qualitative and quantitative studies highlight the often complex set of oppressive social, institutional, familial, political, cultural and religious norms that either intentionally or unintentionally serve to alienate and marginalise LGBTI individuals. Historically these systems have created a social environment that is both detrimental to the development to social connectedness, but also to the fostering of positive personal experiences of health and wellbeing. With the often significant gap between the positive health outcomes for LGBTI populations and the rest of the population, current social policy responses in most jurisdictions seem lacklustre, particularly when we investigate how significant the issues are within this group.

While the research results of disparities in health and wellbeing amongst the LGBTI community are clear, many governments across the country have either ignored the health related impacts indicated by this research, or have given only cursory mention to LGBTI health disparities when developing social and health related policy. This paper investigates the policy responses by state and territory governments, revealing Victoria to be the only state or territory to have a specific LGBTI health plan, a Ministerial Advisory Committee (MAC), and a dedicated worker within the government to oversee the plan and related initiatives. South Australia, while previously hosting a Gay and Lesbian Health MAC (established in 2004 to provide the Health Minister with expert advice on priority health concerns) abolished this committee subsequent to the introduction of the new Health Act 2008. This has left South Australia devoid of any specific policy, plan or consultative mechanism to address health inequities within LGBTI communities and also removed a voice to advocate for this marginalised and diverse group. In addition, current South Australian health plans and strategies do not currently list LGBTI populations as vulnerable and therefore no provisions have been made to specifically target these 'at risk' groups. This renders the plight and unequal experience of health outcomes for LGBTI populations invisible to policy makers, the health system, and the wider community.

In light of this, and the underlying evidence demonstrating an unequal experience of health between LGBTI populations and the rest of society, a greater and more meaningful focus by government is needed on these health disparities, to re-establish a connection with the LGBTI population and to create better health outcomes for LGBTI individuals across the state.

Key findings:

- *LGBT people are four times more likely to attempt suicide than the rest of the community.*
- *The LGBTI community is overrepresented in depression, anxiety and other mental illness statistics.*
- *In a recent survey, 40% of LGB respondents indicated regular tobacco use and in a South Australian study, 44% of MSM were current smokers at the time of the study.*
- *Alcohol and substance use is a significant issue for the LGB community, with elevated levels of drug and alcohol use in these populations highlighted by researchers.*
- *Levels of violence and harassment experienced by LGBTI populations is still a significant issue with a recent study showing 80% of LGBTI individuals had experienced public insults, 70% had experienced verbal abuse, 20% had experienced physical threats and 13% had experienced physical assault.*
- *Domestic violence is a significant social issue within LGB populations with rates as high, if not higher, than in the rest of the community.*
- *Incidence rates of obesity and body image and body size issues are much higher within the LGB populations than the rest of the population.*
- *HIV is still a significant health issue amongst MSM with 86% of newly acquired cases of HIV infection affecting this population.*

Policy implications:

- A significant resource allocation to address the health and wellbeing issues of the LGBTI community caused by health disparities.
- Additional strain on the already burgeoning state health budget.
- The need to re-establish consultative mechanisms with LGBTI populations to ensure appropriate and targeted policy responses.
- The need to develop health and wellbeing related policy for the LGBTI community that is cognisant of the disparities in experiences of health between LGBTI individuals and the rest of the population.

Recommendations

With the disparity between the experiences of health and wellbeing in the LGBTI community and the rest of the population evident, a decisive health and wellbeing policy targeting this group is essential. The recommendations contained within this report provide both short and long-term directions for government to address disparities in the experiences of health and wellbeing within the LGBTI community.

Consultation with the LGBTI community

The government to re-establish the connection to the LGBTI community through a range of consultative mechanisms including re-forming the Ministerial Advisory Committee on Gay and Lesbian Health. Consultation with LGBTI populations would greatly assist government in developing informed, inclusive, appropriate and targeted health related policy, plans and strategies.

The development of a LGBTI health and wellbeing plan

The government develop and adopt a health and wellbeing action plan for LGBTI South Australians, in line with the Victorian model. This action plan should be focussed on the following elements:

- Assessing need within the community
- Ensuring access to health services and programs
- Promote policies and strategies to address and reduce identified inequalities, and;
- Incorporate LGBTI health needs into the existing health service

Prevention and early intervention

Research over the last 20 years demonstrates a convincing link between the LGBTI community and marked disparities between their health and wellbeing and that of the wider community. Much more attention must be focussed on exploring why this disparity exists, and to address it at its origin. This will enable policymakers to identify and address the issues that precipitate and contribute to the disparities in positive mental and physical health.

Research into health disparities in the LGBTI community

Research be commissioned by government to investigate the health disparities in the LGBTI community compared to the rest of the community. These pieces of research should be meaningful and representative of all sections of the community, in particular transgender and intersex individuals who have so far been the targets of a small amount of research. This research should look into the following areas:

- The incidence/causes of mental illness and mental ill health in the LGBTI community
- The incidence/causes of domestic violence in the LGBTI community
- The incidence/causes of alcohol and drug use in the LGBTI community
- The relationship between sexual orientation and negative body image/body size/eating disorders
- The relationship between sexuality and increased suicidality

Note:

It is worth noting that while this paper purports to represent research into the entire LGBTI community, in the past gender diverse issues have only garnered cursory attention. Research pertaining to gender diverse (trans and intersex) individuals is only beginning to be explored and therefore the full picture regarding health and social inequities for these groups is not fully known.

Introduction

While the LGBTI community, through decades of fighting and lobbying, have made many inroads into being included by mainstream society, the community is still subject to institutionalised prejudice, social exclusion, rejection (from both society and family), violence, and discrimination. This social environment has had a significant generational impact upon LGBTI populations, and continuing homophobia, heterosexism and transphobia have had a compounding effect on the experience of positive health and wellbeing of LGBTI populations. Disparate incidences of issues such as alcohol and drug use, obesity/body size, body image, domestic violence, and mental health issues only further contribute to increased prevalence of morbidity (King, Semlyen, Tai, Killaspy, Osborn, Popelyuk, Nazareth, 2008).

Over many years, anecdotal and empirical evidence has shown us that the negative social and health related issues experienced by LGBTI individuals are correlated with the often negative social environments in which these populations exist. This social environment is characterised by negative representations of the LGBTI community (in school, by the family, and often by the media), religious doctrine, and conservative political policies. Existing within this environment can be incredibly difficult for many individuals, particularly young people, who identify as LGBTI, and negative psychological and physiological effects often develop as a result.

So what is it about the way that we have ordered and constructed our society that is contributing to negative health effects for LGBTI populations? Our 'identity' within society has been constructed within finite parameters and is based upon traditional sexually based roles that we are expected to adopt and perpetuate throughout our lives. These roles are distinctly heterosexual and usually consist of a male head of the household and a female partner Johnson (2002). Johnson (2002) argues that this 'discursive heteronormative citizenship' is replicated and promoted within every facet of our existence, through religion, tradition, customs, the family, politics and the media. This portrayal of the social 'ideal' isolates and marginalises anyone who does not identify themselves in this way.

It will be demonstrated within in this paper that the negative social environment created by homophobia, heterosexism and heteronormativity has contributed to the health and social disparities between the LGBTI communities and the rest of the community. Such disparities will impact upon many of our citizens (and health budgets) both now and into the future. This is why a comprehensive response from government is imperative to improve health outcomes for LGBTI people in South Australia in the short and longer terms.

The Social Determinants of Health

Our experience of health and wellbeing is not merely thought of in terms of the absence of illness. Our health is contributed to (in positive and negative terms) by our level of income, social status, ethnicity, sexuality, gender, level of education, where and how we live, our early life experiences, access to food, our individual behaviours, social inclusion and access to appropriate health care (Dahlgren and Whitehead, 1991, cited in Cannon, 2008). For example, we know that those with a higher income generally have better health outcomes than those with a lower income. This disparity is due to people with greater levels of income generally having a greater access to better housing, education, employment, health care, food and early life experiences. Conversely, Aboriginal individuals generally have poorer health, and figure disproportionately in poor health and preventable illness statistics based upon poorer Social Determinants of Health (SDOH) indicators. LGBTI populations also experience poor SDOH indicators in a variety of areas. However the greatest and overwhelmingly influential determinant of health for LGBTI populations centres on the social exclusion created by homophobia, heterosexism and heteronormativity (LGBT Health Alliance, 2009b).

SDOH indicators are vital for government in identifying patterns of health inequalities across jurisdictions to assist them developing more appropriately targeted health promotion programs and service delivery (Ministerial Advisory Council on Gay and Lesbian Health, 2002).

The Ageing Population

Our ageing population will also have an impact upon health policy and health budgets for all South Australians, but the unique set of issues related to heteronormativity, homophobia and a lifetime of living within these social, institutional and political environments will compound the experience of disadvantage for older LGBTI populations.

It is projected that South Australians aged over 65 will comprise 31% of the total state population by 2051 (compared to 14.8% in 2002) (Australian Bureau of Statistics, 2004). And while our ageing population has been highlighted by government and policy makers over recent years, this discussion has rarely highlighted the impact of ageing upon LGBTI South Australians (Harrison, 2006). Within this ageing population, LGBTI 'baby boomers' will have many of the same general health issues as the rest of the community but they will also require additional services and health related policies to address issues uniquely experienced by this group. Issues such as isolation, psychological illness, housing, discrimination, homophobia and particular health concerns are uniquely experienced by the LGBTI population and need specific attention within health policy and in related services (Shankle, et al, 2003).

However, the current invisibility of this group within South Australian health and ageing related policies (while also being ignored in Commonwealth health and ageing policies) will not provide older and elderly LGBTI South Australian with the care that they need nor reduce the gap in the experience of health between LGBTI South Australians and the rest of the community (LGBT Health Alliance, n.d.)

LGBTI Community in South Australia

While anecdotal estimates of the lesbian and gay population in Australia sit around 10% of the population (Gay and Lesbian Health Ministerial Advisory Council, 2007), the actual numbers of LGBTI people in the community is an extremely difficult statistic to quantify. The numbers often shown in statistics regarding the breadth of the LGBTI community cannot therefore be completely relied upon to reflect the actual size of the population (National LGBT Health Alliance, 2009a).

There have been some recent surveys that have sought to ascertain the true breadth of the LGBTI community in Australia. According to a national representative study undertaken by Smith, Rissel, Richters, Grulich and de Visser, (2003), approximately 9% of male respondents and 15% of female respondents reported some form of same-sex attraction. Similarly, the Australian Study of Health and Relationships (2007) indicated that 2.5% of the male population between 16 and 59 years identified as gay or bisexual with a further 8.6% of men reporting that they have had some form of same sex attraction or sexual experience. An estimation of the MSM population can then be derived, based upon these figures and compared to current ABS population statistics that shows the MSM population in South Australia ranges between 40,737 and 140,137 individuals (ABS, 2010; Smith et al, 2003; NSWSTI, 2008).

Conversely, a reliable estimate of gender diverse people in Australia is an even more difficult to ascertain. The prevalence of trans people in Australia is thought to range between 1 in 1000 to 1 in 11,500 (Department of Health 2008, Olyslager & Conway 2007, cited in LGBT Health Alliance, 2009a). Estimates of intersex people in Australia range between 1 in 200 to 1 in 2000 people (Diamond 2004, Blackless et al. 2000, cited in LGBT Health Alliance, 2009a).

While it is critical to ascertain the breadth of LGBTI within the community, it is important to remember that LGBTI populations are not one homogenous group where a 'one size fits all' health policy would cater to all needs, but a rich and diverse population with their own specific health needs (LGBT Health Alliance, 2009b).

Health and social issue disparities compared to the rest of the population

In order to measure the overall health and wellbeing of the LGBTI community, the 'Private Lives' study conducted by Pitts, et al (2006) utilised the SF36 measuring tool. While utilising this tool, the average score for this sample was 68.6. The results indicate that SSA men were the only group who obtained above average scores (69.6), while SSA women, trans males and trans females scored slightly below the mean (67.1, 65.1, 66.1 respectively). Intersex males and intersex females obtained scores that were substantially below the mean, 39.8 and 47.3 respectively (Pitts, et al, 2006). The 'Private Lives' study (Pitts, et al, 2006)

also asked participants to rate their general health on a five point scale ranging from poor to excellent. When the results from this study are compared to the ABS national statistics for all men and women, it is evident that the health status of gay men and lesbians in this survey was rated as lower when compared to the rest of the population.

In regards to people who identify as 'bisexual' (or those who have sex with both men and women but may not identify as bisexual), it has been suggested that 'bi-phobia' and bi-invisibility is negatively contributing to health and wellbeing disparities in this population. According to (Miller, et al, 2007), bisexual men and women (similarly to LGBTI populations) experience greater health disparities compared to the broader population, but they also continue to experience bi-phobia and bi-invisibility from healthcare providers, including providers who may be gay or lesbian. The authors contend that this 'bi-phobia', can be perpetrated by gay and lesbian health care providers despite being accepting of their gay and lesbian clients.

One of the few studies that has looked into gender diverse health, the Tranznation study by the Australian Research Centre in Sex, Health and Society (2007, cited in LGBT Health Alliance, 2009a), demonstrates that while most of the 253 respondents were generally happy about their lives, their experience of good health (when using the SF-36 scale) was comparably lower than those cited in the Australian National Health Survey.

Discrimination

There is an abundance of national and international evidence that indicates major health disparities are occurring between the LGBTI community and the rest of the population. The available evidence points to LGBTI populations experiencing poorer health in a number of areas including, but not limited to, mental health, levels of obesity, higher drug, alcohol and tobacco use, as well as experiencing greater levels of domestic violence, suicidality and self harm (Hillier et al, 2005 and McNair and Medland, 2002, cited in Pitts, Smith, Mitchell, and Patel 2006).

When the cause of such significant disparities in the experience of health of LGBTI populations is investigated, the compounding health effects from societal discrimination and stigmatisation is implicated as major influencing factors amongst this population (Pitts, et al, 2006). Discrimination can be experienced in a variety of ways ranging from subtle or implied disapproval to verbal abuse and violence. Figure 1 demonstrates the experiences of discrimination by study respondents in the 'Private Lives' research report (Pitts, et al, 2006). 'Personal insults and verbal abuse' is the most common form of discrimination with social exclusion the third most common form of discrimination faced by LGBTI individuals (Pitts, et al, 2006).

Figure 1: Personal experiences of discrimination, harassment and violence

	Males %	Females %	Transmales %	Trans females %	Intersex Males %	Intersex females %
Personal insults and verbal abuse	61.0	56.4	73.5	69.7	63.6	42.9
Rumours spread about you	45.8	41.0	52.9	51.5	45.5	71.4
Socially excluded or ignored	35.1	34.3	44.1	56.1	45.5	57.1
Threats of violence or intimidation	26.8	15.2	29.4	46.9	27.3	28.6
Physical attack or other kind of violence	17.3	7.2	11.8	18.2	18.2	28.6
Threats to 'out' you	16.8	12.4	17.7	22.7	27.3	28.6
Had objects thrown at you	14.0	7.9	14.7	12.1	27.3	28.6
Obscene mail or telephone calls	10.8	7.9	23.5	18.9	27.3	42.9
Refused employment or promotion	10.4	8.9	23.5	34.9	18.2	28.6
Deliberate damage/defacing of personal property	10.2	5.0	14.7	13.6	9.1	28.6
Hate mail or graffiti	7.9	4.5	8.8	9.1	36.4	42.9
Rape	4.1	2.5	8.8	3.0	18.2	-
Sexual assault	3.7	2.7	8.8	10.6	18.2	28.6
Blackmail	3.6	2.4	5.8	7.6	27.3	28.6
Finance refused or made difficult	2.5	3.7	8.8	7.6	9.1	42.9
Been refused housing	1.7	2.5	14.7	9.1	9.1	28.6
Custody of children reviewed or revoked	0.5	0.9	2.9	3.0	-	14.3

Source: Pitts, et al, (2006).

Following on from this, Figure 2 demonstrates that levels of connectedness (social inclusion) to the wider community is relatively low in LGBTI populations, with 14.4% of SSA males, 10.8% of SSA females, 6% of trans males, 13.6% of trans females and 10% of intersex males feeling connected to their wider social environments. Moreover, less than 40% of SSA males and females feel 'somewhat' connected to their communities and less than 30% of trans males and females feel 'somewhat' included by wider society. Startlingly, 42.9% of intersex females report never feeling connected to their wider communities (Pitts, et al, 2006).

Figure 2: Do you feel connected to the broader community in your everyday life?

	Males %	Females %	Transmales %	Trans females %	Intersex Males %	Intersex females %
Very	14.4	10.8	6.0	13.6	10.0	-
Mostly	38.5	39.1	27.3	28.8	20.0	14.3
Somewhat	33.5	35.8	36.4	31.8	50.0	42.9
Rarely	9.8	11.2	27.3	19.7	20.0	-
Never	3.7	3.0	3.0	6.1	-	42.9

Source: Pitts, et al, (2006).

Just how discrimination affects the health and wellbeing of LGBTI populations can be found in the report by Hillier and colleagues (2005, cited in Pitts, et al 2006) in which it was established that as levels of homophobic abuse increase, levels of drug and alcohol use and self-harm increase congruently. Similarly, in the 2006 study by Pitts et al, where it was found that approximately 67% of self identified LGBTI participants feared being discriminated against in their day to day lives, such fears were expressed to an extent that participants stated they would modify their daily behaviour in certain environments to prevent being vilified. Additionally, the discrimination and homophobia that the LGBTI community experiences can manifest itself in even more invasive and personal ways. D'Augelli (2002, cited in Corboz et al, 2008) found soaring levels of victimisation in the cohort studied. It was found that 81% of the sample had been verbally abused and 16% had suffered serious physical assault due to their sexual orientation. Research into the experiences of young gay men showed that at least one in ten (10%) young gay men had been physically assaulted at some point in their lives simply due to their sexuality (Morgain, 2004). These examples provide a sobering illustration of the often hostile world in which LGBTI individuals live, and the resulting negative affect that discrimination has on the health and wellbeing of these populations.

Alcohol and drug use

An emerging body of research indicates that the LGBTI population has a higher incidence of drug and alcohol use than the rest of the community. Some of this use is considered to be cultural (club culture etc) while others consider that the drug and alcohol use within the community is in response to existing within a homophobic and alienating environment (Pitts, et al, 2006). Within the Longitudinal study of the health of Australian Women, researchers compared drug and alcohol use amongst SSA women and heterosexual women. It was found that SSA women were much more likely to report elevated incidences of drug and alcohol use than their heterosexual counterparts. This is reflected in Figure 3.

Figure 3: Comparison of drug and alcohol use amongst same sex attracted women and heterosexual women.

	SSA women	Heterosexual women
Heavy drinking	7%	3.9%
Marijuana use	58.2%	21.5%
Illicit drug use	40.7%	10.2%
Injecting drug use	10.8%	1.2%

Source: Pitts, et al (2006).

In a 2009 study by the National Centre for HIV Social Research, figures from Adelaide suggest that at least one in two MSM respondents had used at least one illicit drug in the six months prior to the study and 30% of respondents had used more than one drug in the same period. In relation to these figures, there is additional concern regarding the nexus between the use of illicit drugs and increased risk-taking behaviours. In a study cited in the NCHSR report (Prestage, et al, 2009, cited in NCHSR, 2009), it was shown that illicit drugs were associated with increased incidences of unprotected anal intercourse with casual partners. Moreover, each individual illicit drug use was associated with increased risk of HIV infection, compounding with the frequency of drug use (NCHSR, 2009).

In the South Australian study undertaken by Rogers, et al (2004) 16% of MSM participants reported having injected an illicit drug in their lifetime with 5% indicating that they had injected in the last year. This is substantially higher than the figures presented in the 2007 National Drug Strategy Household Survey (AIHW, 2008), which showed in the 20+ age group for males 10% who had ever injected illicit drugs with 3% who had injected drugs in the last 12 months. Further it was shown that there was significant alcohol use amongst the MSM cohort. It was found that 97% of the participants of the study had ever used alcohol and 89% were current drinkers. This is in stark contrast to alcohol use amongst the general community. In 2004-2005 15% of adult males indicated that they drank alcohol at risky (high risk) levels while 55% of males reported drinking at a lower risk level (Australian Bureau of Statistics, 2006).

Marijuana use amongst the MSM participants in the Rogers, et al (2004) study was also quite high with 62% having ever used cannabis, 44% having used cannabis in the 12 months prior to the study and 22% having used cannabis in the fortnight before the study.

Tobacco use

Tobacco use is an important health issue across all population groups and is one of the leading causes of morbidity and mortality in its users. Despite this, the illnesses associated with tobacco use — for example cancer, stroke, and heart disease — are the most preventable health issues (Gruskin, and Gordon, 2006). There has been a significant decrease in the number of people in Australia who smoke daily. According to the AIHW National Household Drug Survey (2007, cited in Quit SA, 2008), less than one in six (16.6%) people aged 14 and over reported smoking daily; a significant decline from the 1998 figure of 21.8%. This is indicative of a downward trend showing that daily smoking has reduced by 40% since 1985. Despite this marked reduction in smoking rates, in 2004-05 15,000 people died nationally from smoking related illnesses, costing the health system \$669.6 million (Quit SA, 2008).

When compared to the rest of the population, the LGBTI community is at a much higher risk of smoking and therefore run a significantly greater risk of developing the negative health related consequences, including tobacco related morbidity (Gruskin, and Gordon, 2006). Numerous studies (e.g. Gruskin, and Gordon, 2006; Rogers, Curry, Oddy, Makinson, Thompson, Beilby, 2004; Tang, Greenwood, Cowling, Lloyd, Roeseler, and Bal, 2004) have illustrated that gay and lesbian individuals experience higher rates of smoking when compared to the rest of the community. In fact, according to Pitts, et al (2006), just under 40% of the LGBTI population sampled stated that they used tobacco more than five times in the past month. The rate was found to be higher in a South Australian study by Rogers et al (2004) where it was found that 67% of MSM study participants had ever smoked in their lifetime and 44% were current smokers at the time of the study. In addition, rates of smoking amongst HIV-positive participants was even higher with 75% of participants indicating that they had ever smoked with a further 58% indicating that they were current smokers at the time of the study. The results of a study conducted by Gruskin, and Gordon (2006) concur with the previous studies where it was found that lesbians were not only more likely to have used tobacco, but were also more likely to have used it on a regular basis. Again, the study illustrated that gay men were also more likely to be smokers than heterosexual males.

Although the previous studies are illustrative of tobacco use in a percentage of the gay and lesbian community, it failed to investigate those who are bisexual, transgender, or intersex. One study that investigates the use of tobacco in those who are bisexual was conducted by Tang et. al (2004). Tang and colleagues (2004) found that lesbians were 70% more likely to smoke compared to heterosexual women, while bisexual women were also more likely to be smokers, with this group displaying higher levels of smoking behaviour compared to heterosexual women. Similarly, gay men were more likely to smoke compared to their heterosexual counterparts, with those in the former group having smoking levels that were 55.9% higher than the latter.

There was no significant difference between bisexual men and their heterosexual counterparts. There are also disparities amongst GLB populations in regards to numbers of smokers. For example, it was illustrated that gay men were more likely to smoke compared to bisexual men, whereas bisexual men were as likely to smoke as heterosexuals.

Experience of violence and harassment

Violence and harassment can and does manifest itself in many ways for LGBTI populations and this experience can be life changing in the short to longer terms. In a recent Victorian study of LGBTI people (McNair and Thomacos, 2005, cited in Pitts, et al 2006) it was shown that 80% of participants had experienced public insults, 70% had experienced verbal abuse, 20% had experienced physical threats and 13% of respondents had experienced physical assault. Similarly, the Pitts, et al (2006) study showed that 59.3% of LGBTI individuals had experienced personal insults and personal abuse, 23% had experienced threats of violence or intimidation, 13.7% had experienced a physical attack, and 10% had experienced obscene mail or telephone calls. Overall, 67.3% of participants reported that fear of violence and harassment had caused them to alter their day to day activities at work, at home, in public, with their families and in social settings in order to protect themselves (Pitts, et al, 2006).

There were similar results in the South Australian study, (Rogers, et al, 2004), with 26% of MSM participants reporting being subject to verbal abuse by a stranger in the 12 months prior to the study, a further 11% indicating that they had been subject to threats of violence and a further 4% of participants reporting actual physical violence by a stranger.

For bisexual youth (or SSA youth) experiences of homophobia in the classroom and in their everyday lives can also be disparate compared to their heterosexual peers. For example, bisexual and lesbian girls are more likely to experience harassment than heterosexual girls. In a study in the US conducted in 2000 (Bochenek, M. & Brown, A. W., 2001, cited in Miller, et al, 2007) it was found that 63% of lesbians and bisexual girls had reported being "touched, brushed up against, or cornered in a sexual way". This is compared to 52% of heterosexual girls. Further, the study also highlighted that this harassment often escalates into sexual violence with 23% of bisexual and lesbian girls reporting that their peers had tried to hurt them (rape and attempted rape) in a sexual way. This is compared to 6% reported by heterosexual girls (Miller, et al, 2007).

The violence and harassment felt by the LGBTI community can alter the way that these populations are able to exist within society and have been linked to experiences of internalised homophobia, mental health issues, suicidal ideation and suicidality.

Domestic Violence

Mainstream society often considers a male/female relationship to be the only legitimate relationship. Recent moves by both the Commonwealth government and the federal opposition to block same sex unions, based upon the assumption that a marriage is between a man and a woman, is indicative of this. It is through this inability to accept the legitimacy and prevalence of same sex relationships that causes same sex domestic violence to often remain invisible. This begins in school when same sex relationship and sex education is forgone in place of heteronormative discourses concentrating on opposite sex relationships and issues surrounding procreation (Donovan and Hester, 2008).

Notwithstanding the aforementioned state sanctioned discrimination against same sex couples, community and institutional attitudes towards same sex relationships are slowly beginning to change. However, discrimination, heterosexism and homophobia are still rife within the community and this often hostile social (and sometimes familial) environment impacts negatively on people in same sex relationships. This situation is also impacted upon by the coming out process and the isolated existence individuals often live (Donovan and Hester, 2008).

Such oppression, discrimination, rejection and isolation have been indicated in increasing the chances of LGBTI individuals experiencing violence within relationships (Donovan and Hester, 2008), but researchers agree that both same sex and opposite sex relationships (and the propensity for violence) are impacted upon by socialised masculinities/femininities, gender role assumptions, stereotypes and issues of power and control (McKenry, et al, 2006). The difference for heterosexual and non-heterosexual couples is that heterosexual domestic violence has been studied since the 1970s, and from this research government responses have been developed to address it. For same sex domestic violence, the same attention has not

been forthcoming from government and researchers, and has therefore received little to no empirical or social policy attention (McClennen, 2005).

Researchers suggest that while the exact nature of domestic violence within same sex relationships is difficult to quantify within the context of a still largely homophobic society, the available studies suggest that rates of violence within heterosexual and non-heterosexual relationships is similar (McClennen, 2005; Seelau and Seelau, 2005). The prevalence rate of 25%-35% of all partners experiencing violence was comparable in both groups (McClennen, 2005). McKenry, et al (2006) concur, stating that levels of violence experienced within same sex relationships is as high, if not higher, than in heterosexual relationships.

Heterosexism and homophobia also play a part in how same sex domestic violence is (if at all) dealt with by the police or the courts. There is evidence that the sex of the abuser or the same sex status of the relationship may influence the way in which the justice system responds to domestic violence. Seelau and Seelau (2005) suggest that police are less likely to arrest a perpetrator or enforce apprehended violence orders unless they are dealing with male against female domestic violence, and are less likely to intervene in same sex violence cases. Much of this reluctance on the part of the justice system is thought to spring from homophobia and gender role stereotypes that implicitly and explicitly state that women cannot be abusers and men cannot be abused, even if they are in same sex relationships.

Body image and body size

Body image, body size and the increased risk of obesity are issues that particularly affect the LGBTI community (Carpenter, 2004). While there has been a dearth of research within this area, there have been a modest number of studies exploring the link between sexual orientation, body weight, body image and the risk of obesity. A number of these studies have demonstrated that women who identify as lesbian are more likely to be obese than heterosexual women (Carpenter, 2004). Pitts et al (2006) support this finding in the results of their study which indicated that lesbians were more likely to be overweight or obese (49%) when compared to females in the entire population (38%). Boehmer et al (2007) concur through the results of their research into obesity levels in sexual-minority women, indicating that a lesbian identity is a significant predictor of being overweight or experiencing obesity. There are a range of secondary health effects and diseases linked to obesity such as hypertension, cardiovascular disease, type 2 diabetes, osteoarthritis, sleep apnoea, reproductive issues in women, and mental health issues (AIHW, 2004). Obesity is a chronic disease and has significant impacts not only on the LGBTI population (SSA women in particular) but also on already stretched health services and budgets.

Conversely for gay men, the experience is often different. An emphasis on body image has historically been linked to gay males and is increasingly becoming a driving force in the lives of many gay men (particularly young gay men). In Australia and around the Western world, gay and mainstream media, iconography, pornography, advertising and community events celebrate and endorse a particular body shape to encapsulate the ideal for gay men. That image is mostly Caucasian, tall, lean, muscular and hairless. Duncan (2007) asserts this is best illustrated with the images and iconography that permeates and promotes the Sydney Gay and Lesbian Mardi Gras each year. These images are sustained and have been recycled over generations. This ideal (and the associated pressures to conform) to what constitutes 'attractiveness' and feelings of being worthy are difficult for young gay men to reject and as such, influences the way that feel about their bodies and themselves.

Duncan (2007) states that quantitative studies have been undertaken illustrating that gay men have a higher incidence of body dissatisfaction and disordered eating behaviours than heterosexual men, and a corresponding level of body dissatisfaction with heterosexual women. Many studies have identified that the cause of this dissatisfaction and disordered eating is the pressure to conform to the social construction of what constitutes attractiveness. Most men cannot physically conform to this ideal so begin to reject their own image and become increasingly dissatisfied with their bodies. As highlighted earlier, this dissatisfaction often leads to disordered eating, body dysmorphia, anorexia and other body image related issues (Duncan, 2007; Carpenter, 2004).

Body image issues (with accompanying health and psychological issues) and the subsequent health effects of obesity create significant risk factors linked to depression, anxiety, suicidality and chronic disease and morbidity (AIHW, 2004, Cannon, 2006).

Mental health issues and mental illness

In regards to mental health issues and illnesses, just under half of the LGBTI respondents in the Pitts, et al (2006) study had scores on at least one of the two criteria for major depressive episode. Even more alarming is the high level of suicidal ideation in respondents in the two weeks prior to the survey. As was seen with the general health scores, there was a decrease in depression scores for the older sample in this survey. The Figure 4 demonstrates the perceived mental health over the preceding fortnight for respondents to the Private Lives study (Pitts, et al, 2006).

Figure 4: Mental Health among LGBTI study respondent

	Males	Females	Total Sample
	%	%	%
Trouble falling asleep or sleeping too much	55.3	55.3	44.4
Feeling tired or having little energy	69.5	71.3	70.1
Poor appetite or over eating	40.7	43.0	41.7
Little interest or pleasure in doing things	34.7	27.9	32.4
Feeling down, depressed or hopeless	41.8	39.1	41.2
Feeling bad about yourself	35.3	39.1	37.0
Trouble concentrating	23.0	24.5	23.7
Change in activity levels	23.7	23.8	23.9
Feeling you would be better off dead	15.7	14.6	15.7

Source: Pitts, et al, (2006)

In addition, the Australian Bureau of Statistics in their 2007 survey of mental health and wellbeing by sexual orientation found that nationally, the SSA people sampled in the survey scored higher than their heterosexual counterparts when asked about mental health and mental illness across their lifetime (Figure 5).

Figure 5: 2007 Survey of Mental Health and Well-being Lifetime mental disorders by sexual orientation.

	Has a lifetime Affective Disorder	Has a lifetime Anxiety Disorder	Has a lifetime Substance Use Disorder	Has a lifetime Mental Disorder
Heterosexual	3.4	2.8	2.7	1.6
Homosexual/Bisexual	11	6.7	11.8	6.3
Total persons aged 16-85 years	3.3	2.6	2.6	1.6

Source: National Survey of Mental Health and Wellbeing: Summary of Results, 2007 Cat. No. 4326.0

Many of the psychological issues that affect SSA and gender diverse individuals stem from the homophobia that this population experiences. Constant reinforcing of the perception that being LGBTI is wrong or deviant leads to the fostering of internalised homophobia, and a sense of self loathing and marginalisation that can be the antecedent of many psychological and mental health issues including, anxiety, depression, deliberate self harm, suicide ideation and suicide (Williamson, 2000).

Feelings of connectedness to the community are known to be a protective factor for many people experiencing depression (Corboz, et al, 2009); in fact Maslow proposed that a sense of belonging to the community around you is a basic human need (Maslow, 1954, cited in McLaren, Jude and McLachlan, 2007). According to studies (e.g. Corboz, et al, 2008), those SSA and gender diverse people who reported feeling little to no sense of belonging or connectedness to the community around (and the research results from Pitt, et al, 2006, suggest a lack of environmental connectedness for LGBTI individuals), lead to the development of symptoms of depression. Similarly, McLaren, et al (2007), in their study linking social isolation, sexual orientation and depression, suggest that the reason why many gay men figure so highly in statistics for depression, anxiety and suicidality is that they are socially isolated within communities affected

by a prevailing heterosexual identity. These men can feel increasing externalised and internalised homophobia and loneliness, and a decreased sense of connectedness to the community around them.

While not all LGBTI individuals suffer from or experience depression and other mental illnesses, studies indicate that there is a significantly higher risk of developing depressive and anxiety related disorders in this group than in the rest of the population (Corboz, et al, 2008).

Suicide ideation and suicidality

For some time, researchers and advocates have argued that there is a significant disparity in the rates of attempted and successful suicide between the LGBTI community and the rest of the community. Through researching this phenomenon, there appear to be several unique elements (that this paper has already highlighted as contributing to other health and social issues) that interplay and intersect to place the LGBTI community, particularly young people identifying as LGBTI, at greater risk of suicide ideation and suicidality. Heteronormativity, heterosexism, homophobia, rejection, school and post school bullying, violence, isolation, negative self-image, and discrimination have all been cited as considerable contributing factors to explain increased suicidality within this community (Bagley & Tremblay, 1998, Hoogland & Pieterse, 2000, Remafedi, et al, 1998, Rivers, 2000, Nicholas and Howard, 1998, Henderson, 2006, Macdonald and Cooper, 1998 and Brown, 2002, cited in Cannon, 2006).

In the United Kingdom the incidence of suicide and deliberate self harm (DSH) amongst the LGBTI population increased steadily during the 1980s and 1990s, reaching its peak towards the end of the 1990s with a DSH rate of 400 in every 100,000 per annum (King, et al, 2008). Moreover, in 2006, increased suicidality within the LGB population was highlighted in the mainstream media in Northern Ireland with newspapers reporting that suicides had climbed by almost 50% from figures obtained in 2005 (Guardian, 2006, cited in Cannon, 2006). This report followed research in Northern Ireland over a three year period in which 190 young men were surveyed to ascertain the level of suicidality within the cohort. The research found that at least a quarter of the men had attempted suicide, two-thirds of them had seriously thought about taking their own lives, and four out of five who had had suicidal thoughts indicated that those thoughts were related to same sex attraction (Henderson, 2006, cited in Cannon, 2006).

In a recent, seminal work conducted by King, et al (2008), the results of their meta-analysis of 13,706 clinical research studies indicate that LGBTI individuals are at a much higher risk of suicidal behaviour, mental illnesses and substance abuse than their heterosexual counterparts. In fact, the accumulative studies showed that LGBTI people were four times more likely to attempt suicide than the rest of the community and 1.5 times more likely to experience depression, anxiety, alcohol and substance misuse than the rest of the population.

In South Australia, 26 out of the 184 HIV-positive MSM (14%) and a further 60 (17%) of HIV-negative participants in the Rogers, et al (2004) study answered 'yes' to a question about suicidal ideation in the two weeks prior to the survey. Moreover, one quarter of the study participants reported that they had attempted suicide at some point in their lives.

Studies have sought to explain this increased prevalence of suicidality amongst LGBTI populations, particularly in younger people. Kirby and Fraser (1997, cited in Brown, 2002: 4) cite increased incidences of suicidality are once again as a direct result of homophobia, heterosexism, fear of rejection, and discrimination, causing undue stress within an already tumultuous stage in the lives of LGBT youth in which they develop their sexual identity.

HIV

HIV research and responses have traditionally been centred on gay men, due to HIV disproportionately affecting this section of the population. Nationally, in 2004 – 2008, MSM accounted for 68% of newly diagnosed cases of HIV. In addition, among newly acquired cases of HIV infection, exposure to HIV was attributed to sex between men in 86% of cases; 1% was attributed to women who had had sex with heterosexual men who had injected drugs; 10% of cases were attributed to a history of heterosexual contact only; and 3% of cases were of undetermined origin. There have been previous concerted efforts by government to use health promotion to attempt to reduce the new cases of HIV (National Centre in HIV Epidemiology and Clinical Research, 2009). Many remember the campaigns that flooded the media in the early to mid 1980s. These promotions have disappeared from our screens and our consciousness, and as a result new cases of HIV are slowly on the increase across the country. Over the past decade the number of new HIV diagnoses in Australia increased by 38%, from 718 in 1999 to 995 in 2008. In South Australia the rate of new HIV cases increased from 1.4 in 1999 to 4.0 in 2006, but then the figure declined slightly to 3.0 in 2008 (National Centre in HIV Epidemiology and Clinical Research, 2009).

By September 2009, HIV infection was diagnosed in 39 individuals in South Australia, which demonstrates an increase of 9 individuals (23%) from the same period in 2008. As with all diagnoses for HIV, MSM are disproportionately represented within these statistics with over 73% of individuals reporting male to male sexual contact (STD Services, 2010).

These figures demonstrate that HIV infection is still a significant health issue in Australia and South Australia and cases of HIV are still overwhelmingly affecting MSM.

Jurisdictional analysis

This paper has highlighted a range of research that demonstrates that LGBTI populations experience poorer health outcomes than their heterosexual counterparts. Based upon this knowledge, in the same way that governments seek to address disparate experiences of health amongst other vulnerable groups, what (if any) specific LGBTI health related policies or plans are in place at the federal, state and territory levels to improve health outcomes for LGBTI populations? The following two pages contain a table of each jurisdiction's response to LGBTI health disparities and including the implementation of LGBTI health policies/plans.

Figure 6: Jurisdictional analysis of government responses to GLBTI health disparities

	National	SA	WA	NT	ACT
Responsible Minister/s:	None	None	None	None	None
Ministerial Advisory Structure and role:	None	None	None	None	None
Designated Departmental Unit:	None	None	None	None	None
Dedicated LGBTI Health Policy/Plan/Strategy:	None	None	None	None	None
Overview:	<p>In addition to their being no Minister, no advisory group, no designated departmental unit, no national strategy specifically on this population there is also no explicit inclusion of LGBTI populations within any Federal health strategy to date (with the exception of HIV related strategies in relation to gay and bisexual men).</p> <p>While there is an NGO Peak Body (the National LGBT Health Alliance), this organisation is currently funded through membership and fundraising.</p>	<p>There is currently no specific health policy in South Australia that aims to promote the health and wellbeing of the LGBTI community. Previously, a Gay and Lesbian Ministerial Advisory Committee was established to provide key advice and information to policy makers in regards to health needs within the LGBTI populations; however this was abolished when the new Health Act 2008 was introduced.</p>	<p>While there is no specific policy for SSA and gender diverse communities in Western Australia there is also currently no concerted effort by the sector to lobby for government to develop a policy or a plan (there have previously been efforts to lobby the government to provide a LGBTI policy or plan to no avail). However, the WAAC view the health and wellbeing of LGBTI as an important issue, and believe they are well placed to take the lead on this issue in the future.</p>	<p>The Northern Territory government has no specific health policy or plan for the LGBTI population. However, the NTAHC are currently negotiating funds for a project officer who can commit time to researching this issue.</p>	<p>Similarly, the ACT does not have a specific health policy for the LGBTI community, nor are funds allocated to such work. The AAC is seen as the key organisation involved in the health and wellbeing of GLBTI; however the funding that is provided by government does not make specific reference to this, except in the context of gay men's health and HIV. In addition, the AAC is pushing for the development of a MAC in the ACT</p>

	QLD	NSW	TAS	VIC
Responsible Minister/s:	None	None	None	The Hon. Lisa Neville MP
Ministerial Advisory Structure and role:	None	None	None	Ministerial Advisory Committee on Gay and Lesbian Health
Designated Departmental Unit:	None	None	None	Victorian Department of Human Services
Dedicated LGBTI Health Policy/Plan/Strategy:	None	None	None	Health and sexual diversity: A health and wellbeing action plan for GLBTI Victorians
Overview:	<p>There is also no LGBTI specific health policy these population groups in Queensland; however there is a 'LGBT Health Issues Working Group' within the Queensland Department of Health. This working group, which is co-chaired with the QAHC, brings together people from Queensland Health, non-government health services and the LGBTI community to discuss health issues particular to these populations.</p>	<p>While there is no specific LGBTI health policy, plan or MAC in New South Wales, ACON advocates for the inclusion of LGBTI health into various state and national policies. ACON are also advocating for the inclusion of a question to ascertain data surrounding sexuality in key national data collections and research documents.</p>	<p>While there is no specific health policy, plan or MAC for LGBTI populations in Tasmania, there is a LGBTI Reference Group that was established by the Department of Health and Human Services. The reference group was formed in December 1999 and consists of LGBTI representatives and professionals who work towards protecting and enhancing the health and wellbeing of LGBTI individuals (Department of Health and Human Services (DHHS), 2009). It is the job of this group to gather information on the health and wellbeing needs of LGBTI communities and feed them back to government.</p>	<p>Victoria has in place a health and wellbeing action plan for LGBTI Victorians, the first of its kind in Australia (Leonard, 2003). The action plan was developed by the MAC on Gay and Lesbian Health and aims to improve the health and wellbeing of this community by: making recommendations to government regarding major health concerns with the aim of improving the health and wellbeing of LGBTI populations (Leonard, 2003). This Action Plan doesn't recommend that new or LGBTI specific services are created, rather it argues for existing programs and services to be tailored to all Victorians. The Action Plan not only looks at health issues that are specifically related to stigma and discrimination that are experienced by LGBTI people, it also looks at other health issues affecting this community, including drug and alcohol use.</p> <p>There are four key recommendations that are proposed in this action plan:</p> <ul style="list-style-type: none"> • Establishing a Gay and Lesbian Health and Wellbeing Policy and Research Unit • Combating homophobia and transphobia and supporting diversity • Maximising access to mainstream services; and • LGBTI specific and specialist services <p>Each of these recommendations has a number of tasks that can be conducted to work towards improving the health and wellbeing of LGBTI Victorians.</p>

South Australian health strategies scan

This paper has established that South Australia has no specific policy or strategy to address the unequal experience of health for LGBTI populations — but are these populations already represented in current health related policies? The following provides a scan of current South Australian Health Department policies/plans/strategies/frameworks and how they relate to addressing LGBTI health inequities. Note that there is neither a youth specific health strategy, nor any policy document detailing the need to address general and LGBTI youth health disparities in South Australia.

Women's Health Action Plan 2010-2011

The South Australian Women's Health Policy was developed in 2005 to improve the health of women who have had the least access to appropriate health care and subsequently experience the worst health outcomes (Department of Health, 2009a). The plan lists the six key areas for inclusion in the 2010-2011 action plan and they were:

- Gender influences on health
- Sexual and reproductive health
- Women's safety and impact of violence on women's health
- Mental health
- Chronic disease prevention and self management
- Aboriginal women's health (Department of Health, 2009a).

From this policy, the Women's Health Action Plan was developed. The priority groups for all of the key initiatives and strategies of the 2010-2011 Action Plan were:

- Aboriginal women
- Rural women
- Women from culturally and linguistically diverse backgrounds, including refugee women
- Women with disabilities
- Women in prison
- Women who are socially and financially disadvantaged (Department of Health, 2009a).

While some of the initiatives could generically benefit SSA and gender diverse women, there is no explicit mention of SSA women or gender diverse populations as being vulnerable, experiencing a disparate level of health, or in any other capacity anywhere in the document. Similarly there is no mention of SSA women and related health inequities in the 2005, SA Women's Health Policy that underpins this action plan (Department of Health, 2005).

South Australian Men's Health Strategic Framework 2008-2012

The South Australian Men's Health Strategic Framework is linked at a national level to the Australian Better Health Initiative, and at a state level to the *2007 South Australian Strategic Plan, the South Australian Aboriginal Health Policy 2007* and the *Cultural Respect Framework for Aboriginal and Torres Strait Islander people* (Department of Health, 2008b).

The framework has been designed to support the plans identified above and to engender better health outcomes for South Australian men. Item 1.2 of the objectives and key directions section mentions that

"The purpose of the strategic framework is to support state and national policies or programs that address differences in health and wellbeing associated with Aboriginality, ethnicity, gender, socio-economic status, age, disability, sexuality and geographic location" (Department of Health, 2008b).

Issues of sexuality (or gender diversity) in regards to inequities in health are not mentioned anywhere else in the framework, nor are they mentioned in any companion document, including the underpinning national document (the Australian Better Health Initiative).

The Chronic Disease Action Plan for South Australia

The Chronic Disease Action Plan (2009c) outlines the Department of Health's plan to address chronic disease across the state. The plan details evidence and associated actions to prioritise prevention and early intervention strategies to address increasing preventable chronic disease in South Australia. The government hopes that the plan will achieve the following three aims:

- Prevent chronic disease, by reducing risk associated with biomedical and lifestyle factors
- Detect disease and risk of disease early and intervene effectively
- Manage existing disease effectively and proactively (Department of Health, 2009c).

The Chronic Disease Plan for South Australia, 2009-2018 stipulates that the approach of the plan will:

"...involve the promotion of good health and wellbeing for the population as a whole, with a particular focus on the needs of groups at risk of, or with, established chronic disease"
(Department of Health, 2009c).

The plan suggests that 'vulnerable' populations in South Australia include culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander communities, and rural and remote populations. There is no mention of LGBTI communities nor are these populations considered 'at risk' or vulnerable, or in need of a secondary prevention and early intervention focus (Department of Health, 2009c).

SA Health Disability Action Plan

The South Australian Health Disability Action Plan (2008a) provides recognition of the rights of people with disabilities to have similar opportunities as other members of the community to participate fully within their communities. The plan provides guidelines to the Department of Health to:

"Support access and equity for all South Australians with Disabilities and prevent discrimination on the basis of age, gender, sexuality, race, ethnicity, religion, language and culture"
(Department of Health, 2008a).

Akin to the *South Australian Men's Health Strategic Framework 2008-2012*, sexuality is mentioned within the guidelines of the plan, but this is not expanded upon and issues of sexuality and disparate health outcomes are not included anywhere else in the document.

Improving with Age: our ageing plan for South Australia / the State of Ageing in South Australia

Within the *Improving with Age* (2006) report, the government suggests that with our rapidly ageing population a swift, appropriate and decisive policy response is necessary to address the burgeoning health needs of our ageing baby boomer population. The *Improving with Age* (2006) plan sets out priority actions in which the government seeks to provide a comprehensive plan that addresses the 'diverse needs' of older people in the years to come. In fact, the document makes the following reference to the disparate nature of this group:

"No one size fits all when it comes to delivery of services. We must tailor our responses to the active, articulate baby boomers who, at one end of the spectrum, are now entering their sixties, and also those frail, elderly who may be suffering ill health and social isolation (Government of South Australia, 2006)".

The report then expands upon references to 'diverse needs' within the ageing population by detailing the needs of Aboriginal and Torres Strait Islander populations, multicultural communities and people with disabilities. The term 'diverse' unfortunately is not expanded to encompass those who are further marginalised from the heterosexual population and experience an unequal level of health and wellbeing as well as an unequal and often discriminatory experience within services and authorities (LGBT Health Alliance, 2009b).

Similarly, the State of Ageing in South Australia (2009) report researches the current issues involved with ageing in South Australia and makes projections regarding what an ageing population will mean to South Australia into the future. Again, the disparate experience of health and wellbeing for older Aboriginal and Torres Strait Islander and CALD populations are presented in some detail but the issues affecting the health and wellbeing of LGBTI populations, their specific issues/needs, their poor outcomes of health, and potential strategies for the future are not presented.

Health Service Framework for Older People 2009-2016

Likewise, the Department of Health suggest that the South Australia's Health Service Framework for Older People 2009-2016 has been designed to plan for the increasing demand that our ageing population will have on our healthcare system in the future (Department of Health, 2009b).

As with most of the other policies/plans/strategies/frameworks featured within this paper, the Health Service Framework for Older People 2009-2016 (Department of Health, 2009b) makes specific mention of Aboriginal and Torres Strait Islander and CALD populations as being vulnerable groups in regards to positive health outcomes, and provides strategies to address the related issues. Again this framework fails to recognise LGBTI populations as being similarly vulnerable and having similar specific needs (Department of Health, 2009b).

In sum, subsequent to this review of South Australian health-related policies it is clear that LGBTI populations remain virtually invisible within government strategies and plans that have been designed to increase better health outcomes for all vulnerable populations. While it is acknowledged that LGBTI populations could benefit generically from some of these policies and plans in some form, unless there are specific plans of action on the sociological, psychological and physiological contributors to poor health amongst this population, the current policies will do little to redress these issues (Bassett et al., 2002).

The way forward

Ultimately it can be seen that the health of the LGBTI population has remained relatively ignored within the public health system across the country (Bassett et al., 2002), despite evidence of a growing need to address the poor health and wellbeing that this group experience. Apart from Victoria, no other state or territory, nor the federal government, has included references to LGBTI health and wellbeing within health policies or created comprehensive health plans to improve health outcomes for this group. As the jurisdictional analysis showed, there has been no policy, plan or strategy from the South Australian Government in regards to these health disparities, and the only mechanism that the government had to gather information and seek expert advice from the LGBTI population was abolished in 2008 with the introduction of the new Health Act. This begs the question: in the wake of the findings of the research shown in this report, how does the South Australian Government propose to appropriately address the clear health disparities within the LGBTI population when their only consultative mechanism to assist them in developing appropriate policy, strategies and plans has been dismantled?

This paper has made a series of recommendations, informed by the available research, that seek to redress the current situation for many within the LGBTI population in South Australia in regards to their health and wellbeing. To work towards ameliorating health disparities between the LGBTI community and wider society, decision makers will need to focus on the following areas:

Consultation with the LGBTI community

The government needs to re-establish the connection to the LGBTI community through a range of consultative mechanisms, including the reformation of the recently abolished Gay and Lesbian Ministerial Advisory Council. This would bring South Australian policy in line with the current Victorian LGBTI health plan and the Social Inclusion principles espoused by the South Australian Social Inclusion Unit. Consultation with LGBTI populations would greatly assist government in developing informed, inclusive, appropriate and targeted health related policy, plans and strategies.

The development of an LGBTI health policy/plan/strategy

To minimise the health disparities experienced by this population, a comprehensive health plan for LGBTI populations needs to be developed and implemented. Within the plan, four key areas need to be addressed. These areas are:

- assess the need in the community
- ensure access to health services and programs
- promote policies to address and reduce inequalities
- incorporate LGBTI health needs into existing health services and programs (Bassett et al., 2002).

Without incorporating these elements, it will be difficult to adequately address the health issues affecting this community.

Research into health disparities in LGBTI populations

The ability of policy makers to develop health policy in order to provide appropriate services to identified groups depends upon the research and data that is available to inform this process. LGBTI populations have received little empirical attention and as such, reliable data that provides a definitive picture of the state of health for non-heterosexual communities does not exist at this stage (Gay and Lesbian Medical Association, 2001). Thus, there is an urgent need for further research to test larger cohorts of the LGB community, with an increased focus on the health and wellbeing of transgender and intersex individuals. This research would assist in identifying need within the community, identify strategies to address issues and to develop and form the basis of a LGBTI health and wellbeing plan for South Australia.

Prevention and Early Intervention

As part of the LGBTI health policy, a much greater focus by government on preventing illness needs to occur to increase these statistics. Through an exploration of how negative social environments increase the incidences of illness, more appropriate prevention and early intervention strategies can be developed in line with public health model principles that can reduce negative experiences of health by LGBTI populations.

While the data presented within this report demonstrates a clear and urgent need for policy makers to act on addressing health disparities within this marginalised population, it is acknowledged that there are several challenges to overcome if current and historical trends in this group's experience of health is to be reversed. Discrimination and heterosexism felt by generations has resulted in many LGBTI individuals being either unwilling or unable to be involved with government to develop social and health policy or strategies. Therefore, government needs to ensure that mechanisms such as MACs and other collaborations with LGBTI populations are maintained in order to provide a voice for this marginalised and often disparate group, and to provide the most appropriate information and insight into LGBTI health issues (LGBT Health Alliance, 2009).

Pertinently, both South Australian and Commonwealth Governments are embracing a 'social inclusion' agenda in which all within society should be able to feel included and to participate fully in their communities and wider society. Addressing health disparities amongst this marginalised and diverse group is the first step in improving health outcomes and including the LGBTI population within social, political, educational and health care systems.

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